A Process Evaluation of Ynys Saff, the Sexual Assault Referral Centre in Cardiff

FINAL EVALUATION REPORT

Dr Amanda L Robinson
Cardiff University

Dr Kirsty Hudson
Cardiff University

Dr Fiona Brookman
Glamorgan University

15th JUNE 2009

BWRDD CYFIAWNDER TROSEDDOL DE CYMRU
System cyfiawnder troseddol: gweithio gyda'n gilydd er mwyn y cyhoedd
SOUTH WALES CRIMINAL JUSTICE BOARD
Criminal Justice System: working together for the public

Table of Contents

List of Tables

List of Figures and Charts

Acknowledgments

The authors would like to thank the South Wales Local Criminal Justice Board for funding that helped make this research possible. Much gratitude is due to the many professionals involved in Ynys Saff for the time and effort they invested in this research. Whilst every effort has been taken in the preparation of this publication, no liability is assumed for any errors or omissions.

Executive Summary

Methodology

A process evaluation of the Sexual Assault Referral Centre serving the Cardiff area[1], known as Ynys Saff ('safe island' in Welsh), was conducted over more than two years (beginning in January 2007), the findings of which are presented in this report. The SARC was opened on 2nd October 2008; therefore, the evaluation describes both a pre-operational development period and a post-implementation operational period. The aims of the research were:

1. To describe the SARC including its premises, staffing and in particular the *model of service provision at the SARC*, and how it is similar or different to other existing SARCs;
2. To describe the *initial throughput of victims* accessing services at the SARC using one quarter of referral data; and
3. To describe the *multi-agency approach* used to develop and implement the SARC, and the levers available and barriers facing those involved.

To achieve these aims, a mixed-method methodological approach was employed, involving interviews with practitioners and key informants (n=34), site visits to other Welsh SARCs, visits to facilities in Cardiff used before the opening of the SARC and Ynys Saff once opened (n=10), and information about the men, women and children accessing services at the SARC during its first operational quarter (n=92).

Findings

1. Description of Ynys Saff

Ynys Saff is located in a refurbished section of the Cardiff Royal Infirmary (CRI), in the city centre of Cardiff. Since 2nd October 2008 it has provided services to victims of sexual violence (men, women and children of any age) from Cardiff and the Vale of Glamorgan and child victims from Gwent. It is open from 9am to 5pm Monday through Friday with 24-hour services provided for police referrals. The bespoke facilities, designed especially for victims of sexual violence and in particular child victims, enable services to be provided in a safe and comfortable environment. Specifically the services that the SARC provides include:

- General information and advice
- Police engagement
- Forensic medical examinations
- Crisis intervention, emotional support and advocacy

Staffing at the SARC consists of a core team including a SARC Manager, two advocates (Independent Sexual Violence Advisors or ISVAs), administrative support and Crisis Workers to cover both in- and out-of-hours referrals. An extended team of

[1] Whilst the SARC covers Cardiff, the Vale of Glamorgan and child victims from Gwent, for ease of reading we will refer simply to Cardiff or the Cardiff area throughout the report.

staff, indicative of the partnership approach used in both the development and operation of the SARC, includes officers from South Wales and Gwent police services, Forensic Medical Examiners (FMEs), Paediatricians and Social Services. In addition, referrals can be made on behalf of clients to a number of outside agencies and services including integrated sexual health, Genitourinary Medicine (GUM Clinic), the Women's Safety Unit (service for domestic violence victims), substance misuse services, and community mental health teams including psychology and counselling.

2. Early Findings from the Referral Data

A new monitoring tool, expanded from that used by the Home Office to monitor SARC and ISVA services nationally, was developed in consultation with staff before the opening of Ynys Saff. It was designed to collect information on all cases referred to the SARC, and data from cases received during the SARC's first operational quarter (2nd October – 31st December 2008) were made available for this research. Although they provide a helpful early snapshot of the SARC's workload, they should be viewed as preliminary (see limitations noted on page 16). Indeed, it is likely that these findings will change over time as Ynys Saff becomes more established in the Cardiff area and as data collection procedures become more robust.

Analyses indicated that the 'typical' client was a white female, generally young, capable of speaking English, with few disabilities. This is similar to the profile of victims of serious sexual assault in the last British Crime Survey. However a significant minority of clients were men (14%). This is double the amount of men reporting to SARCs in past research and represents an exceptional level of engagement with male clients.

Notably, most clients being referred to Ynys Saff were young: 84% were 30 or younger and 50% were 18 or younger. Younger victims were also the largest group in other national studies of sexual violence, but perhaps the amount of very young clients sets Ynys Saff apart: 24% were aged 12 or younger. Indeed, most sexual violence services do not even accept child referrals let alone have children make up a significant proportion of their workload.

Data were collected to assess clients' levels of vulnerability and findings indicated that a substantial proportion experience, in particular, mental health issues (35%), alcohol use (18%), history of sexual abuse (18%), and domestic violence (16%). This has implications for those attempting to care for and support these victims (most notably ISVAs) and demonstrates the importance of offering a range of services in a 'one-stop-shop' environment.

The 'typical' case referred to Ynys Saff was one of rape or sexual assault, which took place within the past month and was most likely committed by an acquaintance or relative in a domestic/private setting. The distribution of offences and where they took place is similar to that found in other research. The police were the primary referral source to Ynys Saff, accounting for 65% of all referrals in the first quarter, which is also comparable to other SARCs nationally.

Information was collected about 8 types of services offered at Ynys Saff. Similar to other research, forensic medical exams were the most common service provided within the SARC. In terms of services organized or offered to victims by ISVAs, about three-quarters of clients received both non-therapeutic support and advocacy. A lesser proportion (41%) received crisis intervention, which is understandable given that the relevance of this depends on when the offence was committed and in about one-quarter of cases the offence was committed some time ago (over one month, to more than one year or during childhood). Furthermore, in more than one-quarter of cases the ISVAs were known to have provided emotional support to someone other than the victim, usually a parent or sibling of the victim. This was a previously 'hidden' feature of ISVAs work that has been evidenced by the current research. Furthermore, it indicates the ripple effect that sexual violence has on the wider community and to which Ynys Saff is attempting to respond.

3. Multi-Agency Work to Develop and Implement the SARC

The evaluation clearly showed that the development, implementation and operation of Ynys Saff could not have been achieved without a strong commitment to effective partnership work, especially between the voluntary sector, police and health. At the same time, the voluntary sector played a crucial role in the SARC's development over time. In 2007, a multi-agency steering group was set up to manage the early development of the SARC. Its role was to coordinate all available services working with victims of sexual violence into a holistic framework; to identify untapped provision for these victims as well as current gaps in service provision; and then to generate income to fund the SARC so that a more comprehensive service could be provided to victims of sexual violence in the Cardiff area. The steering group included representatives from the police, local authority, voluntary sector agencies, CPS, NSPCC, and health. It was chaired by a voluntary sector representative, who played a large role in bringing partners together and hosting the initial meetings. The diverse membership of the Steering Group was indicative of the widespread support and commitment to the project across various agencies.

Since its opening in 2008, Ynys Saff has been overseen by a multi-agency executive partnership board whose membership includes senior members of the following organisations: South Wales Police; Gwent Police; Cardiff and Vale NHS Trust; Cardiff Local Health Board; Community Safety Partnerships and the Voluntary Sector. The board meets on a regular basis and is responsible for:

- Maintaining an overview of the project
- Identifying any deficiencies in the service
- Suggesting improvements to the service
- Reviewing the performance reports
- Establishing pooled budget arrangements to meet the costs of the service

It was unanimously accepted that the facilities at Ynys Saff were far superior to the facilities previously available to victims of sexual violence in the Cardiff area. Apart from victims having to access the SARC via the main entrance to the CRI, which was viewed as unwelcoming, antiquated and lacking privacy, the facilities within the SARC were seen to work well, both for practitioners and victims.

The principle aim to provide a '*victim centred'* SARC, and uniquely a SARC that is able to cater especially for the needs of child victims, was widely perceived by those interviewed to have been achieved. In this regard, the work of the ISVAs was highlighted as particularly important, given that the principle role of the ISVA within Ynys Saff was to ensure that victims' perspective and experiences were brought to the forefront of the process. Furthermore, measures were put in place to ensure that the crisis workers within the Cardiff SARC were able, and had the skills, to work within a victim-focussed occupational culture. This included training and job shadowing with experienced advocates from the Women's Safety Unit. Such measures had been successful at creating a '*culture of challenge'*, whereby a system was created that *'worked for the victim, as opposed to the victim fitting around the system, or fitting around the convenience of other people'.*

The role undertaken by the victim advocates (ISVAs and Crisis Workers) was also seen as evidence of 'institutional advocacy' since they helped to facilitate improved performance by others working with victims of sexual violence across many different agencies. For example, comments from the police described how the SARC had helped professionalise their investigative process by improving their ability to effectively collect evidence. Respondents also commented on how the SARC had made the process of how to engage with victims, when they do come forward, more transparent and effective. Consequently, the support that the advocates were able to provide to victims' meant that the other professionals involved in the SARC could do their jobs more efficiently and timely, while the victim was still given the care and attention that they needed. Therefore outcomes for criminal justice (e.g., police investigation of sexual violence offences) as well as for individual victims (e.g., health needs, satisfaction) were perceived to have been met. It should be noted, however, that the current research was not an outcome evaluation of the SARC *per se*, so these perceptions will need to be substantiated with further research. It should be noted that criminal justice outcomes and longer-term health and well-being outcomes for victims are included in the monitoring tool being used at Ynys Saff, and will therefore be available to use for future assessment of the service.

Finally, the current study explored, in detail, the current and continuing challenges associated with the SARC's multi-agency approach, some of which have been overcome to a certain extent, while others remain potential challenges that will need to be overcome in the future. First, funding was an aspect that helped to cement multi-agency commitment to the project, but it also posed a continuing challenge, especially in the face of the current economic climate and budget cuts. Even before the SARC became operational, many respondents were concerned at being able to adequately resource and sustain the staff needed to run the SARC successfully. Immediately after opening it was still felt by many that the SARC was not adequately staffed, and the throughput of victims in the first quarter was both larger than anticipated and included more child victims than expected. It remains to be seen how the staffing/resource issue will affect the future operation of Ynys Saff.

Second, there was some evidence of a general lack of understanding with regard to the cultural differences and the working practices and limitations of partner agencies, both before and after Ynys Saff became operational. This was linked to a concern raised during both stages of the evaluation over a possible conflict between criminal justice goals and the needs of the victim. While in the initial stages of the SARC's

development, it appeared that the victims' needs took precedence over any criminal justice goals, there was some apprehension that this might change over time. Post-operation there were many examples indicating this did *not* happen, although this will need continuous monitoring. Furthermore, the importance of developing an effective multi-agency dialogue to ensure that the best outcomes can be achieved for all partners, as well as victims, was widely recognized.

Challenges were also raised with regard to agency representation. While this research indicated that agency representation was on the whole excellent, it became apparent that certain agencies were less involved than others. A similar concern arose out of the provision of paediatricians and out-of-hour's services, resulting in SARC staff needing to contend with resource and funding issues, existing child protection rotas and an overstretched service. Arguably, this posed one of the greatest challenges to the multi-agency partnership work, and one that is yet to be fully resolved.

In conclusion, Ynys Saff appears to be another of Cardiff's remarkable victim-centred and multi-agency interventions for victims of crime, demonstrating again the positive benefits from collaboration between the voluntary sector and statutory agencies.[2] As evidenced by this research, there are a number of difficulties as well as opportunities posed by multi-agency work on sexual violence. The importance of the voluntary sector in the development of the SARC and in taking the initial lead, in partnership with senior health and police officers, cannot be overstated. This finding is consistent with other research which has shown how, particularly for the crimes of domestic and sexual violence, voluntary/community agencies are absolutely crucial for promoting a community culture that is responsive to the needs of victims. However, alongside the role undertaken by the voluntary sector, considerable work has been undertaken by *all* partner agencies involved in the venture (regardless of sector) to embrace a 'victim-focussed occupational culture'. This has, in part, been developed, and is sustained, through the role of victim advocates (e.g., ISVAs), not only in terms of the services and support that they provide to victims, but uniquely due to the leading role that they have been given within this multi-agency initiative.

Recommendations

This process evaluation, drawing upon both qualitative and quantitative data over a two-year period that included both pre-and post-operational phases of Ynys Saff, has indicated several recommendations to help improve future performance at the SARC:

1. The access to Ynys Saff should be changed or refurbished to bring it to the same high standard as the rest of the SARC.
2. A paediatric lead would be a useful post to add to the current contingent of core staff at the SARC as coordinating the response to the (significant proportion of) child victims is necessary to ensure that appropriate and sustainable levels of services to meet their unique needs are available.

[2] For example, for victims of domestic abuse Cardiff implemented the Women's Safety Unit in 2001 and a few years later the Dyn Project to provide services for male victims. Cardiff was one of the first cities in the UK to implement a Specialist Domestic Violence Court (SDVC), which has been operational since 2002. Furthermore, multi-agency risk assessment conferences (MARACs) which are now running in more than 100 locations across the UK were developed in Cardiff in 2003.

3. Regular reviews of operational practice on recent or current cases should either be incorporated into existing meeting held by the Executive Partnership Board and Operational Task and Finish Group or implemented on a regular basis. These should be attended by all core staff to monitor performance and keep channels of communication open between relevant agencies.
4. As the contribution of the voluntary sector to the development, implementation and operation of Ynys Saff has been widely recognized and highly valued, this should continue for the foreseeable future. This will help to preserve the SARC's independence and that of its staff, especially the Independent Sexual Violence Advisors (ISVAs), whose independence from statutory partners is crucial to their role and delivery of services to victims.
5. A review of the systems in place to support staff working in Ynys Saff should be carried out to ensure that their health and welfare needs are being met, in both the short- and long-term.
6. A review of the monitoring tool developed for Ynys Saff should be carried out to ensure that all relevant data are being collected and that the tool is 'fit for purpose' for the foreseeable future. Continuous monitoring of both criminal justice outcomes (e.g., investigation and prosecution of sexual offences) and victim outcomes (e.g., health, safety, well-being, and satisfaction) is recommended.
7. An outcome evaluation of Ynys Saff should be commissioned, at a minimum to report on the outcomes achieved with cases from its first 12-month period of operation. This larger sample of referrals will enable more detailed analyses of the various outcomes across different types of victims (e.g., by age, gender, ethnicity, etc.).

A Process Evaluation of Ynys Saff, the Sexual Assault Referral Centre in Cardiff

Background to the Research

Several years ago the UK government acknowledged the importance of multi-agency partnerships and collaborative efforts with respect to improving criminal justice performance, especially with regard to domestic and sexual violence. [3] The Sexual Assault Referral Centre (SARC) is the latest well-known example in a raft of initiatives based on this premise. The SARC model of providing assistance to victims of sexual violence has been adopted by the Home Office as it seeks to address the unsatisfactory criminal justice performance recently highlighted by criminal justice inspectorates and in the media. SARCs involve a partnership approach between the police, health services, and good liaison with other statutory and voluntary agencies. The two main priorities of SARCs are:

- Forensic examination so that evidence can be collected for use in the investigation of crime;
- Care of the victim to minimize the risk of subsequent physical and mental difficulties and promote recovery.

In addition, the government has recently provided £1.25M to voluntary sector organizations providing services to victims of sexual violence, and is engaged in expanding the network of SARCs in England and Wales[4] (there were 5 in 2003 and the funding made available resulted in 28 now operating in England and Wales[5]).

In 2007, the Interdepartmental Ministerial Group on Sexual Offending published a cross-government *Action Plan on Sexual Violence and Abuse*.[6] The plan sets out three objectives: (1) to maximise prevention of sexual violence and abuse; (2) to increase access to support and health services for victims of sexual violence and abuse; and, (3) to improve the criminal justice response to sexual violence and abuse. The government also noted that:

> *"The important work that needs to be done is also the responsibility of local criminal justice and health agencies, working in partnership with specialists from the voluntary sector. Crime and Disorder Reduction and Community*

[3] See HMIC/HMCPSI (2007) Without Consent: *A report on the joint review of the investigation and prosecution of rape offences* available at: http://inspectorates.homeoffice.gov.uk/hmic/inspections/thematic/wc-thematic/them07-wc.pdf?view=Binary, also the reports *Justice for All* and *Narrowing the Justice Gap*, both published in 2002.

[4] See the Home Office Sexual Offences Mini-Site at: http://www.crimereduction.gov.uk/sexualoffences/sexual01.htm

[5] For their area and location see: http://www.homeoffice.gov.uk/crime-victims/reducing-crime/sexual-offences/sexual-assault-referral-centres/referral-centre-locations/ .

[6] The Implementation Guide and Action Plan are available at: http://www.crimereduction.gov.uk/sexualoffences/sexual03.htm .

Safety partnerships are perfectly placed to bring the right partners together, and make a real difference for victims and criminal justice. [emphasis added]"[7]

Central to the SARC model is the coordination and participation of representatives from across a range of agencies (e.g., police, Crown Prosecution Service, voluntary sector, health, local councils, etc). Ultimately, a SARC aims to provide "an accessible, multi-agency, forensically secure, one-stop-shop provision for victims" (Cardiff SARC application, 2006). Similar programmes, known as SARTs (Sexual Assault Response Teams), have been set up in the US. These multi-agency teams aim to "provide the information, assistance, and response that meets the individual needs of the survivor" (Preston, 2003: 242). Thus, collaborative multi-agency partnerships across relevant agencies are the foundation for programmes in many areas that aim to provide an improved response to victims of sexual violence. Furthermore, evidence from a range of studies conducted in the US and UK shows that collaboration between agencies can result in improvements across both institutional outcomes (e.g, criminal justice outcomes such as arrest, prosecution and conviction) and outcomes for individual victims (e.g., increased satisfaction and confidence, reductions in long-term health problems, etc.).[8]

Methodology

Aims of the Study

Despite the importance of multi-agency partnership work, there has been relatively little research which addresses the processes, by which types of interventions such as SARCs are set-up, the challenges facing those working to develop SARCs in their areas, and the various barriers present which impinge on productive multi-agency partnerships that are vital to the success of SARCs. This study goes some way towards addressing this gap. A primarily qualitative approach is employed to address the following overarching research aims:

1. To describe the SARC including its premises, staffing and in particular the *model of service provision at the SARC*, and how it is similar or different to other existing SARCs;
2. To describe the *initial throughput of victims* accessing services at the SARC using one quarter of referral data; and
3. To describe the *multi-agency approach* used to develop and implement the SARC, and the levers available and barriers facing those involved.

In addition, the information gathered will be used to suggest recommendations for improving the processes by which the SARC delivers services to victims of sexual violence. The evaluation was conducted in two stages. Each is described in the sections that follow.

[7] Tackling Sexual Violence: Guidance for Local Partnerships, 2006, p. 2. Available at: http://www.crimereduction.gov.uk/sexual/sexual26.pdf

[8] See, Campbell, 1998, 2005; Campbell & Raja, 1999; Cook et al., 2004; Konradi, 1996; Martin, 2005; Preston, 2003; Resick, 1993; Robinson, 2003, 2006; Schafran, 1996; Shepard & Pence, 1999; Zweig & Burt, 2006.

Evaluation of Pre-Operational SARC

The first stage of the evaluation was designed to explore the development of the Cardiff SARC by presenting the results from qualitative interviews with practitioners involved in its initial conception and development, along with information collected from visiting sites of existing service provision in the South Wales area.

The time period for this stage of the evaluation was Jan 2007 – Oct 2007, although the lead author had been attending implementation meetings since they began the preceding summer (Aug 2006). Although this report includes findings from the first stage of the evaluation, readers may also wish to consult an academic paper published on this part of the research.[9]

Evaluation of Post-Operational SARC

The second phase of the evaluation was conducted after the official opening of the SARC (1st Oct 2008). Therefore there was a 'gap year' between the first and second stages where the SARC was continuing to be developed, yet data was not being routinely collected. This was due to the research design which necessitated having some period of data collection after the SARC became operational. It was not initially envisioned that the pre-operational stage would be so lengthy; numerous delays to the opening of the SARC account for this.

Thus, the focus of this second stage was to capture aspects of the implementation and delivery of the SARC, as well as the experiences of those delivering the service and key individuals engaged with the centre. Interview data as well as referral data from the initial 3-month period after the SARC became operational are used to describe the actual multi-agency delivery of the model of service provision and the initial throughput of victims receiving these services.

In combination, both stages of the evaluation enable us to identify and compare the vision and intentions of the original designers and various partner agencies with the reality of its implementation. The implications of the study are wider than for those working in SARCs, given the current policy climate which promotes multi-agency collaboration as a key element of successful crime victim assistance and crime prevention initiatives, and the need for better responses to the victims of sexual violence.

Data Collection

Table 1 presents an overview of the methodological approaches adopted during both stages of the evaluation. These methodological approaches and their application within this study are then discussed in more detail below.

[9] Robinson, A., Hudson, K. and Brookman, F (2008) 'Multi-Agency Work on Sexual Violence: Challenges and Prospects Identified From the Implementation of a Sexual Assault Referral Centre (SARC)', *The Howard Journal* 47 (4):411–428.

Table 1: Methodological approaches employed.

Evaluation stage		Methods Employed			
		Interviews	*Site Visits*		*Referral Data*
			Existing Facilities	The CARDIFF SARC	
1	Pre-operational	15	4	-	-
2	Post- operational	19	3	3	92
Total		**34**	**7**	**3**	**92**

Interviews

For the pre-operational stage of the evaluation, semi-structured interviews were conducted with fifteen members of the Cardiff SARC's steering group[10] one year into the development of the SARC and five months before its original proposed opening date in May 2008[11]. The sample of interviewees included five representatives from the Criminal Justice System (including senior police officers working within Public Protection and directly with SARCs); five representatives from Health (including an acting paediatrician, a senior nurse manager and a senior member of the Local Health Board or LHB); and six representatives from the Voluntary Sector (including representatives from Safer Wales[12]; the Women's Safety Unit[13] and the NSPCC). Respondents were asked to comment in detail upon their experience of dealing with sexual violence and their opinions on current provisions within Cardiff and the Vale before reflecting upon the development of the Cardiff SARC in terms of what had been achieved to date, barriers and continuing challenges.

In order to fulfil the aims of the post-operational phase of the evaluation, a total of 19 interviews (a mixture of face to face (17), telephone (1) and e-mail (1)) were conducted. This included five interviews with current members of the Executive Partnership Group[14] (within this category two interviews were conducted with the project lead and single interviews were conducted with representatives from the

[10] A steering group was set up to manage the early development of the SARC, the details of which will be discussed later in the report.
[11] This original opening date was postponed and the SARC was eventually opened on 1st Oct 2008. The reasons for this delay will be explored later in the report.
[12] Safer Wales is a charitable organisation that through multi-agency partnership working seeks to combat fear and create a safer and more cohesive Wales. For further information see http://www.saferwales.com.
[13] The WSU is a community-based advocacy organisation for victims of domestic violence. For more information, see Robinson, A. L. (2003). *The Cardiff Women's Safety Unit: A Multi-Agency Approach to Domestic Violence*. School of Social Sciences: Cardiff University.
[14] The original steering group was re-organised and an Executive Partnership Board took its place in order to meet the changing needs of the project.

police, health and the LHB), seven interviews with operational staff (within this category the SARC's project manager, and the independent sexual violence advocates (ISVAs) for children and adults were interviewed twice, with additional interviews conducted with representatives from health and the police)[15]; and finally four interviews with partner representatives[16] in order to explore how well the Cardiff SARC had been implemented and promoted to other agencies.

Seven of the participants that took part in the post-operational phase of the evaluation had also been interviewed during the first stage of the research and were therefore members of the Cardiff SARC's original steering group (see above). From the analysis of these interviews the research was therefore able to specifically identify and compare the vision and intentions of these respondents for the Cardiff SARC to the reality of its implementation. The interviews for the post-operation phase of the evaluation were conducted between October 2008 and March 2009.

All face-to-face interviews (conducted in both phases of the evaluation) lasted approximately one hour and were digitally recorded, as was the telephone interview (which lasted approximately half an hour). Interviews were then transcribed and all data (interviews and e-mail documentation) were systematically coded using NVivo, a computer package designed specifically for qualitative data. All transcripts were coded using a common framework, thereby making comparisons between participants' perspectives relatively straightforward. More detailed analysis was undertaken by coding each of the interviewee's transcripts to the agency that they represented as well as the time in which they were interviewed (initial and/or second phase of the evaluation).

Site Visits

Site visits were made to the facilities within, and around the Cardiff area, available for victims of sexual violence. This included an interview suite for child victims of sexual violence; the medical facilities available to child victims of sexual violence at a local hospital, an adult rape suite housed in a local police station; and an existing SARC near to the area. Site visits were also made to the proposed site for the Cardiff SARC prior to any building work commencing and then to the newly opened premises once the Cardiff SARC became operational.

Referral Data

Referral data on all adult and child victims of sexual violence that accessed services from the SARC are also included in this report. For the 3-month period ending 31st December 2008, n=92 women, men and children were clients of Ynys Saff. This represents all clients referred to the SARC during its first operational quarterly period. The information collected from these referrals includes the demographic profile of clients, referral and offence characteristics, services accessed within Ynys Saff, services provided/organised by ISVAs, and referrals by ISVAs to an outside agency or service,

[15] This category includes individuals employed at the SARC as well as those who work directly with victims at the SARC (for example, doctors, FMEs, paediatricians and SOLO officers).
[16] This category includes representatives from partner agencies who either work directly with the SARC or (possible) referral partners that work with victims of sexual violence.

While the referral data allow an initial glimpse at the types of cases going through the SARC, several limitations should be noted. First, the data collection period encompassed the Christmas holidays and this has undoubtedly impacted upon both the nature of referrals and the completeness of the data. Second, due to the length of time that many if not most cases will need to be resolved, about one-third (n=33, 36%) of cases in this sample were classified as 'ongoing' and therefore information about the cases was not yet complete. Finally, the monitoring tool used to gather the data was being piloted during this initial period. It was expanded and developed from the Home Office monitoring tools for SARCs and ISVAs, and tailored to the service provision offered at Ynys Saff. Although measures such as victims' safety and well-being, health, and criminal justice outcomes are included in the monitoring tool they are not discussed here as 1) this research was designed as a process evaluation and 2) the cases are too 'new' for outcome information to be reliably captured. Despite these limitations, the referral data are useful for a number of reasons not least of which is that they can suggest areas where processes at Ynys Saff can be improved.

Structure of the Report

The remainder of this report will present an overview of the findings gathered during the evaluation. The data will be presented in line with the aims of the study outlined above. No identifying information (e.g., agency or sector) has been provided when direct quotations are used in order to preserve the anonymity of respondents.

The report first presents a detailed description of the 'model of service provision at the SARC'. This includes a description of the Cardiff SARC in terms of actual facilities, as well as a detailed description of how the SARC operates within a multi-agency remit.

Data is then presented in order to evidence the 'initial throughput of victims accessing services at the SARC'. This includes information on all victims that have used the facilities at the SARC for the 3-month period ending 31st December 2008. The details obtained about these victims include their age, sex and offence details. Data is also presented with regard the nature of their referral (for example, whether a police referral, third party referral or self referral) and the type of services victims were offered and received at the SARC (for example, whether they had a forensic medical exam, police interview and/or ISVA support).

The remainder of the report presents findings from the interview data in order 'to describe the multi-agency approach used to develop and implement the SARC, and the levers available and barriers facing those involved'. Within this section of the report, the findings obtained from the development phase of the evaluation (the pre-operational stage) are first discussed. Comparisons are then made between the vision and intentions of the Cardiff SARC to the reality of its implementation (the post operational stage). In doing so, the report is able to portray the aspiration behind the Cardiff SARC and the aspects of multi-agency working that helped to make the Cardiff SARC a reality. The interview data are also used to highlight a number of current and continuing challenges that occurred during both the pre and post operational stages of the Cardiff SARC's development.

The final section re-examines some of the themes that run throughout the report and how they intersect with current debates, policies and practices about how best to work with victims of sexual violence. Particular attention is given to the challenges faced by those engaged with the development and running of the Cardiff SARC, and specifically how these situations have been resolved to ensure that lessons can be learnt and other strategies, and future developments, can avoid recurrent problems or ameliorate their impact more successfully.

Findings

The name given to the Cardiff SARC is Ynys Saff, which translated from Welsh means 'Safe Island'. The following section provides a detailed and 'visual' description of Ynys Saff and the model of service provision that it supplies to victims. The data presented has been obtained from interviews, site visits as well as documented information about the service.

1. Description of Ynys Saff

Model of Service Delivery

Ynys Saff is a Sexual Assault Referral Centre (SARC). It is located in the Cardiff Royal Infirmary on the ground floor of the hospital. Described in its literature,[17] Ynys Saff is '*a facility dedicated to meeting the needs of children and adults who have experienced sexual violence in Cardiff and the Vale of Glamorgan*'. In doing so it provides a holistic service in a safe and comfortable environment to all victims that enter its doors. Specifically the services that the SARC provides are:

- General information and advice
- Police engagement
- Forensic medical examinations
- Crisis intervention, emotional support and advocacy

All these services are available at the request of the victims and are not a requirement of using the SARC. These services will now be discussed in more detail under the appropriate headings.

General Advice and Police Engagement

All victims that enter the centre can obtain general information about what to do when they have become a victim of sexual violence regardless of whether they wish to use the services offered. Victims can for example talk informally with specially trained police officers, known as Sexual Offence Liaison Officers (SOLOs), at the centre without feeling there is an obligation to report the offence. The SARC does however have interview facilities whereby police can conduct interviews with victims who wish to pursue a criminal conviction. Examples of other services available include risk assessment for domestic violence, child protection/exploitation, and sexual health (e.g., the SARC manager is qualified nurse and experienced sexual health practitioner).

[17] From a document entitled 'Description of how Welsh SARCS meet Home Office minimum requirements' and a pamphlet designed for adult clients 'Ynys Saff, a port in a storm: information about our services for adults'.

Forensic Medical Examinations

The SARC also has the facilities to conduct forensic medical examinations, which are carried out by specially trained doctors (Forensic Medical Examiners or FMEs) to collect evidence that can be used should the case go to trial. Such examinations can however be carried out if the victim has not yet decided to talk to the police. The advantage here is that evidence can at this point be collected should the victim decide to report at a later date. Within the centre there are two examination suites, to accommodate child and adult victims and to ensure the centre can cope if there is a high demand on the service.

The FMEs are currently provided by Reliance Medical Services through a contract with South Wales Police (SWP). The FMEs are contracted to attend a sexual offence examination within two hours of call out. They are currently both male and female FMEs; however, if a client wishes to have a different gender FME they are entitled to do so, although this may cause a delay in the time the victim has to wait for an FME to attend the centre. In light of this the SARC is working towards a female only dedicated sexual offence rota in collaboration with the Cardiff and Vale NHS trust. In the cases of child victims of sexual violence, paediatricians with experience working with sexual violence victims would also be present and responsible for conducting the medical examination.

Emotional Support and Advocacy

As well as medical care, the Cardiff SARC also offers victims of sexual violence support throughout the entire process. 'Crisis workers' are employed to provide all victims with initial support, and to ensure that individuals make informed choices and are cared for with dignity and respect. Crisis workers are available 24 hours a day and are thus usually the first point of contact for the victims. Consequently, their role is to support victims through the medical examination and deal with any immediate concerns.

Ynys Saff also employs two advocates (known as 'Independent Sexual Violent Advisors' or ISVAs), one whose remit is adult victims and the other supports children/young people. The ISVAs offer crisis intervention, ongoing non-therapeutic emotional support, and practical assistance and advice to all clients accessing the SARC. The emotional support they provide is distinctly different to counselling and consists of exploring coping strategies, assessing safety, well-being and providing information and help with responding to trauma and anxiety. The nature of the support aims to help manage the distress of sexual violence, to explain criminal procedures, to liaise between the client and criminal justice and other relevant agencies, and to provide referrals to agencies and services outside of the SARC that the victim might require. At present there are no counselling or psychological services available at the SARC. However, the ISVAs will, if required, signpost clients on to other counselling and support services.

Staffing

While the section above has discussed the various staffing roles within the Cardiff SARC, this section presents a brief overview of the Cardiff SARC's core and

extended team. Their employers are indicated in brackets (funding for these posts is from a pooled budget).
The core team consists of:

- SARC Manager (Cardiff and Vale NHS Trust)
- ISVA for adults (Safer Wales)
- ISVA for children and young people (Safer Wales)
- In-hours Crisis Worker/Administrative support (Cardiff and Vale NHS Trust)
- Out-of-hours Crisis Workers (Cardiff and Vale NHS Trust)

The extended team includes:

- South Wales Police
- Gwent Police
- FMEs (via Reliance Medical Services)
- Paediatric team
- Social Services

Partnerships

Along with the core and extended team the Cardiff SARC also has strong links with partner agencies that work directly with victims of sexual violence, including Integrated Sexual Health. For example, all clients are offered sexual health screening and can be referred to the Genitourinary Medicine Clinic (GUM Clinic). In addition, the SARC is currently able to provide emergency hormonal contraception, prophylactic antibiotics for Sexually Transmitted Infections (STIs) and pregnancy testing. It is also in the process of developing protocols to provide the initial doses for post exposure prophylaxis following sexual assault (PEPSA) for HIV and the Hepatitis B vaccination.

Ynys Saff also has links with, and work closely with the Women's Safety Unit (for cases related to domestic violence) and were at the time of writing developing links with many other services including:

- Accident and Emergency
- Community Addictions Unit
- Psychology
- Psychosexual counselling

Multi-agency approach

As the data above clearly highlights, the Cardiff SARC operates within a multi-agency remit. In line within this principle, the service is overseen by a multi-agency executive partnership board whose membership includes senior members of the following organisations: South Wales Police; Gwent Police; Cardiff and Vale NHS Trust; Cardiff LHB; Community Safety Partnerships and the Voluntary Sector. The board meets on a regular basis and is responsible for:

- Maintaining an overview of the project
- Identifying any deficiencies in the service
- Suggesting improvements to the service

- Reviewing the performance reports
- Establishing pooled budget arrangements to meet the costs of the service

Referral Pathways

The SARC is available 24 hours a day for police referrals including those that require a forensic examination. This service is facilitated out of hours by the on call crisis worker. Self referrals and third party referrals are accepted at Ynys Saff during the centre's opening times (Monday to Friday, 9am – 5pm). Outside of these hours there is an answer phone with details of advice lines and opening times. Clients may leave a message for staff to contact them when the SARC opens. Clients would then be assessed and offered an appointment that suited their needs.

Bespoke Facilities

In order to fulfil the services offered, the space the SARC occupies has been refurbished to a very high standard and specification. **Figure 1** (page 25) presents a floor plan of facilities available at the Cardiff SARC. A more detailed description of each room is also presented below, corresponding to the numbers on the floor plan.

Entrance to the SARC

Access to the SARC is via the main entrance of the Cardiff Royal Infirmary (CRI) (not shown on the floor plan). The entrance to the CRI has 24 hour on site security in addition to CCTV and an alarm system. In order to access the SARC victims have to walk down a long corridor, passing a number of offices/ rooms (some of which are in use). Unfortunately the walk to the entrance of the SARC has not been decorated to the same standards as the SARC itself. Access to the SARC is controlled by security swipe pass.

Staff Facilities

Table 2. Staff Facilities at Ynys Saff.

Floor plan number	Room Description
27	STAFF ROOM
28	STAFF SHOWER FACILITIES
20	OFFICE

The office enables all partner agencies that access the SARC a place to work; each team member has their own space in this shared office. The SARC has also been linked to the Police Computer Network, which can be accessed only by the police.

Forensically Cleaned Rooms

Table 3. Forensically Cleaned Rooms at Ynys Saff.

Floor plan number	Room Description
07	ADULT FORENSIC WAITING ROOM
11	ADULT ADVOCACY AND SUPPORT ROOM

01	ADULT FORENSIC EXAMINATION ROOM
12	CHILDREN'S FORENSIC WAITING ROOM
22	CHILDREN'S FORENSIC EXAMINATION ROOM
23	CHILDREN'S ADVOCACY AND SUPPORT ROOM
04/05	VICTIM SHOWER/ TOILET FACILITES

The children and adults' waiting and examination rooms are forensically cleaned. Forensic cleaning is carried out by the crisis workers following each case to the recommended Forensic Science Service standard. Once cleaned each room is sealed using a unique (numbered) tag and a cleaning log is updated. Consequently, evidence can be gathered from the victim at this point. For example, each waiting area will contain an 'Early Evidence Kit'; these are modular kits for the collection of non-intimate (urine and/or mouth swabs) samples from the victims. The kit is designed to ensure effective recovery and storage of non-intimate samples where evidence may be lost with the passing of time. Both the crisis workers and ISVAs are trained in the use of Early Evidence Kits.

The adults' waiting room has comfortable seating and a television. The television does not have a live signal in order that everything that the victim wishes to watch can be monitored in order to avoid further distress. Similarly, the children's waiting room is a comfortable space where the child victim can be made to feel at ease. In addition, the children have access to a Nintendo Wii and play cubes.

Victims are also able to wash and/or shower at the SARC. Each victim will be given their own towel, cloth dressing gown and toiletry bag.

There are two forensically clean examination suites at the SARC, designed for both adults and children. Each room is fully equipped to carry out a forensic examination including high quality colpolscope facilities and can be ready within one hour of a call out. Consequently, there is very little difference in the rooms (aside from the children's room being slightly smaller). Both rooms could therefore be used for either an adult or child victim. Having two examination suites within the SARC reduces the probability of any delays for an examination occurring.

Police Interviewing Facilities

Table 4. Police Interviewing Facilities at Ynys Saff.

Floor plan number	Room Description
10	ADULT VIDEO/ INTERVIEW ROOM A
24	ADULT VIDEO/ INTERVIEW ROOM B
13	CHILDREN'S VIDEO/ INTERVIEW ROOM
14	VIDEO MONITORING ROOM

The interview rooms at the Cardiff SARC have again been designed to put the needs of the victim before the investigation process. The rooms are comfortable and friendly ensuring that, should the victim have to undertake a lengthy interview process they do so in as a relaxed atmosphere as possible. The video monitoring room has been designed to enable three interviews to take place and monitored at the same time.

Additional Rooms

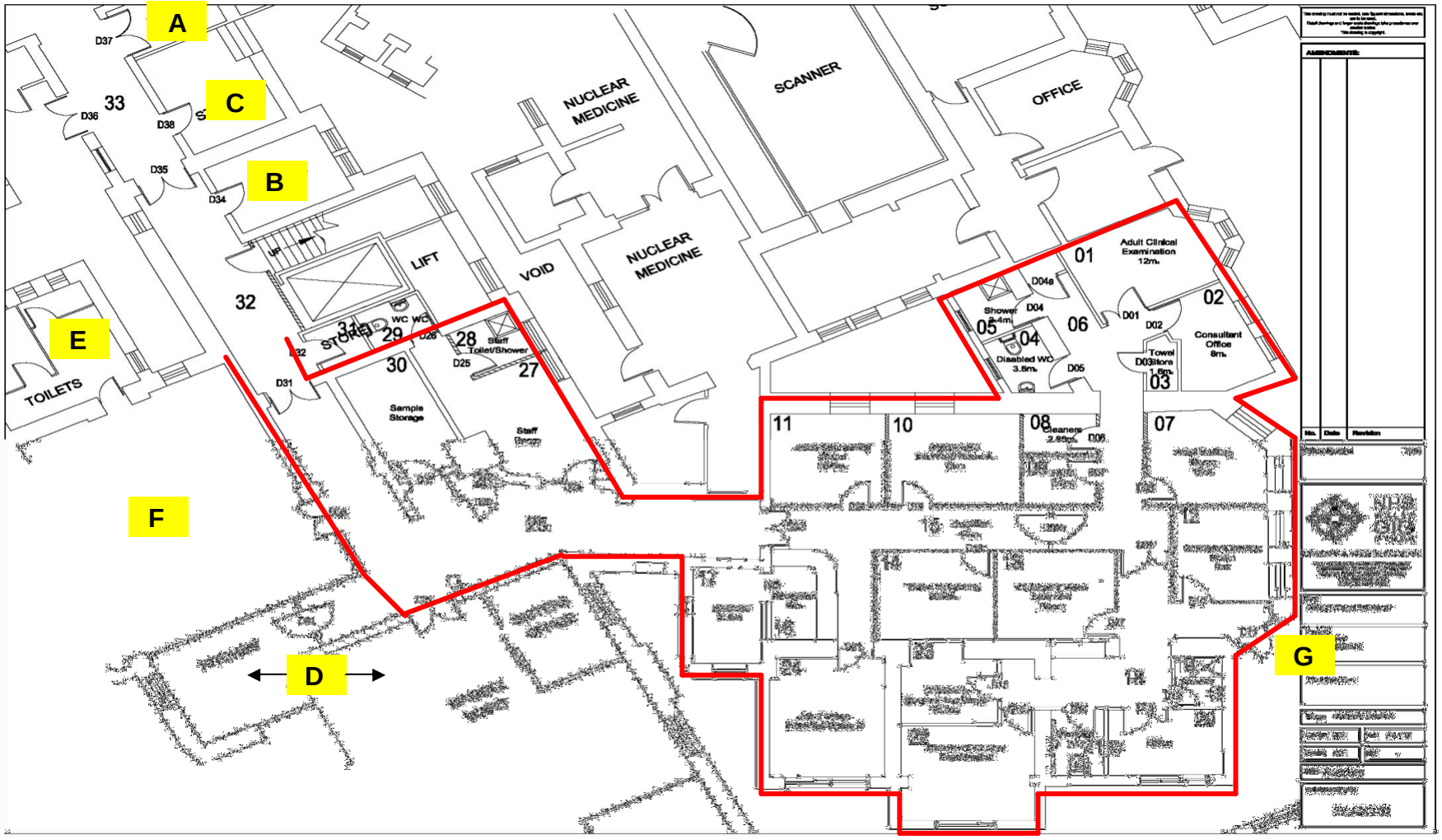
Since the SARC became operational in October 2008, additional space has been acquired within the CRI. The planned use of each room is described below:

Table 5. Additional rooms at Ynys Saff.

Floor plan number	Room Description
A and B	Two storage rooms.
C	One small office for future staff members.
D	A new waiting room with kitchen facilities. This will be used as a non-forensic waiting room for relatives etc. of clients but will also double up as an adult advocacy/support room and/or children's play room.
E	A small set of clinical rooms to be used for sexual health screening (e.g. HIV or pregnancy testing). In addition, these rooms are to be used to provide a 'portal' or a 'gateway' for women existing prostitution, including trafficked women and will have links to StreetLife, a multi-agency project under the umbrella of Safer Wales[18] The facilities aim to provide 'crash' beds that vulnerable women will be able to access for the night, close to the SARC and the Genitourinary Medicine Clinic (GUM Clinic), which is also located within CRI.
F	A large open room which will be used as a multi-agency training room and for awareness raising days more generally. This will enable all professionals working with victims of sexual violence to be trained on site.
G	In addition, due to the problems associated with how victims enter the SARC (namely through the main entrance of the CRI) it was hoped that this fire door could be used as an alternative entrance for child victims only.

[18] StreetLife is currently developing a portal or gateway model at another city centre site, for street sex workers, and other women who are victims of exploitation or violence who may access the gateway. The "Gateway" which will also provide access to safe emergency accommodation is being funded by the Welsh Assembly Government.

Figure 1: Floor Plan of Ynys Saff



2. Early Findings from the Referral Data

This section describes the information collected from the first 92 referrals to Ynys Saff and is presented as follows: *Demographic Profile of Clients*, *Referral and Offence Information*, *Services Accessed within Ynys Saff*, *Services provided/organised by ISVA*, and *Referrals by the ISVA to an agency or service*. It is important to recall the limitations of these data and the recommendation of the authors that further analyses on a larger sample of cases be carried out in the near future. These findings are presented to offer an early glimpse at the characteristics of victims accessing the SARC; it should be expected that these findings will change over time as Ynys Saff becomes more established in the Cardiff area and as data collection procedures become more robust.

Demographic Profile of Clients

This section describes the demographic profile of Ynys Saff clients. Data from the initial operational period indicate that the 'typical' client receiving services at Ynys Saff can be summarized as a white female, generally young, capable of speaking English, with few disabilities. This is similar to the profile of victims of serious sexual assault in the last British Crime Survey.[19]

The majority of clients were female (n=79, 86%) although a significant minority were male (n=13, 14%). This is double the amount of males reporting to SARCs in past research (Lovett et al., 2004). The figure of 14% represents an exceptional level of engagement with male clients, especially for an initial period of operation for a SARC. This may reflect the fact that Cardiff runs the Dyn Project which specifically provides support to men who are experiencing domestic abuse from a partner.[20] Most of the male clients seen at Ynys Saff were young: of the 13, 11 (85%) were aged 18 years or younger. One of the male clients (aged 25) was homosexual.

The youngest client seen during this period was 11 months old and the oldest was aged 52 years; the average age of clients was 20 years old. Most clients being referred to Ynys Saff were young (see Chart 1 below): 84% were 30 or younger and 50% were 18 or younger. Younger victims also were the largest group in other national studies of sexual violence, [21] but perhaps the amount of very young clients sets Ynys Saff apart: 24% were aged 12 or younger. Indeed, most sexual violence services do not even accept child referrals let alone have children make up a significant proportion of their workload. Respondents commented on how this was largely unanticipated prior to the SARC's opening:

---

[19] See *Homicides, Firearm Offences and Intimate Violence 2006/07*, available at http://www.homeoffice.gov.uk/rds/pdfs08/hosb0308.pdf

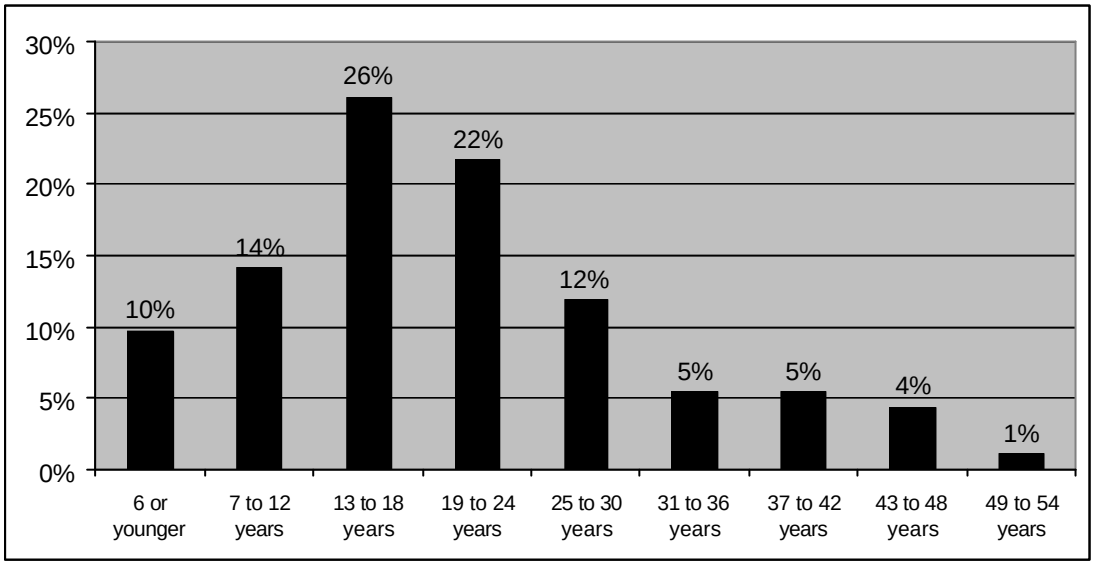
[20] For more information on the Dyn Project, see: http://www.dynwales.org.Also the evaluation research conducted by Robinson & Rowlands (2006) and available at http://www.cardiff.ac.uk/staff/robinsona

[21] The eight force study conducted by Feist et al. (2007) found that victims aged 16-25 accounted for 42% of the total. In another national study, analysis of data from one of the six sites (a SARC) showed an increasing proportion of clients aged 20 or younger, representing 43% in 2002 (Kelly et al., 2005). The latest BCS figures showed that 78% of victims of serious sexual assault were aged between 16 and 29 years. Research also has found a younger age profile in SARCs versus sexual violence services located in the voluntary sector (Lovett et al., 2004; Robinson, forthcoming).

"[This is] a much higher rate than we planned for… it shows that there were in accuracies, big inaccuracies in the way that data had been collected before, because this is not a sudden [jump], we don't get sudden peaks in this area, and we haven't done any advertising…"

"What we've discovered is that actually… agencies don't always speak to each other when they have a child who's disclosed sexual abuse. So the police may interview and go forward with a case, and that child might never have a medical. So Health wouldn't have that data. So what we're finding is actually our data now will be more accurate, it will reflect more accurately what's going on."

Chart 1. Age distribution of Ynys Saff clients.



Of the clients, a small proportion were known to be black or minority ethnic (n=8, 9%). This is consistent with the demographic profile of the area, which is predominantly white. Three clients had no understanding of the English language and two had some difficulty understanding English.

A small proportion of clients reported some form of disability: 2 reported a physical disability[22], 5 reported a psychological disability[23] and 10 reported some form of learning disability[24]. Three of the clients reported having both a physical and psychological disability.

[22] The Home Office national SARC monitoring definition was used: 'Deafness or severe hearing impairment, blindness or severe visual impairment, or a condition that substantially limits one or more basic physical activities such as walking, climbing stairs, lifting or carrying.'
[23] The Home Office national SARC monitoring definition was used: 'Any long-standing psychological or emotional condition.'
[24] The Home Office national SARC monitoring definition was used: 'The presence of a significantly reduced ability to understand new or complex information, to learn new skills; with a reduced ability to cope independently.'

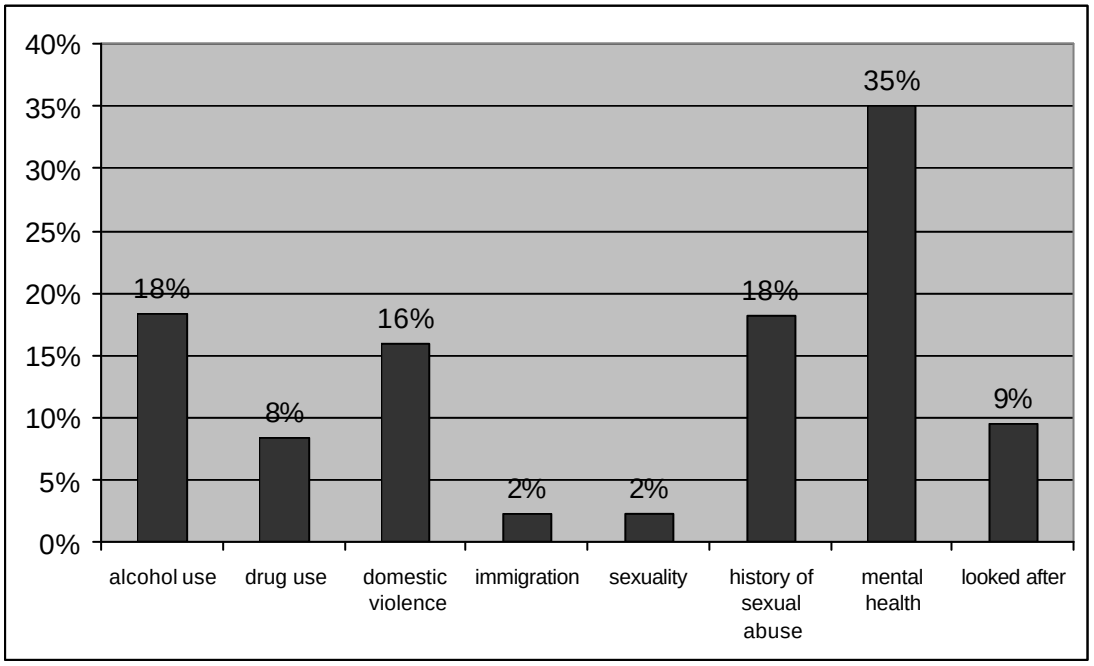
Table 6 below shows the employment status of Ynys Saff clients. The large percentage of clients (54% where data are available) in education is indicative of the youthfulness of clients being referred to the SARC thus far.

Table 6. Employment status of clients.

	Frequency	Percent	Valid Percent
Unemployed	9	9.8	13.8
In education	35	38.0	53.8
Looking after children	6	6.5	9.2
Working full or part-time	15	16.3	23.1
Total	65	70.7	100.0
Unknown	27	29.3	
Total	92	100.0	

The new monitoring tool included questions that attempt to establish clients' levels of vulnerability (see Chart 2 below). This can be considered an improvement on past research that has not included such a broad spectrum of indicators of vulnerability. It also is useful to collect this information because the perception amongst service providers is that more vulnerable clients will require more support, services, and time (i.e., resources). Therefore capturing average levels of vulnerability can be important for planning and workload monitoring. Eight yes/no items indicate whether clients were experiencing the following: alcohol use, drug use, domestic violence, immigration status, sexuality, history of sexual abuse, mental health issues, or were looked after/in the care system.

Chart 2. Clients' experiences of 'vulnerability factors'.



The data show that a substantial proportion of clients have experienced, in particular, mental health issues (n=28, 35%), alcohol use (n=15, 18%), a history of sexual abuse (n=12, 18%), and/or domestic violence (n=13, 16%).

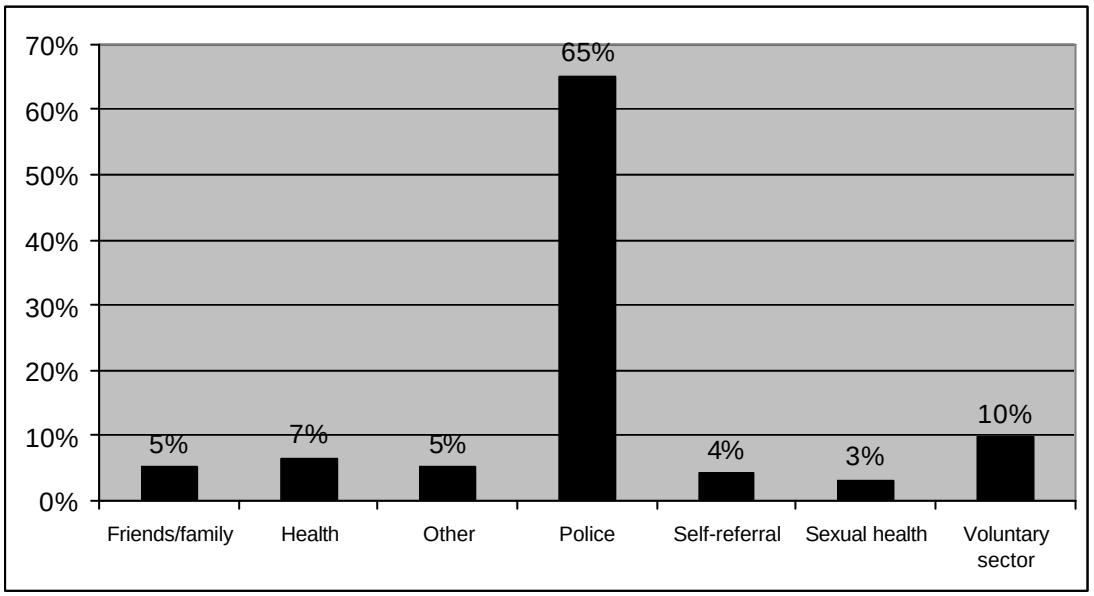
Furthermore, bivariate analyses revealed two 'clusters' of vulnerability. First, alcohol, drug and mental health problems were significantly correlated. Of 25 clients with mental health issues, 9 also had alcohol problems, and 4 had both alcohol and drug problems. Another cluster of vulnerability concerned mental health issues, a history of sexual abuse and being looked after/in the care system, which were also significantly correlated. Of 24 clients with mental health issues, 8 also reported a history of sexual abuse, and 2 had both sexual abuse and had been in the care system. None of the other vulnerability factors (domestic violence, immigration status, or sexuality) were significantly associated with any of the others.

Referral and Offence Information

This section describes the sources of Ynys Saff referrals and the characteristics of referral incidents. The 'typical' case can be described as one of rape or sexual assault, which took place within the past month and was most likely committed by an acquaintance or relative in a domestic/private setting, referred to the SARC by police.

The police were the primary referral source to Ynys Saff, accounting for 65% of all referrals in the first quarter (see Chart 3). This is consistent with a previous study of three SARCs that found that police referrals accounted for 59-73%, with the next largest source coming from self-referrals (16-27%) (Lovett et al., 2004). The second largest source of referrals to Ynys Saff was from the voluntary sector (10%).

Chart 3. Sources of referrals to Ynys Saff.



The most commonly reported offence was rape (n=41, 45%), followed by child sexual abuse (n=16, 17%) and sexual assault (n=14, 15%). Offences of rape were more commonly reported by adult victims whereas children and young people most often reported sexual assault, sexual abuse and 'other' types of offences. More than one-quarter of clients (n=22, 28%) experienced multiple (more than one) type of offence. In 13% (n=10) of cases, multiple perpetrators were involved in the incident. Where information was available (there was a good deal of missing data), the youthfulness of perpetrators was apparent: 11% were under 18 and 11% were aged 18-24.

One offence during this period was related to prostitution and one to trafficking. More than one-third of cases (n=35, 38%) were classified as substance-assisted sexual assaults (SASA).This is much higher than figures reported in other research, which may reflect Ynys Saff's young client base and/or different interpretations of the term SASA and thus the inclusion of cases involving a broader spectrum of behaviour. The level of SASA cases at Ynys Saff needs further monitoring.

Table 7 shows that the majority of incidents handled by Ynys Saff were recent attacks, taking place within the previous month. One in four took place within the past few days. About 15% took place some time ago – one year or more, or during childhood.

Table 7. When incident took place.

	Frequency	Percent	Valid Percent
Less than 24 hours before contact	24	26.1	32.9
1 to 3 days before contact	13	14.1	17.8
Over 4 days but less than 4 weeks	15	16.3	20.5
Over 4 weeks but less than 1 year	7	7.6	9.6
1 year or more	4	4.3	5.5
During childhood	10	10.9	13.7
Total	73	79.3	100.0
Unknown	19	20.7	
Total	92	100.0	

Table 8 shows that nearly half (47%) of incidents took place in domestic settings, either the victim's home, the assailant's home, or in a home shared by both. Only 4 of the 9 assaults that were committed in a 'home shared by both' can be considered to be part of domestic violence (i.e., committed by partners or ex-partners).

Table 8. Location of incident.

	Frequency	Percent	Valid Percent
Victim's home	4	4.3	6.8
Assailant's home	13	14.1	22.0
Home shared by both	9	9.8	15.3
Public building	6	6.5	10.2
Victim's workplace	2	2.2	3.4
Outdoors	16	17.4	27.1
Transportation	2	2.2	3.4
Other	7	7.6	11.9
Total	59	64.1	100.0
Unknown	33	35.9	
Total	92	100.0	

Table 9 below shows the type of relationship between victims and offenders. The largest category was assaults committed by acquaintances (35%), followed by relatives (31%) and strangers (21%). The relationship between the victim and offender varied according to the victim's age: children and young people reported more assaults by relatives and acquaintances whereas adults reported more from strangers and ex/partners. In 9 cases the sexual violence was committed within the context of an intimate relationship (domestic violence), but as noted above, these assaults did not always happen in a domestic setting. The distribution of offences and where they took place is similar to that found in other research (see Feist et al., 2007; Kelly et al., 2005).

Table 9. Relationship of offender to victim.

	Frequency	Percent	Valid Percent
Acquaintance	29	31.5	34.5
Partner	3	3.3	3.6
Ex-partner	6	6.5	7.1
Relative	26	28.3	31.0
Stranger	19	20.7	22.6
Client/customer	1	1.1	1.2
Total	84	91.3	100.0
Unknown	8	8.7	
Total	92	100.0	

Services Accessed within Ynys Saff

This section discusses the services accessed by clients within the SARC. These are distinct from the services provided to clients by ISVAs which are discussed in the next section. This makes the findings comparable to past research on SARCs which may not necessarily employ ISVAs. Also, these are services that are more health-related whereas the direct services provided by ISVAs are more aligned with emotional support and practical assistance, as previously mentioned and discussed further in the next section.

Information was collected about 7 types of services offered at Ynys Saff (see Table 10). Forensic exams were conducted at about half the rate compared to existing research on SARCs. For example, the rate was 76% in the research conducted by Kelly et al. (2005). The study conducted by Feist et al. (2007) found that just over half of all crimed incidents had a FME. This finding warrants further attention in the future, to determine if these levels are maintained and to ascertain the potential causes of this if they are. Finally, what is notable about Table 10 is that most of the services were deemed 'not relevant and not offered' to the vast majority of clients. This is a difficult finding to interpret as it is not clear whether this is an accurate reflection of services delivery or a product of a lack of clarity about how to collect this type of data (which has also affected other research into SARCs).

Table 10. Services accessed within Ynys Saff.

	Yes ***No***	**Offered, taken up**	**Offered, not taken up**	**Offered, take up unknown**	**Relevant and not offered**	**Not relevant and not offered**
Forensic Exam	n=33, 37% *n=56, 63%*					
Emergency Contraception		n=11, 12%	n=2, 2%	n=1, 1%	n=2, 2%	n=75, 82%
Medication for STIs		-	n=1, 1%	n=1, 1%	-	n=88, 98%
Prophylactics against HIV		n=2, 2%	n=2, 2%	-	-	n=86, 96%
Support during examination		n=22, 25%	n=3, 3%	-	-	n=63, 72%
Follow-up sexual health services		n=19, 21%	n=6, 7%	n=2, 2%	-	n=63, 70%
Paediatric services	Already involved: n=4, 5%	N=8, 9%				n=73, 86%

Note: All percentages listed are valid percents. Levels of missing data for these items were very low (<5%).

Services Provided/Organised by ISVA

This section discusses the methods used by ISVAs to contact victims and the amount and types of services provided by ISVAs to victims directly (emotional support, information, practical assistance). Those services organized by ISVAs on behalf of victims (referrals to outside agencies) are discussed in the next section. It is important to recall that more than one-third (36%) of cases are still considered to be on-going and therefore levels of service provision have not reached their maximum/final levels in a significant proportion of cases.

Chart 4 below displays the information about the length of time between receiving a referral and initial contact with the victim. Overall, the timeliness of the contact is apparent with one-quarter of clients being contacted within 24 hours and a further quarter between 1 and 4 days.

Chart 4. Timeliness of contact between ISVA and client.

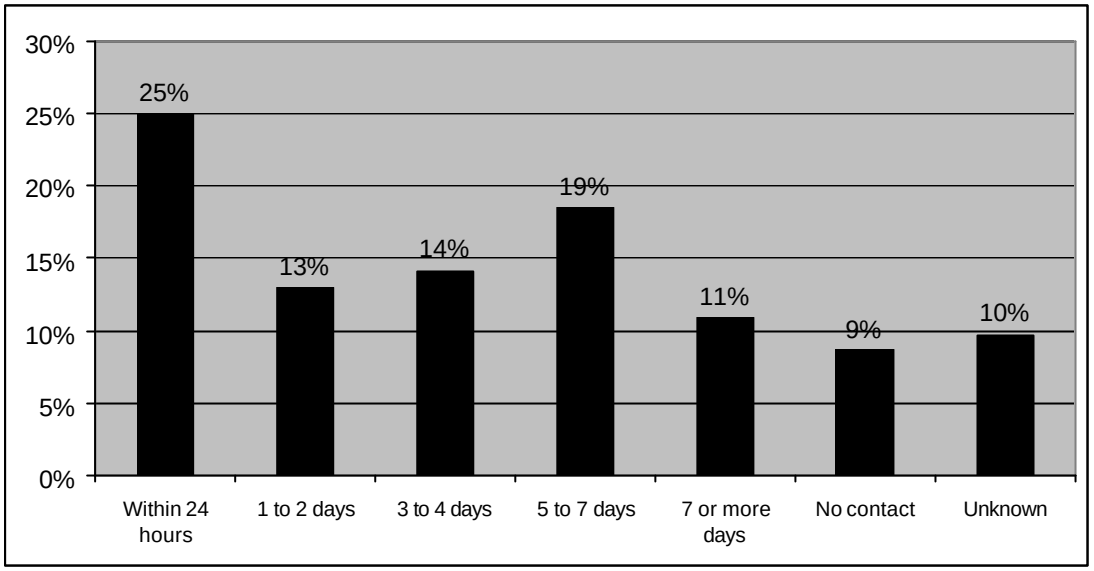


Chart 5 below indicates that face-to-face and telephone are the most frequently used methods of contact between ISVAs and clients. However in a substantial proportion of cases (52%) data were not available.

Chart 5. Method of contact.

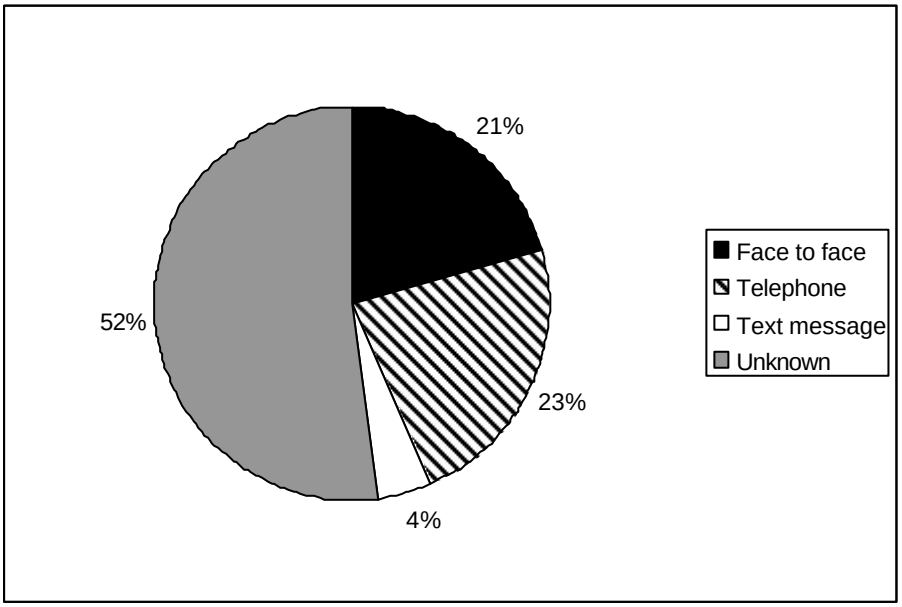
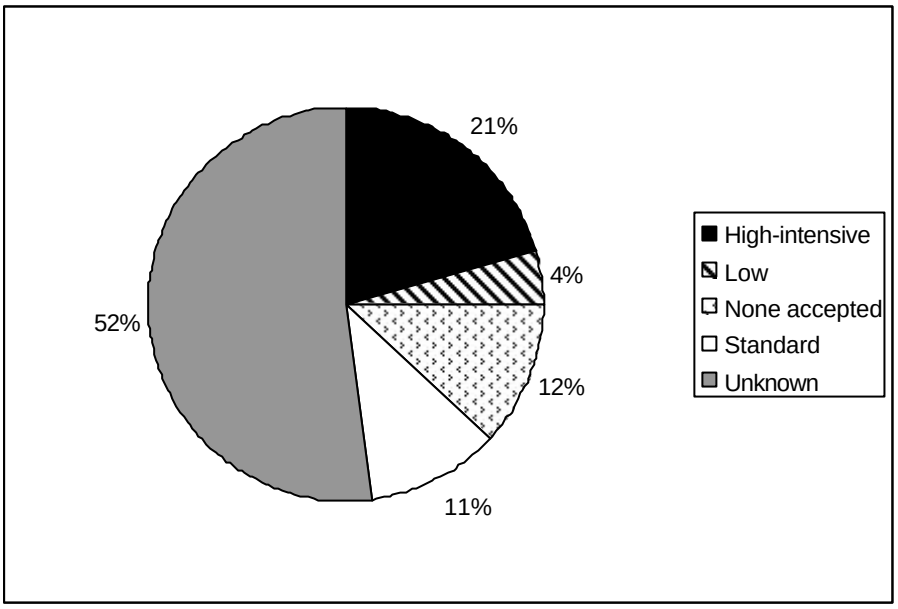


Chart 6 below indicates the level of contact between ISVAs and clients. This is a new measure included in the monitoring tool in an attempt to further document the type and nature of contact between ISVAs and clients, which often does not neatly translate into quantitative measures such as the number of contacts. It is an assessment made by ISVAs and shows that, whilst a substantial proportion of clients were considered to require a high-intensive amount of contact, not all required this amount (i.e., ISVAs do not 'offer to much too soon'). Indeed, nearly the same amount did not accept contact or required only a low level of contact. This is also a useful reminder of the heterogeneity of clients – they do not all want or need the same

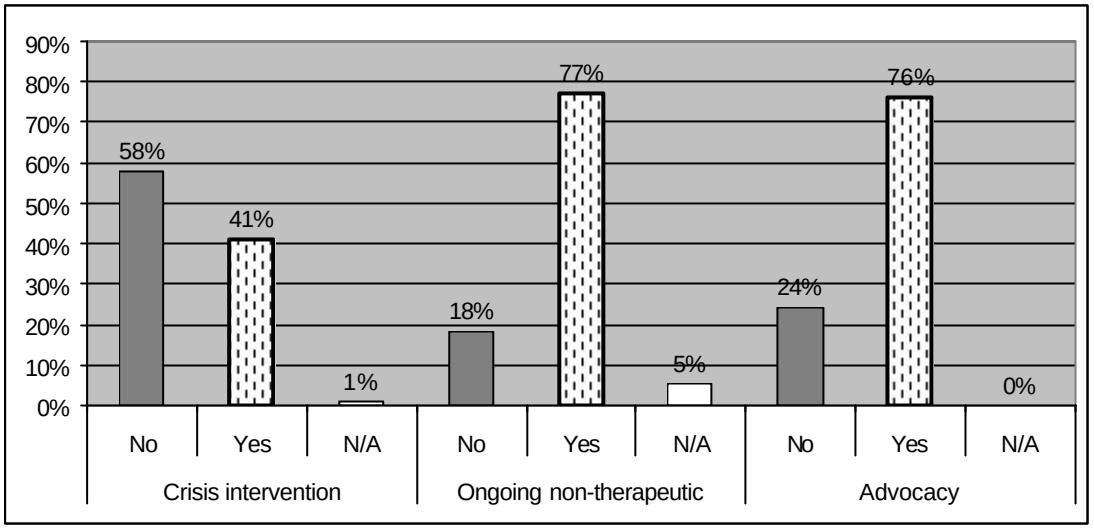
amount or type of support from ISVAs. Unfortunately, there are no national figures for ISVAs working in SARCs with which to make comparisons about the timeliness, method, or level of contact.

Chart 6. Level of contact.



The emotional support provided by ISVAs to victims was also captured by the monitoring tool in an expanded fashion compared to existing research. Three categories of emotional support (crisis intervention / ongoing non-therapeutic / advocacy) are documented (see Chart 7 below). There were very low levels of missing data (<5%) for these indicators. About three-quarters of clients received both non-therapeutic support and advocacy. A lesser proportion (41%) received crisis intervention, which is understandable given that the relevance of this depends on when the offence was committed and in about one-quarter of cases the offence was committed some time ago (over one month, to more than one year or even during childhood, recall Table 7).

Chart 7. Types of emotional support provided by ISVAs.



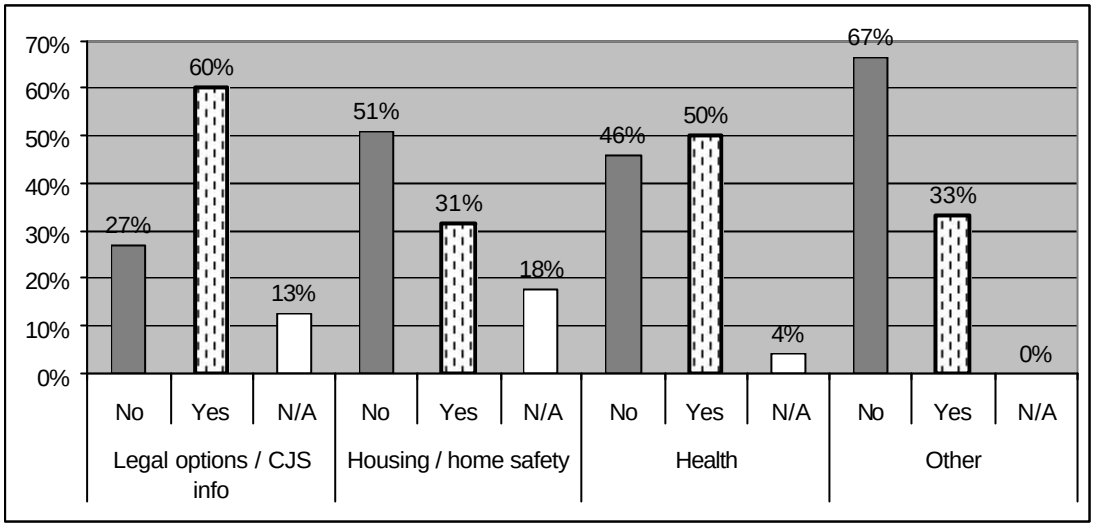
The amount of emotional support provided to victims was not statistically different according to whether the victim was male or female. In terms of ethnicity, this is also true with the exception that a higher rate (2 out of 8 or 25%) of BME cases were classed as 'not appropriate' to receive ongoing non-therapeutic support. This was due to these referrals coming from outside the Cardiff area and subsequently these victims were referred to another SARC for follow-up support. There were no statistical differences in the other two types of emotional support (crisis intervention and advocacy) received by BME versus white victims.

No significant differences were found according to age for ongoing support and advocacy; however, significantly less crisis intervention was received by those clients younger than 18. Specifically, 4 of 8 (50%) age 6 or younger; 1 of 12 (8%) aged 7 to 12; 7 of 24 (29%) aged 13 to 18. The group aged 7 to 12 received the lowest level of this type of support across all age categories. In contrast, the age group that received the highest level of crisis intervention was aged 25 to 30 (8 of 11, 73%).

In 26 cases (28%), emotional support was provided to other people than the victim. Usually it was just one other person however in 4 cases more than one person (other than the victim) received support. Most frequently, this was a parent (10 of 26, 39%), followed by a sibling (7 of 26, 27%). Yet children, partners, grandparents, guardians and other family members were also documented as having received support from the ISVA. In the overwhelming majority of cases the victim also received at least one type of emotional support; however, in one case the victim did not accept any type of support yet the ISVA provided support to a sibling. In another case, it was unknown whether the victim accepted support yet it was known that support was provided to a sibling.

Next, Chart 8 below displays the type and amount of information received by clients from ISVAs. The most commonly provided type of information related to legal / criminal justice (60%), followed by health information (50%), other types of information (33%) and housing / home safety (31%).

Chart 8. Types of information provided by ISVAs.



Significant levels of missing data (about 45%) necessitate interpreting any analyses with these items with extreme care. However bivariate tests did not reveal any significant differences in the amount of information provided to victims based on their sex, ethnicity, or age. There was some evidence of a trend of providing more information to adults compared to children. This is understandable given that much of the information would be material that is either not relevant or too advanced for children to comprehend (e.g., information about housing or the criminal justice process).

Information was gathered about 9 types of practical support that ISVAs could provide to victims (see Table 11).

Table 11. Types of practical support provided to victims by ISVAs.

	No	**Yes**	**Not applicable**	**Unknown / Missing**
Attended police report / statement taking	n=36, 39%	n=10, 11%	n=2, 2%	n=44, 48%
Provided regular updates on the case	n=32, 35%	n=7, 8%	n=6, 7%	n=47, 51%
Accompanied client to solicitor	n=37, 40%	n=1, 1%	n=10, 11%	n=44, 48%
Accompanied client to court	n=25, 27%	n=4, 4%	n=8, 9%	n=55, 60%
Accompanied client to health appointment	n=37, 40%	n=6, 7%	n=2, 2%	n=47, 51%
Accompanied client to other agencies	n=40, 44%	n=4, 4%	n=1, 1%	n=47, 51%
Provided help/advice with applications	n=31, 34%	n=10, 11%	n=4, 4%	n=47, 51%
Arranged childcare	n=34, 37%	n=1, 1%	n=13, 14%	n=44, 48%
Other	n=25, 27%	n=7, 8%	-	n=60, 65%

Further analyses were not conducted due to the very high levels of missing data (about 50% or more) as well as very low numbers of ‘yes’ responses.

Referrals by the ISVA to an agency or service

Information was collected on 15 types of referrals that ISVAs could make on behalf of victims to agencies or services located outside of the Ynys Saff. Referrals are a good indication of the types of services being made available to victims as well as multi-agency working.

Table 12. Referrals made by ISVAs to other services.

	No	Yes	Not appropriate	Already involved
Counselling service (external)	n=85, 94%	n=5, 6%	n=1, 1%	-
Sexual health services	n=48, 53%	n=27, 30%	n=13, 14%	n=2, 2%
Family planning services	n=59, 65%	n=4, 4%	n=28, 31%	-
GP	n=56, 62%	n=8, 9%	n=16, 18%	n=11, 12%
Community paediatrician	n=56, 62%	-	n=34, 37%	n=1, 1%
Drug treatment	n=52, 58%	-	n=35, 39%	n=3, 3%
Alcohol treatment	n=54, 60%	n=1, 1%	n=33, 37%	n=2, 2%
Mental health services	n=58, 64%	n=2, 2%	n=25, 28%	n=5, 6%
Social services	n=36, 41%	n=11, 13%	n=16, 18%	n=24, 28%
Police	n=17, 19%	n=1, 1%	n=2, 2%	n=71, 78%
Child Protection	n=47, 54%	n=12, 14%	n=13, 15%	n=15, 17%
Domestic violence organization or Refuge	n=51, 56%	n=6, 7%	n=29, 32%	n=5, 6%
Victim Support	n=81, 89%	n=3, 3%	n=4, 4%	n=3, 3%
Witness Service	n=83, 91%	n=1, 1%	n=5, 5%	n=2, 2%
Housing services	n=60, 66%	n=6, 7%	n=20, 22%	n=5, 6%

Note: All percentages listed are valid percents. Levels of missing data for these items were very low (<5%).

Bivariate analyses indicated no significant differences in the amount of referrals provided according to whether the victim was male or female, or according to his or her ethnicity. As expected, some variation was found in terms of age (e.g., fewer sexual health referrals for those under 18; GPs, Social Services and Child Protection more likely to already be involved when the victim was younger than 18, etc.).

3. Multi-Agency Work to Develop and Implement the SARC

This section explores the evidence gathered during the pre-operational stage of the evaluation.[25] Consequently it explores the aspiration behind the Cardiff SARC, to it becoming operational, a time period that in the end lasted more than two years. In doing so, this section presents the more positive aspects of multi-agency work. The challenges that were faced during this time will be discussed later in the report.

A Multi-agency Approach

From the very beginning, a principle aim of the SARC was for partnership work to encompass every aspect, from its initial development, including its design and protocols. With this in mind, a steering group was set up to manage the early development of the SARC. Its role was to coordinate all available services working with victims of sexual violence into a holistic framework; to identify untapped provision for these victims as well as current gaps in service provision; and then to generate income to fund the SARC so that a more comprehensive service could be provided to victims of sexual violence in the Cardiff area. The steering group included representatives from the police, local authority, voluntary sector agencies, CPS, NSPCC, Community Safety Partnerships and health. It was chaired by a voluntary sector representative, who played a large role in bringing partners together and hosting the initial meetings. The diverse membership of the Steering Group clearly shows widespread support and commitment to the project across various agencies:

> *"I think it's been fantastic that the organisational group is very dynamic, very committed and it is going to groups like that that makes me love my work, because when you actually get all those partners round the table and they are all talking the same language, they are all enthusiastic…"*

At the time, respondents were perhaps most surprised at the involvement and commitment from the Health Service. Indeed, while there has been a genuine reluctance of voluntary participation from agencies across all sectors to address their poor performance in relation to responding to sexual violence, this has been particularly the case for non-criminal justice agencies such as health. For example, it was acknowledged that the health service had fewer reasons to engage with partnership work of this type, compared to other agencies, such as the police[26]:

> *"They deal with sexual assault in A&E so why should they provide another facility… while you can see the long term outcomes for health these are hard to evidence, yet health is on board."*

> "*While the police, it could be said have a whole agenda where they need a SARC, for health it's not seen as a mainstream priority, they could have*

[25] Readers should also refer to Robinson, A., Hudson, K. and Brookman, F (2008) 'Multi-Agency Work on Sexual Violence: Challenges and Prospects Identified From the Implementation of a Sexual Assault Referral Centre (SARC)', *The Howard Journal* 47 (4):411–428.

[26] Similar acknowledgements were made but to a lesser extent with regard to the local authority and social services engagement with the venture. For example, while Social Services have to adhere to the 'Safeguarding Children' Agenda it was recognised that children make up a fraction of the SARC's workload.

> *removed themselves from that responsibility, and there are no direct targets in the NHS that would tie into a SARC."*

The importance of Health's involvement in this venture was acknowledged by nearly all of the different partners interviewed, including representatives from the Health service itself:

> *"It's a question of priority really and it is unusual for this to be a priority for something like a LHB [local health board] because they have so many demands."*

Health played a vital role in obtaining the site for the SARC. As already discussed the SARC is based in the Cardiff Royal Infirmary (CRI) which was viewed by many of those interviewed as a key achievement, in terms of its location as well as its symbolism within Cardiff:

> *"The CRI is symbolic, it's about health, people see it as a health premises, it's in people's consciousness as a centre of health and well being even though it's been a crumbling ruin for a long while now. So I think that building is terribly symbolic for people in Cardiff…"*

Furthermore, the fact that the CRI needed to be developed and restored added to its appeal, allowing for *"endless possibilities"* and *"very little compromise in what the ultimate SARC will look like …"* :

> *"It's located at the heart of the community. You also have Genito-Urinary Medicine (GUM)* Clinic *on site, you've got the emergency duty team for social service and out of hours medical services. These are the other key services it needs to mesh with. You couldn't get a better mesh with other services and you've got spare accommodation and its slap bang in the middle of Cardiff City Centre."*

With the initial funding and the site for the Cardiff SARC secured, the agencies involved showed further commitment to development of the SARC in their willingness and receptiveness to change their operational style as the project developed. For example, at the time, the initial steering group was disbanded to form an Executive Partnership Board and an Operational Task and Finish Group. The membership and role of both groups was also tailored to meet the needs of the project at any given time. For example, the Operational Task and Finish Group, prior to the opening of the SARC, was responsible for working out '*how the SARC would operate on the ground level*'. Since then (and with further changes made to its membership) its role has become to '*problem solve issue*s', '*deal with the day to day problems and evaluate practice*' (this will be discussed in more detail later in the report).

The interview data revealed several reasons why there was this level of commitment for the development of a SARC in Cardiff across agencies. Each of these is explored in detail below.

Shared Concern over Existing Arrangements

Perhaps key to the level of multi-agency engagement, was the extent to which each of the partners saw a pressing need for a SARC. Drawing on examples from their own agency's involvement with victims of sexual violence, nearly all of the interviewees identified barriers to the current service and provisions available for such victims. Learning how victims were dealt with elsewhere only increased their desire to bring about change:

> *"Getting everyone around the table, adopting a common vision and we did that through looking at the current pathways and once people saw, visually saw what happened to a victim, people decided …we ought to do something about it."*

The main barriers to provision available to victims of sexual violence prior to the SARC can be summarised as follows:

- Service provided described as 'ad hoc' both in terms of professional expertise and service offered;
- Distance to travel and time victims had to wait in order to be examined and/or interviewed;
- Poor facilities; and
- Lack of aftercare/ follow-up treatment.

These provisions were examined on a scale of one to five (where one represented 'poor' and five represented 'good'). The mean score from participants was two. Respondents were unanimous in their poor impressions of how the system in Cardiff dealt with and responded to victims of sexual violence at that time. The following quotation was typical:

> *"The services are delivered around what is convenient for the professionals involved as opposed to the victim… about when is it convenient for [agency] to give an appointment … it's designed around professionals as opposed to being designed around service delivery…"*

The result, victims were said to 'fall through the gaps', subsequently becoming 're-victimised' by the process. Unfortunately, the only way to avoid this, under previous arrangements, was for victims to choose not to report the crime.

Planning Bespoke Facilities

The overall impression of existing facilities was supported by the site visits undertaken as part of the evaluation. For example, the facilities viewed for adult rape victims at a local police station simply consisted of two rooms; one where interviews could be conducted and another where the victim could be medically examined if they had not already received an examination at a hospital. The examination room, however merely had an examination couch in it. A temporary curtain was also used to partition off half of the room, where the observation and recording equipment was stored and used. The overall impression was that these rooms had been '*thrown together*'. Indeed, the officer showing the evaluation team the site openly acknowledged that it "*wouldn't take a lot to offer better than this*".

Similarly, the interview facilities for children (aged up to 17) who had suffered physical or sexual abuse were little better. In these circumstances the children were taken to a closed down, small police station which was now used primarily for this purpose. However, it was poorly decorated and had certainly not been refurbished with children in mind. Furthermore, any medical examination of a child victim of sexual violence would have had to have been carried out within a different facility. Within the Cardiff area, forensic medical examinations were conducted within the children's centre of a local hospital. While there were dedicated facilities for child victims of sexual abuse within this centre the disadvantages were that these children would have to be passed from one service to another.

Given the existing facilities for adult victims of sexual violence, they too would typically have to undertake the interview and medical examination within different venues. Consequently, the existing arrangements for victims of sexual violence to necessitated that victims move around the system, constantly having to get accustomed to new surroundings at each point in the process. Evidence from previous research in this area has shown that this can invariably add to their distress and heighten their perception and shame of being '*seen'* as a victim of sexual violence (see for example, Campbell, 2005; Campbell and Raja, 1999; Konradi, 1996; Martin, 2005).

Shared Vision for a Better Response to Victims

Aside from a shared view that the provisions and arrangements were at that time deficient for victims of sexual violence in the Cardiff area, the interviewees also shared many views about what the SARC would be able to achieve in order to overcome these limitations. First and foremost all the partner representatives interviewed in the initial stages of the evaluation felt that the SARC would provide a more holistic approach in comparison to the picture presented above, described on numerous occasions as a '*one stop shop'*, whereby all the agencies working with victims of sexual violence would be '*under one roof*'. Supporting the criticisms of existing arrangements, it was felt that this would prevent both adult and child victims being passed around to different services; provide a more joined up system; and ensure better facilities and provision of care:

> *"[The SARC] will mean a better more responsive service, more joined up at the point of disclosure and identification and referral so it will be quicker…. So [the victims] won't have to repeat their story to 3 or 4 people, it will be more focussed and therefore be beneficial for individual children."*

An added perceived advantage was that joining up all the services in this way, and creating 'care pathways' would help to remove bias within the existing system, whereby certain victims received priority of care:

> *"I think you take prejudice out of [the process] by giving people very clear job descriptions and very clear processes that have to be followed regardless of whether [the victim] is a smelly person who has been on the streets or a middle class doctor who is walking to the hospital car park after a very long shift of saving lots of people's lives…"*

Consequently, the main aim of the SARC for all partner representatives during the developmental stage was to create a more 'victim focussed' system – the essence of which is captured in the following quotation:

> *"A gold standard service for the patient really whether a man, woman or child."*

In light of this, victims from the Women's Safety Unit (WSU) survivor forums had been consulted on the actual design and in choosing materials for the final presentation of the SARC, as had 18 of the 39 nationally appointed Independent Sexual Violence Advisors (ISVAs).[27] For example, as one ISVA commented:

> *"[We were asked] about what colours, what lighting we should have in the room, about the entrance - one person goes in this way and then out another to try and minimise who the client comes into contact with…so the way the rooms have been put together have all been thought about with the victim in mind …"*

Other agency representatives also saw themselves as acting as advocates on behalf of the victims they had worked with, with regard the design and development of the Cardiff SARC:

> *"I do think that we all have the victim there in our heads when we are talking and thinking about [the SARC]…"*

Thus, it became apparent that the victim was seen to be integral to how the SARC was developed. Indeed, all the interviewees that took part in the initial evaluation were asked to rate how 'victim centred' they thought the development of the SARC had been to date (where one represented 'not at all victim centred' and five represented 'extremely victim centred'), and the mean score was four.

<u>Sharing a Broader View of the Victim</u>

In addition, multi-agency involvement helped to develop a wider understanding of the range of victims of sexual violence that were currently known to these services and that would be supported through the development of the SARC. Indeed, referral data from the first operational quarter showed that a wide range of types of victims were seen at the SARC. These included: men, women, children, adult victims who disclosed abuse that happened in their childhood, black and minority ethnic (BME) victims, victims of stranger attacks as well as known perpetrator assaults, and depictions of the "good" and "bad" victim (Graham, 2006; Kitzenger 1997; Konradi, 1996; Martin, 2005).

> *"I'm thinking about a 14 year old who is sexually active and is maybe dabbling in some street drugs and maybe has been involved in some prostitution, is unattractive as a victim. Who's going to believe them? They have difficult relationships with teachers with parents and other adults, so I'm thinking about*

[27] ISVAs are victim advocates that may work in a SARC or other voluntary organisation such as Rape Crisis Centres. For more information, see http://press.homeoffice.gov.uk/press-releases/support-victims-of-sexual-abuse . Also see Robinson (forthcoming) *Independent Sexual Violence Advisors: A process evaluation. London: Home Office*. The use and role of ISVAs within the Cardiff SARC has also been discussed earlier in the report.

> *your worst case and how do we make that person feel valued and how do we keep their dignity intact really…"*
>
> *"[Cardiff has] a significant sex industry, a whole range of … concerns around things like asylum seekers, there are inevitably people coming who have been subject to horrific sexual assaults when they've come from other parts of the world, as well as what is sadly inevitable within your own residential population around sexual assault…"*

Ultimately, it was envisaged that this more accurate picture of victims of sexual violence would filter out into the wider community. Hence it was acknowledged that the SARC had the ability, and to some extent long term role, of changing public perceptions regarding sexual abuse. Indeed this was recognised by respondents interviewed at both stages of the evaluation:

> *"There is a need to recognise the sexual identity in young people and not just brush this under the carpet. The SARC presents an avenue to do this."*
>
> *"SARC by its very nature for me was about the elephant in the room, about recognising that by having a SARC we were saying sexual assault happens, sexual assault occurs in communities and is part of society so I felt that the very existence of one was raising and profiling a topic that was, by its very nature, often surrounded with secrecy… certainly with young people in terms of how they disclose and [their experience of] not being believed, so I kind of felt the SARC was very political in that way."*

Whether or not this long term goal has been achieved, and indeed how, will be discussed later in the report.

Commitment to Multi-Agency Work

The evidence presented to date presents a number of reasons to account for such a positive response to multi-agency working. As already identified, the shared concerns about existing provisions for victims of sexual violence were perhaps the most significant driving force behind multi-agency engagement. However, evidence was also presented that suggested that additional factors also played an important role in the project's success at building and sustaining partnership capacity. These will now be discussed.

Role of the Voluntary Sector and Key Personalities

The development of Ynys Saff was led by the voluntary sector. One key benefit to this is that the voluntary sector invariably has more entrepreneurial freedom than its statutory/public partners. This has enabled it to be more innovative and to cut across bureaucracies as the following quotation suggests:

> *"As the voluntary sector, third sector, we feel very strongly in Cardiff generally that we are very good …at leading on initiatives. It means we can build on strengths and we can bring in innovation and we can challenge things that other people can't …"*

However, during the development of the SARC there was the expectation that once opened and operational, Ynys Saff would eventually be mainstreamed:

> *"I expect ultimately that it should be mainstreamed. We shouldn't be managing that, but what the third sector will do is set the standards of delivery, we will prescribe what we want and that's the voluntary sector setting the highest possible quality standards that it can for the statutory sector to deliver against so that's the added value we can bring…"*

> *"I believe that these are things that should be provided by the statutory services and what we will do is put these in for a short period of time, demonstrate that it can be effective and then withdraw, because it's not right for the voluntary sector to fund these posts but what we may need to do is make the case."*

Moving the SARC into the statutory sector may take away some of the freedom the voluntary sector is able to operate within. The voluntary sector taking the lead has successfully pursued partnership activity through genuine collaboration rather than within a framework of enforcement, compliance and top-down managerial pressure, as is more evident in statutory sector agencies. This has helped to win commitment from partner agencies and to some extent encouraged some form of ownership towards the project. This may be lost if the project is mainstreamed too soon.

In addition, to some extent the initial development of the SARC had been driven by some key personalities and many of those interviewed were aware of the importance of this:

> *"A lot of it is personalities, and that has been the strength of it, it wouldn't have happened without [project lead's] engagement and their networking skills and drive…"*

For example the Project lead was a member of the Local Health Board and responsible for running a voluntary organisation that had vast experience working with the police and other criminal justice agencies. Consequently, they were able to *"understand the language of health"* as well as *"speak the language of the police"*; as such the project's lead became *"the glue to a certain extent".* However, for some this was seen as problematic in terms of the on-going commitment and sustainability, whereas others believed that while personalities may have been the driving force behind key achievements in the development of the SARC, they had successfully secured agency commitment to the process. Whether, in fact, the drive from certain key personalities was able to secure their agency's full commitment to the running and future of the SARC will be explored in more detail later in the report.

<u>History of Multi-agency Work</u>

On the basis of interviews conducted during both stages of the evaluation it was also recognised that Cardiff, as a city, was good at partnership work (see Robinson & Pickles, 2003). Many of the interviewees presented examples of existing initiatives (all of which were engaged with the SARC) that work in partnerships:

> *"South Wales are much more advanced than many English forces in terms of partnership working, the Women's Safety Unit, Domestic Violence (DV) courts, DV teams. So we have that level of increased partnership engagement and*

> *that helps. I think we are more mature in Wales because social policy is driven by WAG [Welsh Assembly Government] so we are better with child protection procedures. I just think we are more mature in terms of overarching public protection…"*

This history of successful partnership working clearly set a positive context within which the SARC could emerge and develop.

Shared Funding

Finally, it can also be argued that such commitment was achieved through the nature of the SARC's funding. The financing of this project, through to its fruition, came from a number of different outlets, including the Home Office, two police forces, two Community Safety Partnerships, seven Local Health Boards (LHB) and Third Sector funding which was accessed (by WSU/Safer Wales) from the Lloyd's TSB[28]. While this in itself is an example of good practice, it has also ensured that there is a level of shared responsibility for the SARC, and ultimately commitment to the project and in the long term to the work undertaken with victims that will come though its doors:

> *"The police are accountable for the police input, health for the health input, and the [Women's Safety Unit is] accountable for the third sector input into the SARC. As agencies we are all accountable and it's a visible process… and it has to be a shared responsibility. If it's run by health for the police then they tend to be health facilities, if it's run for the police by the voluntary sector they tend to be police facilities… It has to be a shared responsibility because these are people that are impinging on mental health, physical health, policing, counselling services, voluntary services, these [victims] are people that… if not properly dealt with will be presenting with issues for years to come and costing us as a city…"*

Vision Turned into Reality

The SARC became operational on 2nd October 2008 (nearly two years after the idea was first conceived and approximately five months after its proposed opening). The main reasons for the delay in the opening of the SARC have been put down to building and funding issues[29] (the latter will be discussed in more detail below). Nonetheless, for many, the very fact that the SARC now exists at all in Cardiff represents a huge success in multi-agency working:

> *"The CRI building was in a huge state of disrepair. It really looked an impossible task and yet now we have a SARC."*

While this report has already presented a detailed impression of the actual rooms and layout of the SARC, this section outlines the views and perceptions of those engaged with the centre in terms of the facilities and services that the Cardiff SARC now offers to victims of sexual violence.

[28] The Third Sector funding was especially important in that it enabled the specialised role of the ISVA for children and young people to be provided at the SARC.

[29] For example, there was a funding deficit for the final fit-out which was resolved during the last week in March 2008 with the revenue funding for the SARC Manager only being confirmed at the end of May 2008.

Using Bespoke Facilities

It was unanimously accepted that the facilities at the SARC were far superior to the facilities previously available to victims of sexual violence. The accommodation was described as '*therapeutic*', the '*best [agency representatives had] ever seen'*, as having the '*wow factor'*, and as a '*safe environment*' by many of those interviewed. As anticipated the location of the SARC at the CRI was also seen to '*make a world of difference*'. Victims, it was argued, were no longer having to be '*dragg[ed] through police stations and parad[ed] in front of everyone but [instead] taken to bespoke facilities which [were] fantastically kitted out, and is, as it says on the tin, a safe island'*:

> *"You can take the victim in a plain car, no uniformed officer, it calms the victim. You go into a safe environment that isn't a police station that you have a centre where everything is clean, it's multi-purpose and again you are away from police officers and away from the visible investigation side of things which I think is very important for the victims."*

Concerns were however raised with regard to the '*unwelcoming*' entrance of the CRI and the route that the victims have to take in order to enter the SARC. As discussed previously, access to the SARC is via the main entrance of the Cardiff Royal Infirmary (CRI). To reiterate, in order to access the SARC victims have to walk down a long corridor, passing a number of offices and rooms, some of which will be in use. Consequently, the victims that access the centre may feel that they are still (although hopefully to a lesser extent than previous arrangements) being paraded in front of others. Furthermore, the CRI is generally in a state of disrepair and this does not present a welcoming first impression. Therefore the corridor leading to the entrance of the SARC has not been decorated to the same standards of the SARC itself. Nonetheless, efforts had already been made to minimise the impact that this had on victims that entered the centre. For example, whenever a referral was made, a crisis worker or ISVA would meet the victim at the entrance of the CRI and '*begin that kind of grounding stuff from literally first contact so walking down that corridor isn't as scary, or isn't as scary as it could be*'. In addition, an alternative entrance was at the time of writing being discussed and considered by the Executive Partnership Board (recall Figure 1). Furthermore, recent funding has been secured for a complete renovation of the CRI which will help to improve the appearance of the rest of the building.

In addition, concerns were raised by one interviewee regarding the size of the children's examination room within the SARC being smaller than the one provided for adults. Whilst children are smaller than adults, it is generally the case that more people are in attendance during their examinations – including family members, the police and health staff.

These concerns aside, there is little doubt of a consensus amongst all of those interviewed that the facilities are dramatically superior to those that existed prior to the establishment of the SARC.

A Victim-Centred Facility

The principle aim to provide a '*victim centred'* SARC was clearly perceived to have been achieved:

> *"I think the focus on the victim care is there now where it wasn't before, I think the balance was wrong, it was investigation first and victim second and now it's completely different and you've got the SARC there to ensure that no actually this is what the victim wants."*

The above quotation also captures the essence that the SARC had actually '*raised everyone's game*' in facilitating an improved performance by all those working with victims of sexual violence and a desire to make sure that the process worked, and worked well:

> *"Everyone was really keen to do a really good job. And there was a sense of us all being one team … [For example], a police officer saying to me 'Do you think it's going OK, and [me saying], 'Yes I think it is' and it was lovely we were all working together."*

Further cases were also presented. For example, the interviewees commented on how the SARC had improved provision by making the process of how to engage with victims, when they come forward, more transparent:

> *"It's made it clearer where the [victim] goes, what happens to the [victim], I'm hoping if they present at casualty they get sent to the SARC so I'm hoping that will be easier… so I think it is an improved provision."*

Indeed, evidence gathered from the referral data clearly shows that this had actually started to happen in practice, with 7% of referrals coming from Health.

Comments from the police in particular described how the SARC had 'assisted in professionalising their investigation'. For example the forensic side of their investigation was said to be '*vastly improve*d', due to the simple fact that they were now able to collect evidence far more effectively, such as '*the fact that the room had been cleaned, that you have the seal number, things like that we didn't do before*' (recall *Model of Service Delivery* section for information on how and which rooms are forensically cleaned).

The police representatives that took part in the second stage of the evaluation were also extremely appreciative of having someone to take responsibility for looking after the victims and their families. All were honest in their acceptance that this was something that the police had '*not been very good at*' and had been '*criticised*' for in the past:

> *"We don't have the training or qualifications to give them the care that they need. Now we are able to step away and do your role knowing that that part of the job is being done by someone."*

Victim Advocates

Indeed, the role undertaken by the victim advocates (e.g., ISVAs and crisis workers), in terms of the services and support that they provide to victims, was seen to be critical to the SARC's success to date. To reiterate, the Cardiff SARC employs an ISVA for adults, an ISVA for children/young people, and eight 'crisis workers'[30]. ISVAs are trained support workers who provide assistance and advice to victims of sexual violence. ISVAs work closely with a range of partners and may be based in SARCs or voluntary sector projects. Recognising the value of these posts, the government's *Action Plan for Tackling Violence, 2008-11* calls for providing ISVA support to *all* victims of sexual violence by 2011.

The official Home Office job description of an ISVA, along with recently concluded national research (Robinson, forthcoming) indicates that the main responsibilities of an ISVA can be broadly grouped into the following areas:

- *Advice and support*: providing crisis intervention and non-therapeutic support to victims; providing other types of practical help and advice;
- *Supporting victims through the CJS*: giving information and assistance through the criminal justice process as requested/required; and,
- *Multi-agency partnership working*: liaising with partner agencies in a multi-agency context, providing 'institutional advocacy'.

Similarly, the role of the crisis worker is to provide all victims with initial support, and to ensure that individuals make informed choices and are cared for dignity and respect during their arrival and initial time at the SARC.

As the above section suggests, the simple fact that these roles are available to help support victims of sexual violence within the SARC, meant that the other professionals could do their jobs more efficiently and timely, while the victim was still given the care and attention that they needed.

> *"It just took the pressure off because they [the ISVA and crisis workers] were there, the [ISVA] looked after the mum and the child and I was able to take mother and child around the SARC separately while [ISVA] looked after the other."*

> *"There is always somebody there for the victim when you've finished with the medical the interview, that is there to look after the victim and families, it allows the police to get on and brief the paediatrician, the FME, without worrying [for example, about] where is the child, where is the mum, do they need a drink. [ISVA] completely takes over that role…"*

The importance of the ISVAs' role in particular was also seen to aid the longer term investigation of sexual violence offences reported to the police. The following quotation presents an example of good practice, in which ongoing communication between the police and the ISVA enabled the ISVA to keep the (child) victim and her family updated with the progress of the case. In addition, the ISVA encouraged the

[30] The role of Crisis Worker was initially undertaken by advocates (IDVAs) from the WSU. The implications that this had on the running of the SARC will be discussed later in the report.

victim's willingness to cooperate with the police investigation, in terms of the collection of medical evidence:

> *"They're [the ISVA] not just there for that day, it follows on from there, keeping in touch with me [police] and I've been updating her with the progress of the investigation, but she is then linked in with the mother and the child…I was notified by the paediatrician that they wanted to do a follow up with the little girl and the paediatrician was a bit concerned about sending a letter out without some pre-warning so I brought that to [ISVA] attention and she contacted the family, so it's just really really well joined up."*

Finally, the evaluation has also been able to capture feedback from the victims in terms of their appreciation of the work undertaken particularly by the ISVAs, as the following quotation indicates:

> "*And the feedback from clients…both verbal and I've got some written feedback as well. And it is that they always feel very calm and reassured and we're kind of supporting them and giving them control back."*
>
> *"Parents actually say that their children kind of look forward to coming."*
>
> *"The best feedback is that the [victim] communicates in the way that is appropriate to them and they are happy to come here. I always think I'm the person they never really want to meet because the reason they come here is because of what has happened, but I think as much as it can be it is safe."*

Previous research looking at the experiences of sexual violence advocates has uncovered a number of challenges that they face within multi-agency partnership work (Payne, 2007) including: overstepping boundaries (e.g., sexual assault nurse examiners taking on the role of the advocate during examinations); occupational subcultural problems (e.g., health professionals not seeing domestic/sexual violence as a health issue); communication barriers (e.g., professionals not referring victims to available services in the area); and role ambiguity (e.g., other partners not viewing the advocate as a 'real' professional). Within this research there was some evidence of minor tensions, relating to role ambiguity.

One example relates to a situation where one of the ISVAs had been seen to question the role of the police when dealing with sexual violence victims at the SARC. Here, the interviews revealed how an ISVA had criticised the police during a presentation for not relaying the options available for victims of sexual violence at the point of trial, earlier enough in the process[31]. The police in contrast felt that this was not always appropriate at the first meeting with the victim due to the fact that '*the victim has enough to think about'* at this time, and *'won't take it all in'.* This clearly highlights a difference in opinion with regard to working practices, which can lead to negative working relations. Indeed, for the police, their initial reaction was the ISVA was overstepping her boundaries and their response was *'you do your role and we'll do ours'.* However, at the same time, the police representative also recognised that

[31] This relates to special measures that a victim can apply for during the trial, including giving their evidence via video link or from behind a screen, or where the victim is a child, for the Judge to remove their wig and gown.

this issue could be easily resolved in an appropriate and non-confrontational manner due to the good working relationships between themselves and the ISVA, and the lines of communication that were in place:

> *"It's all about communication… our relationship with the SARC workers are good enough for you to have a chat about these disagreements over a cup of tea."*

Furthermore, it needs to be noted that the presentation given by the ISVA (where the above comment was made) was part of a wider initiative to inform and educate all partners of the work undertaken at the Cardiff SARC, and in particular the role of the staff, including the ISVAs. The overall perception of such events was positive, as the following quotation highlights:

> *"The ISVA and the SARC manager were represented at SOLO training day at South Wales police. That gave us a real insight of the work undertaken by the SARC, beyond the police's involvement… the nature of multi-agency work [that is going on]…It all helps at an operational level for the police to know what to expect and how they fit into the process."*

A further example where minor tensions had arisen between the ISVA and other partner representatives was again related to role ambiguity. For example, there was some evidence to suggest a degree of ambiguity as to how the ISVAs work fitted alongside the role undertaken by social services. In this instance, it was argued that social services lack of '*hands on*'[32] engagement with some of the cases presented at the SARC was due to the fact that their role was being done, in some measure, by the children's ISVA. Again, however, concerns over the role of the ISVA had been raised through the appropriate channels and the issues were being dealt with. In fact, the way in which both examples were being dealt with actually reflects good practice in terms of working relationships and channels of communication.

It would thus appear that many of the problems cited in previous research relating to the work undertaken by sexual violence advocates have, to date, not materialised within Ynys Saff. Furthermore, when tensions did emerge, effective working relationships had been developed to help resolve them. Indeed, as the following quotation demonstrates, there appeared to be proactive collaboration between the respective agencies, and a genuine desire to improve services for victims (see also Campbell, 1998; Martin, 2005):

> *"Everyone was really keen to do a really good job. And there was a sense of us all being one team… [for example] a police officer saying to me 'do you think it's going OK', and [then I responded], 'yes I think it is' and it was lovely we were all working together."*

This may of course be due to the fact that the involved partners already have vast experience working with advocates in a multi-agency capacity (e.g., the WSU, Specialist Domestic Violence Court, and MARACs). However the following section

[32] Issues surrounding agency engagement will be discussed in more detail later in the report.

outlines further explanations to account for this level of support for the role of advocates within Ynys Saff.

Victim-Focussed Occupational Culture

The evidence presented above clearly highlights a genuine appreciation of the role that victim advocates take in this area. One key example relates to the principle role of the ISVA and the crisis workers within Ynys Saff being to ensure that victims' perspective and experiences were brought to the forefront of the process. This is consistent with previous research in this area, where victim advocates are said to help to tell "the other side of the story" (Campbell, 2005). In other words, advocates are able to keep in mind the victim's perspective and experience, and as such they are usually the only participants in a multi-agency partnership that are able to bring 'the other side' fully into focus.

Previous research has argued that this is due, in part, to their voluntary status, as Payne (2007:82) explained:

> *"Because they are not bureaucratically attached to any specific criminal justice agency, [professionals in the voluntary sector] are able to provide more direct assistance to victims who are unwilling to participate in the criminal justice process and to those victims who choose to participate in the criminal justice process."*

Similar conclusions emerged from the data within this study. In terms of funding, the adult ISVA was jointly funded by the Home Office and the Community Safety Partnership. The children's and young person's ISVA was funded by the Lloyds TSB Foundation. The financing of both posts however comes through Safer Wales, and both roles are managed by the voluntary sector. Consequently, in practice, they are '*not accountable to any larger policy or procedures'* but instead seen to be there *'to police all agencies'*. However, funding streams from the voluntary sector are often not secure or indeed permanent (the challenges presented by the various funding streams will be discussed in more detail later in the next section of the report). Consequently ensuring that these roles are maintained and indeed managed by the voluntary sector poses a continuing challenge to those involved with the SARC. For example, the funding for the children's ISVA ran out on the 31st March 2009 and alternative funding had to be found. While the following quotation clearly highlights the conundrum that this presents, it nonetheless shows that the management by the voluntary sector was seen to be crucial in terms of maintaining the independence of SARC staff, especially ISVAs:

> *"But the difficulty with the ISVA and the children's ISVA is that although I want the funding to be mainstreamed, I want them to remain independent, so I think they have to stay within the voluntary sector. So Health taking on that post is not the solution because once you're into a hierarchy it's very difficult then to challenge, to stay the voice of the victim. An advocate always has to be on the outside, especially if you're undertaking institutional advocacy."*

The crisis workers on the other hand are funded through the Heath Service. Evidence is presented later in the report that points to problems encountered as a result of the different agency cultures and practices of partner agencies, in particular

those of the Health Service. Indeed, some viewed the Health Service as an overly bureaucratic organisation. However, measures were put in place to ensure that the crisis workers within the Cardiff SARC were able, and had the skills, to work within a victim-focussed occupational culture.

As this report has already highlighted, in terms of their role within the Cardiff SARC, the crisis workers are usually the first point of contact for the victims, particularly if cases are presented out of hours (between 5pm and 9am). They are therefore present to offer initial support to the victims and deal with any immediate concerns, usually at the most difficult times (both for the victim and the professionals).However, their role within this field has often been given a relatively low status (evidenced in their salary). A primary aim within the Cardiff SARC was therefore to 'empower them' to become 'the voice of the victim', similar to the role undertaken by the ISVAs. This was achieved firstly through training, with the aim to give the crisis worker the permission and skills to challenge. This training was multi-agency to reflect the ethos of the SARC; it was delivered by police, FMEs, ISVAs and the SARC manager. It was co-ordinated and overseen by the SARC manager and competencies were developed to ensure the crisis worker team were well trained and dedicated:

> "B*ecause at two in the morning everybody's tired, there's a high pressure on, it's an emergency situation, and people tend to revert to type. So in order to give them permission to say to a forensic medical examiner, or a police officer, 'This is not the right moment for the victim, the victim needs more time, the victim's not ready, you won't get best evidence from the victim at the moment.' In order to have that very clear voice they had to be empowered to do that…[so the training was about*] *giving them very clear permission that regardless of where they regarded their status, they had the right to challenge."*

Once in post, the crisis workers were also paired up with experienced advocates from the Women's Safety Unit. They were also 'shadowed' by the SARC manager and adult ISVA. By pairing them up with trained staff it was hoped that this would help re-enforce a victim-focussed occupational culture:

> *"The aim was to create a culture and that's the key thing, it's the culture of an organisation that impacts on service delivery. So it was for me creating that victim-led culture which would mean that at two in the morning that crisis worker, regardless of how much she's paid, or whatever her status, would challenge somebody who was a senior and experienced professional in their own field and say 'This isn't right for the victim.' So to get that victim's voice there it was critical as a process to put them all in parallel."*

Finally, additional support mechanisms had also been put into place to ensure that the notion of a victim-focussed occupational culture was sustained in the future and, as the following quotation highlights, in recognition of the support needed to carry out the role of an advocate within this field:

> *"Being the voice of the victim, what you do is you absorb all that isolation and hostility and loneliness that the victims often feel. Within the system you can often feel like a lone voice challenging, and in order for them to be*

> *able to continue to do that year after year, it's not about just making it work in these next few months, it's about the long term success of the project. So putting in a whole network of support for these posts is critical if they're going to, in the long term, keep their edge."*

The evidence presented within the report would seem to suggest that these measures had been successful at creating a '*culture of challenge'*, whereby a system was created that *'worked for the victim, as opposed to the victim fitting around the system, or fitting around the convenience of other people'.*

Challenges Past and Present

The report thus far has predominantly focussed on the positive achievements and major in-roads that the SARC has accomplished in terms of partnership work and provision. The remainder of the report however identifies a number of tensions apparent within the multi-agency work undertaken to date[33]. While some of the challenges that will be discussed were identified, or at least anticipated, during the pre-operational stage of the evaluation,[34] the opening of the SARC brought to the forefront a number of underlying tensions surrounding multi-agency working. The following sections therefore explore, in detail, current and continuing challenges associated with multi-agency working exposed by the opening of the SARC, some of which have been overcome to a certain extent (in such cases evidence will be presented to show how these have been dealt with), while others remain potential challenges that will need to be overcome in the future. It is important to recognise throughout that any multi-agency endeavour, especially one that is embarking upon uncharted grounds (in this case including infants and children as SARC clients), will inevitably experience some tensions and challenges. Indeed, many of these challenges were expected by those involved, many of whom had extensive experience of multi-agency partnership work before the development of Ynys Saff.

Political pressure versus operational detail

To reiterate, the SARC became operational on 2nd October 2008 (nearly two years after the idea was first conceived). For some, however, the SARC was still not ready to be opened at this time. For example, a number of interviewees felt that the SARC was opened due to *'political pressure as opposed to operational detail… [that in turn] created an initial tension, which is not the best way it start such a complex service*'. Indeed, one interviewee acknowledged clear tensions between the Executive Group and staff that would be working with the victims of sexual violence in the SARC. For them it was apparent that while '*the executive group had the vision, they weren't in touch with the reality on the ground level'*. In response, members of the executive group argued that there had been no political pressure to open the SARC, and that the pressure to delay until everything was 'perfect' reflected the problems of working within risk adverse occupational subcultures. Nonetheless, the impact that this was felt to have on the service that the operational staff were able to deliver will now be discussed under the appropriate headings.

[33] The multiple problems associated with partnership work have been extensively documented elsewhere (see for example, Hudson 2007; Hughes 2007; Maguire 2004; Martin, 2005; Payne, 2007; Ullman & Townsend, 2007).

[34] See Robinson, Hudson & Brookman (2008) for a full discussion.

Funding and Staffing

Funding has already been described as an aspect that helped to cement multi-agency commitment, but as this report has to some extent acknowledged it also posed a continuing challenge, especially in the face of the current economic climate and budget cuts. To reiterate, the funding for the Children's ISVA, originally provided by Lloyds TSB ran out on the 31st March 2009 and alternative funding had to be found. Implicitly interlinked with funding are problems surrounding staffing. Even before the SARC became operational, many of the interviewees voiced their concern at being able to adequately resource and sustain the staff needed to run the SARC successfully. In fact, at the time of opening, the SARC was, in many respondents' views '*not adequately staffed*'. In place was the SARC manager (although only for a short period of time prior to the SARC's official opening), and two ISVAs. Once opened, the SARC was initially solely reliant on crisis workers from the WSU, with eight posts funded by the Health Service being appointed directly to the SARC at a later date[35]. The SARC also did not have administration support, a clinical director or, as some argued, suitable (or 'sustainable') paediatric cover. In terms of the latter, while the clinic had a level of paediatric cover, this was not considered to be enough required or expected by some involved in this venture. Indeed, this issue remains to be fully resolved, despite important progress (e.g., the implementation of three clinical sessions for children offered each week - this will be discussed in more detail later in the report). The lack (or perceived lack) of staffing for the SARC presented some staff with a number of challenges, not least, as already mentioned, tension between the Executive Group and those appointed to work directly with victims of sexual violence.

In the first instance, a number of interviewees considered that the late appointment of the SARC manager meant that some of the '*operational detail was not thought through*':

> *"It was a case of inputting policies and procedures that weren't in place before the SARC was opened which arguably should have been, so we have concentrated in setting up the SARC whilst we are actually in it rather than setting up the SARC before we came operational".*

> *"The building was there and some of the material was there, but the detail had not been looked at".*

In fact, there were few protocols or procedures that were not already in place when the SARC became operational – on paper at least. Rather, some staff seemed unaware of their existence which points perhaps to a lack of communication during the early opening stages of the Centre or, as has been suggested by one interviewee, a perfectly natural anxiety which arises from people's unfamiliarity with working in a new venture with a '*new way of doing things*'. Indeed, there was some acceptance from all respondents '*that most projects like [the SARC] will undergo change once they become operational*'. Furthermore, as the SARC is a '*client led'* initiative, there was a degree of expectation that changes would have to be made '*based on client feedback and recommendations'* which of course is only available

[35] It should be noted that it was always the intention for crisis workers from the WSU to work alongside newly appointed staff at the Cardiff SARC to help instil and promote a victim-focussed occupational culture. This will be explored in more detail later in the report.

once clients start coming through the doors. Nonetheless, it was clearly felt by some that further preparation was needed:

> *"We could have worked through the detail, could have walked the victim pathway and made sure that the standard operational procedures fed into that pathway and was actually what was going to happen on the ground, whereas we were very much at risk of not being able to fill gaps if things happened for example, in terms of health and safety for staff and clients."*

The following account provides an example of the type of problems that may arise in multi-agency working. It related to the issue of equipment used by the police in the SARC, for example, the modules used during the examination or the DVDs used for recording police interviews. The procedure at the time of writing, as to who would supply this equipment to the SARC, was described as '*ad hoc':*

> *"Someone from the SARC team will call Cardiff police, perhaps because the links there are stronger in these early stages, due to the location of the SARC if nothing else, and they will bring them over to the SARC."*

However, it was envisaged that such an informal procedure could lead to tensions among the partner groups as the following quotation highlights:

> *"Who is going to order and pay for them in the future …especially when you consider the SARC is going to be used by Newport and Barry… I don't care who provides them, but at some point South Wales Police may object to the fact that Gwent are using them and not actually contributing."*

There is evidence to show that Gwent police had contributed to the funding of the SARC, while at this time were not actually benefiting fully from the service it could offer (for example, the SARC at this time was unable to provide paediatric cover for children in the Gwent area). Consequently, it could be argued that the frustration expressed by these respondents is perhaps more due to a lack of communication and information regarding the involvement of the different partners. Nonetheless, factors associated with staffing and, linked to this, preparation and communication, clearly present challenges that will need to be managed to maintain everyone's commitment, enthusiasm, and funding for the continuing development of the SARC.

Funding was not however seen to be the only barrier to the staffing issue. In some cases the issue was simply one of a lack of suitable staff to attract to the the project, particularly from Health:

> *"There is an issue around whether there is the personnel to do the work and that is across the country in terms of finding hands on people, be that doctors, nursing, paediatricians… "*

This was certainly the case with the clinical director (in this instance a position was advertised but a suitable candidate was not found) and has some resonance with the difficulty in providing suitable paediatric cover (this will be discussed in more detail later in the report). The difficulties in attracting staff were put down to a number of

factors, including the hours they would be expected to work:

> *"People don't want to be on call and that is perfectly reasonable at one level…"*

Linked with this is the fact that the SARC operates a 24 hour service and the implications that this will have on both staffing (in terms of available crisis workers, ISVAs and FMEs) and resources.

Diverse Agency Cultures

The second barrier to emerge from the research reflects the cultural differences of each agency representative. This has already been discussed in relation to the nature of funding for the Cardiff SARC and thus management of staff employed to work with victims of sexual violence. As it has already been suggested, there was some evidence of a general lack of understanding with regard to the cultural differences and the working practices and limitations of partner agencies during both stages of the evaluation process:

> *"Partnership working means working to the same aims but at the same time fulfilling the needs and aims and targets of individual agencies and not everybody gets that. Some people think it's just going to create more work and they are not going to be able to get anything out of it, they are not going to be able to fulfil their own aims and targets whereas if you get it right you don't create more work, what you actually get is other agencies helping you do your bit and that's great…"*

For example, some agencies (while appreciative of Health's involvement) felt at times that members of the Local Health Boards and the Trust were 'dragging their heels' with regard to certain developments, particularly in relation to funding issues and staffing problems (in particular paediatric cover). As this report has already noted, the SARC was initially reliant on crisis workers employed by the WSU as Health could not get these posts filled in time. In addition, the Trust's inability to resolve, in a timely fashion, the complex issues surrounding the provision of paediatricians and out of hour's services, particularly for children from the Gwent area, had caused some considerable distress[36]. Consequently, for some there was initial apprehension that the SARC manager was employed by the Trust, seen to be an '*overly bureaucratic organisation'* and a '*slow moving machine*':

> *"The Trust seems to move a lot slower and seems to have a lot of constraints placed upon it… The voluntary sector … doesn't necessarily work in the same way, it works to protocols …"*

In some respect, this reflects a lack of understanding with regard to the cultural differences between the Health Services and other partners, relating for example, to the budget that the Health Service has access to, and/or a lack of understanding of the Human Resources and Clinical Governance framework that necessarily guides

[36] This issue will be discussed later in the report under the section entitled 'Providing Services to Child Victims'.

decision making within the Health Service. However, as the above quotation suggests these differences were beginning to filter through to all agencies involved with the SARC. As this report has already suggested, these issues were to some extent overcome through the different agencies' involvement in this venture (for example, though their representation on the Steering Group and later Executive Partnership Group and Operational Task and Finish Group and their ability to work directly with individuals from the different organisations) as well as the role that the project lead was able to play in acting as a '*go-between*' for the different agencies. Such multi-agency working enabled each partner organisation the opportunity to communicate differing aims and restrictions that they might encounter. Indeed, police representatives that took part in this evaluation, described a more '*pro-active role'* in partnership work than they had embarked on in the past. The advantages of such working practices were that they were able to '*see the wider picture'* and that other partners would be able to *'understand the difficulties [that the police faced] in investigating incidences of sexual violence*'. Nonetheless, tensions in the ways different partners operated clearly became problematic once the SARC went operational, and will therefore need to be managed. Linked to this are the wider interests and responsibilities of the different agencies involved, which will now be discussed.

Competing Agendas and Priorities

Most if not all agency representatives are highly performance driven and exist to some extent within a culture of 'Performance Targets'. For the public sector these may be centrally driven, whereas the voluntary sector will need to prove their model works in order to secure additional or mainstream funding. One potential obstacle that was raised through the interviews at both stages of the evaluation was the possible conflict between criminal justice goals (e.g., increased number of convictions) and the needs of the victim. While in the initial stages of the SARC's development, it appeared that the victims' needs took precedence over any criminal justice goals, there was some apprehension that this might change over time:

> *"I can see some problems with evidence gathering where victims don't want to pursue a police investigation but there could still be evidence there which could lead to a serial rapist etc. So a bit of a stumbling block is regarding how we deal with forensic samples from people in that situation. I think it can be overcome but how we sell it to victims is an issue."*

> *"I think there might be some conflict between the criminal justice route and the civil route and also between criminal justice and the therapeutic services within the actual SARC itself. The police may want to really push it as a criminal justice matter when that's not really what the victim wants at all, and that may become quite difficult."*

Since becoming operational the overall priority of the SARC remained the individual who had been assaulted *'whether that is a man, women or child and the care that they receive after that has happened to them'*. In terms of victims' needs taking precedence over criminal justice goals, evidence was presented whereby police were willing to come to the SARC to offer informal advice to victims without any expectation that the case will proceed into a '*formal police process'*:

> *"I've got a young woman who has disclosed, but doesn't know if she wants to disclose to the police. But I can get the police to come here informally and talk to her, and they will do that. For me, my role is, knowledge, its power, so [that the victim can] make [their] decision based on what [the police] say to them. And being able to pick up the phone and facilitate that is great. So, although we might be stepping into a formal police process, we might not. But the police are still willing to come and engage with that young person and see them."*

Furthermore, as this report has already acknowledged, many of the partner representatives appreciated the different ways of working, from all those engaged with the process, in helping improve the overall care that a victim will receive. To provide a further example, the following quotation highlights how the needs and priorities of the different partners involved in the venture were being incorporated into how the SARC operates:

> *"[The SARC staff] understand that we have a duty to investigate and arrest…They have quickly grasped the importance of sharing intelligence with us. So for those people who walk in they have devised a fantastic intelligence Proforma, where they will get all the detail of the offence and although the person doesn't want any involvement with the police they can share it with us [in an anonymous capacity with the victim's consent] so we can build up a picture and identify for example problem areas… So everyone understands their role but we are bringing it closer together so that we share information and we work together."*

In relation to the above example, the SARC staff had begun, in collaboration with the police and CPS, to develop an 'evidence collection protocol' which, it was hoped would eventually become an 'All Wales Document'.

In addition, new partnerships and initiatives whereby multi-agency dialogues were taking place, were (at the time of writing) already being formed and developed to ensure that the best outcomes could be achieved for everyone involved. For example, the CPS has directed a senior prosecutor to lead on violence against women as part of a national strategy. From this, the lead prosecutors from both Cardiff and Gwent, having visited the Cardiff SARC, had agreed to undertake pre-trial interviews with victims. These will cover all aspects of the trial process and crucially, will be undertaken within the SARC itself. While this is seen to be in the interest of the victims (in terms of ensuring that they are prepared, not just with regard to their evidence, but of what to expect from the trial process, as well being undertaken in a facility that is neutral and known to them) it is also envisioned to assist in reducing attrition rates in cases of sexual violence.

The SARC was also highly involved in a 'Christmas Campaign', a joint venture with the police and sexual health to put sexual health nurses on the streets during the Christmas period (2008) in order to provide advice and support to people out during the party season, with an overarching aim to reduce the incidences of sexual violence over this period. The SARC's involvement was also, in part, to help promote a more accurate picture of victims of sexual assault and to challenge some of the

stereotypes surrounding sexual violence:

> *"Part of that Christmas Campaign, was that about sharing a broader vision of the victim as well, and trying to, you know, change people's perceptions about that… [challenge the idea that] we working people are supposed to be so sensible we wouldn't put ourselves in that position, when that's not the evidence…"*

This was one of the longer-term goals set for the SARC which has already begun to affect operational practice within the first quarter, indicating a very robust beginning.

However, despite examples of good working practices, some competing priorities had begun to emerge in actual delivery. For example, an issue was raised that the police were anxious that the so-called '*golden hour*' for the collection of forensic evidence was not being met, particularly in the cases of child victims. This had become a factor in cases that were presented in the middle of the night where the on-call paediatrician had refused to come out until the morning. The reasons for which were that it was felt that children, were "*better sleeping".* The issue here is that despite being presented during the night, the child would be tired. It was therefore considered best practice for the child to sleep, and for the examination to proceed in the morning, when the child would be in a more comfortable state. In addition, it was recognised that a child may fall asleep while waiting for the paediatrician to attend during the night, which compromises the child's wellbeing further:

> "*They are better sleeping; there is nothing worse than waking up a sleeping child to examine their genitalia."*

It can of course be assumed that the police's frustration may have been exacerbated as a result of the (mis)perception that paediatricians were not fully committed to the venture (see above and discussed in more detail later). For whatever reason, competing agendas and priorities can be seen as real future challenges that may have negative impacts upon agency commitment and enthusiasm.

Other partner representatives also identified unique goals they expected the SARC to achieve that might not be in line with the expectations and perceived outcomes of other partner agencies that might lead to agencies becoming frustrated and withdrawing from the venture. For example, this report has already suggested that Health had fewer reasons to engage with partnership work of this type compared to other partners. Indeed, the long-term priorities for Health, some of which are summarised below, are extremely difficult to evidence:

- Reducing waiting lists
  "…there are different levels of priorities across the different agencies... health might [want] to reduce waiting lists …"
- Reduction in resources accessed by victims
  "I think from the very longitudinal outcomes, there is going to be a need to … evaluate whether by providing a more comprehensive service earlier on following the assault, whether that will reduce the need to access health care services further down the line…people who access the health care services

months, years whatever retrospectively, … use quite considerable amounts of health care services within the NHS…"

- Reduction in the number of historical/ retrospective cases presented
  "I think there is a significant amount of evidence that the longer people take to disclose and to get help from a whole range of services, the longer it takes for them to recover..."

The report also identified some tensions with regard to the function and role that the SARC should fulfil. Some representatives from Heath had hoped that the SARC would be able to fully accommodate a children's clinic that was currently being run in a local hospital, and indeed, thought that this was a priority. However, it was felt that the SARC at this stage was a centre for *acute* sexual violence[37] and did not have the (appropriate) facilities to deal with *all* historical cases that were seen within the clinic. This meant that the clinic at the local hospital would still have to operate a service for children with gynaecological problems where there was no evidence or disclosure of sexual offence, or children that were receiving on-going (long-term) care after an incidence of sexual abuse. In addition, some of the interviewees from across the different partner agencies felt that the SARC should cater for all child protection cases (i.e., physical abuse as well as sexual abuse). The latter example presents an interesting area for discussion, in terms of the future development and role that the SARC may wish to pursue.

Maintaining Agency Commitment

Evidence from previous research has also shown that competing agendas can instil a level of competitiveness that is not conducive to successful partnership activity (Hudson 2007; Maguire 2004) and can impact on a range of outcomes, in particular maintaining agency commitment. Funding too was also seen to be clearly linked to problems surrounding maintaining agency commitment in light of different priorities and goals. With funding streams from many different directions (see above), it was seen to be essential that all partners maintained motivated and committed to the running and the future of the SARC:

> *"[The SARC will] have to look very closely at how they are delivering what they are delivering and its value. So in a way to compete within that for some very scarce resources the SARC has to really evidence the value. And where my fears are that where the savings are being made may not be directly beneficial to the agencies that are putting the investment in, so if the funding isn't matching their central aims [then they will] appear to be funding something that they aren't benefiting from straight away…If they have to go back to their managers and justify why they are putting in this investment it becomes increasing hard to do so…"*

However, as one interviewee stated, this can and to some extent has been managed by the continuing adaptation of the SARC to meet the different aims of each individual agency as well educating people to the needs and priorities of their partners (see above):

[37] Here acute sexual assault includes victims that have been assaulted within the past seven days. It does however also include cases of historical abuse where the victim has disclosed a past offence to the police and is going through the criminal justice process for the first time.

> *"A lot of people often worry about this in partnership work, multi-agency work- they think 'well how can we get people to share the same aims and objectives?' [but] I always say you don't have to…what you have got to do is create something that allows them to meet their targets whatever they may be. Now for the police if they are increasing conviction rates … they are happy, if they are reducing violence they are happy …if they aren't seen to be getting the numbers they won't be so happy so [the SARC] needs to [try to meet this objective] and this is fine. So it's about trying to meet everyone's expectations bringing them in line with what the SARC can realistically achieve but also educating people to other people's expectations…"*

> *"If you see an increase in conviction rates than I think the police will be motivated, if you see people using the health element of the service it will be very difficult to demonstrate that they use it less once they leave the SARC but evidence suggests that early intervention usually leads to a better outcome, so it will be harder to convince the health partners to invest more money and commitment, but once you get more deliverables that people can see it working then you'll start to get some powerful feedback that highlights the successes of the SARC and people will be on board."*

However, as the report has already suggested and as this latter quotation reinforces, evidencing that the SARC is meeting their particular objectives will be more difficult for some partners, particularly Health. Conversely, as it was recounted by a number of interviewees from different partner agencies, the fact that the Health Service and the Trust were still so much engaged with the SARC is an example of good practice. Nonetheless, care will need to be taken to ensure that the SARC's wider benefits are at least acknowledged and promoted in any future documentation.

Maintaining Agency Commitment: Evidencing the 'One-Stop-Shop'

As this report has already suggested one of the perceived benefits of the SARC was that it would provide a more holistic process, whereby all the agencies working with victims of sexual violence would be '*under one roof*' within the concept of a '*one-stop-shop*'. The benefits of now having all the facilities needed to provide the care needed for the victim within the SARC are appreciably articulated in the following quotation:

> *"The fact that they can have their medical examination there and the fact that after that we can now say have a shower, here is a change of clothes, here is your changing bag with absolutely everything in it, because obviously cleaning is really, really important … now the interview can be done, but they can have a shower first, we're not saying we want you to sit in your dirty clothes because you already feel dirty and violated and uncomfortable and we want you to sit through a two hour interview, and now all of that is made so much easier and better for the victims."*

In addition, evidence has also been presented that shows that the SARC has helped in certain areas to improve performance by those working with victims of sexual violence. To reiterate, it has been acknowledged that the SARC has '*assisted in professionalising [police] investigations*', as well as making referral procedures more transparent (see above).

It was further expected that the concept of a '*one-stop-shop'* would ensure that all agencies and services working with sexual violence victims would be more '*joined up'* and readily available to meet the needs of those entering the SARC in a timely and efficient manner. While this report has presented a number of good examples of partnership working, and commitment to the SARC, there is some evidence that this commitment is not permeating through to actual delivery. For example, it was noted that in some cases the victim's criminal justice 'key worker' (either a police officer or social worker) were not present at the medical examination which meant that medical examiners were not fully briefed before the examination. The implications that this has on both the medical examiner and the victim are described below:

> *"I don't like re-interviewing the family… I know what I am looking for really and they shouldn't have to go through it all again. So I would say that it's not totally working yet."*

Furthermore, evidence was presented to suggest that where police officers were present, they were unable to undertake the interview as they were not trained to the sufficient level. On these rare occasions, victims would have to return to the SARC at a later date to complete this part of the process.

Challenges were also raised with regard to agency representation. While this report has argued that agency representation was on the whole excellent, it became apparent that certain agencies were less involved than others. For example, Social Services were perceived to be less involved than it was thought they should be, due to the role ambiguity between their service and the role undertaken by the ISVAs. However, it has also been acknowledged that Social Services have fewer reasons to engage with partnership work of this type, compared to other agencies.

Similarly, a primary goal of the Cardiff SARC was to work with child victims (the under 16 population) from the Gwent area. However, it has faced numerous problems with regard to providing paediatric cover for this area. This will be discussed in more detail in the following section. In terms of dealing with these problems it needs to be understood that care will need to be taken to ensure that all partners (including new partners) are properly integrated into the existing structure so that they bring added value without causing disruption to the service or defensiveness amongst other partners.

A final challenge associated with the task of maintaining agency commitment (and one that has been discussed previously) is linked to the role that key individuals have played in both the development and the operational phase of the SARC. Indeed, it would appear that both these stages have been driven, to some extent by certain key personalities.

> *"A lot of it is personalities, and that has been the strength of it…"*

These individuals are unmistakably fully engaged and committed to the SARC, and '*hungry to make it work'*. Their current enthusiasm to the delivery of the key services that the SARC offers is based partly on the fact that they can now see how good these facilities are, and the difference it can make to victims of sexual violence. For example, as the children ISVA commented, the pride taken in ensuring that the

SARC was designed from the beginning with children in mind, instead of as an afterthought, has not only improved the provision and care given to children but also made her role easier and more rewarding:

> "*Being able to offer squash, to be able to go get tea, coffee, coke or squash because in most places the adults get offered a drink and the children get left and I love to be able to be able to do that and those little things.*"

However, these same individuals also recognised that a reliance on key personalities could be problematic in terms of the on-going commitment and sustainability of the SARC. Evidently, this is a problem that has yet to be sufficiently managed.

Providing Services to Child Victims

One clearly unique feature of Ynys Saff is that it provides services to all victims in the Cardiff area, regardless of age. As stated previously, most sexual violence service providers nationally, of which SARCs are one type, cater for adult victims and very few cater for young people, let alone children or infants. Therefore there was not an existing recommended model of service provision that could helpfully inform the policies and practices of Ynys Saff. To add to this difficulty, from the beginning there was the challenge of trying to expand the service provided beyond the initially agreed boundaries to allow Gwent children to come to the SARC. In the first instance, the SARC was only able to offer these victims the interview facilities and access to the children's ISVA. It is only recently that the Cardiff SARC has been able to provide a more holistic service to these victims, including the forensic medical examination (during three dedicated clinics per week). The main challenges were around the provision of paediatricians and out of hour's services. Consequently, those engaged with the SARC had to contend with resource and funding issues, existing child protection rotas and an overstretched service. Arguably, this has posed one of the greatest challenges to the multi-agency partnership work and is yet to be fully resolved. Specifically, complexities remain around issues of clinical governance and the availability of staff. Nevertheless, the commitment from those engaged in Ynys Saff to bring about the improvements already apparent and to work to resolve those that remain is evident and reflects the pride discussed above, in ensuring that this SARC became the first that was designed, from the beginning, with children in mind.

This is an important point that cannot be overstated. Ynys Saff was the first SARC designed from the beginning to provide services to victims of all ages. It did not start as an adult project that was subsequently expanded to include young people or children. In effect, there was no best practice to follow from other SARCs in relation to infants and children and no lessons to be learnt from elsewhere in the country. Moreover, given the particular difficulties/sensitivities of working with very young infants and children it would be naive to assume that this area of service provision would not pose particularly difficult challenges for the multi-agency partnership.

Conclusion

Summary of Key Findings

1. Description of Ynys Saff

Ynys Saff is located in a refurbished section of the Cardiff Royal Infirmary (CRI), in the city centre of Cardiff. Since 2nd October 2008 it has provided services to victims of sexual violence (men, women and children of any age) from Cardiff and the Vale of Glamorgan and child victims from Gwent. It is open from 9am to 5pm Monday through Friday with 24-hour services provided for police referrals. The bespoke facilities, designed especially for victims of sexual violence and in particular child victims, enable services to be provided in a safe and comfortable environment. Specifically the services that the SARC provides include:

- General information and advice
- Police engagement
- Forensic medical examinations
- Crisis intervention, emotional support and advocacy

Staffing at the SARC consists of a core team including a SARC Manager, two advocates (Independent Sexual Violence Advisors or ISVAs), administrative support and Crisis Workers to cover both in- and out-of-hours referrals. An extended team of staff, indicative of the partnership approach used in both the development and operation of the SARC, includes officers from South Wales and Gwent police services, Forensic Medical Examiners (FMEs), Paediatricians and Social Services. In addition, referrals can be made on behalf of clients to a number of outside agencies and services including integrated sexual health, Genitourinary Medicine (GUM Clinic), the Women's Safety Unit (service for domestic violence victims), substance misuse services, and community mental health teams including psychology and counselling.

2. Early Findings from the Referral Data

A new monitoring tool, expanded from that used by the Home Office to monitor SARC and ISVA services nationally, was developed in consultation with staff before the opening of Ynys Saff. It was designed to collect information on all cases referred to the SARC, and data from cases received during the SARC's first operational quarter (2nd October – 31st December 2008) were made available for this research. Although they provide a helpful early snapshot of the SARC's workload, they should be viewed as preliminary (recall limitations noted on page 16). Indeed, it is likely that these findings will change over time as Ynys Saff becomes more established in the Cardiff area and as data collection procedures become more robust.

Analyses indicated that the 'typical' client was a white female, generally young, capable of speaking English, with few disabilities. This is similar to the profile of victims of serious sexual assault in the last British Crime Survey. However a significant minority of clients were men (14%). This is double the amount of men

reporting to SARCs in past research and represents an exceptional level of engagement with male clients.

Notably, most clients being referred to Ynys Saff were young: 84% were 30 or younger and 50% were 18 or younger. Younger victims were also the largest group in other national studies of sexual violence, but perhaps the amount of very young clients sets Ynys Saff apart: 24% were aged 12 or younger. Indeed, most sexual violence services do not even accept child referrals let alone have children make up a significant proportion of their workload.

Data were collected to assess clients' levels of vulnerability and findings indicated that a substantial proportion experience, in particular, mental health issues (35%), alcohol use (18%), history of sexual abuse (18%), and domestic violence (16%). This has implications for those attempting to care for and support these victims (most notably ISVAs) and demonstrates the importance of offering a range of services in a 'one-stop-shop' environment.

The 'typical' case referred to Ynys Saff was one of rape or sexual assault, which took place within the past month and was most likely committed by an acquaintance or relative in a domestic/private setting. The distribution of offences and where they took place is similar to that found in other research. The police were the primary referral source to Ynys Saff, accounting for 65% of all referrals in the first quarter, which is also comparable to other SARCs nationally.

Information was collected about 8 types of services offered at Ynys Saff. Similar to other research, forensic medical exams were the most common service provided within the SARC. In terms of services organized or offered to victims by ISVAs, about three-quarters of clients received both non-therapeutic support and advocacy. A lesser proportion (41%) received crisis intervention, which is understandable given that the relevance of this depends on when the offence was committed and in about one-quarter of cases the offence was committed some time ago (over one month, to more than one year or during childhood). Furthermore, in more than one-quarter of cases the ISVAs were known to have provided emotional support to someone other than the victim, usually a parent or sibling of the victim. This was a previously 'hidden' feature of ISVAs work that has been evidenced by the current research. Furthermore, it indicates the ripple effect that sexual violence has on the wider community and to which Ynys Saff is attempting to respond.

3. Multi-Agency Work to Develop and Implement the SARC

The evaluation clearly showed that the development, implementation and operation of Ynys Saff could not have been achieved without a strong commitment to effective partnership work, especially between the voluntary sector, police and health. At the same time, the voluntary sector played a crucial role in the SARC's development over time. In 2007, a multi-agency steering group was set up to manage the early development of the SARC. Its role was to coordinate all available services working with victims of sexual violence into a holistic framework; to identify untapped provision for these victims as well as current gaps in service provision; and then to generate income to fund the SARC so that a more comprehensive service could be

provided to victims of sexual violence in the Cardiff area. The steering group included representatives from the police, local authority, voluntary sector agencies, CPS, NSPCC, Community Safety Partnerships and health. It was chaired by a voluntary sector representative, who played a large role in bringing partners together and hosting the initial meetings. The diverse membership of the Steering Group was indicative of the widespread support and commitment to the project across various agencies.

Since its opening in 2008, Ynys Saff has been overseen by a multi-agency executive partnership board whose membership includes senior members of the following organisations: South Wales Police; Gwent Police; Cardiff and Vale NHS Trust; Cardiff Local Health Board; Community Safety Partnerships and the Voluntary Sector. The board meets on a regular basis and is responsible for:

- Maintaining an overview of the project
- Identifying any deficiencies in the service
- Suggesting improvements to the service
- Reviewing the performance reports
- Establishing pooled budget arrangements to meet the costs of the service

It was unanimously accepted that the facilities at Ynys Saff were far superior to the facilities previously available to victims of sexual violence in the Cardiff area. Apart from victims having to access the SARC via the main entrance to the CRI, which was viewed as unwelcoming, antiquated and lacking privacy, and some concerns regarding the size of the children's examination room, the facilities within the SARC were seen to work well, both for practitioners and victims.

The principle aim to provide a '*victim centred'* SARC, and uniquely a SARC that is able to cater especially for the needs of child victims, was widely perceived by those interviewed to have been achieved. In this regard, the work of the ISVAs was highlighted as particularly important, given that the principle role of the ISVA within Ynys Saff was to ensure that victims' perspective and experiences were brought to the forefront of the process. Furthermore, measures were put in place to ensure that the crisis workers within the Cardiff SARC were able, and had the skills, to work within a victim-focussed occupational culture. This included training and job shadowing with experienced advocates from the Women's Safety Unit. Such measures had been successful at creating a '*culture of challenge'*, whereby a system was created that *'worked for the victim, as opposed to the victim fitting around the system, or fitting around the convenience of other people'.*

The role undertaken by the victim advocates (ISVAs and Crisis Workers) was also seen as evidence of 'institutional advocacy' since they helped to facilitate improved performance by others working with victims of sexual violence across many different agencies. For example, comments from the police described how the SARC had helped professionalise their investigative process by improving their ability to effectively collect evidence. Respondents also commented on how the SARC had made the process of how to engage with victims, when they do come forward, more transparent and effective. Consequently, the support that the advocates were able to provide to victims' meant that the other professionals involved in the SARC could do their jobs more efficiently and timely, while the victim was still given the care and attention that they needed. Therefore outcomes for criminal justice (e.g., police

investigation of sexual violence offences) as well as for individual victims (e.g., health needs, satisfaction) were perceived to have been met. It should be noted, however, that the current research was not an outcome evaluation of the SARC *per se*, so these perceptions will need to be substantiated with further research. It should be noted that criminal justice outcomes and longer-term health and well-being outcomes for victims are included in the monitoring tool being used at Ynys Saff, and will therefore be available to use for future assessment of the service.

Finally, the current study explored, in detail, the current and continuing challenges associated with the SARC's multi-agency approach, some of which have been overcome to a certain extent, while others remain potential challenges that will need to be overcome in the future. First, funding was an aspect that helped to cement multi-agency commitment to the project, but it also posed a continuing challenge, especially in the face of the current economic climate and budget cuts. Even before the SARC became operational, many respondents were concerned at being able to adequately resource and sustain the staff needed to run the SARC successfully. Immediately after opening it was still felt by many that the SARC was not adequately staffed, and the throughput of victims in the first quarter was both larger than anticipated and include more child victims than expected. It remains to be seen how the staffing/resource issue will affect the future operation of Ynys Saff.

Second, there was some evidence of a general lack of understanding with regard to the cultural differences and the working practices and limitations of partner agencies, both before and after Ynys Saff became operational. This was linked to a concern raised during both stages of the evaluation over a possible conflict between criminal justice goals and the needs of the victim. While in the initial stages of the SARC's development, it appeared that the victims' needs took precedence over any criminal justice goals, there was some apprehension that this might change over time. Post-operation there were many examples indicating this did *not* happen, although this will need continuous monitoring. Furthermore, the importance of developing an effective multi-agency dialogue to ensure that the best outcomes can be achieved for all partners, as well as victims, was widely recognised.

Challenges were also raised with regard to agency representation. While this research indicated that agency representation was on the whole excellent, it became apparent that certain agencies were less involved than others. A similar concern arose out of the provision of paediatricians and out-of-hour's services, resulting in SARC staff needing to contend with resource and funding issues, existing child protection rotas and an overstretched service. Arguably, this posed one of the greatest challenges to the multi-agency partnership work, and one that has only been partially resolved to date. That said, it was always recognised that paediatric services would likely present the greatest challenges, not least because this was innovative work in an already stretched area of service provision.

Discussion

Ynys Saff appears to be another of Cardiff's remarkable victim-centred and multi-agency interventions for victims of crime.[38] That so many already overcommitted individuals, representing many different agencies across different sectors, came together with a common vision and goal is clearly at the heart of the success of this important venture. As demonstrated by this research, there are a number of difficulties as well as opportunities posed by multi-agency work on sexual violence. The importance of the voluntary sector in taking the initial lead and ownership of the project cannot be overstated. This finding is consistent with other research which has shown how, particularly for the crimes of domestic and sexual violence, voluntary/community agencies are absolutely crucial for promoting a community culture that is responsive to the needs of victims (Cook et al., 2004; Campbell, 1998; Martin, 2005; Robinson, 2006).

Unfortunately however, the situation is complicated by the nature of funding for this type of work. While there may be greater flexibility and willingness to undertake work on behalf of victims in the voluntary sector, the funding streams for these agencies is often not secure and in need of constant maintenance. In contrast, agencies in the public/statutory sector are more financially secure yet *historically* have rarely committed, outside of the work that they are already doing, to further improving services for victims, especially victims of domestic and sexual violence. The conundrum that is often presented is thus that the willingness and the resources do not necessarily coincide. As one advocate in Payne's (2007:90) research noted, *"Collaboration isn't the issue. Money is the issue."* Even the best multi-agency relationships will not be able to provide good services to victims if there is a lack of funding or resources:

> *"The Voluntary and Community Sector (VCS) provide valuable longer-term support and therapeutic services to victims of sexual violence and abuse, but the capacity of this sector is stretched and sustainability is a major issue."* (Home Office, 2007: iv)

The dangers of 'under-serving' victims have been recognised and addressed. However, in the case of Ynys Saff, while the issue of funding (and the factors associated with the different funding streams) still pose a real and continuing challenge to the SARC's future, it would appear that it is *not* the case that the public/statutory services involved (at least to date) are 'unwilling' to engage with such a venture. Indeed, evidence has been presented to suggest the opposite. Nonetheless, while this research has shown that mainstream funding is needed, the management of victim advocates (e.g., ISVAs) by the voluntary sector is seen to be crucial in terms of maintaining their independence and ensuring that victims' perspectives and experiences are, and remain, at the forefront of the process. Considerable work has been done to ensure that *all* partner agencies involved in the venture (regardless of

[38] For example, for victims of domestic abuse Cardiff implemented the Women's Safety Unit in 2001 and a few years later the Dyn Project to provide services for male victims. Cardiff was one of the first cities in the UK to implement a Specialist Domestic Violence Court (SDVC), which has been operational since 2002. Furthermore, multi-agency risk assessment conferences (MARACs) which are now running in more than 100 locations across the UK were developed in Cardiff in 2003.

sector) embrace a 'victim-focussed occupational culture'. This has, in part, been developed, and is sustained, through the role of victim advocates (e.g., ISVAs), not only in terms of the services and support that they provide to victims, but uniquely due to the leading role that they have been given within this multi-agency initiative.

In conclusion, this research has documented the incredible challenge of multi-agency work, but also the incredible rewards that are possible. In both an operational sense and a strategic sense, at both a community and at an individual level, the development of Ynys Saff in Cardiff has the potential to achieve measurable success across a range of outcomes. Only time will tell whether the challenges can be overcome; however, the following recommendations are offered in the hope of increasing the likelihood this will happen.

Recommendations

1. The access to Ynys Saff should be changed or refurbished to bring it to the same high standard as the rest of the SARC.
2. A paediatric lead would be a useful post to add to the current contingent of core staff at the SARC as coordinating the response to the (significant proportion of) child victims is necessary to ensure that appropriate and sustainable levels of services to meet their unique needs are available.
3. Regular reviews of operational practice on recent or current cases should either be incorporated into existing meeting held by the Executive Partnership Board and Operational Task and Finish Group or implemented on a regular basis. These should be attended by all core staff to monitor performance and keep channels of communication open between relevant agencies.
4. As the contribution of the voluntary sector to the development, implementation and operation of Ynys Saff has been widely recognized and highly valued, this should continue for the foreseeable future. This will help to preserve the SARC's independence and that of its staff, especially the Independent Sexual Violence Advisors (ISVAs), whose independence from statutory partners is crucial to their role and delivery of services to victims.
5. A review of the systems in place to support staff working in Ynys Saff should be carried out to ensure that their health and welfare needs are being met, in both the short- and long-term.
6. A review of the monitoring tool developed for Ynys Saff should be carried out to ensure that all relevant data are being collected and that the tool is 'fit for purpose' for the foreseeable future. Continuous monitoring of both criminal justice outcomes (e.g., investigation and prosecution of sexual offences) and victim outcomes (e.g., health, safety, well-being, and satisfaction) is recommended.
7. An outcome evaluation of Ynys Saff should be commissioned, at a minimum to report on the outcomes achieved with cases from its first 12-month period of operation. This larger sample of referrals will enable more detailed analyses of the various outcomes across different types of victims (e.g., by age, gender, ethnicity, etc.).

Bibliography

Campbell, R. (1998) 'The community response to rape: Victims' experiences with the legal, medical, and mental health systems', *American Journal of Community Psychology*, 26(3), 355-379.

Campbell, R. (2005) 'What really happened? A validation study of rape Survivors' help-seeking experiences with the legal and medical systems', *Violence and Victims*, 20(1), 55-69.

Campbell, R. and Raja, S. (1999) 'Secondary victimization of rape victims: Insights from mental health professionals who treat survivors of violence', *Violence and Victims*, 14(3), 261-276.

Cardiff SARC application (2006). 'Description of how Welsh SARCS meet Home Office minimum requirements'

Cardiff SARC (2008).'Ynys Saff, a port in a storm: information about our services for adults'.

Cook, D., Burton, M., Robinson, A. L., & Vallely, C. (2004) *Evaluation of Specialist Domestic Violence Courts/Fast-Track Systems.* London: Crown Prosecution Service and Department of Constitutional Affairs.

Feist, A., Ashe, J., Lawrence, J., McPhee, D., & Wilson, R. (2007). *Investigating and detecting recorded offences of rape.* London: Home Office Online Report 18/07.

Graham, R (2006) 'Male Rape and the Careful Construction of the Male Victim', *Social Legal Studies*, 15 (2): 187-208

HMIC/HMCPSI (2007) *Without Consent: A report on the joint review of the investigation and prosecution of rape offences* available at: http://inspectorates.homeoffice.gov.uk/hmic/inspections/thematic/wc-thematic/them07-wc.pdf?view=Binary

Home Office (2006) *Tackling Sexual Violence: Guidance for Local Partnerships*, Available at: http://www.crimereduction.gov.uk/sexual/sexual26.pdf

Home Office (2007) *Action Plan on Sexual Violence and Abuse*. Available at http://www.crimereduction.gov.uk/sexualoffences/finalsvaap.pdf

Home Office (2008) *Homicides, Firearm Offences and Intimate Violence 2006/07*, available at http://www.homeoffice.gov.uk/rds/pdfs08/hosb0308.pdf

Hudson, K. (2007) 'The SWing Model of Resettlement', in Hucklesbury, A. and Hagley-Dickinson, H (eds.) *Prisoner Resettlement: Policy and Practice*, Devon: Willan Publishing

Hughes, G. (2007) *The Politics of Crime and Community*, Basingstoke, Palgrave/MacMillan

Kelly, L., Lovett, J., & Regan, L. (2005). *A gap or a chasm? Attrition in reported rape cases*. London: Home Office Research Study 293.

Kitzinger, J. (1997) 'Who are you kidding? Children, Power and the struggle against sexual abuse'. In A. James and A. Prout (Eds) *Constructing and reconstructing childhood: contemporary issues in the sociological study of childhood*, Falmer Press, London, pp. 165- 189.

Konradi, A. (1996) 'Preparing to testify', *Gender and Society*, 10, 404-433.

Lovett, J., Regan, L., & Kelly, L. (2004) *Sexual Assault Referral Centres: developing good practice and maximising potentials*. London: Home Office Research Study 285.

Maguire, M. (2004) 'The Crime Reduction Programme in England and Wales: Reflections on the vision and the reality', *Criminal Justice*, 4(3): 213–237.

Martin, P. Y. (2005). *Rape work: Victims, gender, and emotions in organization and community context*. New York: Routledge.

Payne, B. K. (2007) 'Victim advocates' perceptions of the role of health care workers in sexual assault cases', *Criminal Justice Policy Review*, 18(1), 81-94.

Preston, L. D. (2003) 'The sexual assault nurse examiner and the rape crisis center advocate: A necessary partnership', *Topics in Emergency Medicine*, 25(3), 242-247.

Resick, P. A. (1993) 'The psychological impact of rape', *Journal of Interpersonal Violence*, 8(2), 223-256.

Robinson A. L., & Pickles J. (2003) 'Gweithio Gyva Ein Gilydd: Y Profiad Cymreig (Working Together: The Welsh Experience)', *Safe: The Domestic Abuse Quarterly, a national journal for practitioners*, 7, 4-6.

Robinson, A. L. (2003). *The Cardiff Women's Safety Unit: A Multi-Agency Approach to Domestic Violence. School of Social Sciences*: Cardiff University.

Robinson, A. L. (2006) 'Reducing Repeat Victimisation among High-Risk Victims of Domestic Violence: The Benefits of a Coordinated Community Response in Cardiff, Wales', *Violence Against Women*, 12(8), 761-788.

Robinson, A., Hudson, K. and Brookman, F (2008) 'Multi-Agency Work on Sexual Violence: Challenges and Prospects Identified From the Implementation of a Sexual Assault Referral Centre (SARC)', *The Howard Journal* 47 (4):411–428.

Robinson, A (forthcoming) *Independent Sexual Violence Advisors: A process evaluation.* London: Home Office.

Schafran, L. H. (1996) 'Topics for our times: Rape is a major health issue', *The American Journal of Public Health*, 86(1), 15-18.

Shepard, M. F. and Pence, E. L. (1999). *Coordinating community responses to domestic violence: Lessons from Duluth and beyond*. London: Sage Publications.

Ullman, S. E. and Townsend, S. M. (2007) 'Barriers to working with sexual assault survivors: A qualitative study of rape crisis center workers', *Violence Against Women*, 13(4), 412-443.

Zweig, J. M. & Burt, M. (2003) 'Effects of interaction among community agencies on legal system responses to domestic violence and sexual assault in stop-funded agencies', *Criminal Justice Policy Review*, 14, 249-272.