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research article

Measuring the long-term support needs of adult service-users at Saint Mary's Sexual Assault Referral Centre

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This article outlines a feasibility study to investigate the potential of measuring the support needs of adult service users of a sexual assault referral centre (SARC). A self-completion questionnaire was designed with the aim of capturing these needs, as well as how they change over time and with support provided. The questionnaire underwent revisions following consultations with organisations representing survivors. Survivors of sexual assault who attended Saint Mary's SARC were invited to complete a questionnaire at three-month intervals after their first visit to the SARC. The process of recruitment was necessarily complex, potentially compounding the issue of low response: only 18 participants completed the questionnaire at the first time point, and only nine of those completed a follow-up questionnaire three months later. The responses demonstrated the value of connecting information gathered by forensic physicians with a social survey. This study design reduced the potential of re-traumatisation by avoiding the need for participants to revisit any details of the alleged assault. More work is required to understand what methods will help establish an enduring commitment to completing follow-up questionnaires from a population dealing with the aftermath of trauma.

Key words sexual assault • sexual violence • rape • long term needs • trauma • mental health

Key messages

- A self-completion, online questionnaire, combined with existing datasets (for example, forensic medical examination records) has the potential to be an efficient way of collecting data about the long-term needs of SARC service users, that minimises the distress caused by asking them to recount traumatic experiences.

- The questionnaire we designed is now freely available online and can be used by service providers seeking to gather information about those for whom they provide support services.

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Introduction

The Crime Survey for England and Wales (CSEW) estimates that, for the year ending March 2022, 3 per cent of adults aged 16 to 59 years old had experienced sexual assault or attempted sexual assault in the previous year (ONS, 2023). Sexual violence can devastate victims. As well as dealing with the psychological trauma of abuse (Kilpatrick et al, 1981; Briere et al, 1995; Elliott et al, 2004; Elkit and Christiensen, 2010; Stermac et al, 2014), some have to contend with injuries (Bowyer and Dalton, 2005), unwanted pregnancies (Holmes et al, 1996), sexually transmitted infections (Sena et al, 2015), sexual dysfunction (Ellis et al, 1981; Bartoi and Kinder, 1998; Feldman-Summers et al, 1979; Orlando and Koss, 1983; Becker et al, 1986; Burgess and Holstrom, 1979; Letourneau, 1996), and the inability to work (Loya, 2014). Effects can be mutually compounding. For example, life disturbances from the attack – such as relationship breakdown, financial insecurity, and disrupted periods of study and employment – are made worse as the psychological trauma from the assault diminishes the survivors' capacity to cope with them (Herman, 2015; Hydén et al, 2016).

For some, negative impacts are resolved in the months following an assault, while for others they endure over the long term. Sexual dysfunction and mental health challenges – including guilt, anger, anxiety, depression, sleep disturbance and symptoms of trauma – have been found among some survivors several years following an assault (Ellis et al, 1981; Burgess and Holmstrom, 1979; Kilpatrick et al, 1981; Krug et al, 2002; Elliot et al, 2004; Stermac et al, 2014). Other key long-term impacts include repeat victimisation and the fear of it – over half of all victims have been previously sexually assaulted (ONS, 2018), with victims known to the perpetrator being at particular risk. In addition, victims who support prosecutions against those who assaulted them can face several years of retraumatisation, particularly when they are asked to repeatedly recount what happened in order to provide evidence. This can take a significant financial and psychological toll, especially when (as is true in nearly all cases) the legal process does not yield a conviction; in 2019/20, only 0.8 per cent of rapes/attempted rapes reported to the police resulted in a conviction (Centre for Women's Justice, 2020). Indeed, the conviction rate for rape and sexual assault in England and Wales is so low that some commentators have equated it with the decriminalisation of sexual violence (Walker et al, 2021).

In recent years, the British government has emphasised a requirement to provide for the longer-term needs of sexual assault survivors, rather than focusing mainly on their short-term needs. In 2018, NHS England (2018) reoriented priorities for sexual assault services so that they focused on 'lifelong care' for victims and survivors. Sexual assault referral centres (SARCs) were tasked with providing medium- and long-term support of survivors. SARCs – that are scattered throughout the UK and offer a range of support to sexual assault survivors – have demonstrated competence at providing the medical support needed in the immediate aftermath of sexual assaults (Majeed-Ariss et al, 2019; Massey et al, 2019), but they have not always been able to provide the social support most survivors need over the longer term. Instead, most follow-up support for adult sexual assault survivors is typically provided by independent sexual violence advisors (ISVAs) and voluntary sector organisations, whose funding is insecure. Waiting lists for therapy can be long, while access to the legal support some victims need is variable.

In turn, failures in the provision of long-term support for survivors contributes to poor conviction rates for perpetrators. As the government's own 'End-to-end rape review report on findings and actions' confirmed, one of the main reasons for the low conviction rate in rape cases is that most victims (around 57%) decide against supporting a prosecution, often fearing that they will be disbelieved or judged, and that the process will impact negatively on their mental health (HM Government, 2021). A 2021 survey of victims of domestic and sexual violence who were attending family, magistrates, or crown courts, found that over 70 per cent of these victims were receiving no specific support at all by that stage (SafeLives and Domestic Abuse Commissioner, 2021). Research suggests that the long-term effects of sexual assault are also shaped to some degree by the availability of high-quality support. Disclosing the assault, either formally to a public service, or informally to a friend or family member, generally decreases the symptoms of trauma (Ullman and Peter-Hagene, 2014). However, if the service or individual in which the victim confides reacts negatively, blames the victim, or forces them to go to the police, disclosure cases can compound symptoms of trauma (Campbell et al, 2001). In summary, research is needed that captures the long-term needs of SARC service users. This research ought to capture how these needs are shaped, both by the nature of the alleged assault, and ongoing engagement with, or disengagement from, sources of formal and informal support.

This study

This project sought to do just this. Its aim was to investigate the feasibility of measuring the long-term needs of adult SARC service users, and how these needs related both to the abuse they had experienced, and their experiences with potential sources of support. In trying to capture this relationship between trauma, support needs and support received – we sought to demonstrate the need for services for victims, how these services could be improved, and the extent to which such improvements might secure better criminal justice outcomes. There are few longitudinal studies of sexual assault survivors' long-term needs, and most existing research focuses on issues such as sexual dysfunction and mental health challenges (Krug et al, 2002; Elliot et al, 2004; Stermac et al, 2014). The feasibility study reported here is a contribution towards developing a more encompassing longitudinal study of SARC service users' long-term needs through the development and piloting of an online survey.

Questionnaire design

The feasibility study adopted a quantitative and longitudinal approach to measurement. This was to make possible the collection of data from larger samples of participants than qualitative interviews would allow, using a format that was sensitive to the needs of those concerned about their privacy and at risk of retraumatisation. Ahead of a successful application (awarded in 2020) to the Violence Abuse Mental Health Network (VAHMN), in 2018 we secured a small grant from the University of Manchester that enabled us to conduct an audit of questions posed to sexual assault victims in the International Crime Victims Survey and the Crime Survey of England and Wales. We compared these questions with the kinds of data we knew to be routinely collected and coded when victims attend St Mary's SARC. This helped us to formulate a short battery of questions that we were able to review with professionals at St Mary's SARC.

It took approximately two years to develop a self-completion online questionnaire. Service users of Saint Mary's SARC were to be invited to complete the questionnaire at three time points: three, six and 12 months following the report of a sexual assault and subsequent attendance for a forensic medical examination (though for the purpose of this feasibility study, participants were only invited to complete the questionnaire at three and six months). The questionnaire took approximately 20 minutes to complete and mainly consisted of tick box responses, organised across three sections. Section one asked the participant for some key demographic information. Section two asked about the formal types of support they had received following their alleged assault, including which services they used (for example, police, doctors, accident and emergency, sexual health clinics, substance use support, Rape Crisis, Women's Aid and refuges, counselling and mental health support, charities, solicitors and legal advice, the courts, victim and witness support, and helplines). It also asked whom they had told about the alleged assault (for example, family, friends, partner, children, colleagues, employer, tutors), and how satisfied they were, using a five-point scale for each source of support they received. The support section concluded by asking participants about the type of support participants would like to receive given their current needs. Here participants could rate the importance (or otherwise) of 15 forms of support which included: a restraining order against the perpetrator; legal support during the court process; information about how their case was proceeding in the criminal justice system; psychological support; the chance to listen to other victims; the chance to share experiences with others; care of children while attending support services or criminal justice; financial support to cover expenses related to the assault; help to come back into work or studies; language support; help with dealing with the police; additional security and access to emergency services; support with stopping further online, text or phone harassment; support with stopping further verbal or emotional abuse; and support with stopping further physical or sexual harassment. Finally, section three measured participants' wellbeing using validated inventories of depression (Kroenke et al, 2001), anxiety (Spitzer et al, 2006), post-traumatic stress disorder (PTSD) and complex PTSD (Cloitre et al, 2018). With a limited budget, we were only able to make the survey and its supporting documentation in English.

The online questionnaire was preceded by a consent form, which (among other things) asked for the participant's consent to have their survey responses linked with data from their SARC record so that some socio-demographic information (for example, age, sex, ethnicity) and information about the alleged assault (for example, the nature of the assault, the service user's relationship to the alleged perpetrator/s) did not have to be collected again. The questionnaire was designed in such a way that if a participant did not consent to data linkage, they were asked additional questions about their socio-demographic characteristics, but not the alleged assault. Once the main sections of the questionnaire were completed, participants indicated (via a yes/no response) if they were happy to be contacted again to complete a further questionnaire in three months' time.

The questionnaire needed to be a reliable and valid measure of participants' long-term needs, robust enough to speak compellingly to service commissioners, but also sensitive to participants' rights to privacy. Thus, before distributing the questionnaire – which had been designed by the multi-disciplinary project team consisting of a criminologist, forensic physician, clinical psychologist, social statistician, sexual assault survivor, sexual violence researcher and former ISVA – consultations were conducted with five organisations who provided support services to survivors of sexual assault. Some of these organisations were able to solicit views on the project's proposed methodology with sexual assault survivors themselves. Via these consultations, feedback was sought about the specific questions asked, as well as the online self-completion methodology and the acceptability of asking if questionnaire responses can be linked with medical records. Much of this consultation happened remotely as it coincided with the UK's first COVID-19 lockdown in 2020.

Feedback regarding the questionnaire was largely positive in terms of the project's ambitions and method. However, six key suggestions were made, enabling the refinement of the survey. First, while the online self-completion nature of the questionnaire was welcomed, the possible need for paper copies among participants who were not computer literate or did not have internet access was raised. It was also suggested that invitations to participate be sent via SMS as well as email to maximise uptake. Second, there was strong support for the idea of linking data from the survey with the SARC forensic medical records to reduce demands on participants. However, it was suggested that a clearer explanation regarding this linkage be given to participants, especially regarding how personal identification numbers (PINs) would be secured and how this would maintain confidentiality. Third, some of those consulted expressed concern about the questionnaire's length, while also wanting new items added to it regarding substance use, self-medication, and the impacts of sexual assault on sexual desire and/or intimacy. Fifth, there was an understanding of the need to ask questions of a personal nature, but some of those consulted recommended that a call-back service be offered at the end of the questionnaire in case any participant was upset by completing the survey. Finally, some of those consulted suggested that the questionnaire was not accessible to people with learning disabilities. They explained that to do this appropriately a separate project with a different methodology would be needed. Once this feedback was implemented, the questionnaire, participant information sheets, and informed consent forms were submitted to the NHS IRAS (281719) committee for ethical approval, which was granted after incorporating further revisions, in October 2020.

Recruitment process and sample

The sample of participants was drawn from the client base of Saint Mary's SARC: a SARC located in Manchester, UK that provides an integrated forensic medical, ISVA and counselling service. To recruit participants, crisis workers at the SARC asked all service users who attended for a forensic medical examination following an alleged assault, if they were willing to be contacted by a researcher about completing a questionnaire. Members of the research team trained the crisis workers on how to ask for consent, giving the crisis workers detailed information about the project both via an online meeting and a video that was made available on the SARC website.

Three months after a service user consented to be contacted, they received an invitation email from the research team. Included in the email was a unique PIN and instructions that it should be inputted in the questionnaire so that it could be used to link their responses to their SARC forensic medical record. Attached to the email was a detailed participant information sheet. To ensure potential participants had time to reflect on whether to participate in the study, the hyperlink to the consent form and survey was sent to them 24 hours later. Participants were only given access to the survey once the consent form was completed and signed (online). Upon completion of the survey, participants were offered a £20 shopping voucher to compensate for their time. Participants who had requested a paper version of the questionnaire were sent a hard copy of the email invitation to the study, followed by the participant information sheet, consent form, questionnaire, and a stamped addressed envelope for its return.

Results and discussion

As this was a feasibility study the key results pertain to the study design. Was the questionnaire designed and delivered in a way that makes it feasible to measure the long-term needs of SARC service users? The answer to this question is mixed: recruitment to the study was limited, but the questionnaire worked well. The study demonstrated that data linkage with SARC forensic medical records is feasible.

Recruitment

The study aimed to achieve a sample of 50 participants. Recruitment took place between February and August 2021, during which time 348 adults attended the SARC for a forensic medical examination. Of these, 95 (27%) consented to be contacted in three months' time to learn more about the research project. In some cases, service users were not approached for consent to contact – reasons for this included the service user was not an English speaker or had low levels of literacy, had no access to telephone or the internet, or were deemed to be too unwell by their crisis worker. Of the 95 service users who consented to be contacted, 18 (19%), completed a questionnaire at the three-month follow-up. Only nine of these 18 completed a questionnaire at the six month follow up. Due to small numbers, the 12-month follow-up questionnaire was abandoned.

The data collection of this study coincided with the COVID-19 pandemic, which included prolonged periods in lockdown. A recent study reported that while overall attendance at Saint Mary's SARC decreased during the pandemic, significantly more South-Asian adults, adults aged over 57 years old, and adults who had met their alleged perpetrator online attended the service during the same period (Majeed-Ariss et al, 2023). The reduced overall attendance may have contributed to the low response, though it is likely other features of the project's methodology were also implicated.

First, there was a three-month lapse between consent to contact being requested by SARC crisis workers (just after the forensic medical examination had been completed) and the participant being approached by the study team. In the absence of any continued dialogue about the study, it seems likely that some of those who agreed to consider participating lost interest or simply could not remember what the study was about, having only been made aware of the study in the immediate aftermath of trauma. Second, the way in which prospective participants were contacted to take part in the survey did not lend itself to engaging those who had consented to contact in a discussion about why the study was important. Due to ethical requirements, when a participant had given their consent to be contacted, they could only request that the research team email, text, or write to them. The supporting Participant Information Sheet was four pages long – and so time-consuming to consider – and explained the process by which a PIN would be used to pseudonymise their data, as well as relevant electronic data storage processes and data protection legislation. Some potential participants who might have been willing to complete the survey upon receipt of the participant information sheet possibly lost interest or changed their minds before they received the survey, via email or post.

Data linkage

These methodological issues aside, those who proceeded to complete the questionnaire did provide valuable information. The process of combining results from the self-completion questionnaire with data from the SARC records of participants was effective. All but two of the participants consented to having their data linked in this way. This enabled us to collect important data without asking respondents to have to recall the details of the alleged assault. While a call back support service was offered to all those who completed the questionnaire, only one person used this service.

Questionnaire design

Before the survey's launch, it was questioned whether the length and complexity of the questionnaire would prove prohibitive. However, all but one participant who started a questionnaire completed it fully. The answer options provided in each question seemed to meet the requirements of all participants. There is always a risk with questionnaires with predominantly closed questions that important response options are excluded. In the questions asking about participant needs and services used there were options for the participants to specify 'other', but these were rarely used. This suggests the list provided was a comprehensive one. Open text boxes were included in the questionnaire so that participants could add any additional information which they thought the questions precluded, but these boxes were only ever used to confirm the importance of the study and the participant's inclusion in it.

Initial results with the Rasch rating scale model (Wolfe and Smith, 2007; Bond and Fox, 2015) proved promising in measuring aspects of survivors' long-term needs (for example, service satisfaction, wellbeing experience). However, with a small number of respondents at this pilot stage, assessments of the validity of the measures created were inconclusive. We have nevertheless made the tool publicly available to organisations looking to measure the long-term needs of sexual assault survivors. The questionnaire is downloadable here: https://www.stmaryscentre.org/professionals/research/measuring-long-term-support-needs

Substantive findings

Based on the socio-demographic data provided via the questionnaire and SARC forensic medical record, it was possible to compare the characteristics of the study sample with that of the wider SARC client base to explore whether the recruitment process was able to provide a representative survey sample. As we expected, within the survey sample EAL (English as an additional language) individuals and those with learning disabilities were underrepresented. The study sample (age range 18–54) was generally younger than the population of adult clients who attended St Mary's SARC that year (age range 18–82). This is perhaps due to poorer internet access or digital literacy among those in the older age bracket. There were also no men (who otherwise represent 6.6 per cent of the SARC's adult client base) and fewer participants from minority ethnic groups in the survey sample. By way of contrast, students were overrepresented in the survey sample, as were people who disclosed histories of mental health problems prior to being sexually assaulted. There were no significant discrepancies between those in the survey sample and those in the wider SARC adult client base in terms of the type of alleged assault and relationship to alleged perpetrator.

With only 18 responses to the first survey (three months following the alleged assault), and nine follow-up responses (three months later), this study does not offer reliable findings about the long-term needs of SARC service users. However, the data collected has been analysed, offering tentative insights into this important topic.

First, responses to the questionnaire underline how important informal emotional and professional psychological support is to SARC service users several months following an alleged assault. Tables 1 and 2 show the levels of anxiety and depression reported by the survey respondents at both three and six months. At three months, almost 40 per cent reported severe anxiety or depression, with 33 per cent reporting both. Levels of severe anxiety were even higher at six months (44%), though levels of severe depression had reduced to 22 per cent. Of course, we do not know the extent to which these levels of anxiety and depression existed prior to the alleged assault. Tracking individuals at three and six months revealed some alleviation of anxiety and depression over time, though not for everyone. Of those who completed the survey

Table 1: Level of anxiety reported by survey sample at three and six months following an alleged sexual assault

	Three months post-assault	Six months post-assault
None	11% (2)	11% (1)
Mild	17% (3)	33% (3)
Moderate	33% (6)	11% (1)
Severe	39% (7)	44% (4)
Total	100% (18)	100% (9)

Table 2: Level of depression reported by survey sample at three and six months following an alleged sexual assault

	Three months post-assault	Six months post-assault
None	0% (0)	22% (2)
Mild	17% (3)	11% (1)
Moderate	17% (3)	11% (1)
Moderate-Severe	28% (5)	33% (3)
Severe	39% (7)	22% (2)
Total	100% (18)	100% (9)

at both time points, 67 per cent reported a lower level of depression at six months post-assault compared to three months earlier; 22 per cent reported a lower level of anxiety. Meanwhile, 22 per cent reported higher levels of depression over time, while 33 per cent reported a higher level of anxiety. Similarly, 67 per cent of participants met the clinical threshold for a diagnosis of complex PTSD three months following the alleged assault; 56 per cent met this threshold three months later.

Three months following the assault, almost 40 per cent of respondents described 'support with stopping further physical or sexual harassment' as essential. This was unsurprising given that in our sample half of the participants had reported being sexually assaulted more than once: just over a fifth reported at least ten previous assaults. Similarly, around a third viewed it as essential to get a restraining order against the alleged perpetrator, and slightly lesser percentages wanted support with stopping non-physical abuse (that is, online, verbal, or emotional abuse). These figures were slightly lower six months following the assault.

When asked about the effects of the alleged assault, the most often cited from those listed in the survey was 'fear of being assaulted again' with 78 per cent claiming this affected them 'a lot' three months following the alleged assault. This was followed by anger and difficulties with sexual intimacy, with 71 per cent and 63 per cent respectively claiming these issues affected them 'a lot'. Other common effects reported were concerns about appearance, avoidance of travelling alone, fear of private information being shared, avoidance of family and friends, problems with physical health and lack of interest in sex. The percentage of respondents reporting these as issues decreased by the six-month follow-up, except for fear of being assaulted again, which remained at 78 per cent.

As Table 3 reveals, participants' support needs mirrored some of these shifting concerns. Three months after the assault, 'emotional/other support during the court process' was most likely to be regarded by participants as essential (72%). Two other needs related to support during the legal process that were listed ('information about my case in the criminal justice system' and 'legal support during the court process') were third and fourth most likely to be regarded as essential three months after the assault but were much less likely to be regarded as important at six months. Conversely, 'psychological support (therapy/counselling)' was the second most likely item to be viewed as 'essential' three months following an assault, and the most likely item to be regarded as essential six months following the assault. In short, survivors' needs for emotional support endured while they were coming to realise that a prosecution was not imminent.

Table 3: Potential support needs of survivors of sexual assault, and how important they are viewed by survivors three and six months following an alleged sexual assault (six-month figure in brackets)

	Essential	Very important	Quite important	Unimportant
Emotional/other support during the court process	72% (25%)	6% (0%)	0% (13%)	22% (63%)
Psychological support (therapy/counselling)	67% (67%)	11% (11%)	22% (11%)	0% (11%)
Information about my case in the criminal justice system	65% (25%)	6% (13%)	0% (13%)	29% (50%)
Legal support during the court process	50% (22%)	17% (11%)	11% (11%)	22% (56%)
Help with dealing with the police	47% (22%)	12% (11%)	12% (0%)	29% (67%)
Support with stopping further physical or sexual harassment	39% (33%)	6% (22%)	17% (0%)	39% (44%)
The chance to listen to other victims	33% (44%)	22% (11%)	33% (44%)	11% (0%)
A restraining order against the alleged perpetrator(s)	35% (22%)	12% (0%)	18% (33%)	35% (44%)
Support with stopping further online, text or phone harassment	33% (22%)	11% (11%)	11% (11%)	44% (56%)
Support with stopping further verbal or emotional abuse	26% (38%)	21% (13%)	11% (13%)	42% (38%)
Help to come back into work or studies	28% (44%)	17% (0%)	28% (22%)	28% (33%)
Personal and/or home security	28% (22%)	11% (0%)	17% (33%)	44% (44%)
The chance to share experiences with others	22% (44%)	28% (11%)	22% (44%)	28% (0%)
Financial support to cover expenses related to the alleged assault	22% (33%)	11% (11%)	11% (0%)	56% (56%)
Language support (translation services)	12% (11%)	0% (0%)	0% (11%)	88% (78%)
Care of children while attending support services or criminal justice	6% (33%)	18% (11%)	0% (0%)	76% (56%)

Conclusion

The conclusions that can be drawn from the substantive findings of the survey are limited due to the small sample size. However, there are some key methodological findings from this feasibility study. The first is that a self-completion, online questionnaire, combined with existing datasets (for example, forensic medical examination records) has the potential to be an efficient way of collecting data about the long-term needs of SARC service users that minimises the distress caused by asking them to recount traumatic experiences. The questionnaire we designed is now freely available online and can be used by service providers seeking to gather information about those for whom they provide support services. We have shown it to be a broad-ranging measure of participants' needs, participants' engagement and satisfaction with formal and informal sources of support, and participants' mental wellbeing. Engagement from participants revealed the questionnaire to be an appropriate length, not too complex – at least for those who are English literate without learning disability – and generally not upsetting to complete.

The study revealed the willingness of many SARC service users to participate in research, with 27 per cent of those asked agreeing initially to be contacted by a researcher. However, the study also revealed significant obstacles in converting consent to contact into participation. Embedding a researcher in the recruitment site (the SARC) to request the consent to contact (rather than a crisis worker doing it) could have helped potential participants feel more connected to the project, as could working more closely alongside the Independent Sexual Assault Advisers who typically make contact with victims in the days after a forensic medical examination. Alternatively, face-to-face meetings arranged at the SARC three months later, so the researcher could share details of the questionnaire and help administer it, probably would have helped recruit participants who were put off by the lengthy paperwork and/or online aspects of participating. Of course, both changes would have required substantial additional funding and ethical approval.

Finally, it is probably necessary to simplify the communication from the researcher to the potential participant when administering the questionnaire, though this is difficult with a population whose privacy must be fully protected by service providers. While ethics panels and research protocols exist to protect research participants from harm, if the processes required to participate in a study are so arduous that they exclude some people from taking part – denying them a voice in the research – the process becomes counter-productive. Our experience of trying to recruit participants from a largely hidden group, via an otherwise successful questionnaire, is instructive in this regard.

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Conflicts of interest

Professor Cath White was formally the Clinical Director of Saint Mary's SARC and Rabiya Majeed-Ariss is employed as a research fellow at Saint Mary's SARC. The other authors have no conflicts of interest.

References

Bartoi, M.G. and Kinder, B.N. (1998) Effects of child and adult sexual abuse on adult sexuality, *Journal of Sex & Marital Therapy*, 24(2): 75–90.

Becker, J.V., Skinner, L.J., Abel, G.G. and Cichon, J. (1986) Level of post assault sexual functioning in rape and incest victims, *Archives of Sexual Behaviour*, 15(1): 37–49. doi: 10.1007/BF01542303

Bond, T. and Fox, T. (2015) *Applying the Rasch Model: Fundamental Measurement in the Human Sciences*, 3rd edn, New York: Routledge.

Bowyer, L. and Dalton, M.E. (2005) Female victims of rape and their genital injuries, *Obstetrics & Gynaecology*, 104(5): 617–20. doi: 10.1111/j.1471-0528.1997.tb11543.x

Briere, J. and Runtz, M. (1991) The long-term effects of sexual abuse: a review and synthesis, *New Directions for Mental Health Services*, 51: 3–13. doi: 10.1002/yd.23319915103

Briere, J., Elliott, D.M., Harris, K. and Cotman, A. (1995) Trauma symptom inventory: psychometrics and association with childhood and adult victimization in clinical samples, *Journal of Interpersonal Violence*, 10(4): 387–401. doi: 10.1177/088626095010004001

Burgess, A. and Holmstrom, L. (1979) Rape: sexual disruption and recovery, *American Journal of Orthopsychiatry*, 49(4): 648–57. doi: 10.1111/j.1939-0025.1979.tb02650.x

Cahill, C., Llewelyn, S.P. and Pearson, C. (1991) Long-term effects of sexual abuse which occurred in childhood: a review, *The British Journal of Clinical Psychology*, 30(2): 117–30. doi: 10.1111/j.2044-8260.1991.tb00927.x

Campbell, R., Wasco, S.M., Ahrens, C.E., Sefl, T. and Barnes, H.E. (2001) Preventing the 'second rape': rape survivors' experiences with community service providers, *Journal of Interpersonal Violence*, 16(12): 1239–59. doi: 10.1177/088626001016012002

Centre for Women's Justice (2020) *Super-complaint by Centre for Women's Justice: Failure to Address Police Perpetrated Domestic Abuse,* 9 March 2020, https://static1.squarespace.com/static/5aa98420f2e6b1ba0c874e42/t/5e65fd0ba29cd069c4f3ca3c/1583742221663/super-complaint2+report.FINAL.pdf.

Cloitre, M., Shevlin, M., Brewin, C.R., Bisson, J.I., Roberts, N.P., Maercker, A., Karatzias, T. and Hyland, P. (2018) The International Trauma Questionnaire: development of a self-report measure of ICD-11 PTSD and complex PTSD, *Acta Psychiatrica Scandinavica*, 138(6): 536–46. doi: 10.1111/acps.12956

Elkit, A. and Christiansen, D.M. (2010) ASD and PTSD in rape victims, *Journal of Interpersonal Violence*, 25: 1470–88. doi: 10.1177/0886260509354587

Elliott, D.M., Mok, D.S. and Briere, J. (2004) Adult sexual assault: prevalence, symptomatology, and sex differences in the general population, *Journal of Traumatic Stress*, 17: 203–211. doi: 10.1023/B:JOTS.0000029263.11104.23

Ellis, E.M., Atkeson, B.M. and Calhoun, K.S. (1981) An assessment of long-term reactions to rape, *Journal of Abnormal Psychology*, 90(3): 263–6. doi: 10.1037//0021-843x.90.3.263

Feldman-Summers, S., Gordon, P.E. and Meagher, J.R. (1979) The impact of rape on sexual satisfaction, *Journal of Abnormal Psychology*, 88(1): 101–105. doi: 10.1037//0021-843x.88.1.101

Herman, J. (2015) *Trauma and Recovery*, New York: Basic Books.

HM Government (2021) The end-to-end rape review report on findings and actions, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/994816/end-to-end-rape-review-report.pdf.

Holmes, M.M., Resnick, H.S., Kilpatrick, D.G. and Best, C.L. (1996) Rape-related pregnancy: estimates and descriptive characteristics from a national sample of women, *American Journal of Obstetrics and Gynecology*, 175(2): 320–5. doi: 10.1016/s0002-9378(96)70141-2

Hydén, M., Gadd, D. and Wade, A. (eds) (2016) *The Response Based Approach to Interpersonal Violence*, London: Palgrave McMillan.

Kilpatrick, D.G., Resick, P.A. and Veronen, L.J. (1981) Effects of a rape experience: a longitudinal study, *Journal of Social Issues*, 37(4): 105–22. doi: 10.1111/j.1540-4560.1981.tb01073.x

Kroenke, K., Spitzer, R.L. and Williams, J.B. (2001) The PHQ-9: validity of a brief depression severity measure, *Journal of General Internal Medicine*, 16(9): 606–13. doi: 10.1046/j.1525-1497.2001.016009606.x

Krug, E.G., Dahlberg, L.L., Mercy, J.A., Zwi, A.B. and Lozano, R. (eds) (2002) *World Report on Violence and Health*, Geneva: World Health Organisation.

Letourneau, E.J., Resnick, H.S., Kilpatrick, D.G., Saunders, B.E. and Best, C.L. (1996) Comorbidity of sexual problems and posttraumatic stress disorder in female crime victims, *Behavior Therapy*, 27: 321–36. doi: 10.1016/s0005-7894(96)80020-7

Loya, R.M. (2014) The role of sexual violence in creating and maintaining economic insecurity among asset-poor women of color, *Violence Against Women*, 20(11): 1299–320. doi: 10.1177/1077801214552912

Majeed-Ariss, R., Smith, D., Mohamed, L., Wood, L. and White, C. (2023) The impact of COVID19 pandemic and government enforced lockdowns on levels of attendance and context of sexual assaults reported at Saint Marys Sexual Assault Referral Centre, *Journal of Forensic and Legal Medicine*, 97: 102550. doi: 10.1016/j.jflm.2023.102550

Majeed-Ariss, R., Walker, T., Lee, P. and White, C. (2019) The experiences of sexually assaulted people attending Saint Mary's Sexual Assault Referral Centre for a forensic medical examination, *Journal of Forensic & Legal Medicine*, 66: 33–7. doi: 10.1016/j.jflm.2019.06.001

Massey, K., Horvath, M.A., Essafi, S. and Majeed-Ariss, R. (2019) Staff experiences of working in a Sexual Assault Referral Centre: the impacts and emotional tolls of working with traumatised people, *Journal of Forensic Psychiatry & Psychology*, 30(4): 686–705. doi: 10.1080/14789949.2019.1605615

NHS England (2018) *Strategic Direction for Sexual Assault and Abuse Services, Lifelong Care for Victims and Survivors: 2018 – 2023*, London: NHS.

ONS (Office for National Statistics) (2018) *Sexual Offences in England and Wales: Year Ending March 2017*, Newport: ONS, https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/sexualoffencesinenglandandwales/yearendingmarch2017#which-groups-of-people-are-most-likely-to-be-victims-of-sexual-assault.

ONS (Office for National Statistics) (2023) *Crime in England and Wales: Year Ending September 2022*, Newport: ONS (ons.gov.uk).

Orlando, J.A. and Koss, M.P. (1983) The effects of sexual victimization on sexual satisfaction: a study of the negative-association hypothesis, *Journal of Abnormal Psychology*, 92(1): 104–6. doi: 10.1037//0021-843x.92.1.104

Safe Lives and Domestic Abuse Commissioner (2021) Understanding court support for victims of domestic abuse, https://safelives.org.uk/sites/default/files/resources/Court%20Support%20Mapping%20Report%20-%20DAC%20Office%20and%20SafeLives.pdf.

Sena, A.C., Hsu, K.K., Kellogg, N., Girardet, R., Christian, C.W., Linden, J., Griffith, W., Marchant, A., Jenny, C. and Hammerschlag, M.R. (2015) Sexual assault and sexually transmitted infections in adults, adolescents, and children, *Clinical Infectious Diseases*, 61(8): S856–S64.

Spitzer, R.L., Kroenke, K., Williams, J.B. and Löwe, B. (2006) A brief measure for assessing generalized anxiety disorder: the GAD-7, *Archives of Internal Medicine*, 166(10): 1092–7. doi: 10.1001/archinte.166.10.1092

Stermac, L., Cabral, C.M., Clarke, A.K. and Toner, B. (2014) Mediators of posttraumatic mental health in sexual assault survivors, *Journal of Aggression, Maltreatment & Trauma*, 23: 301–17. doi: 10.1080/10926771.2014.881948

Ullman, S.E. and Peter-Hagene, L. (2014) Social reactions to sexual assault disclosure, coping, perceived control, and PTSD symptoms in sexual assault victims, *Journal of Community Psychology*, 42: 495–508. doi: 10.1002/jcop.21624

Walker, T., Foster, A., Majeed-Ariss, R. and Horvath, M. (2021) The justice system is failing victims and survivors of sexual violence: a response to the 2021 Rape Review, *The Psychologist*, 34: 42–45.

Wolfe, E. and Smith, E. (2007) Instrument development tools and activities for measure validation using Rasch models: Part II – validation activities, *Journal of Applied Measurement*, 8(1): 204–34.