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Extended Research Article

# Exploring voluntary sector specialist services for victim-survivors of sexual violence in England: the PROSPER co-production study

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**Disclaimer:** This report contains transcripts of interviews conducted in the course of the research and contains language that may offend some readers.

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## This article

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# Abstract

**Background:** There is increasing recognition in England that voluntary sector specialist sexual violence services are essential in providing crisis and longer-term support to victim-survivors. However, there is limited empirical evidence about the scope, range and effectiveness of voluntary sector specialist provision and commissioning, or what victim-survivors want from services.

**Objectives:**

1. Explore victim-survivors' experiences of accessing and using voluntary sector specialist services.
2. Analyse the range, scope and funding of voluntary sector specialist services and how demand is managed.
3. Explore the usefulness of different approaches to service delivery and different therapy models.
4. Explore how different principles underlying service provision influence service delivery.
5. Investigate referral patterns and pathways, and how voluntary sector specialist services fit with each other and link to the wider network of services for victim-survivors.
6. Explore how arrangements for commissioning and funding services for victim-survivors across health, local authorities and criminal justice have evolved.
7. Develop a taxonomy of the voluntary sector specialist services/service models being commissioned and provided.
8. Make recommendations for the commissioning and provision of voluntary sector specialist services at practice and policy levels.

**Data sources:** Interviews with key stakeholders, focus groups with victim-survivors; a national survey of key stakeholders.

**Methods:** This multimethod study comprised five sequential work packages: work package 1: exploratory interviews with commissioners and providers and focus groups with victim-survivors; work package 2: national survey of service providers and commissioners; work package 3: in-depth case studies in four areas of England; work package 4: co-research with victim-survivors; work package 5: data integration. Co-production was built into the study from its inception through robust patient and public involvement and engagement activities. These included a co-applicant who is a survivor of sexual violence, plus the appointment of five expert-by-experience co-researchers.

**Results:** We captured the combined findings conceptually and diagrammatically into a new model comprising six themes: the complex and precarious funding landscape; the challenge of competition for funding and contracts; the importance and success of partnership working with organisations; the pressured environments within which voluntary sector specialist services work; different roles, scope and eligibility of voluntary and statutory services within an area; and the ways services are organised and delivered, underpinned by services' values and philosophies.

**Limitations:** The COVID-19 pandemic meant that we were unable to use the proposed methods of data collection for the qualitative components. Mitigation was through developing online modes of data collection. Recruitment to the case study phase did not reach intended thresholds, but rich insights were drawn from earlier phases of the study.

**Conclusions:** The PROSPER study has provided hitherto missing evidence regarding the funding and commissioning of sexual violence services in England. The findings are likely to be useful in informing future commissioning of such services. The PROSPER study has also presented some unexpected opportunities for learning, particularly regarding co-research in the field of sexual violence. We also claim a contribution to theory development through the expansion of a current theoretical framework that may be of use to others working in the specialist voluntary sector.

**Future work:** The model will require development and testing to assess its usefulness as a resource for training and education or as an aid to communications in any interactions that are concerned with the delivery, funding and commissioning of voluntary sector specialist services.

**Study registration:** This study is registered as Research Registry researchregistry5144.

**Funding:** This award was funded by the National Institute for Health and Care Research (NIHR) Health and Social Care Delivery Research programme (NIHR award ref: 18/02/27) and is published in full in *Health and Social Care Delivery Research*; Vol. 13, No. 10. See the NIHR Funding and Awards website for further award information.

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# List of abbreviations

| | |
|---|---|
| CAMHS | Child and Adolescent Mental Health Services |
| CCG | Clinical Commissioning Group |
| CSA | child sexual abuse |
| CYP | children and young people |
| EDI | equality, diversity and inclusion |
| GP | general practitioner |
| ICS | integrated care system |
| ISVA | Independent Sexual Violence Advisor |
| LA | local authority |
| LGBT | lesbian, gay, bisexual and transgender |
| MoJ | Ministry of Justice |
| NHSE | National Health Service England |
| OPCC | Office of the Police and Crime Commissioner |
| PCC | Police and Crime Commissioner |
| PPIE | patient and public involvement and engagement |
| RASASF | Rape and Sexual Abuse Support Fund |
| RC | Rape Crisis |
| SARC | Sexual Assault Referral Centre |
| SV | sexual violence |
| VSS | voluntary sector specialist |
| WP | work package |

# Plain language summary

Sexual violence is a sexual act against a person, or attempted act, that has not been agreed to. This may or may not include physical violence. In England and Wales, over half a million people experience sexual violence each year. More females than males experience sexual violence. The impacts for all people who experience sexual violence can be long-lasting and life changing. Often, people need a range of support services to help them recover. Many services, although now with paid staff, were started by and still use volunteers. These staff and volunteers understand a lot about sexual violence and they help many people. However, we do not know enough about where they are or what they do. We do not know how well they run their services or where their money comes from. We also do not know enough about what people using the services think about them. This research tried to answer these questions by speaking with people who provide the funding, people who work in the services and people who use the services. Some people who had experienced sexual violence were employed to help with the research. We found many differences in funding. Often, there is not enough money and organisations are trying to take the same 'pot' of money. Sometimes, those in control of the money do not know how best to spend it. Staff are sometimes unsure how to work with other services and are regularly stressed by a lot of people needing help. Those using sexual violence services had mixed experiences. How to access a service could be confusing and there were often long waiting lists. Many liked the special understanding that staff have about sexual violence. The research has helped us to make suggestions for improvements and will be widely shared to bring about change.

# Scientific summary

## Background

Sexual violence (SV) is defined as any sexual activity or act that takes place without consent. In England and Wales, crime survey data indicate that over half a million people experience SV each year and the number who disclose to the police or seek support is increasing annually. More than 90% of victim-survivors are female. There is strong evidence that SV affects health, relationships, confidence, work and family life over the life course. In most parts of England, grassroots voluntary organisations have developed services in response to local needs. Although services vary from area to area, they often include crisis and longer-term counselling/therapy; telephone helplines; face-to-face advice; advocacy; play therapy for children; practical support in accessing other services; support groups and social and holistic activities. Most victim-survivors self-refer, while others are referred to voluntary sector specialist (VSS) SV services by a general practitioner (GP)/health/social care professional. VSS services sit alongside other local services for victim-survivors.

In the last 12 years, there has been increasing national recognition in England that VSS services are essential in providing crisis and longer-term support to victim-survivors, enabling them to recover and thrive in the longer term. However, there is very little empirical evidence about the scope, range and effectiveness of VSS provision, or what victim-survivors value and want from services. There is no systematic review evidence and the few previous studies that exist are small scale and local. In addition, there is no literature on the effectiveness of different approaches to commissioning services for victim-survivors. There is also a paucity of evidence about the needs and experiences of staff working in VSS services, who can do so in a voluntary capacity. The aim of the study was to develop a comprehensive, national profile of VSS specialist services for victim-survivors in England, giving voice to service users' experiences and using a comparative analysis of the range, scope and funding of services, victim-survivors' service experiences, service models and approaches, service linkages and commissioning arrangements. The purpose was to make policy and practice recommendations to strengthen the overall service response to victim-survivors of SV.

## Objectives

- Explore victim-survivors' experiences of accessing and using VSS services, identifying what needs are being met for which groups of victim-survivors and what encourages victim-survivors to take up services.
- Analyse the range, scope and funding of VSS services and how demand is managed.
- Explore the usefulness of different approaches to service delivery (including peer support and delivery by volunteers) and different therapy models.
- Explore how different principles underlying service provision influence service delivery, including feminist and trauma-informed principles of care.
- Investigate referral patterns and pathways, and how VSS services fit with each other and link to the wider network of services for victim-survivors.
- Explore how arrangements for commissioning and funding services for victim-survivors across health, local authorities and criminal justice have evolved over the last 3–5 years, and how they have impacted on VSS service provision.
- Develop a taxonomy of the VSS services/service models being commissioned and provided.
- Make recommendations for the commissioning and provision of VSS services at practice and policy levels, in order to strengthen overall service provision for victim-survivors of SV.

## Methods

Co-production was built into the study from its inception through robust patient and public involvement and engagement activities. These included a co-applicant who is a survivor of SV, plus the appointment of five expert-by-experience co-researchers. The study was divided into the following work packages (WPs): WP1: exploratory interviews with commissioners and providers and focus groups with victim-survivors; WP2: national survey of service providers and commissioners; WP3: in-depth case studies in four areas of England; WP4: co-research with victim-survivors; WP5: data integration.

We drew on Billis and Glennerster's theory in relation to voluntary sector services as the underpinning framework. The theory identifies the unique features of voluntary sector services as: flatter organisational structures with less distance and distinction between senior or decision-making staff and those on the front line; closeness to communities; being mission-led and driven by core values and purpose. These three domains were relevant and appropriate in shaping our analysis. However, our findings went beyond values, communities and organisations, to include a broader commissioning context. We chose to adapt the theory and add a broader, macro level that encompassed the commissioning level/context. Data integration was thus achieved with reference to four theoretical domains: (1) macro commissioning context; (2) organisational structures; (3) relationships and people; (4) values and principles.

## Results

Macro commissioning context: Overall, we found a complex (and precarious) funding landscape. It is a context in which national government and centralised funding policies are not reflecting local needs and the reality of demand. The study highlighted the challenges of competing for funding and contracts, where formal partnerships are viewed as beneficial from the commissioners' perspective, and support VSS services to pool knowledge and resource and compete for bigger contracts. In the absence of which, joint-funded, large contracts favour larger, often generic providers. This macro environment has impacts on victim-survivors, because the commissioning agenda acts to move services away from being truly victim-survivor led.

Organisational structures: The study highlights the increasing range of VSS services providing therapeutic and practical support to victim-survivors through the commissioning process. A feature of this has been the 'upskilling' of staff to provide services to victim-survivors. In addition, there is clear evidence of services working closely with each other to support victim-survivors. However, from a less positive viewpoint, we identified a complex patchwork of services across statutory and VSS organisations that victim-survivors can struggle to naviagte. Within the VSS context, a concerning feature is the pressurised environment (e.g. high caseloads, rising demand, higher client need) and working with increasing complexity in clients' lives. There is evidence that practitioners are leaving VSS services, with an attendant loss of specialism and expertise from the sector. In terms of service provision, we heard from practitioners and victim-survivors that there are problems with referral processes. We identified a contradictory pattern as regards the degree to which VSS services meet the needs of victim-survivors: there are unmet needs and under-represented groups, but this is balanced by examples of good links to support for under-represented populations.

Relationships and people: We found that good relationships do exist between many statutory and voluntary sector services with examples of innovation and close partnership working. Most services work with a variety of commissioners, but there is varying satisfaction with these arrangements. From the viewpoint of victim-survivors, services can be hard to navigate and access. Moreover, uncertainties about waiting times can undermine victim-survivors' trust and the perceived quality of support they receive.

Values and principles: The study provides clear evidence that VSS services are highly valued by victim-survivors. VSS services offer a dedicated, protected environment for victim-survivors where the shame and stigma of SV are understood and challenged. Needs-led services are important, which focus on survivor empowerment. Feminist and trauma-informed approaches are valued within the VSS sector, a viewpoint that was shared across the participant groups. Gender awareness is also important, within a broad framework that takes account of intersectionality. From the perspective of VSS organisations, detailed understandings of sexual abuse constitute what it means to be a specialist, trauma informed service. We captured the combined findings conceptually and diagrammatically into a new model. It comprises six prominent themes: the complex and precarious funding landscape; the challenge of competition for funding and contracts; the importance and success of partnership working with organisations; the pressured environments within which VSS services work; different roles, scope and eligibility of voluntary and statutory services within an area; the ways services are organised and delivered, underpinned by services' values and philosophies.

## Conclusions

The PROSPER study has provided missing evidence regarding the funding and commissioning of VSS SV services in England. Even if the focus of future research is on VSS delivery (as is the case with much research in this field), it is likely that the wider lens of commissioning such services will have relevance. We claim a contribution to theory development through the expansion of a current theoretical framework that may be of use to others working in the VSS sector. The PROSPER study has also presented some unexpected opportunities for learning. At the forefront of these are the insights gained into co-research in the field of SV. We have presented transparent accounts of the strengths and limitations of this process.

## Core implications for policy, practice and education

1 The study indicates the need for a sustainable funding framework for VSS services (e.g. a minimum 5-year funding period) with joined-up commissioning (and funding) from all statutory bodies whose services refer into specialist SV services.
2 The findings highlight the need for contracts and grants to cover core service costs (e.g. contribution to employee pensions, sickness pay, rent, overheads, clinical supervision, etc.). In addition, innovation activities should be funded separately to core funding. It would be helpful for any statutory or non-statutory guidance issued by government to reflect this expectation.
3 The findings indicate that VSS providers would benefit from being entrusted with greater autonomy and discretion in how they use allocated funding. VSS services know their local area and population and are the best placed to know where to allocate resource. Similarly, the study findings suggest that commissioners need to have the ability to operate flexibly as regards movement of funds to respond to local needs.
4 The study findings show the importance of grants within the funding landscape and suggest that there should not be an exclusive focus on contracting/tendering services. We suggest that funding for grants should be increased substantially .
5 We recommend that commissioners are trained (where they are not already) and supported to develop requisite specialism in the field of sexual and gender-based violence. They would be required to do so in other areas of specialist and clinical commissioning. This is crucial for the strategic and decision-making aspects of their role. Similarly, senior VSS practitioners need support and ‘upskilling’ to manage roles relating to grant funding and engaging with commissioners (e.g. training workshops, mentor relationships, etc.).
6 Evidence from the study suggests the need for a closer relationship between commissioners and the services they fund, to ensure a greater understanding of the realities, complexities and needs of service provision. This could involve time spent shadowing within the VSS service.
7 Based on the study findings, commissioners should support the development of local partnerships, through the allocation of funding, space to host meetings and facilitating introductions between key service staff. However, the study has also shown how partnerships work best when bottom-up and can develop without commissioners specifying who the key agency partners should be.
8 The study findings point to the need for commissioners to commission services with a consideration of the needs of the workforce (competitive pay reflective of the trained workforce, resource to support staff training, job stability,, manageable workloads, to foster wellbeing and combat vicarious trauma).
9 There is currently a disproportionate burden on commissioners and practitioners regarding reporting and monitoring requirements which needs to be reduced, for example, through use of similar/the same reporting/monitoring templates. What is considered 'good' in these key performance indicators must also be contextualised with an understanding of sexual violence recovery.
10 Victim-survivors need ‘choice’ and different options at different time points. This study findings suggest that there needs to be recognition of the value of a range of VSS services – peer support, counselling, advocacy, etc. – and resistance to promoting overly medicalised models of support. The current focus on short-term counselling often fails to meet need and can overshadow other linked types of support (e.g. creative or systemic therapeutic work, political engagement, etc.).

11 Sustainable, long-term design and organisation of services could help to eradicate the current hierarchies or 'tiers' that van exist within the VSS support system (i.e. referral pathways restricted by funding/criteria controls). This would mean that services can be accessed irrespective of how victim-survivors report/or to whom, how recent their experience of SV or based on demographic characteristics.
12 Training of front-line health professionals (e.g. GPs, health visitors) is important as they are often the first entry/disclosure point to services, making it possible for health professionals to refer and signpost victim-survivors into specialist SV services. There is an opportunity to consider learning from pilot and/or localised schemes that are currently in operation in some areas of England.
13 Recognition of the unique value of VSS services – and the different modalities that they offer – is currently patchy and the expertise of practitioners and senior leaders is not consistently understood amongst all commissioners and/or statutory services. There needs to be cultural change and a shifting of the recognition of what expertise 'looks like' when it comes to the provision of practical, therapeutic and social support for victim-survivors of SV.
14 Victim-survivors (especially those from under-represented groups) need to be authentically involved in the decision-making around and development of SV services/provision. This should include involvement at various stages of the commissioning cycle. It should also include involvement at the points at which VSS services conceptualise/develop SV service provision.

In addition to the recommendations relating to the empirical WPs on the PROSPER study, we also have some recommendations arising from the experiential, co-research work.

## Working with co-researchers

1. Begin the process as early in the research cycle as possible.
2. Avoid piecemeal co-production payments.
3. Do not underestimate the power of in-person connection and support.
4. Robust protocols, clear lines of communication and defined areas of responsibility need to be in place to manage and minimise destabilising incidents.
5. Principal investigators are responsible for actively challenging and working against any systems that perpetuate victim-survivors' silence.
6. Principal investigators need to foster a culture of co-researchers being seen in '3D', that is, seeing a co-researcher's skill set beyond their lived experience.
7. Research leaders and funders need to remain open to novel and unexpected benefits from research and respond to these in creative ways, so that insights are harnessed for future use.
8. Research leaders and funders need to embrace the transformative and healing power of creativity – to recognise it as a credible area for financial investment.
9. Critical reflection is crucial on how to embody intersectional approaches into co-research and the limitations associated with such attempts.

## Core implications for research

The model that we have developed from the PROSPER findings will require development and testing to assess its usefulness as a resource for training and education in the VSS sector. Future studies can assess its potential as an aid to communications in any interactions that are concerned with the delivery, funding and commissioning of VSS services. It would be useful to expand the model by exploring the broad social impacts and how they relate to commissioning. This was not part of the PROSPER objectives and is missing from the current model. Future research would be useful to measure the full value of undertaking a co-researched study when the study participants are victim-survivors. This needs to be from the perspective of those taking part in the research.

## Study registration

This study is registered as Research Registry researchregistry5144.

## Funding

This award was funded by the National Institute for Health and Care Research (NIHR) Health and Social Care Delivery Research programme (NIHR award ref: 18/02/27) and is published in full in *Health and Social Care Delivery Research*; Vol. 13, No. 10. See the NIHR Funding and Awards website for further award information.

# Chapter 1 Introduction

## The problem of sexual violence

Sexual violence (SV) is defined as any sexual act or attempted sexual act that takes place without consent.[1] Globally, one in three women across their lifetime are subjected to physical or SV by an intimate partner or SV from a non-partner.[2] In England and Wales, crime survey data indicate that over half a million people experience SV each year and the number who disclose to the police or seek support is increasing annually. SV can affect health, relationships, confidence, work and family life over the life course. In 2010, the costs of SV were estimated to be £8.46 billion, with each rape costing £96,000.[3] It is likely that these costs have risen considerably since then. A recent study using administrative data from Rape Crisis (RC) centres in one English county[4] estimated that the lifetime cost of adult sexual abuse in that county alone was £248,431 per victim (£32,599 of which were the costs to specialist voluntary services). By comparison, the estimated lifetime cost of child sexual abuse (CSA) was £472,048 per victim (£32,316 of which were the costs to specialist voluntary services).

## Role of the voluntary sector in supporting victim-survivors of sexual violence

In most parts of England, grassroots voluntary organisations have developed services in response to local needs. Although services vary from area to area, they often include crisis and longer-term counselling/therapy; telephone helplines; face-to-face advice; advocacy; play therapy for children; practical support in accessing other services; support groups and social and holistic activities. Most organisations offer specialist services to victim-survivors living in the local area. Some provide for specific groups, such as children/women/men-only services. More than 90% of victim-survivors who report SV are female, although male victim-survivors are often more heavily represented amongst those who have experienced childhood sexual abuse. Some services are grounded in feminist approaches to SV, while others take a more neutral political/philosophical approach. Most victim-survivors self-refer, while others are referred to voluntary sector specialist (VSS) SV services by a general practitioner (GP)/health/social care professional.[5] An increasing number of individuals are referred by police or Sexual Assault Referral Centres (SARCs), which provide forensic examination and crisis support in the aftermath of SV and abuse. As of January 2018, there were known to be at least 207 VSS organisations in England providing support to victim-survivors,[6] with 162 affiliated to one or more of the three umbrella organisations: The Survivors' Trust; RC; and the more recently formed Male Survivors Partnership.

Voluntary sector specialist services sit alongside other local services for victim-survivors, for example, Independent Sexual Violence Advisers (ISVAs) who can provide crisis support, information, advice, advocacy and support through a criminal justice process. ISVAs can be linked into and based within SARCs,[5] as well as being employed by and located in VSS organisations. Victim-survivors may also need NHS sexual health, drug/alcohol services or specialist mental health services. Given the potential long-term consequences of SV, other agencies/sectors may also be providing support, for example, housing or education.

## National policy and the commissioning of voluntary sector specialist services for victim-survivors

In the last 12 years, there has been increasing national recognition in England that VSS services are essential in providing crisis and longer-term support to victim-survivors, enabling them to recover and thrive in the longer term. The Stern report in 2010[3] and several cross-government action plans on ending violence against women and girls,[7,8] most recently in 2021,[9] have highlighted the need for specialist support and therapy for victim-survivors to be provided in the voluntary sector. National commissioning guidance in 2013 highlighted the need for good linkages between all services for victim-survivors,[10] and SARC specifications in 2015 required SARCs to have clear pathways into, and working relationships with, relevant third-sector services.[11] The 2018 NHS national strategy statement highlights that many victim-survivors need lifelong care and calls for services to be more integrated so that individuals can access them seamlessly across agencies and sectors.[12] Most recently, in March 2022, The Home Office refreshed their 2016 National

Statement of Expectations,[13] setting out how local commissioners should work together to commission effective, collaborative violence against women and girls services that ensure a whole system approach. This was underpinned by an accompanying 'toolkit' to help commissioners practically bring this vision to fruition.[14]

Despite the plethora of national guidance, evidence suggests that national policies have not necessarily resulted in local improvements, with VSS services being under extreme funding pressures,[15] particularly in a 'post-pandemic' climate. One study found a 31% cut in English local authority (LA) funding to domestic and SV services between November 2010 and December 2011.[16] Evidence submitted to the 2018 All-Party Parliamentary Group inquiry into the funding and commissioning of SV services found that organisations were struggling with unprecedented demand. This linked to increased awareness of SV due to national and global sensitising campaigns such as *#MeToo* and *Everyone's Invited*, in parallel with greater recognition of non-recent childhood sexual abuse through, for example, the Independent Inquiry.[17] The Inquiry found that funding of specialist SV services has not kept pace with need, and this has created inconsistencies and gaps in service provision across England and Wales. VSS services have been particularly hard hit by public sector funding cuts and devolution of certain commissioning arrangements.[18] Funding pressures have been exacerbated by coronavirus 2019 (COVID-19), where increases in demand and the level of support existent victim-survivors require have intensified.[19] The Rape Crisis report Holding it Together[20] found that across 39-member organisations, 1.1 million sessions of specialist support were delivered between 2020 and 2021, constituting a 41% increase from 2019 to 2020. While unprecedented financial investment [largely from the Ministry of Justice (MoJ) and Police and Crime Commissioners (PCCs)] has been directed into VSS services to manage this need, as of April 2021, over 10,000 victim-survivors remained on RC waiting lists – some of which spanned 2 years. Perhaps more than ever, COVID-19 has underscored the need for long-term funding for the specialist voluntary sector, in order for services to upscale in a way that can meet demand. In May 2022, the government released its Victim Funding Strategy,[21] aimed at simplifying and aligning funding for victim services across government, introducing national commissioning standards and consistent outcomes across services. Within the strategy, a commitment to multiyear funding is made and it is anticipated that the upcoming Victim's Bill will include a statutory responsibility for local authorities, PCCs and Integrated Care Boards to collaborate when commissioning domestic, sexual and other forms of serious violence service. How these aspirations will translate into practice is yet to be established.

The position in England contrasts with that in Scotland, where a strong national focus on preventing and responding to SV has already led to new standards for health care;[22] a workforce knowledge and skills framework for trauma-informed care;[23] and a national taskforce work-plan focusing on improving the design and delivery of services, strengthening care pathways, improving quality and developing the workforce.[24] A national mapping exercise of advocacy services for victims of violence against women and girls across Scotland has also been undertaken, which identifies gaps in services for rural areas; women who are trafficked or in sex work; children/young people; black and minority ethnic groups; and asylum seekers.[25] Work is well underway to improve the governance, financial management and sustainability of VSS services for victim-survivors in Scotland.[26]

In England, the funding and commissioning of services has become increasingly complex, as a result of changes to the structure and funding of health[27] and criminal justice. Funding for VSS services comes from charitable trusts plus local and national statutory sources, via health, local authorities and criminal justice organisations. This creates a complex network of responsibilities at a local level, requiring a high degree of collaboration between commissioners.[18] The complex and changing nature of commissioning, and by default local services, creates challenges for providers in ensuring there are integrated, multidisciplinary care pathways available.[28] It also compounds VSS service difficulties in establishing and maintaining relationships, particularly with public sector providers, not least because there is a prevailing attitude that VSS services are 'amateur' and small scale.[28]

Future planned changes for the sector potentially include further devolution of the MoJ Rape and Sexual Abuse Support Fund (RASASF) to PCCs and/or mayors – following the piloting of devolution in several areas of England – although this is unlikely to happen before March 2023. Ambiguities also exist around how Clinical Commissioning Groups' (CCGs) transition into integrated care systems (ICSs) will impact local relationships and funding arrangements. In response to the complexity, commissioning appears to have become quite fragmented.[18] In some areas, new and untested local models of collaborative commissioning are emerging, such as contracting with a lead provider for a network of local services, which may include VSS providers.[18] One consequence is that the previous model of a mixed economy of provision for victims, that included smaller organisations who are adept at meeting the needs of specific groups at the local level, has become untenable under the drive towards a free market model.[29] In other areas, VSS providers are taking the initiative and collaborating between themselves, moving to common standards and seeking to join up services locally via partnerships and consortia.[30] They are also working with statutory providers, particularly SARCs, to deliver crisis counselling and other responses.[31] Commissioners, in turn, are looking for evidence to support these new approaches;[10,11,18,32] however, little is known about their effectiveness and how they might impact on services for victim-survivors.

## Evidence base for the value of voluntary sector specialist services for victim-survivors

There is very little empirical evidence about the scope, range and effectiveness of VSS provision, or what victim-survivors value and want from services. There is no systematic review evidence and the few previous studies that exist are small scale and local, typically with < 20 staff and/or victim-survivor respondents. The exceptions are a national survey with 395 adult victim-survivors of CSA[33] and evidence from nearly 7000 victim-survivors submitted to the Independent Inquiry into Child Sexual Abuse.[34,35] Victim-survivors typically want timely, locally available services, a choice of therapy and long-term support from agencies taking a joined-up approach.[34] They want to feel listened to, believed and respected,[33,35] and the independence of VSS services from statutory provision is seen as a key benefit.[36] Counselling and psychotherapy are often cited as the most helpful services, but as noted, waiting lists are often long and therapy may be time-limited.[33] There has also been some trend towards MoJ and PCC funding prioritising ISVA over counselling provision.[20]

Many victim-survivors need and use VSS services over the life course.[33] One study found that VSS services were the most commonly used services by victim-survivors, after GP, mental health and NHS counselling and were more highly rated than statutory provision – by a margin of 41% for counselling and 12% for psychotherapy.[33] Over 70% of victim-survivors who had used both types of service rated VSS as good compared with < 20% for statutory services. In another study, Scottish Rape Crisis centres were seen as trusted places of safety, offering confidential, non-judgemental responses, empowering victim-survivors and providing long-term support.[37] Gekoski *et al.*[35] found that victim-survivors of childhood sexual abuse rated VSS provision most highly out of all forms of support received. Similarly, ISVAs report that victim-survivors have greater trust in and preference for VSS services compared with statutory provision,[36,38] want flexible services which respond quickly and which are delivered in ways which empower and offer control.[38] NHS services have been criticised for being inflexible and time-limited, with victim-survivors often being referred to generic, rather than specialist, support.[18] Indeed, victim-survivors can and do experience secondary trauma in response to the ways in which staff within statutory services (inappropriately) interact with them.[34]

Four small studies on VSS services highlighted the impacts of under-resourcing, resulting in gaps in provision whereby victim-survivors were required to travel considerable distances, sometimes in excess of 100 miles, to access support,[18] as well as geographical variation in the level and types of provision offered.[37] Groups underserved included older victim-survivors[39] and male victim-survivors of rape.[40,41] There is evidence that not all VSS services identify and engage with under-represented populations in a consistent way and this may affect the quality of support received.[40] For example, as noted, many VSS providers are orientated to a feminist-empowerment approach that emphasises structural gender inequalities and inherent power differentials between men and women. These may not neatly translate to accommodate the SV committed by women against other women, for example. It is therefore important that commissioners recognise the different political and philosophical rationales – that are often combined – which underpin services (including survivor empowerment, trauma-informed and intersectional approaches), as this can affect the quality and nature of provision for different population groups.

Referral routes between organisations have been noted as complex with staff not always signposting victim-survivors to other agencies,[36] and SARC and VSS staff reporting problems referring to mental health services specifically.[20,42] VSS staff report that referrals from other agencies are inconsistent and their knowledge about VSS services is variable.[36] As noted, most VSS providers offer counselling and/or therapy which systematic review evidence shows can reduce post-traumatic stress, depression and anxiety.[43] The specialist nature of VSS therapy compared well with NHS therapy in one study,[36] while another found that access to psychological care had improved in the past 10 years.[44] In a more recent study, victim-survivors who had accessed RC centres in England and Wales experienced greater feelings of empowerment and an ability to exercise control, a decrease in the frequency of 'flashbacks' and less frequent panic attacks.[45]

There is no literature on the effectiveness of different approaches to commissioning services for victim-survivors. Anecdotal evidence and research from the sector suggests significant problems exist, including: over-reliance on short-term funding; poor understanding amongst commissioners of what VSS services do leading to service cuts; lack of engagement by the health sector; confusion between services for domestic violence and SV; and confusion about which agencies are responsible for funding what services.[18] There are concerns that as VSS services increasingly rely on funding from large governmental, public sector or charitable organisations (e.g. the RASASF), they have less autonomy to determine the way they care for and support victim-survivors, as they focus on meeting funders' priorities and outcomes.[46] There is also a paucity of evidence about the needs and experiences of staff working in VSS services, who can do so in a voluntary capacity, as highlighted in a recent study which found inconsistencies between the staff support systems and regulatory frameworks underpinning public sector and VSS services.[47]

## Theoretical background and contribution to theory

The academic literature on the voluntary sector suggests that it has distinctive practices, relationships and an ethos of service provision, including being non-judgemental, nurturing users and developing positive relational skills.[48] Voluntary sector organisations also have potentially unique attributes as organisations, compared with both statutory and private sector services. For example, involving users in governance, being driven by a social mission, having a closeness to and expertise in communities or particular groups.[49] Many voluntary organisations involve current and former service users as volunteers or subsequently paid staff, and have relatively flat hierarchies which blur the distinction between staff, volunteers and service users.[50,51] Reducing power differentials in this way between service providers and users can help build the personal capacity of service users, particularly those from vulnerable or excluded groups.[50,52] These positive attributes of the voluntary sector along with a mistrust of state agencies among victim-survivors, and reluctance and/or difficulties in accessing statutory provision, partly explains the dominance of the voluntary sector as an alternative source of support. It seems likely that VSS providers are in a good position to offer services which impact positively on outcomes for users, occupying a specialist 'niche' within the wider ecosystem of services for victim-survivors and offering an alternative approach to statutory sector provision.

Where voluntary organisations work closely in partnership with the public sector, the relationship has been theorised as a collaborative one, suggesting there is scope for synergy between statutory and voluntary services.[53] However, the commissioning and performance management arrangements expected by statutory funders could undermine the distinctive characteristics of the voluntary sector, imposing expectations derived from business models of operation which dissociate voluntary organisations from their social foundations.[49] Other commentators recognise that commissioners have a difficult and conflicted role in shaping and managing networks of care.[54]

For this study, the underpinning theory is Billis and Glennerster's theory that the voluntary sector has a comparative advantage in the provision of human services compared with the statutory and private sectors.[50] This will help us to understand and explain the prominence and distinctiveness of the voluntary sector in providing support to victim-survivors of SV and identify the unique and prominent features that enable them to respond more sensitively to needs. The unique features that the theory identifies include: a flatter organisational structure with less distance and distinction between senior or decision-making staff and those on the front line; closeness to communities; and being mission-led and driven by core values and purpose (for our study, to support victim-survivors of SV). The theory also identifies that the users of voluntary sector services often suffer personal/social disadvantage, stigma and isolation, which make it difficult for them to access statutory services. This is particularly relevant to victim-survivors of SV and abuse. Such states of personal and social disadvantage can also lead to economic disadvantage or financial hardship, so that private support may not be an accessible option. The theory leads us to postulate that it is in their interactions with victim-survivors that the unique and distinctive features of VSS services become important. In accessing VSS services, we expect that victim-survivors are more likely to be met by staff with the required motivation, sensitivity and knowledge to support them, as there is less of a gap between those delivering and those accessing services. Thus, the study seeks to understand: the nature of the distinctive features of voluntary organisations providing support to victim-survivors; the relationship between the distinctive features and the particular support needs of victim-survivors; and how these shape interactions with victim-survivors.

Although the main theoretical underpinning of this study relates to the role of the voluntary sector, the research also draws on the theory of trauma-informed approaches to care, which has been developing over the past 10 years.[55,56] This approach now underpins service delivery in a number of countries, including Scotland,[22,57] although national policy in England has been slow to adopt the approach.[58] A trauma-informed approach is based on six principles of safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; cultural, historical and gender issues. These principles align well with the values, ethos and culture of the voluntary sector in general. The research therefore theorises that what victim-survivors want from and value about VSS provision is likely to be in line with trauma-informed approaches to care.

## Rationale for the study

Given the evolving nature of national policies on SV, the complex nature of the commissioning and funding arrangements which support the local implementation of policy, and the absence of any good-quality evidence, the first step must be to describe and analyse the patterns of VSS provision across England, and identify what needs are being met and for which groups of victim-survivors. This includes looking for explanations for variations in these patterns and the forces that have shaped local provision. In the absence of high-quality evidence about victim-survivors' experiences of VSS services, the research places victim-survivors' views and experiences at its centre. We analysed the degree to which provision meets victim-survivors' expressed needs, looking for gaps and overlaps in service; underserved subgroups in the population; the use of service rationing; the use of recognised service quality standards; and the extent to which VSS services are a coherent part of an area's service offering to victim-survivors, with VSS providers also supporting victim-survivors to access other services.

## Why this research is needed now

To date, there has been limited research into what victim-survivors want from and value about VSS services, how they link with other key services and how they are funded by councils, the police and health services. There is also a lack of evidence around the lifetime cost of SV and abuse, contributing to difficulties in the commissioning of specialist SV services. This research aims to benefit both victim-survivors of SV and the NHS. The number of victim-survivors of SV is increasing year on year. In 2017–8, 150,732 sexual offences were reported to police, a 24% increase on the previous year and the highest figure since records began.[59] Just over one-third of offences are for rape.[59] However, SV is under-reported, with the national crime survey estimating that 2% of adults, 646,000 people aged 16–59 years, experienced SV in England and Wales in 2017–8, while 4 million adults have experienced a sexual assault at some point since the age of 16 years.[60] Added to this are unknown numbers of children and older people, not currently recorded. Increased reporting of non-recent sexual abuse is likely to continue, linked to inquiries exposing abuse within UK institutions, while public health needs assessments continue to predict future increases in demand,[61,62] particularly as lockdown measures ease. As the trend towards greater reporting of SV continues, each year more people will be looking to VSS services for support. Increases in demand are likely to be compounded by statutory services restricting access to services such as mental health, which victim-survivors may have used previously.

The impacts of SV on victim-survivors' health and well-being are well known. Rates of post-traumatic stress disorder are highest for SV compared with all other traumatic events.[63] Depression, anxiety, suicide, self-harm, alcohol/drug abuse and sexually transmitted infection rates are all high[38,64] and impacts on mortality have been found.[65] Victim-survivors report adverse effects on relationships with partners, family and friends and on their confidence/ability to work[66] and participate in social/community life. Some impacts can be passed on to the next generation.[56] Therefore, the burden on individual victim-survivors, the NHS and wider society if these impacts go untreated, is likely to be excessive. Given current and projected rises in SV and the cost to victim-survivors and society if needs go unmet, the time is right for this report. We will produce timely and invaluable evidence for commissioners about the role and distinctiveness of

VSS services for victim-survivors, providing examples of innovative practice, and making recommendations about how funding and commissioning arrangements can be improved in order to strengthen overall service provision for victim-survivors. The findings will therefore support the local implementation of current national policies on responding to SV and violence against women and girls.[7,12]

## A note about terminology

To support with consistency in reporting findings across all work packages (WPs) of the study, certain terminology is used throughout this report. The authors have carefully considered how to use certain words and phrases and have consulted with the co-researcher team throughout the decision-making process. Accepting the limitations and varying interpretations, we have agreed the following terminology.

### *Victim-survivor*

This term is used to describe the individual subjected to any form of SV and abuse, and, in this context, the individual service user/client of the VSS service. We acknowledge that opinions and preferences vary because not everyone who has experienced SV regard themselves as a victim and, similarly, not everyone regards themselves as having survived. The term victim-survivor is an attempt to encompass differing/both perspectives.

### *Voluntary sector specialist*

The acronym 'VSS' is used to refer to SV 'voluntary sector specialist' services. The term is often inadequately defined. We refer to it to mean services located in the third sector that include smaller services as well as those with a national profile. The primary purpose of a VSS service is to support someone who is or has been affected by SV.[14] It is important to highlight the specialist role, whereby staff have a dedicated knowledge (and training) around SV and abuse – understanding its political and social dimensions. Other language that is currently popular is specialist 'by and for' services which are: 'specialist services that are led, designed and delivered by and for the users and communities they aim to serve (for example survivors from ethnic minority backgrounds, deaf and disabled victims and LGBT victims)' (p. 9).[13]

### *Sexual violence*

The term 'sexual violence' (abbreviated to SV) is used as an all-encompassing term following the World Health Organization definition, being inclusive of verbal as well as physical acts. However, different VSS services may use their own terminology to talk about acts and behaviours, and victim-survivors will have personal perceptions of what falls under this definition. Examples of SV may include (but not be limited to) non-consensual touching, stroking, messages, 'jokes' and name calling, penetration and photo-taking/sharing (and attempts at these acts). Under our definition of SV, we include SV and abuse – 'abuse' being the more commonly used term to refer to offences against children.

# Chapter 2 Overview of methodology

## Aims and objectives

The aim of the study was to develop a comprehensive, national profile of VSS specialist services for victim-survivors in England, giving voice to service users' experiences, and using a comparative analysis of the range, scope and funding of services, victim-survivors' service experiences, service models and approaches, service linkages and commissioning arrangements, in order to make policy and practice recommendations that will strengthen the overall service response to victim-survivors.

The objectives were to:

1. explore victim-survivors' experiences of accessing and using VSS services, identifying what needs are being met for which groups of victim-survivors and what encourages victim-survivors to take up services
2. analyse the range, scope and funding of VSS services and how demand is managed
3. explore the usefulness of different approaches to service delivery (including peer support and delivery by volunteers) and different therapy models
4. explore how different principles underlying service provision influence service delivery, including feminist and trauma-informed principles of care
5. investigate referral patterns and pathways, and how VSS services fit with each other and link to the wider network of services for victim-survivors
6. explore how arrangements for commissioning and funding services for victim-survivors across health, local authorities and criminal justice have evolved over the last 3–5 years, and how they have impacted on VSS service provision
7. develop a taxonomy of the VSS services/service models being commissioned and provided
8. make recommendations for the commissioning and provision of VSS services at practice and policy levels, in order to strengthen overall service provision for victim-survivors of SV.

With the aim and objectives in mind, in March 2020, the team agreed the study title of PROSPER (Sexual Violence: The Supporting Role of Specialist Services). The naming of the study proved invaluable in providing a unique identifier that gave it prominence in the field of SV research in England.

## Patient and public involvement and engagement and the co-research study design

Co-production was built into the PROSPER study from its inception; initially through the development of the research proposal with the two patient and public involvement and engagement (PPIE) co-applicants (one of whom is a survivor of SV), and latterly through their continued involvement, *plus* the addition of five co-researchers working on the study. Details of the PPIE activities are expanded upon later in the report. Moreover, an entire section (see *Chapter 6*) is dedicated to explaining and reflecting on the PROSPER co-research design (authorship of that chapter has been led by the co-researchers). As an overview, the PROSPER team has comprised not only an academic team with associated partners (e.g. practitioners, commissioners, academic advisors), but also the five experts-by-experience co-researchers. The co-researchers have worked alongside and with the academic team on numerous activities as detailed in the following chapters. This highly participatory methodology was embedded in order to:

- amplify the voices of victim-survivors
- enhance the collection of highly meaningful data
- empower victim-survivors who were participating in the research
- promote learning and development of new skills among the co-researchers.

## Overall study design

The PROSPER study was divided into the following WPs:

WP1: exploratory interviews with commissioners and providers and focus groups with victim-survivors.
WP2: national survey of service providers and commissioners.
WP3: case study analysis.
WP4: co-research with victim-survivors.
WP5: data integration.

An overview of each WP is provided later in this section and discussed in-depth in subsequent chapters of the report. WPs 1–4 are subsumed within a broader, multimethod framework as shown in *Figure 1*. In the original proposal, we had described the research design as an explanatory sequential mixed-methods study following the work of Creswell and Plano-Clark.[67] In this form of mixed-methods design, the intention is to utilise a qualitative phase to help explain the results from a previous quantitative phase. We envisaged that the case study work (WP3) would help explain the results from the national survey (WP2). While this is the case, the study design evolved into something far more complex than a linear quant–qual mixed-methods design. Originally, the interviews that took place at the beginning of the study were not intended to provide a form of data in their own right. The purpose had been to provide insights into commissioning and VSS services that would inform the development of the national survey (WP2). However, the methodology and insights were sufficiently robust and complete to form a distinct strand of PROSPER (now WP1). In addition, the co-research component provided far greater depth and rich insights than we had envisaged originally. To that end, the co-researcher work, particularly the analysis of data from victim-survivors, forms a significant part of the overall PROSPER findings that warrant inclusion and embeddedness. For these reasons and to capture the complexity of the design, as shown in *Figure 1*, we refer to the design as a multimethod design, allowing for all the component parts to be integrated (into WP5).

## Work package 1: exploratory interviews with service providers and commissioners and focus groups with victim-survivors

### *Overview of work package 1*

Work package 1 was an exploratory qualitative study carried out with victim-survivors, VSS service practitioners and commissioners of services for victim-survivors. It was based on extensive preparatory work and relationship building across the SV sector. The aims of WP1 were:

1. To develop understanding of the principal issues shaping the delivery, funding and commissioning of VSS services and the unique features of these organisations
2. To use the findings to inform the development of three national surveys that will map the provision, funding and commissioning of specialist SV services.

Two experienced, female qualitative researchers (Isham PhD and Gunby PhD) carried out interviews with: (1) senior practitioners of VSS services ($n$ = 13), (2) commissioners of SV services ($n$ = 8) and (3) providers ($n$ = 2) from the statutory sector who worked in the area of SV. We also carried out two focus groups with (1) female victim-survivors ($n$ = 9) and (2) male victim-survivors ($n$ = 5) and one telephone interview with a female victim-survivor. Interviews and focus groups were recorded and transcribed verbatim by a professional transcription company.

### *Topics explored (in the interview and focus groups)*

- The strengths and limitations of VSS services.
- The relationships, pathways and comparative differences between voluntary and statutory sector services.
- Details of current funding and commissioning arrangements, identifying areas where there has been change and continuity.
- Victim-survivors' experiences of accessing voluntary and statutory sector services, their reflections on differences between services and their suggestions for improvements.

### *Transcription and analysis*

The audio recording of the interview and focus groups were transcribed verbatim and then checked and anonymised by the researchers. The transcripts were analysed thematically, drawing on Billis and Glennerster's theory of the comparative advantages of the voluntary sector (see section on 'theoretical framework' for more detail). The findings informed the design and development of the national surveys (WP2) and case study analysis (WP3).

## Work package 2: national survey of service providers and commissioners

Work package 2 involved the development and administration of a national survey of provider and commissioners' views about the design and delivery of VSS services for victim-survivors of SV. Initially, there were to be two online surveys; however, during survey development, it became apparent that separate surveys would be required for the VSS services and SARCs due to differences in their operation and configuration. As a result, we designed and administered three separate online surveys for:

1. Commissioners of services for victim-survivors
2. VSS service providers
3. SARCs.

The surveys were designed to enable comparisons between the three participant groups on a number of key themes (e.g. views of funding and commissioning, the strengths of specialist services, under-representation of victim-survivor groups). The surveys were available for completion electronically between January and June 2021. Once data collection was complete, two members of the co-researcher team were involved with the analysis process.

## Work package 3: case study analysis

Work package 3 involved an in-depth investigation of four areas in England using a case study approach. We explored the role of VSS services, their links with other local services and the funding and commissioning arrangements that underpin them. We also explored victim-survivors' views and experiences of (not) accessing services across their life course. Interviews were carried out with providers of VSS services, commissioner/funders and victim-survivors.

Case studies are well established as an appropriate method for studying contemporary complex phenomena in a holistic way in their real-life contexts, particularly when the boundaries between the phenomenon and context are not clear.[68] They benefit from the prior development of theoretical propositions to guide design, data collection and analysis, and so rely on multiple sources of evidence which need to converge and triangulate in order to provide plausible explanations of observed phenomena. They also help to build theory, providing rich descriptions, which lead to a holistic understanding of the case.[69] This research is largely based on Stake's approach, where multiple perspectives on the case need to be gathered, with a flexible design allowing data collection to adapt in response to experiences in the field, and an inductive analysis of data.[70,71] This WP involved detailed analysis at four distinct geographical areas of England, each selected on the basis of various features, including their different models of VSS service configuration, delivery and funding (see *Chapter 5* for details).

Extensive exploratory work was carried out establishing relationships with key stakeholders in each of the site areas before recruitment of participants began. Recruitment began in the autumn of 2021, and 70 participants across three main participant groups – commissioner/funders, practitioners and victim-survivors – were interviewed by the end of April 2022. Approximately half of the victim-survivor interviews were co-facilitated by a co-researcher and a member of the academic team.

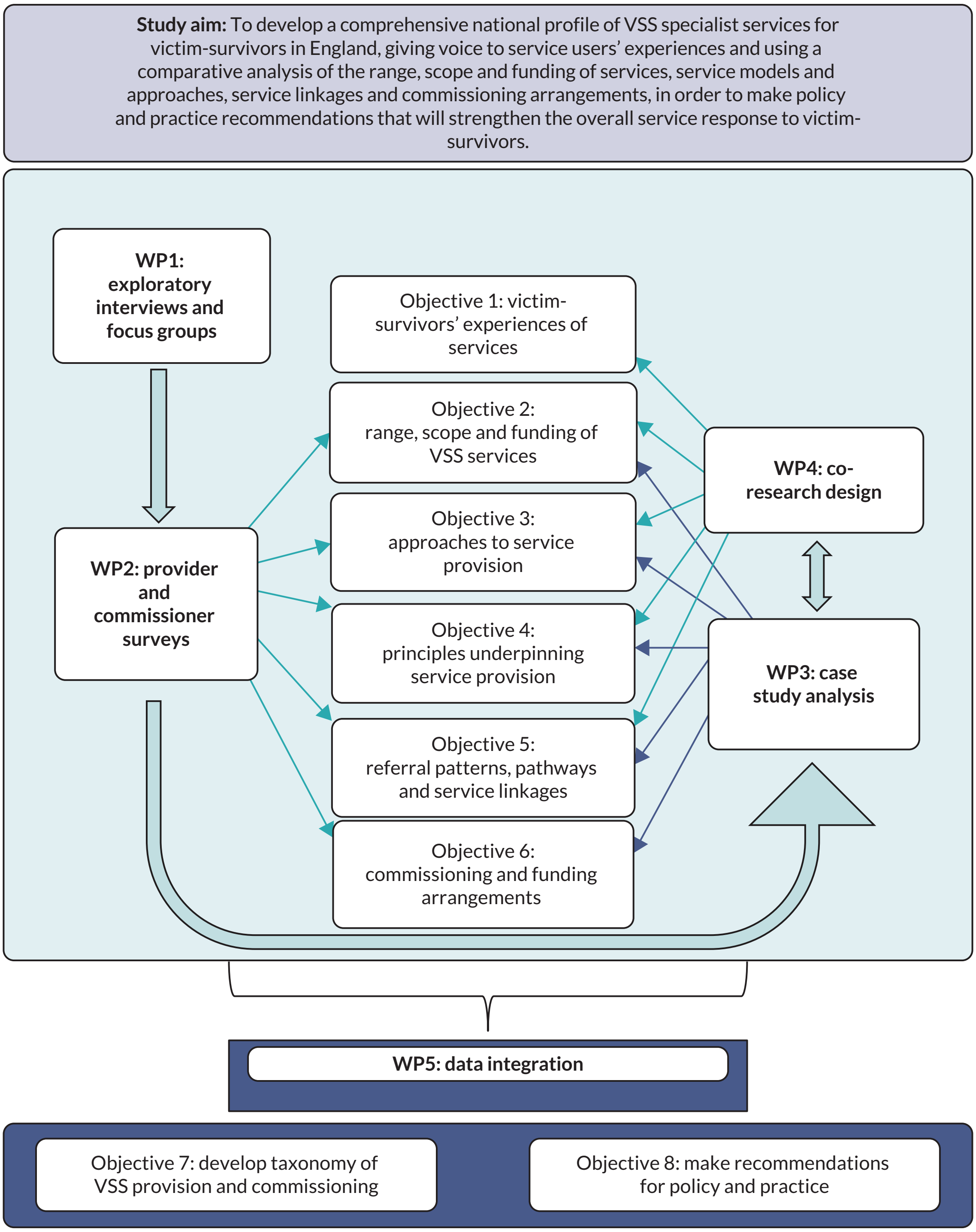


**FIGURE 1** Multimethod design with WPs linked to study aim and objectives. Reproduced with permission from Bradbury-Jones *et al.*[72] This is an Open Access article distributed in accordance with the terms of the Creative Commons Attribution (CC BY 4.0) licence, which permits others to distribute, remix, adapt and build upon this work, for commercial use, provided the original work is properly cited. See: https://creativecommons.org/licenses/by/4.0/. The figure includes minor additions and formatting changes to the original text.

## Work package 4: co-research with victim-survivors

In February 2021, a team of five co-researchers (initially six, but one co-researcher withdrew after several weeks due to personal circumstances) w recruited to join the core study team. The co-researchers have considerable personal and professional expertise (both in practice and research settings) working with victim-survivors and other 'vulnerable' groups. Prior to the case study phase starting, the co-researchers received training in key research skills and methods; this was complemented by one-to-one support from an assigned mentor (a member of the PROSPER core team) and reflective team sessions. Throughout the study, the co-researchers have participated in wider research team meetings, the survey design and analysis, the case study stage and particularly the victim-survivor interviews, data analysis and integration. The co-researchers have contributed to the writing of this report and have led on the development of the chapter that reports on the co-research aspect of the PROSPER study.

## Work package 5: data integration

Triangulation is an accepted method for integrating multiple data sets which have first been analysed individually. In the PROSPER study, this involved:

1. methodological triangulation, comparing data collected using different methods, for example, comparing victim-survivors' experiences using data from focus groups and interviews
2. data triangulation, comparing quantitative with qualitative data, for example, comparing quantitative results about service provision and commissioning from the quantitative surveys with the qualitative case study interviews
3. investigator triangulation, comparing the analysis of the same data by different team members, including different interpretations from individual academics and co-researchers.

In terms of data triangulation, we integrated data at different stages of the research, in line with the multimethod design. For example, qualitative data from initial focus groups with providers and commissioners (WP1) informed the development of the provider and commissioner surveys (WP2). Quantitative data from the surveys then informed the selection of case study sites (WP3) (although not to the degree that we had originally intended). Case study data were analysed separately for each site and then synthesised across sites. Each data set from each source was analysed separately initially, by different members of the team with at least two people analysing each data set and comparing and amending results. The purpose was to avoid bias in relation to the quantitative data and improve trustworthiness of the qualitative analysis. The final stage of data integration at the end of the project was crucial for ensuring the research aims and objectives were answered appropriately and to ensure a resonance and direct linkage to the underpinning theoretical framework.

## Theoretical framework

As laid out in the introductory chapter, the study was informed by Billis and Glennerster's[50] theory of the comparative advantages and unique features of the voluntary sector when providing human services, particularly to 'vulnerable', marginalised and racialised groups. This is a theory that has longevity and has been applied in many contexts, but as far as we know, to date, the theory has not been applied in the context of SV service provision. The unique features of voluntary sector services that Billis and Glennerster identify are:

- flatter organisational structures with less distance and distinction between senior or decision-making staff and those on the front line
- closeness to communities
- being mission-led and driven by core values and purpose

In the context of PROSPER, our rationale for drawing on this particular theory was its potential to help us understand and explain the prominence and distinctiveness of the voluntary sector in providing support to victim-survivors of SV and identify the unique features (and perceived limitations) that shape their response to victim-survivors. During the study, we revisited this theoretical framework frequently, reflecting on how it was shaping and informing our methodologies and subsequent analyses. This ensured that the processes we employed were grounded throughout, not solely in the study objectives, but also in the study's theoretical underpinnings. To bring the theory to the fore, we used it as the guiding framework for integration as described later in this chapter and in chapter 7. This flexible and reflexive use of theory is advocated by Bradbury-Jones *et al.*[73]

As shown in *Figure 1*, we had planned for WP1 to feed into WP2 by way of an exploratory sequential design, whereby the purpose of the qualitative phase was primarily to inform the survey development. WP2 was designed to sequentially inform WP3, but due to factors discussed elsewhere in the report, we did not achieve this fully. However, in its own right, WP2 addressed the objectives as indicated. There was a considerable degree of interaction between WPs 3 and 4, with the co-researchers being appointed to work primarily on this part of the PROSPER study. Data integration followed the first four WPS and from these, objectives 7 and 8 were met.

# **Chapter 3** Work package 1: exploratory interviews and focus groups

## Context of work package 1

This chapter details the findings of the first stage of the PROSPER study. This was an exploratory qualitative study carried out with victim-survivors, VSS service practitioners and commissioners of services for victim-survivors. The aims of this part of the study were:

1. to develop understanding of the principal issues shaping the delivery, funding and commissioning of VSS services and the unique features of these organisations
2. to use the findings to inform the development of three national surveys that will map the provision, funding and commissioning of VSS services.

## Methods

Please see the previous chapter for details of how this study phase was conducted. The following sections of the chapter detail the qualitative findings, organised around the themes of (1) the uniqueness of specialist services and (2) funding and commissioning issues and experiences. The final section of the chapter identifies the key messages from this study stage. We have used illustrative participant quotes in this chapter, all of which are presented using pseudonyms to protect anonymity.

## Findings

### The uniqueness of specialist services

When describing what made VSS services unique, practitioners and commissioners frequently spoke about the nuanced, specialist knowledge and understanding that service staff had about SV and trauma. This, typically, derived from specialist training and/or working in the field for many years. Frequently, VSS services were associated with offering an environment dedicated to victim-survivors, where myths about SV were challenged and a safe space was created for people to meet and share experiences and understanding. This dimension of VSS service provision was consistently and highly valued by victim-survivors: ‘It’s (being in a group of peers) like a solidarity, that you can’t explain and you don’t need to speak about it, it’s just there’ (Female victim-survivor 3).

#### *Mission, values and ways of working*

The mission and values of VSS services also shaped how they supported victim-survivors and distinguished them from other providers. Broadly, VSS services were characterised as promoting a holistic, needs-led approach alongside a philosophy of empowerment. This was in contrast with more clinically focused services which tend to be focused on individual rather than population (or social) changes and interventions. Underpinned by a critical understanding of gender inequalities and, in many cases, feminist philosophies, VSS services also worked to advance explanations of trauma and abuse that are rooted in structural understanding of SV. The promotion of an understanding of SV within a political, cultural and social framework was part of the work that happened with victim-survivors.

By supporting victim-survivors to understand the wider factors that shape how society understands and responds to SV and abuse, specialist services sought to empower victim-survivors and reduce feelings of responsibility and self-blame. In the following extract, a practitioner describes their organisation’s ethos of supporting victim-survivors in this way:

> *We don't focus on, when people come to us and tell us they've been diagnosed with a mental health problem, we kind of usually look at them and think actually, tell me a bit about what your experiences are. Let's forget what you've been diagnosed with.*
>
> *Practitioner 8*

As an expression of these values, workers prioritised building trusting relationships with victim-survivors, founded on a clear belief in their experience of abuse/violence. Victim-survivor participants identified that feeling believed made a critical difference when engaging with VSS services, fostering trust with practitioners and alleviating deep-seated feelings of isolation and shame. Given that many victim-survivors described the process of seeking support as long and complicated – and often taking place many years after they had experienced abuse or violence – the experience of being believed could mark a turning point in their personal journey or recovery:

> *I was always worried about, you know, people are going to say 'well no, it didn't happen. Why have you waited so many years for this to happen?' So to be able to speak to somebody and to build up that little bit of trust with somebody was absolutely massive.*
>
> *Male victim-survivor 3*

### *Voluntary sector specialist services' responsivity and capacity for innovation*

For the most part, VSS services were characterised by participants as demonstrating responsivity and the ability to adapt to emerging needs and challenges. For example, creating new services when needs arose, or reconfiguring services to meet new funding requirements or commissioning specifications. VSS services also had a reputation for developing new approaches and creative forms of support when working directly with victim-survivors, as described by this commissioner 'The voluntary sector is much quicker to be able to respond to things aren't they because they don't have all the bureaucracy that a health trust may have, for example.' (Commissioner 3).

A number of factors allowed for this responsiveness. Combined with an ethos to empower victim-survivors and to amplify their voices, VSS services were frequently described as less hierarchical in structure, with victim-survivors embedded into the different levels of the organisation and volunteers making up a critical part of the workforce. In addition, many VSS services had a strong history of working closely with victim-survivors (a 'co-produced approach') to shape the design and delivery of services 'We have victim-survivors that work here at all different levels from the management to trustees to staff and I think there is something about having that shared knowledge.' (Practitioner 8).

As an expression of this reciprocity, VSS services were widely regarded as having reciprocal connections with their local communities. This enabled them to pick up on emerging trends and changing needs amongst clients and to incorporate this knowledge into the delivery of services quickly and adeptly. Close relationships and proximity to local communities also contributed to their credibility amongst diverse groups.

### *Accessibility and duration of support*

As noted, VSS services were characterised as responsive and person-centred in their approach. For many services, this meant being accessible at the point of need and, in turn, limiting the use of eligibility criteria. This approach went hand in hand with working at the pace of victim-survivors, that is, not being only outcomes focused or inhibited by 'arbitrary timescales'. In a climate of increased demand and limited resources, practitioner participants nevertheless consistently voiced concerns about their ability to protect and maintain certain services, particularly those that offered longer-term support. Over the past 5–10 years, many services have seen a reduction (relative to demand) in funding and/or commissioned contracts for therapeutic provision, with the aim of investing in practical and emotional support services instead. The intention of this change in approach is to free up practitioners' time so that they can better support a greater number of victim-survivors to access and 'move through' services in a timely manner. Yet, participants explained, waiting lists were at historic highs in many areas and victim-survivors continue to face delays. This meant that, in some areas, the drive to create more responsive, streamlined services risked creating a 'revolving door' effect (Practitioner 6). This resulted in victim-survivors needing to access services multiple times when seeking support and undermined the national policy promise to provide lifelong care to victim-survivors 'On the one hand we're giving the message "speak out" and on the other hand we're saying – excuse my French – "shut the **** up".' (Practitioner 13).

Victim-survivor participants attested to the negative impact of waiting long, sometimes protracted periods (several months, sometimes years) before receiving appropriate support. They also talked about the emotional burden that 'fighting' for support had placed on them, particularly when they were in a mental health 'crisis' (Male victim-survivor 3) or 'at a very low point' (Female victim-survivor 6). In response to these challenges, VSS services often went to considerable efforts to provide alternatives for victim-survivors waiting for therapy and counselling. For example, by developing new support groups and resources (online support, self-directed courses) that victim-survivors could access while waiting for counselling or therapy; or, by managing the waiting lists so that people who required support beyond the specified set of counselling sessions would be able to return to the service without experiencing adverse delays. However, several commissioners raised concerns about how this laudable commitment to support everyone on a needs-led basis could lead to high, unsustainable workloads for voluntary sector staff teams.

### *Distinctions and relationships between statutory and voluntary sector services*

We asked participants in all groups about the perceived strengths and limitations of VSS services and the ways these services worked together to support victim-survivors. It was widely recognised that differences in approach stemmed principally from the different agendas and responsibilities of organisations within each sector. Statutory services were often regarded to be less agile, less responsive and less able to innovate because of their additional administrative and decision-making structures. Echoing other participants, statutory services were described by Participant 11 as 'a ship that takes a longer time to turn around'.

Against the backdrop of these wider, structural issues, participants tended to characterise statutory provision as working less well for victim-survivors, particularly when it was non-specialist (e.g. mental health services, social care). These limitations were attributed to the legacy of historic injustices and/or poor care by some statutory institutions, particularly for marginalised groups, for example, sex workers and people from racial and ethnically minoritised groups.

A further barrier was staff often not having detailed knowledge and/or specialist training about SV:

> *it's the societal context, isn't it, of sexual violence and understanding kind of the impact on the person and their sense of self which maybe wouldn't get as nuanced within a mainstream mental health service, it might just be focused on trauma.*
>
> *Commissioner 3*

These factors led to a perception that statutory practitioners were less likely to explore issues of abuse with victim-survivors, resulting in 'missed opportunities' for support and intervention. Observations were also made by victim-survivors about the difficulties finding specialist services in some areas and the limited knowledge that professionals in other (often statutory) services had about VSS services, which further delayed accessing appropriate support 'I actually stumbled across it [VSS service] so therefore that's how I came across it, that's how I found out. Obviously, I self-referred because my GP didn't know anything about it.' (Female victim-survivor 3).

Issues of risk and vulnerability were also seen to be handled differently. VSS practitioners emphasised, for example, that they sought to work closely with people to enable and support them after disclosures of abuse, and offered holistic support, irrespective of the level of perceived risk or vulnerability. There was also a perception that VSS services would focus work on empowering women to make disclosures to statutory services rather than doing so on their behalf. These factors contributed to the view that VSS services facilitated a more trusting relationship with victim-survivors and creating a greater sense of safety when accessing their services 'If there's a safeguarding issue the voluntary community sector would have to make that safeguarding referral, but I think there's just a perception that they're more supportive and protective …' (Commissioner 1).

Despite these differences, many examples were given that underlined positive, productive relationships between voluntary and statutory organisations. There were also examples of innovative partnerships being developed between services (e.g. with mental health and children's social work) and accounts of victim-survivors receiving effective responses from all agencies. Most VSS practitioners spoke of effective, if not close, working relationships and linkages with their local SARCs and individual workers were seen to play a key role in effecting changes in interagency relationships and offering tailored support that recognised the particular needs of victim-survivors. The implication being, however, that while 'good' working relationships were valued, this was not the experience with all colleagues in partner organisations:

> *We have some fantastic police officers that we work alongside and then we have some police officers that are frankly dreadful but that is exactly the same again really in social services … So it's varied, to be honest.*
>
> *Practitioner 8*

Organisations in both sectors were facing similar challenges meeting increased demand for their services without an increase in their funding and infrastructure. This had led to a situation where VSS services were increasingly working with 'complex' and 'high-risk' clients who would have previously been offered ongoing support from statutory services (mental health, social care). In turn, this had blurred the conventional lines of responsibility between some organisations, with the voluntary sector often left 'picking up' support that statutory services no longer carried out (due to higher thresholds to access support and stretched staff). When VSS services, 'stepped in', however, they often did not receive a commensurate rise in funding 'There's quite a lot being put on the shoulders of a third sector organisation that they shouldn't, there's levels of risk and complexity that they shouldn't have to be shouldering.' (Commissioner 8).

Given the complex and shifting nature of how services operated, several commissioners cautioned against overemphasising the difference between statutory and VSS provision. For example, citing the comparable levels of commitment and passion of statutory sector staff. For others, it was important to recognise that there were good and not so good services in both sectors and that the emphasis should be on improving support for victim-survivors across the board.

## Funding and commissioning issues and experiences

### *Evolution of the funding and commissioning of voluntary sector specialist services*

Over the past 10 years, the way VSS services are funded by public sector institutions has evolved from a predominately grant-based approach to a commissioned contract model. This has brought about changes in the relationship between services and the bodies that fund and, increasingly, monitor and influence their work. It has also ushered in significant changes in how VSS services are organised and, in some areas, how they work with one another. The evolution of these VSS services was typically characterised as 'Starting off very much grass roots, volunteer run, and then expanding, diversifying services, diversifying income and professionalising more and more staff members and [having] fewer volunteers.' (Practitioner 4).

However, amongst the practitioners with whom we spoke, the services they ran and worked for were at different stages in their familiarity with the commissioning process and had varying perceptions of its strengths and limitations. It was also evident that practitioners had different experiences of working with local commissioners. While some VSS services were embarking on their first round of tendering for a commissioned contract, others had considerable experience of the process and in working with different commissioning bodies. This speaks to the range of experiences across the sector and across the country regarding to the use of commissioning.

For commissioners, the move to a largely contract-based model was typically considered positive. Participants shared examples of the impact that commissioning had had in fostering new partnerships between services, cost saving and driving up the quality of support to victim-survivors. In a context of reduced public sector finances, the commissioning process was seen as a useful way of improving efficiencies, in part through the competitive tendering process.

Both commissioners and practitioners spoke about the drive for commissioners from different public sector organisations to pool their budgets and offer longer-term, larger contracts across wider regional areas. This was part of a gradual move towards joint commissioning approaches: wherein commissioning organisations collaborate and share responsibility for how services are designed, delivered and identifying their required outcomes. Joint commissioning can involve organisations working together at all stages of the commissioning process, or just some key stages; it can also involve the pooling of different organisations' budgets. Joint commissioning approaches are also associated with cost savings (e.g. through efficiencies of scale) and, as several participants argued, promote a greater level of transparency and accountability about what each partner body was doing in respect to SV. Given the historic inconsistencies in funding of services for victim-survivors, this aspect of joint commissioning was considered to be particularly advantageous, as expressed by this senior commissioner:

> *There has to be, to my mind, a reduction in variation because you can't keep commissioning small amounts of niche services that add up to a totality because actually, they've also got requirements with public money to deliver services to everyone.*
>
> *Commissioner 10*

In addition, joint commissioning was seen to be the principal way to introduce more streamlined and productive solutions to current, complex commissioning landscapes locally, with the aim of building a more 'whole-system' response.

Practitioners expressed concern that in the process of 'scaling up' the size and value of contracts for VSS services, the larger organisations, which tended to be non-specialists and/or private providers, would be attracted to bid for contracts and thus be in competition with smaller, VSS services. These larger services were also seen to be better placed to competitively tender for larger contracts because they had the infrastructure (e.g. finance, marketing, bid-writing personnel) and larger incomes that could be used to offset initial start-up costs and offer assurances to prospective commissioners.

### *Consortia, collaboration and competition*

In a number of areas, VSS services had formed, or were in the process of forming, consortia or formal joint working arrangements with one another. It was clear that most partnerships tended to develop in response to a commissioner-led agenda, including a drive for greater consistency and less burdensome administration processes:

> *[Consortia arrangements] make it easier for the commissioners to deal with because, we like that kind of partnership working and the richness of experience that they bring as a number of organisations. But if we were to commission each of them individually, that's a lot more work …*
>
> *Commissioner 2*

The pooling of smaller organisations' resource, expertise and, in some cases, infrastructures also enabled these VSS services to credibly challenge larger, generic providers in the tendering process (as discussed above). For practitioners, partnership arrangements had sometimes helped to reduce a sense of competitiveness for funding and enabled more open conversations about 'joined-up' approaches to tackling shared strategic challenges. The sharing of resources, the streamlining of referral pathways and the delivery of shared training also brought tangible benefits. However, there was a sense amongst many (although not all) practitioners that they had entered into partnership arrangements principally for pragmatic reasons and felt that their 'hands had been forced'.

For commissioners, successful consortiums had enabled VSS services to protect and develop their work by joining with other specialist centres and, in some cases, partnerships were attributed with enabling diversification and creativity in these services. Commissioners were, in general, keen to promote greater use of consortia and partnership agreements and to actively support smaller voluntary sector organisations engaging in the process. Examples were given of commissioners providing independent consultants to facilitate change management processes and to help 'match-make' smaller and larger organisations so that they could explore potential partnerships. Training and information-giving was also seen as a key part of the upskilling process of smaller organisations and some commissioners had awarded dedicated pots of funding to focus on 'transforming' service delivery and organisation. Indeed, there was a sense amongst many commissioners that over the past 5–10 years 'We have put quite a bit of time and effort into building the local voluntary sector and capacity capability.' (Commissioner 9).

However, several commissioners emphasised that it was 'not enough to put on a few workshops' (Commissioner 8) and that commissioners had to play a lead role in promoting and developing local voluntary sector capacity if they were to compete for contracts on fairer terms. It was also recognised that consortia were not without their challenges. The legal complexities in developing consortia were very real, so too the practical issues involved in managing more complex organisations. Several commissioners discussed how larger VSS services tended to shoulder the burden of this administrative work and there was an inevitable inequality to some partnerships.

### *Co-production and partnership in the commissioning process*

For practitioners, power dynamics and inequalities shaped their interactions with some commissioners. A number of practitioners had faced negative, disempowering experiences of the commissioning process and/or with some individual commissioners. However, practitioners' experiences varied and there were several examples of productive, positive working relationships with individual commissioners. 'Excellent' commissioners were typically characterised as being committed to, and advocates of, the services they commissioned. Underpinning these relationships was a sense of being trusted and their expertise being valued: 'The relationship is absolutely key and being listened to and being seen as an expert' (Practitioner 3). Commissioners who made an effort to understand the work being carried out – that is, through regular visits, ongoing conversations, meeting with service users – were singled out by practitioners as positive examples. These commissioners were seen to make more informed decisions and, resources permitting, to be more willing to invest in VSS services, including covering costs beyond those of 'direct' service delivery.

The flip side of positive working relationships was the insecurity generated by poor ones, where communication and shared understanding were lacking. Several practitioners commented on the 'personality-driven' nature of decision-making within the commissioning process and the lack of redress available to smaller organisations who lost out on funding or disagreed with approaches to monitoring and review 'Sometimes it's very personality driven, you know, those decisions are made not always based on need, but actually because of a relationship between the funder and a chief exec. It's really not a transparent way of doing things.' (Practitioner 4).

Power inequalities also surfaced in the commissioning process itself. A common source of frustration was the limited involvement of victim-survivors or VSS service workers in the development of service specifications. The process was described by some practitioners as feeling 'top down' and involvement was described as superficial. An absence of collaborative working at the service specification stage was also perceived to be associated with the development of services that did not meet victim-survivors' needs. For example, the imposition of short-term, time-bound support was seen to undervalue the role and impact of counselling provided by SV specialists. Short-term, support-focused provision was also associated by some practitioners with clinically orientated ideas about the quick reduction of mental health 'symptoms' rather than the provision of holistic, trauma-informed care 'Commissioners, they would like it just to be neat and tidy – ten therapy sessions. That will be, that's all that is necessary. Of course, that's ridiculous.' (Participant 1).

The importance of providing integrated, consistent support was a concern raised across the participant groups, not least by victim-survivors who reflected on the impact of feeling they had been 'bounced' between services or that long-awaited therapeutic support had ended prematurely. To address this, some commissioners advocated that service specifications should be co-produced and that commissioners should have greater knowledge about victim-survivors' needs and issues. Commissioners also highlighted the importance of improving feedback mechanisms throughout the commissioning process so that the views of VSS staff and victim-survivors were consistently understood.

### *Funding issues*

Responding and adapting to the challenges of insecure funding and contracts and achieving stable, secure and adequate funding was a major challenge for many providers. In the context of historic underfunding of VSS services and a lack of ring-fence protection of SV budgets, VSS services were also grappling with the challenges generated by short-term funding streams from charitable trusts and commissioner grants (and, in a minority of cases, commissioned contracts). This created a high degree of precariousness about the longevity of services, which, in turn, affected staff morale and retention 'We all build our services like Lego, so when that project goes you unbolt it and, with that, the learning, the staff, the expertise, all goes with it.' (Practitioner 11).

In order to secure funding, voluntary sector leaders reported spending significant time writing bids and engaging with the 'politics' of funding calls. Senior practitioners raised concerns about how much of their role now centred on funding processes and fulfilling governance and monitoring requirements: a process Participant 9 described as a 'never-ending hamster wheel'. In small organisations, this was seen as an additional pressure on already stretched staff teams and a poor use of senior staff' time, curbing their 'space for creativity' (Practitioner 4) and ability to 'think strategically around growth and development' (Practitioner 9). A sense of feeling stretched and needing to make careful, sometimes, difficult decisions about competing priorities was common.

To minimise the insecurity created by relying on one or two main funders, many VSS services had diversified their funding streams and were now working with a range of charitable funders and commissioning bodies. This approach was viewed as a positive step towards retaining an independent, critical voice. However, it could also create additional pressures given the time and resource needed to attract and retain such a varied portfolio of funding streams. Several practitioners also emphasised the importance of specialist services guarding against 'mission creep'. They warned that in a bid to diversify, expand and meet the expectations of contracts, VSS services could become stretched too thin and organisations' reputations as specialist providers could be compromised.

Frustration was also expressed at the ending of 'successful' services (services that had met or exceeded their objectives and received positive feedback) and questions were raised about why there was not greater funding available to maintain VSS services that had a proven, positive track record. Practitioners also reported that services could be discontinued at short notice, which compromised continuity of support, sometimes for particularly vulnerable victim-survivor groups. This could negatively affect an organisation's relationship with and reputation within some communities. Some VSS services had also stepped in financially to help wind down (and, if possible, continue) services when funding was stopped. This represented an additional cost to the organisation and meant that some services were being run at a financial loss.

For many practitioners, charities, trusts and foundations provided vital support that helped to 'hold up' VSS services, particularly during times of transition and upheaval. Although charitable funds came with reporting and monitoring requirements, such funding was seen to afford VSS services a greater degree of autonomy in the day-to-day running of services compared with commissioned contracts. In turn, charitable funding was associated with less pronounced power dynamics between funders and providers:

> *… their [charitable funder's] overwhelming agenda all of the time was 'what do you need to succeed and what do you need us to do next?' But at the same time, you were under no illusion that you were accountable …*
>
> *Practitioner 5*

Charitable funding could also be used for services that might be considered 'soft' or 'add on' by public sector bodies, but which are essential to responding holistically to victim-survivors. For example, music groups, yoga, sound therapy and massage. Charities were also a major source of funding for work with victim-survivors' friends and family members which, in most areas, was not routinely commissioned. In another area of comparison, there were examples of some charitable funders now promoting longer-term therapeutic interventions, which seemingly went against the grain of mainstream funding and commissioning practices:

> *She [charity representative] said 'I'm fed up with seeing applications where it's six to eight sessions. How can you do anything in six to eight sessions?' and I was like 'Oh my goodness. Are you stuck in the nineteen seventies or something?' … that's great.*
>
> *Participant 13*

Charities were also a valuable source of funding for VSS services' 'core' infrastructure costs (e.g. employee pension and sickness costs, Human Resources and finance support, building maintenance/rent). This type of investment helped VSS services to grow and strategically plan. Despite these attributes, it was evident that charitable funding was varied and could generate the same instabilities regarding short-termism, as could commissioned contracts and short-term local and national government grants. For example, some charitable funding was seen to focus too much on innovative and 'trendy' topics, rather than maintaining good services and investing in specialist services' infrastructure. In addition, certain charities and foundations could only fund one or two projects per organisation at any one time, or only those services who met certain financial thresholds, impacting their reach and ability to sustain VSS who had limited or inconsistent financial support from state bodies.

## Key messages from work package 1

- The specialist nature of VSS services is highly valued by victim-survivors. In the voluntary sector, specialism relates to the knowledge and expertise of staff and the historic role many organisations have played in shaping responses and understandings of SV. Also, VSS services offer a dedicated, protected environment for victim-survivors where the shame and stigma of SV is understood and challenged.
- Challenges arise from working with 'complex' clients in a pressurised environment (e.g. high caseloads, rising demand, higher client need). Demands on staff within VSS services also centred on the challenges of competing for funding and contracts and the insecurities generated by short-term and innovation-focused funding. Practitioners were reported to be leaving VSS services, with an attendant loss of specialism and expertise from the sector.
- (Most) statutory services were seen to work in a different way with victim-survivors than those in the voluntary sector. Victim-survivors were seen to benefit from (and prefer) the independent and needs-led approach of the voluntary sector. However, good relationships existed between many statutory and voluntary sector services and there were examples of innovation and close partnership working.
- Over the past 10 years, statutory and voluntary sector services have faced increased demand for their services at time of widespread reductions and changes in funding streams. This has led to pressures on both sectors, and it was widely recognised that VSS organisations are now working with more 'complex' clients who in the past would have received statutory support. This transition has occurred without a commensurate realignment of funding.
- While longer-term investment is welcomed, VSS services expressed concern that the move towards joint-funded, large contracts is likely to favour larger, often generic providers. This threatens the survival of smaller, bespoke VSS services who provide valued support to victim-survivors. Developing partnership or consortia arrangements between VSS services can help services to share their resources and expertise. In turn, this can help them to compete alongside larger providers for bigger (often longer-term) contracts. This was the case for some of the practitioners we interviewed.
- In some areas, short-term and/or innovation-focused funding resulted in 'good', established VSS services struggling to survive. The associated precariousness negatively affects staff morale and retention and can undermine the sector leader's ability to work in a strategic and creative way. Uncertainties about how VSS services are delivered can also undermine victim-survivors' trust and the quality of support they receive.

# **Chapter 4** Work package 2: national provider and commissioner surveys

## Context of work package 2

Three national surveys were undertaken in parallel, to allow 'mapping' of VSS service provision across England and describe service commissioning for victim-survivors of SV. Surveys focused on: (1) NHS statutory providers supporting victim-survivors of SV within SARCs; (2) commissioners from LAs, CCGs, Office of the Police and Crime Commissioner (OPCC), the NHS and Health and Justice who commission/co-commission therapeutic services for victim-survivors of SV that may be provided by VSS services and (3) senior staff working in VSS services. Initially, there were to be two online surveys; however, during survey development, it became apparent that separate surveys would be required for the voluntary specialist SV sector and SARCs due to differences in their operation and configuration. As a result, we designed and administered three separate online surveys for (1) commissioners of services for victim–victim-survivors, (2) specialist voluntary sector SV service providers and (3) SARCs. The surveys were designed to enable comparison between the three participant groups on a number of key themes (e.g. views of funding and commissioning, the strengths of specialist services, under-representation of victim–survivor groups).

## Methods

### *Development and design*

Survey content was informed by the relevant academic and policy literature, and by qualitative data collected from service providers, commissioners, policy leads and victim-survivors in WP1. Surveys covered the following topics:

1. Principles underpinning VSS service provision.
2. What services are commissioned and provided, how, by whom and to whom?
3. Criteria for accessing VSS services.
4. Referral patterns and pathways; relationships and partnerships between organisations.
5. Sources of funding and trends over time, including innovative responses to evolving commissioning and funding 'landscapes'.
6. Commissioning approaches/models, including perceived effectiveness, facilitators and challenges.

Surveys included both closed questions (tick-boxes or Likert scales) and open questions (free-text responses) and were piloted within the West Midlands with staff from VSS services (provider survey) and commissioners (commissioner survey) for clarity of wording and relevance of questions to their intended audience(s). Surveys were disseminated electronically using the JISC Online Survey Tool and each took up to 25 minutes to complete.

### *Eligibility and recruitment*

Potential participants accessed surveys via a weblink embedded within a brief invitation e-mail. The research team sent invitations directly to named SARC, VSS provider and commissioner contacts, for forwarding to the appropriate person within each organisation. Weblinks were also disseminated by members of the study Steering Group representing umbrella organisation networks (e.g. The Victim-survivors' Trust); included in articles within professional press communications (e.g. Association of Directors of Adult Social Services newsletter) and publicised on the PROSPER website and social media accounts. Written informed consent was not obtained, but respondents could not progress into the survey without seeing detailed participant information and selecting a consent box embedded on the entry page. All surveys were anonymous, and participants were not asked for any personal information except sociodemographic data (age, sex, ethnicity) and some brief information about their job (e.g. role, time in current post). The surveys remained open from 13 January to 20 June 2021 and non-responders received up to two e-mail or telephone reminders. *Table 1* summarises the inclusion and exclusion criteria.

**TABLE 1** Inclusion and exclusion criteria for staff eligible to complete national surveys

| | Specialist providers SARCs | Commissioners |
|---|---|---|
| Inclusion criteria | Senior staff member who is the nominated representative/ lead practitioner from their organisation | Senior commissioner whose role is to commission services from VSS providers for victim-survivors of SV |
| | Currently in post or had been in post within the previous 12 months | |
| Exclusion criteria | Staff not routinely involved in planning/decision-making about obtaining and managing funding or who are not involved in commissioning processes for their service | Commissioners not routinely involved in planning/decision-making about VSS for victim-survivors of SV |

### *Sample size*

There were no formal sample size requirements for the PROSPER surveys. For statutory and VSS providers, we sought one response per organisation, as surveys focused on respondents' experiences of service provision, funding and commissioning at the organisational rather than individual level. Duplicate responses from the same organisation were deleted and only the first response received (chronologically) was retained. For the commissioner survey, it was recognised that there may be multiple individuals involved in VSS commissioning with different remits within an organisation (e.g. adult services vs. services for children and young people (CYP)). Here, we aimed to obtain as many responses as appropriate from each organisation, to capture service provision and/or commissioning practices as fully as possible.

### *Analysis*

Data were analysed descriptively using Microsoft Excel, to characterise specialist SV service provision, statutory services and commissioning across England, and response counts/percentages are described and presented graphically as appropriate. Respondent views about service quality, possible improvements and how commissioning was perceived to work were also analysed descriptively to identify differences and commonalities by stakeholder group. The small number of responses prohibited subgroup analysis. Free-text comments were analysed thematically.

## Results

### *Responses*

Twelve surveys were returned from SARCs, 54 from VSS providers and 34 from commissioners. *Table 2* outlines the personal (sociodemographic) and professional (role-related) characteristics of respondents.

Across each group, most respondents were female, of white ethnicity and most likely to be aged over 50 years. Professionally, nearly all SARC respondents managed their organisation and most (83.3%) had spent < 5 years in their current post. Commissioner respondents had typically spent fewer than 5 years in their current post (64.7%), with none in the post longer than 15 years. Around a third of commissioners reported that between 10% and 30% of their role involved SV commissioning ($n$ = 12; predominantly in local authorities); eight spent < 10% of their time on SV (23%), and seven (21%) spent > 50%. In VSS services, many were highly experienced, with 18.5% having worked in VSSSVs for > 21 years.

### *Organisational and service characteristics*

Geographically, only Cumbria and Berkshire did not return any surveys. Thirteen areas made a single response. Sixteen areas returned both commissioner and VSS surveys, and seven areas returned at least one survey from each of the three stakeholder groups (*Figure 2*).

Sexual Assault Referral Centres were predominantly private ($n$ = 8) and offered services to CYP ($n$ = 1), adults ($n$ = 5) or both ($n$ = 6). All SARCs offered forensic medical examination, crisis workers, emergency contraception and prophylactic medication. Most (10/12) had dedicated helplines. Less frequent services were sexual health screening ($n$ = 7), children's ISVA (ChISVA) ($n$ = 5), ISVA ($n$ = 4) and counselling ($n$ = 4), either in-house or via onward referral.

**TABLE 2** Personal and professional characteristics of survey respondents

| | | SARCs | VSS providers | Commissioners |
|---|---|---|---|---|
| Characteristic[a] | Group | *n* (%) | *n* (%) | *n* (%) |
| All responses | | **12** | **54** | **34** |
| Role | Manager | 11 (91.7) | 13 (24.1) | 12 (35.3) |
| | CEO | – | 33 (61.1) | – |
| | Senior practitioner or commissioner | 1 (8.3) | 1 (1.9) | 7 (20.6) |
| | Policy officer | – | – | 15 (44.1) |
| | Other[b] | – | 4 (7.4) | – |
| Time in current post | < 12 months | 1 (8.3) | 5 (9.3) | 2 (5.9) |
| | 1–5 years | 9 (75.0) | 29 (53.7) | 20 (58.8) |
| | 6–10 years | 2 (16.7) | 11 (20.4) | 10 (29.4) |
| | 11–15 years | – | 2 (3.7) | 2 (5.9) |
| | 16–20 years | – | 4 (7.4) | – |
| | 21 + years | – | 3 (5.6) | – |
| Time in specialist SV services or commissioning | < 12 months | 1 (8.3) | 2 (3.7) | 2 (5.9) |
| | 1–5 years | 6 (50.0) | 12 (22.2) | 12 (35.3) |
| | 6–10 years | 2 (16.7) | 18 (33.3) | 11 (32.4) |
| | 11–15 years | 2 (16.7) | 7 (13.0) | 7 (20.6) |
| | 16–20 years | 1 (8.3) | 5 (9.3) | 2 (5.9) |
| | 21 + years | – | 10 (18.5) | – |
| Gender | Male | – | 5 (9.3) | 8 (23.5) |
| | Female | 10 (83.3) | 49 (90.7) | 25 (73.5) |
| Age group[c] | 18–40 years | [ … ] | 13 (24.1) | [ … ] |
| | 41–50 years | [ … ] | 13 (24.1) | 13 (38.2) |
| | 51 + years | [ … ] | 28 (51.9) | 14 (41.2) |
| Ethnic group (self-reported) | White British | 9 (75.0) | 40 (74.1) | 30 (88.2) |
| | Other ethnicity | [ … ] | 13 (24.1) | [ … ] |

a Percentages may not total 100 due to missing responses.
b Director of operations (*n* = 3), trustee (*n* = 3), business manager (*n* = 1).
c Cells reporting personal characteristics with fewer than five respondents have data suppressed, denoted by [ … ], to preserve anonymity.
Reproduced with permission from Bradbury-Jones *et al.*[73] This is an Open Access article distributed in accordance with the terms of the Creative Commons Attribution (CC BY 4.0) licence, which permits others to distribute, remix, adapt and build upon this work, for commercial use, provided the original work is properly cited. See: https://creativecommons.org/licenses/by/4.0/. The table includes minor additions and formatting changes to the original text.

Most VSS providers (41/54) described themselves as specialist organisations, and 34/54 offered services to adults and CYP. All but seven reported an affiliation with umbrella bodies such as Rape Crisis England and Wales. One-to-one specialist counselling/psychotherapy was the most widely offered VSS service, alongside a range of other therapeutic support (*Figure 3*), usually for around 26 weeks' duration. Extra support was offered to specific groups for example, males, sex workers by 25/54 VSS providers; 30/54 also offered well-being/holistic services, and 28/54 provided activism-focused support.

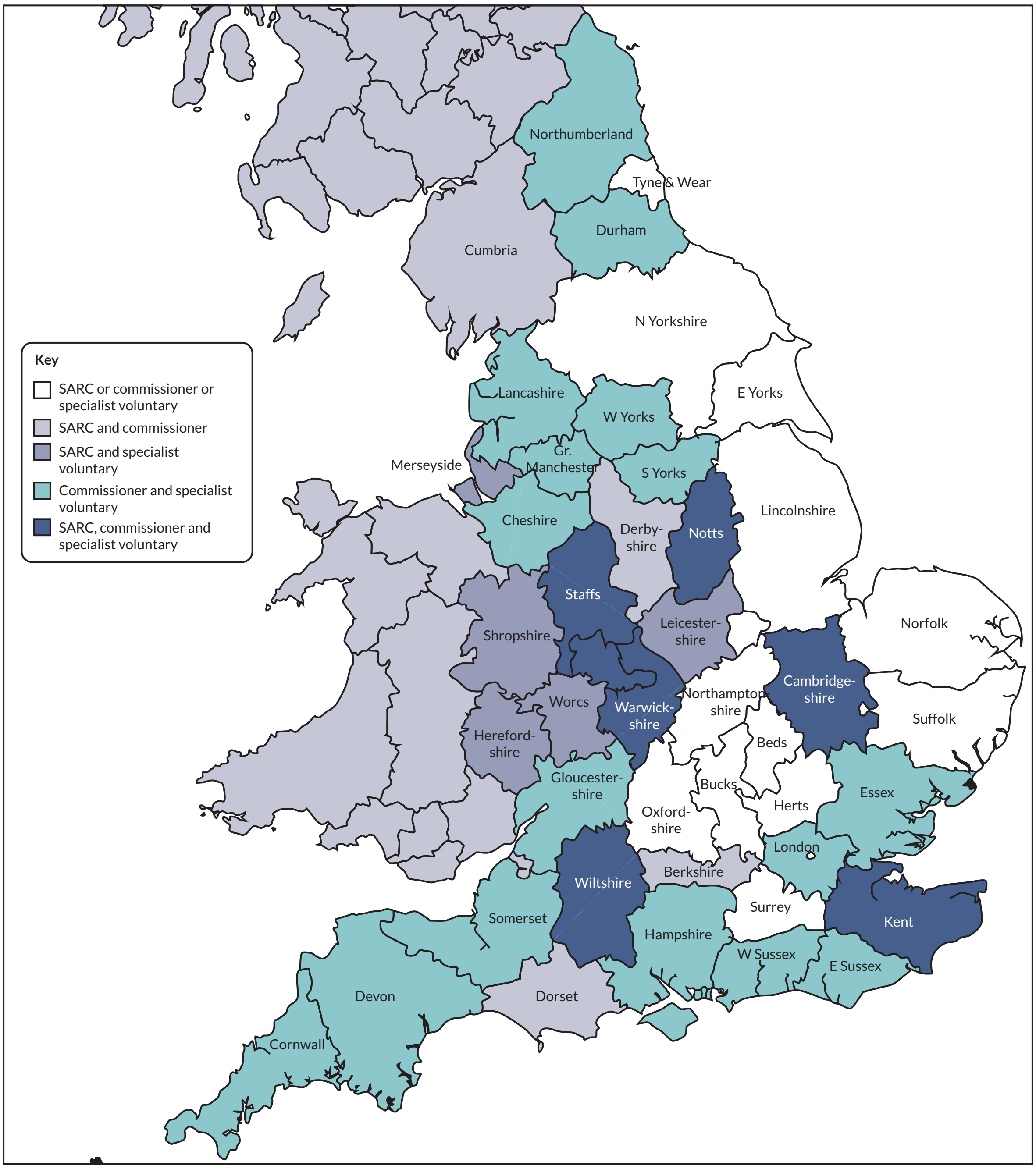


**FIGURE 2** Geographical spread of survey respondents.

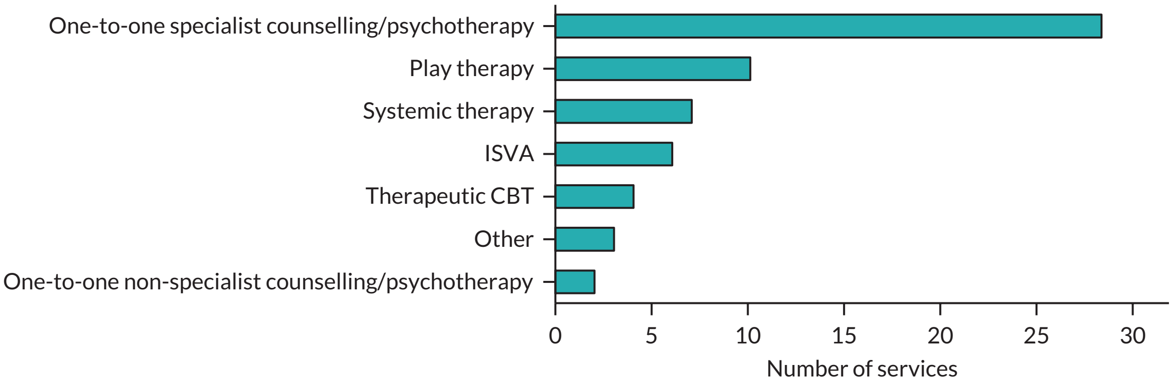


**FIGURE 3** Support offered by VSS services. CBT, cognitive–behavioural therapy.

### *Service funding*

As statutory providers, SARCs are funded directly by National Health Service England (NHSE) for initial support services, with additional therapeutic services usually funded by OPCC. In contrast, VSS respondents reported a complex system of reliance on multiple and varied funding sources, most commonly from charitable trusts (45/54) and fundraising/donations (45/54) (*Figure 4*). VSS providers reported using a mean of 4.8 funding sources (range 1–9) for their services.

### *Service commissioning*

Most SARC services (45%) were commissioned by a single body (usually NHSE), although joint commissioning by OPCC and NHSE was common, particularly for forensic and crisis worker services (*Figure 5*). CCGs and local authorities had minimal involvement in SARC commissioning (*Figure 6*).

Voluntary sector specialist providers described a complex commissioning landscape. Eighty-three services (65%) were single-commissioned, usually by OPCC (56/83); 29 were dual-commissioned (23%), typically by OPCC + NHSE or OPCC + LA, and 16 were triple-commissioned (13%). The greatest variability in commissioning was for one-to-one adult and CYP services (*Figures 7* and *8*).

### *Satisfaction with commissioning*

Providers rated their satisfaction with commissioning arrangements for services (and commissioners rated satisfaction with commissioning arrangements in their area) (*Figure 9*). See *Appendix 1* which describes scoring.

Generally, SARC providers were most likely to be satisfied with commissioning overall and for each commissioning body. Commissioner and VSS providers' levels of satisfaction were lower, and for all commissioners except CCGs, VSS providers reported the lowest rates of satisfaction with commissioning, with over 40% of respondents either dissatisfied or ambivalent (*Figure 10*). The general trend across all respondent groups was that OPCC and NHSE commissioners were rated highest, followed by local authorities and CCGs.

### *Working with commissioners*

Respondents rated agreement with a series of statements characterising perceived facilitators of, and barriers to, working effectively with commissioners (*Table 3*). Facilitators of working with commissioners showed similarly high levels of agreement across groups. Good relationships with individual commissioners, commissioners who understand SV and the voluntary sector, and communication with named commissioners were considered the most important enabling factors. The largest disparity related to the perceived importance of partnerships with other services, to which 97% of SARC respondents agreed, compared with 78% of VSS providers.

Few factors were considered substantial barriers by SARC respondents, with 4/12 citing clashes between health and criminal justice priorities and 4/12 highlighting time-intensive contract management/reporting as the greatest barriers. VSS providers highlighted failure to consult with services (61%) and unrealistic timelines to respond to briefs/tenders

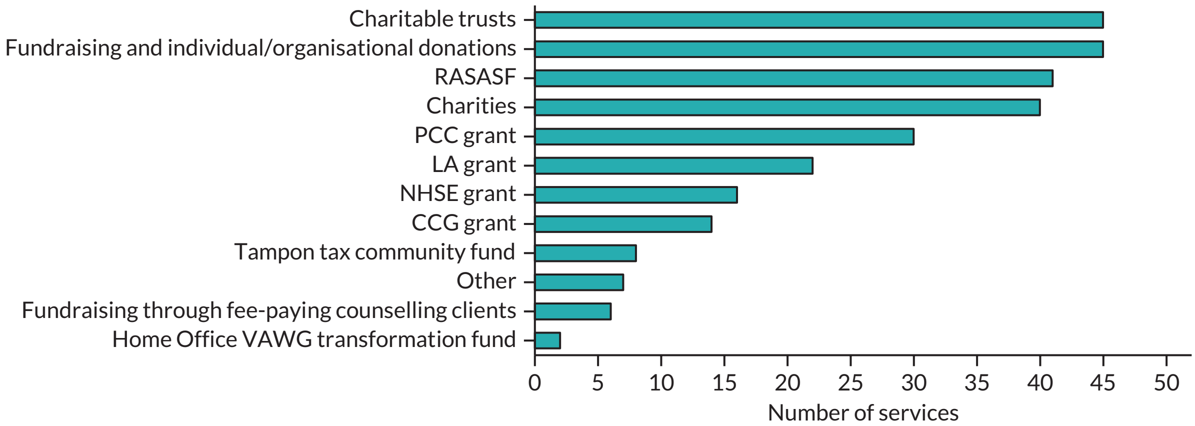
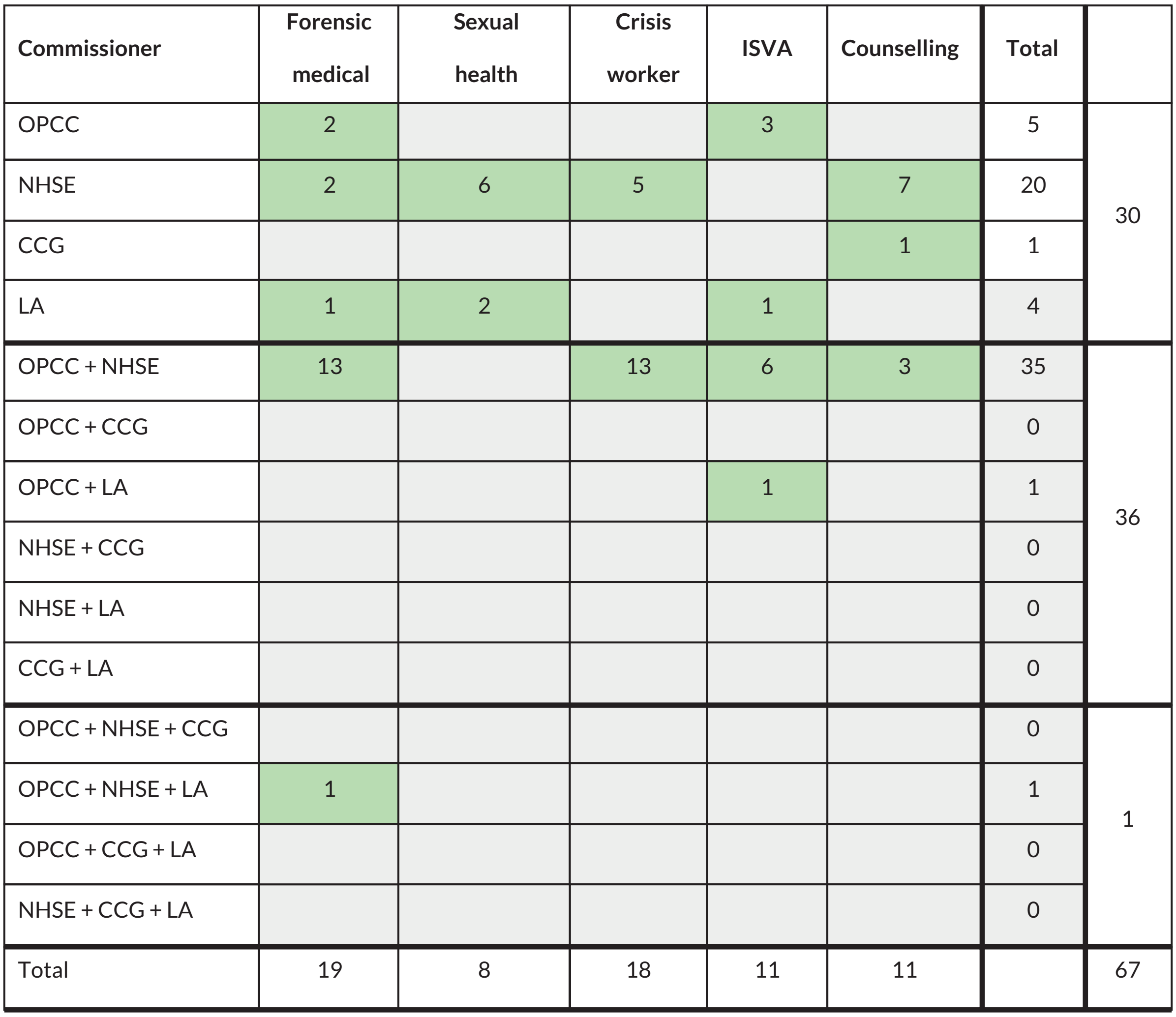


**FIGURE 4** Voluntary sector specialist provider funding sources. VAWG, Violence against women and girls.



| Commissioner | Forensic medical | Sexual health | Crisis worker | ISVA | Counselling | Total | |
|---|---|---|---|---|---|---|---|
| OPCC | 2 | | | 3 | | 5 | 30 |
| NHSE | 2 | 6 | 5 | | 7 | 20 | |
| CCG | | | | | 1 | 1 | |
| LA | 1 | 2 | | 1 | | 4 | |
| OPCC + NHSE | 13 | | 13 | 6 | 3 | 35 | 36 |
| OPCC + CCG | | | | | | 0 | |
| OPCC + LA | | | | 1 | | 1 | |
| NHSE + CCG | | | | | | 0 | |
| NHSE + LA | | | | | | 0 | |
| CCG + LA | | | | | | 0 | |
| OPCC + NHSE + CCG | | | | | | 0 | 1 |
| OPCC + NHSE + LA | 1 | | | | | 1 | |
| OPCC + CCG + LA | | | | | | 0 | |
| NHSE + CCG + LA | | | | | | 0 | |
| Total | 19 | 8 | 18 | 11 | 11 | | 67 |

**FIGURE 5** Commissioning of SARC services. Green cells represent number of respondents reporting each commissioner/combination.

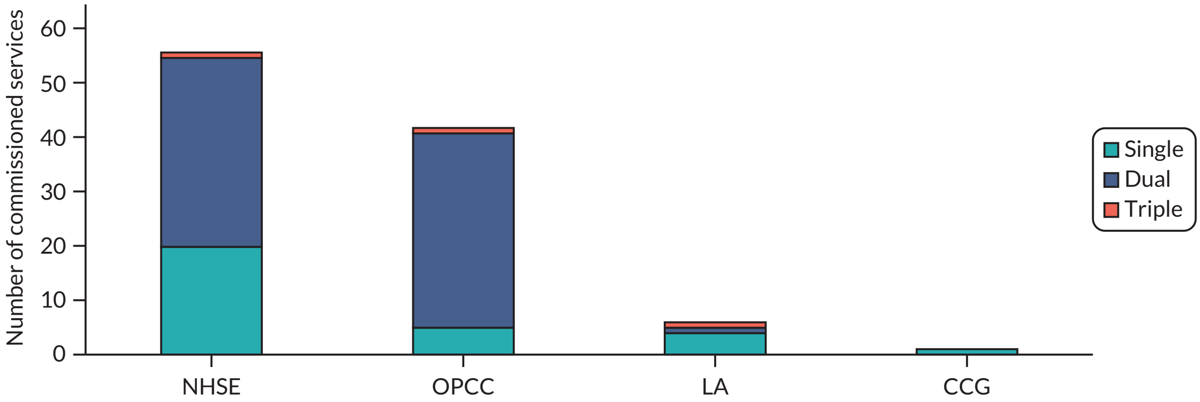
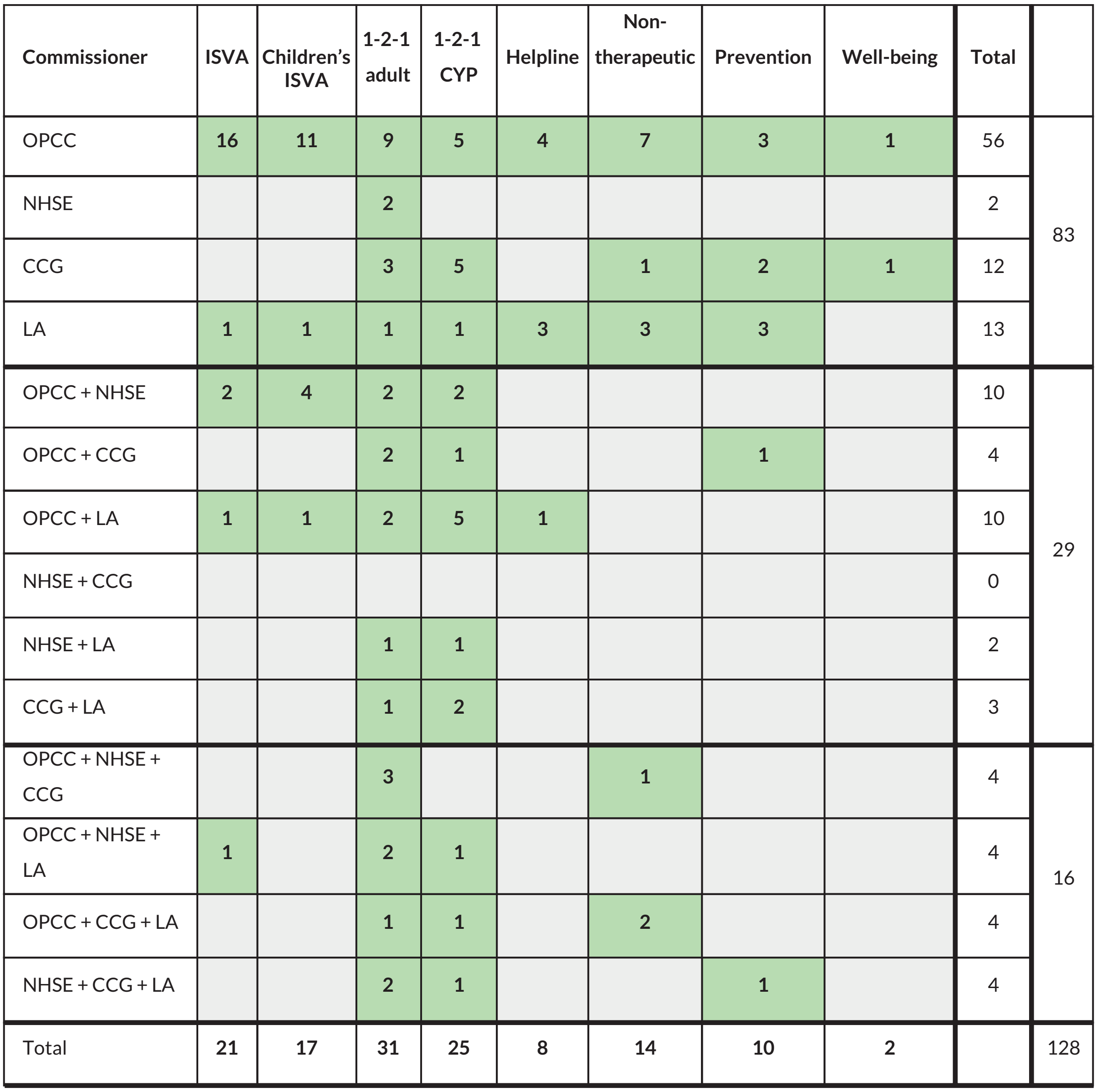


**FIGURE 6** Commissioners of SARC services.

(61%) as the most important barriers; the latter was noted as important by only 6% of commissioners. Other barriers reported by VSS respondents were perceived limited ability to shape service provision (47%), time-intensive contract management/reporting (45%) and unrealistic contracts and expectations (42%).

### *Commissioner views about working with providers*

Commissioners were asked whether any potential barriers (from a pre-specified list) had hampered their ability to work with providers (*Figure 11*).



| Commissioner | ISVA | Children's ISVA | 1-2-1 adult | 1-2-1 CYP | Helpline | Non-therapeutic | Prevention | Well-being | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| OPCC | 16 | 11 | 9 | 5 | 4 | 7 | 3 | 1 | 56 | 83 |
| NHSE | | | 2 | | | | | | 2 | |
| CCG | | | 3 | 5 | | 1 | 2 | 1 | 12 | |
| LA | 1 | 1 | 1 | 1 | 3 | 3 | 3 | | 13 | |
| OPCC + NHSE | 2 | 4 | 2 | 2 | | | | | 10 | 29 |
| OPCC + CCG | | | 2 | 1 | | | 1 | | 4 | |
| OPCC + LA | 1 | 1 | 2 | 5 | 1 | | | | 10 | |
| NHSE + CCG | | | | | | | | | 0 | |
| NHSE + LA | | | 1 | 1 | | | | | 2 | |
| CCG + LA | | | 1 | 2 | | | | | 3 | |
| OPCC + NHSE + CCG | | | 3 | | | 1 | | | 4 | 16 |
| OPCC + NHSE + LA | 1 | | 2 | 1 | | | | | 4 | |
| OPCC + CCG + LA | | | 1 | 1 | | 2 | | | 4 | |
| NHSE + CCG + LA | | | 2 | 1 | | | 1 | | 4 | |
| Total | 21 | 17 | 31 | 25 | 8 | 14 | 10 | 2 | | 128 |

**FIGURE 7** Specialist SV commissioning.

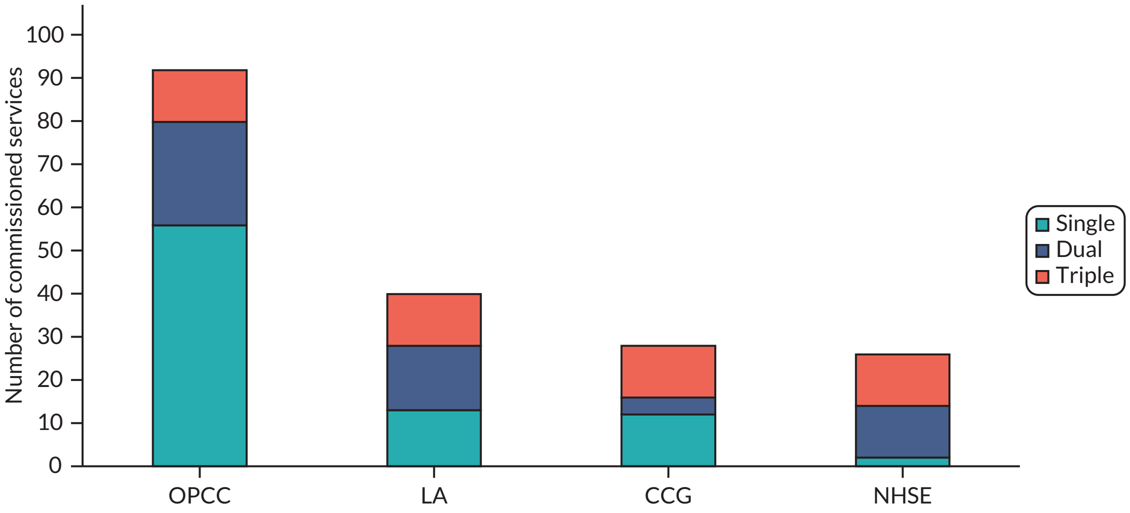


**FIGURE 8** Commissioners of specialist services.

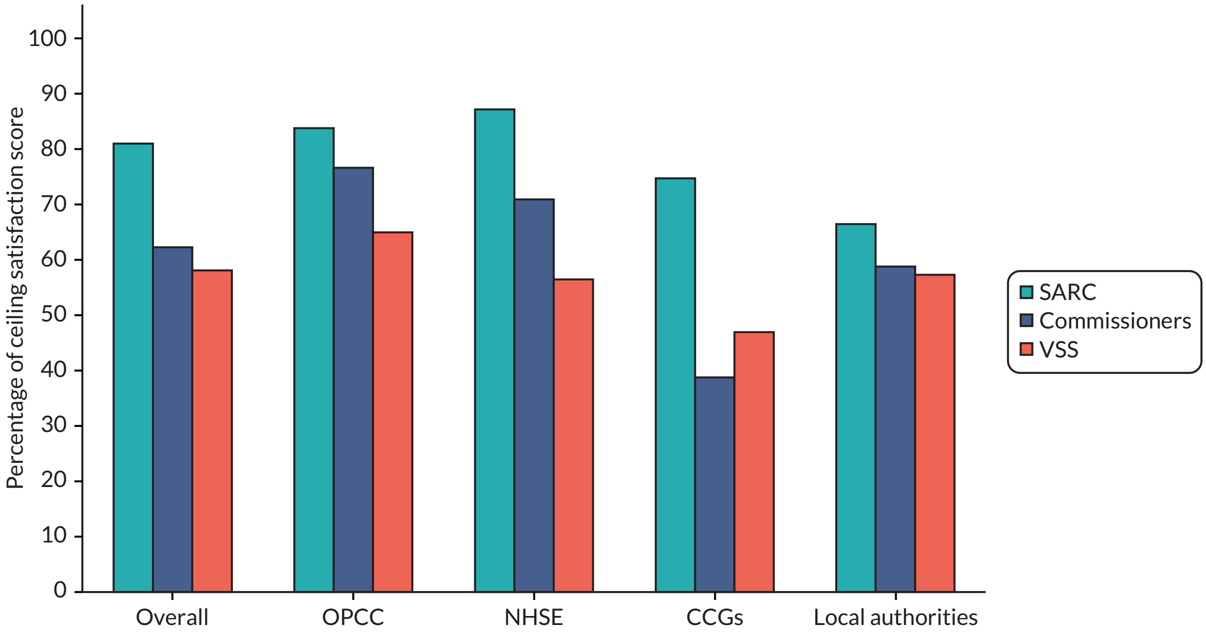


**FIGURE 9** Satisfaction with commissioning.

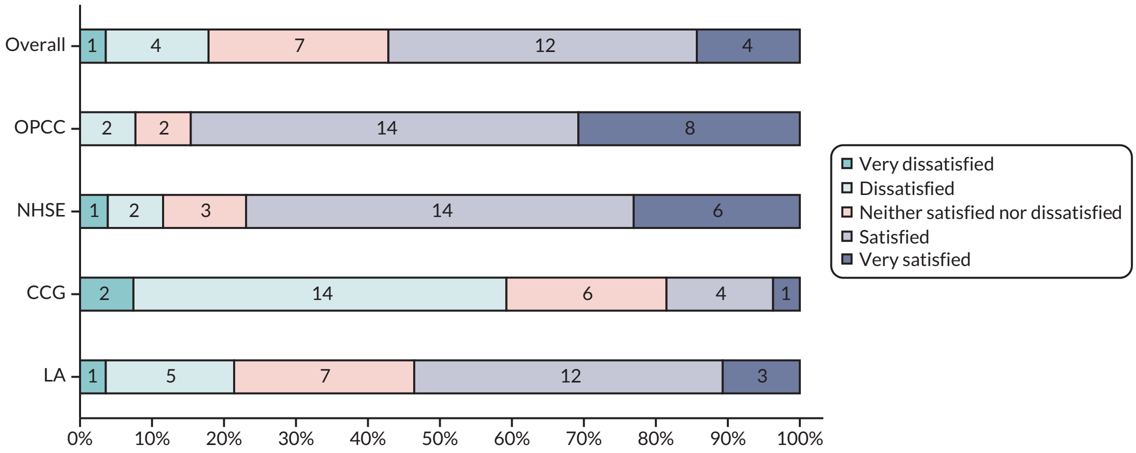


**FIGURE 10** Voluntary sector specialist provider satisfaction with commissioning.

The perceived lack of currently available funding was the most likely to be cited as hampering commissioners' ability to work effectively with specialist providers (38%). Having some service components still subject to national commissioning and the impact of austerity measures on the sector over the last 10 years were reported as important by 11 commissioners (32%). The least important factors, each selected by one individual, were perceived issues with subcontracting arrangements, commissioners' lack of access to data about local SV rates and a lack of time to develop good relationships with providers and other organisations. Commissioners also reported undertaking specific activities to support VSS providers to engage with the commissioning process. These related to consultation and discussions about commissioning (77%), provision of pilot funding for VSS organisations to develop partnerships or joint working (41%) and training support about the commissioning process (35%). Seven commissioners (21%) reported offering all these engagement opportunities.

### *Commissioner perceptions of voluntary sector specialist services*

Commissioners were asked about their perceptions of the strengths and limitations of VSS services, and to select statements they agreed with from a pre-specified list (*Table 4*).

**TABLE 3** Facilitators and barriers to effective working with commissioners

| | % agreeing with statement | | |
|---|---|---|---|
| **Factor**[a] | **SARC** | **VSS providers** | **Commissioners** |
| ***Facilitators*** | | | |
| Good relationships with individual commissioners | 100 | 95 | – |
| Partnerships with other services | 97 | 78 | – |
| Commissioners who understand the SV agenda | 97 | 96 | – |
| Communication with named commissioners | 95 | 95 | 88 |
| Consultation during commissioning process | 93 | 91 | 78 |
| Commissioners leading workshops/training | 87 | 80 | 75 |
| In-person meetings with commissioners | 86 | 84 | 83 |
| Commissioners who understand the voluntary sector | – | 95 | – |
| ***Barriers*** | | | |
| Clashes between health and criminal justice priorities | 25 | – | – |
| Time-intensive contract management and reporting | 25 | 45 | – |
| Failure to consult with services when developing specifications | 17 | 61 | – |
| Not consulting with victim-survivors when developing specifications | 17 | 34 | – |
| Limited ability to shape terms of service provision | 17 | 47 | – |
| Unrealistic timelines to respond to briefs/tenders | 17 | 61 | 6 |
| Insufficient time to develop relationships | 8 | 32 | 6 |
| Unrealistic contracts and expectations | 8 | 42 | – |
| Too many commissioners with different agendas | 0 | 40 | 29 |

[a] Not all statements were included in all surveys.

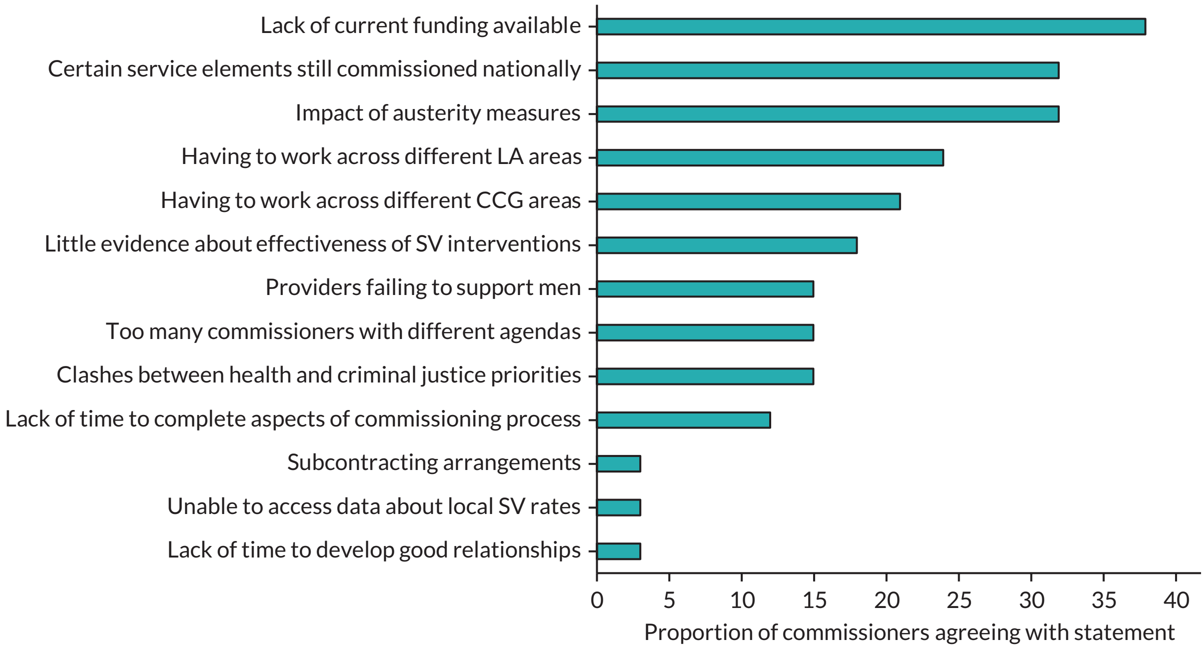


**FIGURE 11** Barriers to commissioners' ability to work effectively with providers.

**TABLE 4** Commissioners' perceived strengths/limitations of VSS services

| Positive factor | % agreeing | Negative factor | % agreeing |
|---|---|---|---|
| Detailed knowledge of SV | 91 | Short-term funding/commissioning means services cannot be guaranteed | 71 |
| Victim-survivor voice central to service design/delivery | 88 | Resist providing services to male victim-survivors | 29 |
| Holistic approach to supporting user needs | 76 | Lack infrastructure to collect/process outcomes data | 27 |
| Commitment to make victim-survivors feel believed | 76 | Resistant to change | 27 |
| Independence, ability to critique statutory services | 74 | Challenging to work with | 18 |
| Role in campaigning for change/victim-survivor voice | 68 | Provide nothing distinct from statutory services | 3 |
| Welcoming environment for users | 59 | Staff lack training/expertise to support those with complex needs | 3 |
| Less bureaucratic, more innovative | 50 | | |
| Knowledge of, and links to local communities | 47 | | |
| SV situated within context of gender inequality | 29 | | |

The factors considered the greatest strengths of VSS organisations were their perceived expertise and knowledge of SV (91%), centrality of the victim-survivor voice to services (88%), holistic approach (76%) and commitment to making service users feel believed (76%). Less frequently cited strengths (although still widely agreed) related to the context of gender inequality (29%), embeddedness in local communities (47%) and balance between bureaucracy and innovation (50%). Limitations of VSS organisations were reported far less frequently. The most cited weakness was the impact of short-term funding/commissioning on service longevity (71%). Others related to the potential for exclusion of male victim-survivors (29%), lack of data collection infrastructure (27%) and potential resistance to change (27%).

### *Consequences of funding/commissioning arrangements*

Voluntary sector providers and commissioners were asked to select from a list of statements, those that they agreed were consequences of SV commissioning/funding arrangements over the past 5 years within their region. VSS respondents were most likely to perceive an increased need for partnership working (61%), an increase in short-term funding (59%), positive relationships between commissioners/funders/providers (50%) and greater competition between VSS providers (50%) (*Figure 12*). Least reported were an increase in mid-long-term funding (17%), money leaving the region (13%) and closure of specialist SV services (7%).

Commissioners were most likely to report positive relationships between commissioners/funders/providers (53%), different commissioners working together (50%) and greater need for partnership working (41%). Two issues showed notable disparities in perceptions. First, only 12% of commissioners believed there had been an increase in short-term funding (vs. 59% of VSS providers), and 6% of commissioners perceived a growing prioritisation of support work over therapeutic provision (vs. 35% of VSS providers).

Not all statements were common to each survey.

Voluntary sector specialist providers were also asked about perceived consequences for their organisation over the past 5 years (*Figure 13*). While job cuts were reported least (13%), around a quarter of respondents reported that there was underinvestment in services for specific groups, there had been changes/scaling back of VS work and that they were

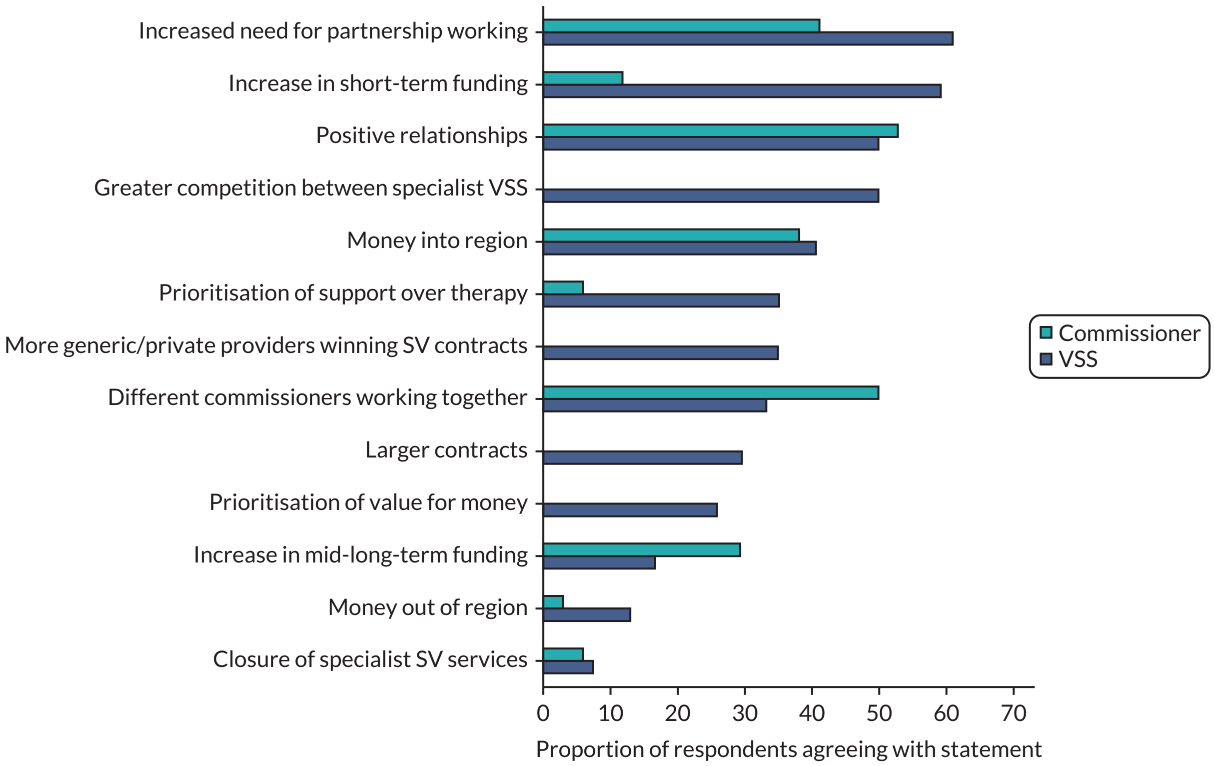


**FIGURE 12** Perceptions of regional commissioning/funding changes.

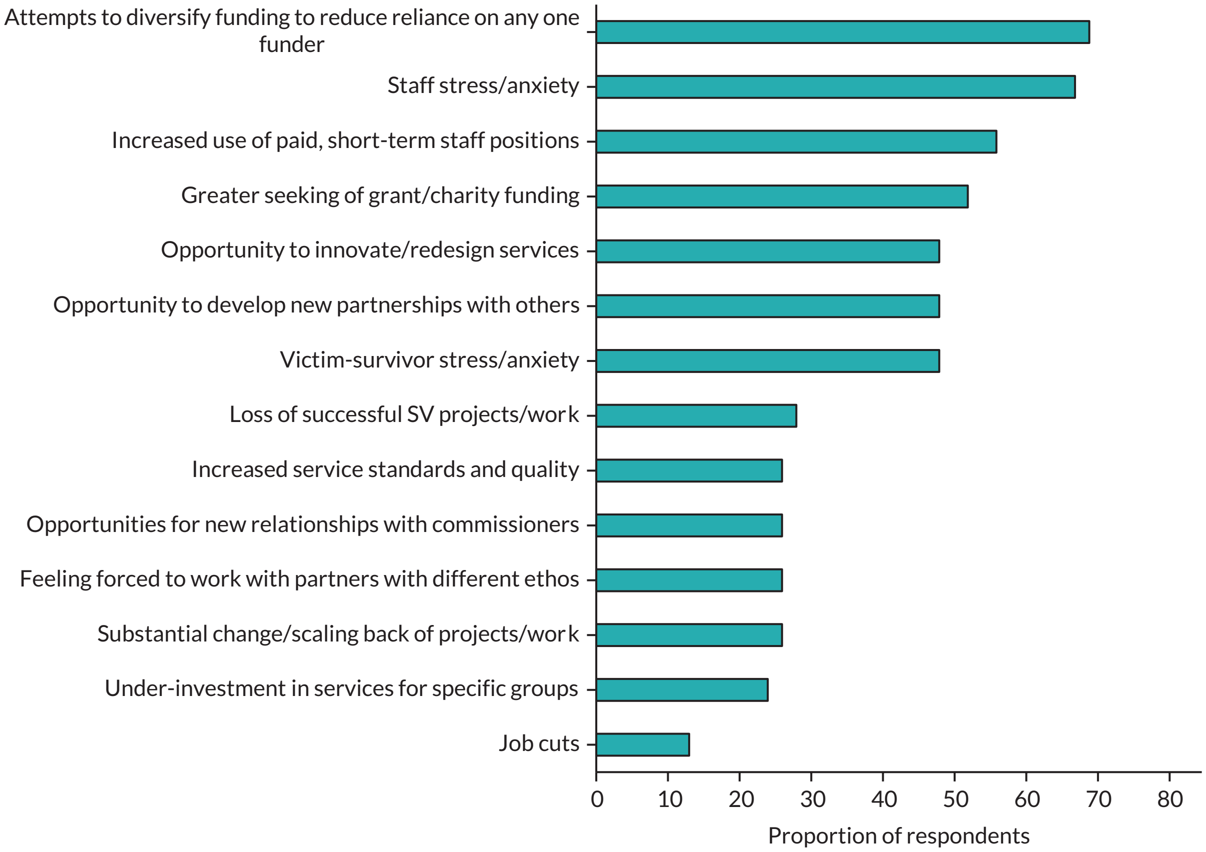


**FIGURE 13** Voluntary sector specialist providers' views about changes in their organisation.

increasingly required to work with partners with a different ethos. Most likely to be reported were attempts to diversify funding sources (69%), staff stress/anxiety (67%) and greater use of paid, short-term staff positions. Around half of respondents reported that there had been opportunities to innovate in service design, and to develop new partnerships, although the same number also reported victim-survivors' stress/anxiety.

### *Partnership working*

Both provider groups were asked about services or partnerships they had developed jointly with other statutory providers [(e.g. IAPT or Child and Adolescent Mental Health Services (CAMHS)] or voluntary sector organisations (e.g. RC or Victim-survivors' Trust affiliated organisations) (*Table 5*).

Nine SARCs (75%) reported at least 1 partnership with another statutory provider, compared with 26 VSS providers (48%), although for those with at least 1, SARC respondents reported a mean of 1.6 statutory partnerships compared with 1.8 for VSS providers. The nature of joint working with statutory organisations was more varied for SARCs than VSS organisations, with the exception of having a co-located worker/service (8% vs. 11%). For both groups, the most frequent type of joint working with statutory organisations was the development of joint referral pathways (67% vs. 41%).

With regard to partnerships with voluntary organisations, SARCs were more likely to have developed these compared with VSS providers (83% vs. 65%), although again, the mean number of partnerships reported with voluntary sector providers was greater for VSS providers than SARCs (2.4 vs. 1.8). VSS providers were more likely than SARCs to have established a co-funded worker/service within the voluntary sector (19% vs. 8%), or to have a co-located worker/service (24% vs. 8%). For both groups again, development of a joint referral pathway was the most reported form of partnership working (75% of SARCs, 46% of VSS providers).

### *Perceived under-representation of specific groups*

Voluntary sector specialist providers were asked to indicate which (if any) groups of adult and CYP victim-survivors were under-represented in their services. Similarly, commissioners were asked their view on under-representation of these groups in their area (*Figure 14* for adults, *Figure 15* for CYP).

Adults from ethnic minority backgrounds were considered to be the most under-represented by both providers and commissioners. Commissioners reported that older adults, adults with learning disabilities and lesbian, gay, bisexual and transgender (LGBT) + adults were more under-represented than those working in services, but proportions were similar. The largest disparities came in relation to refugees and asylum seekers (thought by VSS respondents to be more under-represented than commissioners), people with disabilities and adult men. The latter groups were thought to be far more under-represented in specialist services by commissioners than the staff in those services thought.

**TABLE 5** Partnerships between SV service providers

| Service | SARC + statutory, *n* (%) | SARC + voluntary, *n* (%) | VSS + statutory, *n* (%) | VSS + voluntary, *n* (%) |
|---|---|---|---|---|
| Co-funded worker/service | 2 (17) | 1 (8) | 5 (9) | 10 (19) |
| Co-located worker/service | 1 (8) | 1 (8) | 6 (11) | 13 (24) |
| Joint development/delivery of training | 4 (33) | 5 (42) | 6 (11) | 16 (30) |
| Shared organisational space/resources | 4 (33) | 5 (42) | 8 (15) | 21 (39) |
| Joint referral pathway | 8 (67) | 9 (75) | 22 (41) | 25 (46) |
| No partnerships | 3 (25) | 2 (17) | 28 (52) | 19 (35) |
| One or more partnerships | 9 (75) | 10 (83) | 26 (48) | 35 (65) |
| Mean number reported | 1.6 | 1.8 | 1.8 | 2.4 |

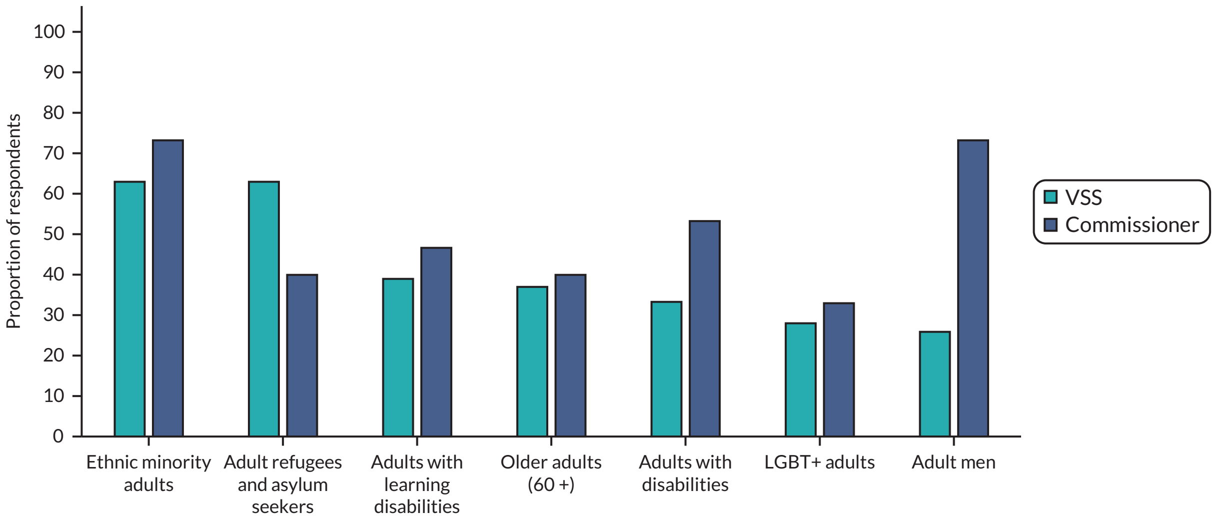


**FIGURE 14** Voluntary sector specialist and commissioner' perceptions about under-represented adult victim-survivors. LGBT, lesbian, gay, bisexual and transgender.

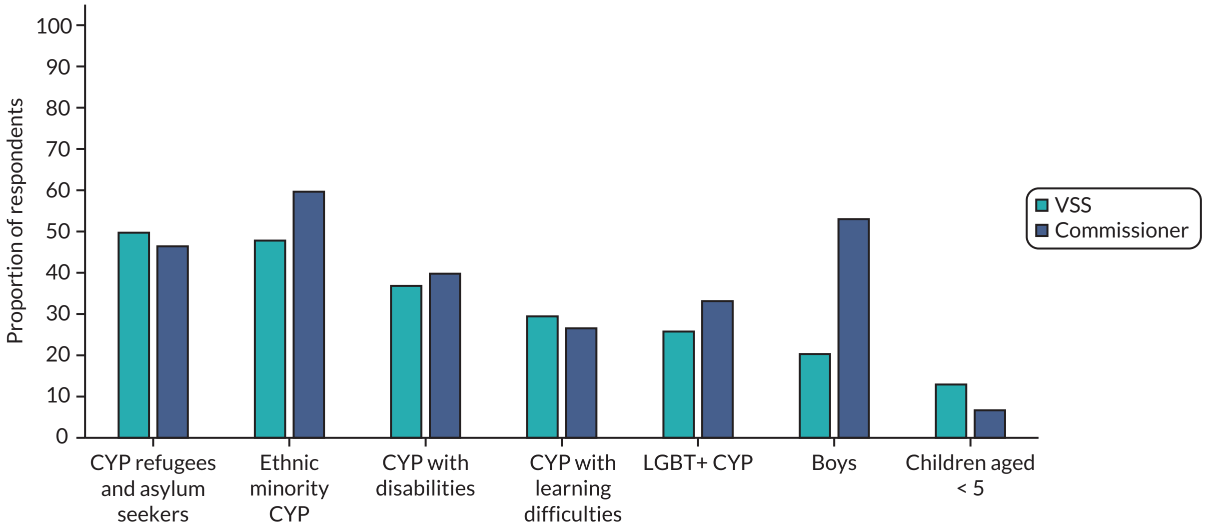


**FIGURE 15** Voluntary sector specialist and commissioner' perceptions about under-represented CYP victim-survivors.

The view on under-representation of CYP in VSS services was again fairly uniform across VSS and commissioner respondents. The largest disparities came in perceptions about the under-representation of ethnic minority CYP, which commissioners reported was more pronounced than VSS respondents did. Similarly, commissioners perceived that there was greater under-representation of LGBT + CYP, and in particular boys, which 21% of VSS respondents considered were under-represented, compared with 54% of commissioners.

### *Innovative practice to engage with under-represented groups*

Fifty-four per cent of VSS providers reported (via free-text comment) at least one way they had tried to engage with under-represented victim-survivors, representing a wide-ranging variety of services (*Table 6*).

## Key messages from work package 2

- Huge variety of service scope, organisation, funding, delivery.
- Complex patchwork of services often working closely with each other to support victim-survivors.

- Service configurations may reflect a legacy of historical funding and commissioning arrangements but evidence of effective, needs-led practice.
- Many VSS service providers offer support that no other services do, and often to under-represented groups, for example, sex workers.
- Most services work with a variety of commissioners, with varying satisfaction with these arrangements.
- Complex funding landscape: most services rely on multiple funders, but a dynamic and evolving picture.
- Providers competing for same funding, an inconsistent/unstable funding picture.
- Substantial unmet need which restricts responsiveness to client need, waiting lists growing over time.
- Service users with complex trauma, restricted duration of support, worries about not meeting victim-survivors' needs, in some areas a need to expand support for under-represented groups.
- Difficulties due to funding competition, problems with referral processes, good links support certain under-represented groups, enhanced working with NHS and statutory services.
- Need for greater capacity and efficiency.
- High turnover, stressful, difficulties funding specialist team staff members.
- Need for more holistic support, increasing provision of wraparound projects that add value to core services.

**TABLE 6** Voluntary sector specialist services to engage with under-represented victim-survivor groups

| Groups | Services |
|---|---|
| Ethnic minority victim-survivors and those from other ethnic groups | • Ethnic minority outreach service and community engagement ISVA<br>• Foreign language speakers and counsellors to engage with non-native English speakers<br>• Post specifically to facilitate ethnic minority outreach and education; new referrals pathway being developed<br>• Ethnic minority community ISVAs; counselling in a range of languages spoken in the local community<br>• Community engagement officer for ethnic minorities<br>• Using social media to raise awareness and dispel myths<br>• ISVA for people who have experienced racism<br>• Ethnic minority women's group in partnership with community organisation<br>• Comic Relief funding to engage with Asian women<br>• Chinese women's social group<br>• Specialist counselling for South Asian women |
| Refugees and asylum seekers | • Partnership with the county-wide refugee and asylum service<br>• New pathways into specialist refugee and asylum seeker organisations<br>• Refugee counselling/refugee support worker<br>• Refugee women's social group<br>• Links with local migrant support organisation |
| Older women | • Targeted services for older women<br>• Project for over 55s to tackle under-representation amongst this group<br>• Counselling, support work, training, resources for older women |
| Mothers | • Development of a mother's support group |
| CYP | • Children's ISVA (13 years and under)<br>• Partnership with Barnardo's<br>• Specialist young women and young men counsellors<br>• Work with local youth agencies |
| Trans/non-binary | • Support group established |
| Complex needs | • Multiple and complex needs ISVA |
| Learning disabilities (LD) | • LD and autism service (counselling, support work, training and development)<br>• Specialist LD counsellor<br>• Working with local LD organisations |

**TABLE 6** Voluntary sector specialist services to engage with under-represented victim-survivor groups (*continued*)

| Groups | Services |
|---|---|
| LGBT+ | • LGBT + ISVA |
| Sex workers | • Sex worker ISVA |
| Men | • Working with male support charities to increase access and referrals<br>• Therapy for male victim-survivors; working relationship with male group who refer to the service |
| Homeless | • Working with homeless shelters to increase referrals |
| Service users with addictions | • Online dance-based groupwork; volunteer peer support programme for victim-survivors with addictions |
| Students | • Ambassador project to engage with university community |
| Disabilities | • Co-development of a video raising awareness of information and community support to respond to deaf victim-survivors with BSL as first language; community workshops for deaf communities |
| General activity to increase engagement | • Specialist ISVAs<br>• Engagement ISVAs<br>• Funding for travel expenses and child care for service users<br>• Informal partnership with specialist organisations for under-represented groups<br>• Development of leaflets and materials<br>• Gender-specific therapeutic groups<br>• Dedicated outreach and inclusion worker to increase engagement from 'easy to ignore' groups<br>• Action plans to address under-representation<br>• Partnership working with organisations who support under-represented groups |

# **Chapter 5** Work package 3: case study analysis

## Context of work package 3

The case study phase was conducted across four areas in England. In these four areas, the interviews with victim-survivors, staff and funders were designed and conducted to investigate: what services exist; how victim-survivors find their way to and through different services; what is valued about these services; what gaps there are; and how well commissioners and funders work together.

The specific objectives for WP3 were to:

1. explore victim-survivors' experiences of accessing and using VSS services, identifying what needs are being met for which groups of victim-survivors and what encourages victim-survivors to take up services
2. analyse the range, scope and funding of VSS services and how demand is managed
3. explore the usefulness of different approaches to service delivery (including peer support and delivery by volunteers) and different therapy models
4. explore how different principles underlying service provision influence service delivery, including feminist and trauma-informed principles of care
5. investigate referral patterns and pathways, and how VSS services fit with each other and link to the wider network of services for victim-survivors
6. explore how arrangements for commissioning and funding services for victim-survivors across health, local authorities and criminal justice have evolved over the last 3–5 years, and how they have impacted on VSS service provision.

In the absence of large-scale evidence about victim-survivors' experiences of VSS services, the case study research phase placed victim-survivors' views and experiences at its centre and analysed the degree to which provision met their expressed needs. It looked for gaps and overlaps in service provision; underserved subgroups in the population; the use of service rationing; the use of recognised service quality standards; the extent to which VSS services are a coherent part of an area's service provision for victim-survivors, and to what degree VSS services also support victim-survivors in accessing other services (e.g. mental health, sexual health, substances misuse) in the statutory, voluntary and potentially private sector.

## Methods

The case study WP involved interviews with victim-survivors, practitioners and commissioner/funders across four areas in England. This WP was designed to build on WPs 1 and 2.

### *Site and service selection*

Within each case study site, the research attention was on all VSS service provision in that area (geographical boundary). Within these areas, there also existed services that provided some support to victim-survivors of SV (e.g. counselling services), but their work encompassed wider areas (e.g. mental health more broadly) and therefore, would not be considered SV 'specialists'. However, to create a full picture of each site, where permitted, we engage with those services and with relevant statutory provision (e.g. services within the NHS such as SARC).

Initially, selection of sites was to be driven by findings from the national surveys. However, due to COVID-related delays, these data were not available at the time of site selection. As an alternative method, the research team developed a list of 11 possible case study sites (with the intention of selecting 4) based on:

- WP1 interviews with 8 commissioners of specialist SV services, 13 practitioners based within VSS services and 2 individuals working in statutory SV organisations

- recommendations and conversations with senior members of specialist SV umbrella organisations who understand their member services and familiarised us with local funding/commissioning tensions, unique approaches to service delivery, etc.
- publicly available data from the Charity Commission (and financial information available to year end March 2020) and the websites of VSS services
- demographic data drawn from the 2011 Census (with estimated population projections used for some areas) and the 2019 Indices for Multiple Deprivation Index as organised by upper-tier local authorities.

When this information was gathered, decisions about site selection were discussed and advice sought from the study steering committee and the wider co-applicant team. Achieving diversity across the four sites was an important consideration. Ultimately, we selected our final four sites based on achieving maximum geographical variation across England (north/midlands/south); population density (urban/rural); demography (disadvantaged/affluent/mixed); and diversity (high/low black and ethnic minority populations). However, our principal criterion for site selection was to achieve variation in the sites' VSS service models and their underpinning funding and commissioning arrangements.

Sites were defined geographically by city and/or county boundaries, or groups of neighbouring districts. It was not feasible for the sites to be of the same population size or area given the varied ways that services are configured, funded and commissioned. For example, the catchment areas for local authorities, CCGs and OPPCCs are rarely coterminous; similarly, VSS services may receive dedicated funding to work with victim-survivors in one area but seek to provide the same service to victim-survivors in another area, drawing on funding from charitable trusts or fundraising. It is also the case that certain areas have no VSS services and victim-survivors must cross city/county boundaries in order to access provision.

Within the case study sites, data were drawn from three primary sources:

1. documentary analysis
2. interviews with staff (e.g. those working in VSS services, commissioners/other funders, NHS/LA staff)
3. interviews with victim-survivors, drawing on techniques of narrative interviewing and the Critical Incident Technique.

### Participant recruitment

Within each case study site, the key VSS services were identified and approached. Those services willing to participate were provided with a £500 honorarium to pay for staff time and as a token of gratitude for helping to facilitate the research process. Victim-survivor participants were alsocompensated for their time in the form of a voucher. In addition to being asked to participate in an interview, staff were asked to identify other potential practitioner and commissioner/funder participants within and across related organisations. Staff in the VSS services also supported the recruitment of victim-survivors. The research team worked with the services in each site to help ensure that the approach to recruitment and interviewing of victim-survivors was ethical and non-intrusive, with minimal selection bias. Victim-survivor participants were also compensated for their time in the form of a £20 voucher.

Criteria for inclusion and exclusion for the victim-survivor participant group:

Inclusion:

- victim-survivor of SV (self-defined; recent or non-recent)
- subjected to SV 6 months or more ago
- if accessed VSS services, done so within the last 5 years
- people aged 16 + years, or children aged 13–15 years
- able to provide consent to take part.

Exclusion:

- subjected to SV < 6 months ago
- if accessed VSS services, done so more than 5 years ago
- children aged below 13 years
- children aged 13–15 years who do not meet Gillick competency
- any adult for whom the research team has concerns about their safety or well-being taking part
- adults who are unable to consent to take part.

*Table 7* outlines the projected and actual figures for recruitment across all participant groups. As shown, the actual recruitment fell short of our intended numbers. *Table 8* shows a detailed breakdown of participants across the case study sites, by way of demographic profile.

### *Prior to/the start of the interview*

To support participants in their decision to engage in the interview, they were sent a participant information sheet which included contact details for the research team. Participants had an opportunity to review the material sent in advance and could ask questions prior to participation. Occasionally, the study team would speak with potential participants on the phone to discuss any questions or concerns they had before they participated in the interview.

If an individual agreed to participate, the researcher confirmed the date, time and location of the interview, as well as who would be conducting the interview. Most participants (*N* = 59) elected for the interview to take place virtually – mostly by Zoom or telephone. In-person interviews were conducted at the location of the VSS service. Around half of the victim-survivor interviews (*N* = 16) were conducted by both a researcher and a co-researcher.

**TABLE 7** Projected and actual figures for recruitment across all participant groups

| Participant group | Projected figures | Actual figures |
|---|---|---|
| Practitioners (VSS and other) | 13–15 per site = 52–60 total | 28 |
| Commissioners | 4 per site = 16 total | 11[a] |
| Victim-survivors | 6–12 per site = 24–48 total | 31 |
| Total | 92–124 total | 70 |

a One commissioner from Stage 1a's data are included in the analysis of the case study data.

**TABLE 8** Demographic information for all participants

| | Practitioners (voluntary) | | Practitioners (statutory) | | Funders/ commissioners | | Victim/survivors | | Total participants | |
|---|---|---|---|---|---|---|---|---|---|---|
| Demographic category | *n* | % | *n* | % | *n* | % | *n* | % | *n* | % |
| ***Age group*** | | | | | | | | | | |
| 18–24 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 12.9 | 4 | 5.63 |
| 25–34 | 2 | 8.70 | 0 | 0 | 4 | 33.3 | 7 | 22.6 | 13 | 18.3 |
| 35–44 | 4 | 17.4 | 1 | 20 | 2 | 17.0 | 8 | 25.8 | 15 | 21.1 |
| 45–54 | 6 | 26.1 | 3 | 60 | 5 | 41.7 | 5 | 16.1 | 19 | 27.0 |
| 55–64 | 9 | 39.1 | 1 | 20 | 0 | 0 | 7 | 22.6 | 17 | 23.9 |
| 65–74 | 1 | 4.35 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1.41 |
| Missing data | 1 | 4.35 | 0 | 0 | 1 | 8.33 | 0 | 0 | 2 | 2.82 |

**TABLE 8** Demographic information for all participants (*continued*)

| | **Practitioners (voluntary)** | | **Practitioners (statutory)** | | **Funders/ commissioners** | | **Victim/survivors** | | **Total participants** | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Demographic category** | ***n*** | **%** | ***n*** | **%** | ***n*** | **%** | ***n*** | **%** | ***n*** | **%** |
| ***Gender*** | | | | | | | | | | |
| Female | 20 | 87.0 | 3 | 60 | 8 | 66.7 | 18 | 58.1 | 49 | 69.0 |
| Male | 2 | 8.70 | 2 | 40 | 3 | 25 | 11 | 35.5 | 18 | 25.3 |
| Non-binary | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 3.23 | 1 | 1.41 |
| Missing data | 1 | 4.35 | 0 | 0 | 1 | 8.33 | 1 | 3.23 | 3 | 4.23 |
| ***Transgender***[a] | | | | | | | | | | |
| Yes | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| No | 21 | 91.3 | 5 | 100 | 11 | 91.7 | 29 | 93.5 | 66 | 93.0 |
| Missing data | 2 | 8.70 | 0 | 0 | 1 | 8.33 | 2 | 6.45 | 5 | 7.04 |
| ***Sexuality*** | | | | | | | | | | |
| Bisexual | 2 | 8.70 | 0 | 0 | 0 | 0 | 2 | 6.45 | 4 | 5.63 |
| Gay | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 6.45 | 2 | 2.82 |
| Heterosexual | 19 | 82.6 | 5 | 100 | 11 | 91.7 | 22 | 71.0 | 57 | 80.3 |
| Lesbian | 1 | 4.35 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1.41 |
| Prefer not to say | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 9.68 | 3 | 4.23 |
| Queer | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 6.45 | 2 | 2.82 |
| Missing data | 1 | 4.35 | 0 | 0 | 1 | 8.33 | 0 | 0 | 2 | 2.82 |
| ***Ethnicity*** | | | | | | | | | | |
| Black[b] | 0 | 0 | 0 | 0 | 0 | 0 | 6 | 19.4 | 6 | 8.45 |
| British Asian[c] | 1 | 4.35 | 0 | 0 | 2 | 17.0 | 2 | 6.45 | 5 | 7.04 |
| White[d] | 16 | 70.0 | 5 | 100 | 8 | 66.7 | 21 | 67.7 | 50 | 70.4 |
| British/European[e] | 5 | 21.7 | 0 | 0 | 1 | 8.33 | 2 | 6.45 | 8 | 11.3 |
| Missing data | 1 | 0 | 0 | 0 | 1 | 8.33 | 0 | 0 | 2 | 2.82 |
| ***Disability***[f] | | | | | | | | | | |
| Yes | 2 | 8.70 | 0 | 0 | 2 | 17.0 | 18 | 58.1 | 22 | 26.8 |
| No | 20 | 87.0 | 5 | 100 | 9 | 75.0 | 13 | 41.9 | 47 | 70.4 |
| Missing data | 1 | 4.35 | 0 | 0 | 1 | 8.33 | 0 | 0 | 2 | 2.82 |

a This question asked whether the participant does or has ever identified as transgender.
b Including Black African and Black Zambian.
c Including British Pakistani, and White Asian, Asian British and Indian.
d Including White British.
e Including White Polish, White Ukrainian, White European, British Roma, mixed British, Irish.
f This question asked about any kind of disability – mental or physical, learning differences and/or long-term conditions.
Participant totals:
Practitioners (voluntary) = 23
Practitioners (other) (including NHS/SARC etc.) = 5
Funders/Commissioners = 12
Victim/Survivors = 31
Total = 71
Reproduced with permission from Bradbury-Jones *et al.*[73] This is an Open Access article distributed in accordance with the terms of the Creative Commons Attribution (CC BY 4.0) licence, which permits others to distribute, remix, adapt and build upon this work, for commercial use, provided the original work is properly cited. See: https://creativecommons.org/licenses/by/4.0/. The table includes minor additions and formatting changes to the original text.

Before the interview, all participants were also sent a copy of the consent form and demographic questionnaire. It was originally envisioned that participants might complete these within/at the time of the interview, but the process was amended to account for most interviews not occurring in person. We sent the consent form to participants prior to their interview and asked them to return it to us (where possible) before their scheduled interview. For those who were unable to return it, we took verbal consent at the beginning of their interview, and reconfirmed consent with those who had already returned it to ensure they were still providing informed consent to participate. All participants were encouraged to ask any questions they had about aspects of the study or consent/their participation. Participants were reassured that their involvement was completely optional and that they were able to withdraw their data up until a pre-defined time after the interview had been conducted. We took measures to ensure that participants' information was secure, and we explained those measures to participants. Participants' contact details were shared only with members of the research team who needed to be aware of them. Participants were made aware of how long their information and documents would be retained and participants were given identifying numbers/codes instead of using their names or any other identifiable information to assign to their data after transcription and anonymisation. All information was securely stored on University of Birmingham networks.

### *The interview*

The interviews began with an opportunity for the interviewer(s) to explain the purpose and scope of the study, provide an overview of the interview process and allow for participants to ask any questions. Audio recording of the interview began after this introduction was complete and the participant was ready to begin.

Interviews followed participant-specific topic guides tailored to each participant group. For victim-survivor participants, the topic guide was designed to support them to recall their experiences of accessing support in relation to having been subjected to SV. The first part of the interview schedule involved a narrative approach,[74] using a small number of open-ended stimulus questions designed to open up a conversation about victim-survivor experiences of services. This was combined with more traditional semistructured interviewing,[75,76] where, once the narrative section of the interview was concluded, a second stage of more defined questions was asked.

Participants were offered the option of mapping their timeline diagrammatically to aid recall of their journey using a Whiteboard feature on Zoom. However, most victim-survivor participants ($N$ = 23) chose to describe their timeline verbally rather than diagrammatically. The focus of the interviews was on the provision (and funding and commissioning – for the practitioner and commissioner interviews) of VSS services and not on details of the SV experienced. However, the sensitivity of the topic matter required that safeguarding measures were in place. If any participant shared information that raised concerns amongst the research team, an assessment of immediate and longer-term risk would be initiated. Examples of immediate risk included concerns regarding suicide risk, evident mental health distress, concerns for the safety of a child or adult. Conditions that mitigated the breaching of confidentiality by the research team were included in the participant information sheet and, for victim-survivor participants, support from their recruiting VSS service was available post interview if appropriate. No situation was identified that required the implementation of urgent safeguarding measures during the data collection phase. Members of the research team often debriefed with the principal investigator and broader team to ensure that consistency was maintained regarding risk assessment and management approaches.

Once the interview schedule was complete, or the allotted time was drawing to a close, the researcher(s) would complete their questions and allow the participant to provide any additional information they wished to convey or ask any questions. Participants were reminded of the support information on the participant information sheet and signposted back to their service for support. The next steps of the research process were explained to the participant, such as when they would next hear from the research team, and what actions would be taken. Participants were reminded of the option to amend their interview transcript in due course, and, where relevant, when they would receive their voucher for reimbursement. Victim-survivors were also asked to provide a name, should they wish to offer one, to act as a pseudonym that would be aligned with their quotes in final publications and presentations (see *Appendix 2* for the participant pseudonym key).

### *Data creation and storage*

With prior consent from participants, all interviews were audio-recorded. At the end of the formal stage of the interview, recordings were stopped by the researcher and the participant was offered an opportunity to provide feedback or ask questions without this element of the conversation being recorded. Audio recordings were sent for transcription by a transcription company registered with the Information Commissioner. The transcripts then underwent surface-level anonymisation. This anonymisation included the removal of people and place names and the addition of an anonymisation key when required. Contextual anonymisation – for instance, when a participant described identifiable features of their city, without specifically mentioning the name of the city – was not completed at this time but was noted within transcripts. When the transcripts were anonymised, they were returned to the participants either by default (victim-survivor participants) or on request (practitioner and commissioner participants) and these participants were given up to 4 weeks to confirm they were happy with the content of the transcript, make amendments or additions or ask for their data to be removed from the data set. After this time, non-anonymised versions of participant data – the original transcript and audio file – were deleted and the participant was no longer able to remove their data.

All information relating to participants was stored securely and participant keys were used to label individual files, rather than using participant names. Identifying details were kept in site-specific folders on a secure drive. When moving interview transcripts – for instance, between the transcription service and back to participants – the files were password-protected. In accordance with University of Birmingham's requirements for the storage and retention of research data, study data will be retained for 10 years.

### *Co-production*

Co-researchers were involved in the creation of the interview schedule, in the interviewing of victim-survivor participants and the analysis and write-up of victim-survivor participant data.

### *Individual site analysis*

Analysis of the data formally started in conjunction with the final stages of data collection. An initial analytical framework was developed using both inductive and deductive methods – using themes from relevant literature. Two members of the research team (Gunby and Smailes) used approximately 10% of the coded data in the initial production of the codes and framework, and further transcripts were used to check the representativeness of the codebook after amendments were made. Initial divergences in coding between victim-survivor and practitioner/commissioner data were reconciled through an iterative process of development and amendments. A 'final' codebook was created, with the understanding that further small refinements might be made as coding progressed.

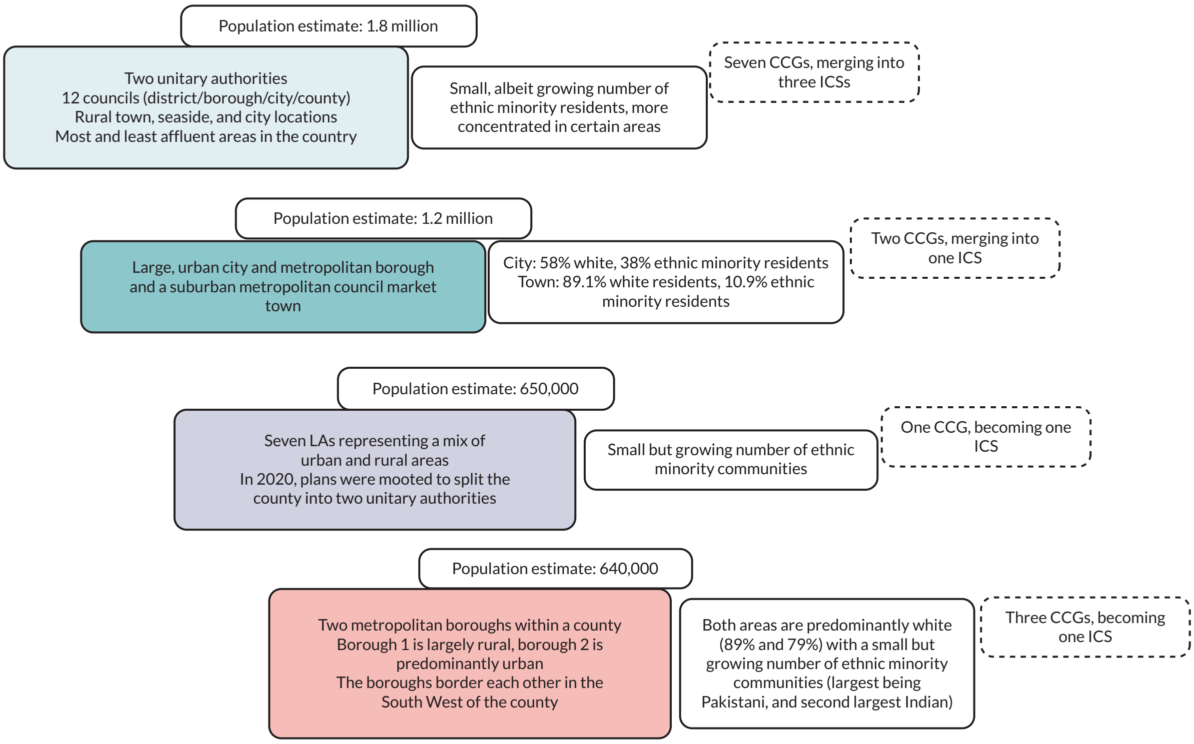
Victim-survivor data (other than a small number of transcripts that had been used in the development of the codebook) were coded by the co-researcher team after 2 days of training and guided support from members of the research team. After the initial 2 days, co-researchers completed the remainder of the coding of transcripts self-paced, with support and feedback from the research team. Practitioner/commissioner data were coded by the research team – in the most part, site leads took responsibility for the coding of their own site's data. Feedback from the co-researchers and research team was encouraged throughout the coding process. Twenty per cent of the victim-survivor data and 10% of the practitioner/commissioner data were verified once they had been initially coded. There were slight additions made to text that had not previously been coded, but, in general, coders were in agreement.

Due to logistics and restricted access for licensed products such as NVivo (QSR International, Warrington, UK), the victim-survivor data were coded using Microsoft Word (Microsoft Corporation, Redmond, WA, USA). The analytical framework was the same as it was for the practitioner/commissioner data, which were coded using NVivo. On Microsoft Word, coders would add a comment to a portion of text they wanted to code with a particular pre-determined label from the codebook. Once the victim-survivor data coding was completed, the comments (code labels) and associated text were extracted from each transcript and collated for each case study site. This allowed the research team to sort the data by participant (using their non-identifiable number/code) and/or by code. A framework analysis was conducted at the completion of coding to determine the most used codes across all three participant groups, and all four case study sites.

## Individual and cross-site analysis

### *Analyse the range, scope and funding of voluntary sector specialist services and how demand is managed*

*Figures 16* and *17* provide an overview of the sites.



Population estimate: 1.8 million

Two unitary authorities
12 councils (district/borough/city/county)
Rural town, seaside, and city locations
Most and least affluent areas in the country

Small, albeit growing number of ethnic minority residents, more concentrated in certain areas

Seven CCGs, merging into three ICSs

Population estimate: 1.2 million

Large, urban city and metropolitan borough and a suburban metropolitan council market town

City: 58% white, 38% ethnic minority residents
Town: 89.1% white residents, 10.9% ethnic minority residents

Two CCGs, merging into one ICS

Population estimate: 650,000

Seven LAs representing a mix of urban and rural areas
In 2020, plans were mooted to split the county into two unitary authorities

Small but growing number of ethnic minority communities

One CCG, becoming one ICS

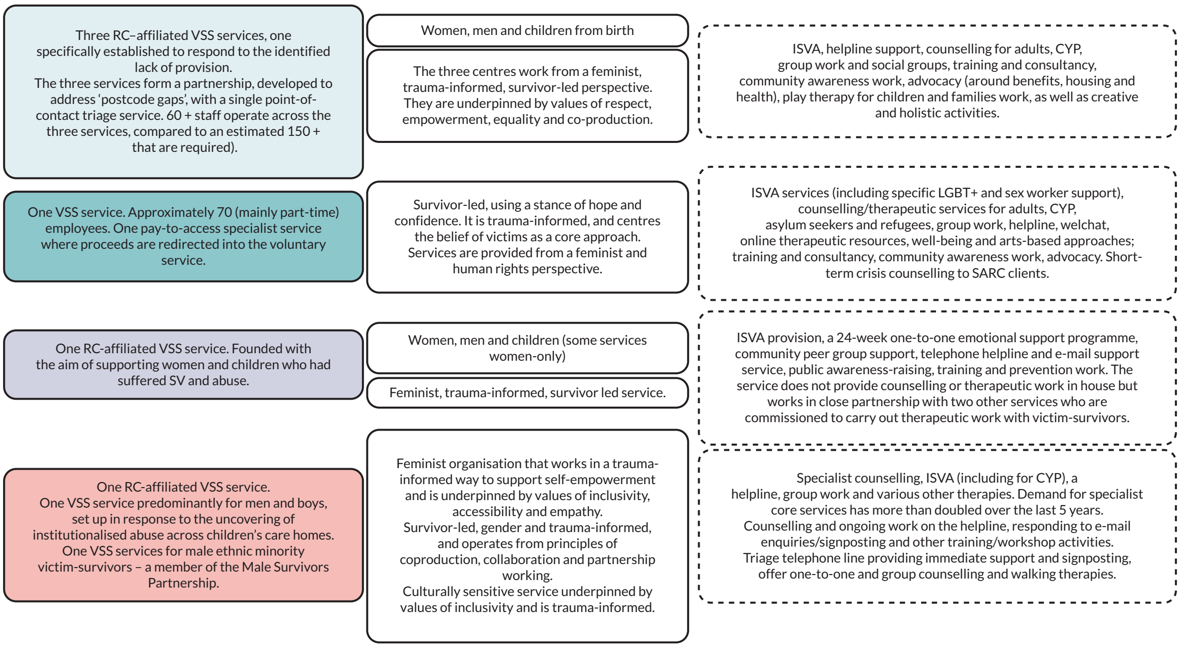
Population estimate: 640,000

Two metropolitan boroughs within a county
Borough 1 is largely rural, borough 2 is predominantly urban
The boroughs border each other in the South West of the county

Both areas are predominantly white (89% and 79%) with a small but growing number of ethnic minority communities (largest being Pakistani, and second largest Indian)

Three CCGs, becoming one ICS

**FIGURE 16** Site overview diagram – features, population, demographics and CCGs/ICSs.



Three RC–affiliated VSS services, one specifically established to respond to the identified lack of provision.
The three services form a partnership, developed to address ‘postcode gaps’, with a single point-of-contact triage service. 60 + staff operate across the three services, compared to an estimated 150 + that are required).

Women, men and children from birth

The three centres work from a feminist, trauma-informed, survivor-led perspective. They are underpinned by values of respect, empowerment, equality and co-production.

ISVA, helpline support, counselling for adults, CYP, group work and social groups, training and consultancy, community awareness work, advocacy (around benefits, housing and health), play therapy for children and families work, as well as creative and holistic activities.

One VSS service. Approximately 70 (mainly part-time) employees. One pay-to-access specialist service where proceeds are redirected into the voluntary service.

Survivor-led, using a stance of hope and confidence. It is trauma-informed, and centres the belief of victims as a core approach. Services are provided from a feminist and human rights perspective.

ISVA services (including specific LGBT+ and sex worker support), counselling/therapeutic services for adults, CYP, asylum seekers and refugees, group work, helpline, welchat, online therapeutic resources, well-being and arts-based approaches; training and consultancy, community awareness work, advocacy. Short-term crisis counselling to SARC clients.

One RC-affiliated VSS service. Founded with the aim of supporting women and children who had suffered SV and abuse.

Women, men and children (some services women-only)

Feminist, trauma-informed, survivor led service.

ISVA provision, a 24-week one-to-one emotional support programme, community peer group support, telephone helpline and e-mail support service, public awareness-raising, training and prevention work. The service does not provide counselling or therapeutic work in house but works in close partnership with two other services who are commissioned to carry out therapeutic work with victim-survivors.

One RC-affiliated VSS service.
One VSS service predominantly for men and boys, set up in response to the uncovering of institutionalised abuse across children’s care homes.
One VSS services for male ethnic minority victim-survivors – a member of the Male Survivors Partnership.

Feminist organisation that works in a trauma-informed way to support self-empowerment and is underpinned by values of inclusivity, accessibility and empathy.
Survivor-led, gender and trauma-informed, and operates from principles of coproduction, collaboration and partnership working.
Culturally sensitive service underpinned by values of inclusivity and is trauma-informed.

Specialist counselling, ISVA (including for CYP), a helpline, group work and various other therapies. Demand for specialist core services has more than doubled over the last 5 years.
Counselling and ongoing work on the helpline, responding to e-mail enquiries/signposting and other training/workshop activities.
Triage telephone line providing immediate support and signposting, offer one-to-one and group counselling and walking therapies.

**FIGURE 17** Site overview diagram – VSS service set-up. Note: One SARC operates in each of the case study site areas.

### Case Site 1

Three VSS services operate across the county. Service 1 was one of the original Rape Crisis Centre's in England, initially formed as a helpline and later registering as a charity. Service 2 was set up in the 1980s, while Service 3 was established in 2010. Each offer a range of services to women, men and children including ISVAs; helpline support; counselling for adults, CYP; group work; training and consultancy; community awareness; advocacy; play therapy, families work and creative and holistic activities.

Each service reported having experienced 'a massive growth' (S1.P5) in demand over the last 5 years (exacerbated by the pandemic). For practitioners, this was a major challenge: 'It frequently feels overwhelming, that sort of relentless number of people coming in and wanting to do the best for all of them' (S1.P5). To meet the need, services had grown and become reliant on a greater range of funding sources. However, the overall funding available had remained static (or been reduced), constituting a loss. In response, waiting lists were operating, spanning several months. Commissioners predicted that demand would intensify further, and this was considered to be the biggest challenge they faced. Concern was expressed that if more money was not made available from central government, systems which rank victim-survivors' needs - in order to prioritise resource - may become necessary. In response to these pressures, practitioners were having to make difficult decisions to de-invest in certain areas, for example, the deprioritising of outreach work. Refusal to accept referrals from agencies where no explicit funded pathway existed was also considered likely.

### Case Site 2

Sexual violence services across the region often lacked strict geographical boundaries, with victim-survivors engaging with a range of services, sometimes across borders. The main VSS service (service 1) in the area was identified as a 'linchpin', with the majority of local SV provision being provided through them (although other voluntary services in the area had some SV specialism). In turn, (service 1) had good working relationships with other local organisations (statutory and voluntary), creating a (mostly) symbiotic provision for victim-survivors. However, the service was operating to a 9-month waiting list, which has been noted as a challenge by both service providers and commissioners. The waiting list had increased from 6 to 9 months following the pandemic.

The most significant funding and commissioning issues identified by the interview participants was the shortfall in funding required to meet the demand for services, and the associated struggle to fund long-term counselling. The commissioners interviewed were open and blunt about the stark gap between service need and service funding, and the lack of progress towards funding models that respond to the needs of the sector. Commissioners (and practitioners from services) described how demand has increased in the presence of funding cuts (and austerity), with waiting lists increasing sharply as a result:

> *There's just not enough funding and not enough to be able to provide for everybody that really needs it. The bits of funding that we can get are a drop in the ocean compared to what is really needed in terms of that long term specialist support.*
>
> *S2.F/C1*

### Case Site 3

A commonly cited enabling factor of joint commissioning and partnership working within the county in regard to NHS, LA and Police was the coterminous borders of the different organisations which enabled shared responsibility and decision-making for the county's population. Practitioners and commissioners suggested that clarity and stability of relationships between these bodies confer advantages to the organisation and to the funding of SV services, underpinned by a 'shared drive' (OPCC Com) to improve support. An example included one dedicated VSS (Service 1), working with two 'Local Partners' to deliver specific, defined elements of support.

At the time of interviewing (December 2021–April 2022), Service 1 had, on average, a 20-week waiting list for its services. The length of the waiting list, Practitioner 4 told us, had 'gone through the roof' over the last year. It was previously 6–8 weeks. Service 1 practitioners signpost those waiting for support to the helpline (during office house), make regular 'check in' calls and offer advice and self-care tools to help manage difficult feelings and to support service users' general well-being. Across its different therapeutic services, Local Partner 1 had over 500 young people waiting for support, an unknown number of whom were victim-survivors of sexual abuse.

### Case Site 4

The local VSS (Service 1) is a major source of support for both women and men victim-survivors in Boroughs A and B and has recently extended services to cover a third borough. A male-specific specialist support organisation (Service 2), established for two decades, supports men and boys, particularly those affected by CSA. An ethnic minority male specialist support organisation (Service 3) was established a decade ago to support male victim-survivors of CSA and to intentionally fill the gap in culturally appropriate services. Services 2 and 3 are both grass roots and micro-sized, employing just one member of staff with minimal volunteer support.

In 2019, the OPCC commissioned an independent review of SV and abuse services in the area. Excessive waiting lists and delays in being able to access specialist support were identified as problems by practitioners and victim-survivors alike. All the VSS services had experienced a steep growth in demand for support in the last 5 years. Demand for services during the COVID-19 pandemic had risen particularly sharply. Providing long-term support was challenging for practitioners and it was difficult to adequately support 'complex' clients. In response to demand for counselling, VSS staff were offering sessions of emotional support, while clients waited for counselling to become available. Due to the general lack of culturally appropriate services, Service 2 had recently evolved to support minoritised men with a wide range of support needs and had started accepting clients nationally.

### Cross-site analysis of victim-survivor perspectives

The under-resourcing of VSS services was recognised by victim-survivors, with an understanding that service provision is 'all down to resources' (Lavinia) and that this impacted the nature and duration of services accordingly. One participant, Mia, explained, 'I'm on the edge of jumping off a bridge in a minute and I'm told "oh five or six months you'll have somebody contact you"'. Some participants articulated the importance of managing demand while ensuring service user safety, recognising that long waiting times can leave people in crisis. Participants Findlaigh and Brooklyn both reflected that opportunities for long-term support and follow-up might currently be missing in the provision of VSS services but understood that 'obviously they don't have unlimited resources' (Brooklyn).

Victim-survivors also recognised that VSS services require ring-fenced, sustained funding in order to enable services to continue the provision of specialist and effective support, and that this must be communicated from the 'bottom up' to commissioners: 'I think that they are saving lives … they are crucial for our society … the fact that it's just for SV and things, it makes it more tailored …' (Blossom).

Participants identified a clear relationship between the numbers on the waiting list and the time limitations of the services they received:

> *with [Service], the free services, we got to the eighth session and it was very clear that I needed to carry on, we hadn't barely scratched the surface, but it was very much well there's only eight sessions and then you will have to go, like, will have to leave.*
>
> *Gen*

It is well recognised that 'one size does not fit all' and that the preferred ways of working within services, and the provision and delivery of specialist support, will vary between VSS services and across victim-survivor groups. For example, there were differing views regarding telephone support: 'I think I actually did ring one once but … I just didn't really feel it from them' (Mia), compared with Blossom: 'a helpline that is open 24/7 … would be really helpful I think just while people are waiting for that support'. Recognition of the heterogeneity of victim-survivors, their preferences and experiences highlights the importance of offering different service models within a specialist service: 'This is not something that's kind of like a broken leg, it's not one treatment that's really good for everyone' (Findlaigh).

## *Explore the usefulness of different approaches to service delivery and different therapy models*

### Case Site 1

In this site, the number of counselling sessions per victim-survivor was not specified in contracts, and instead left to each service to negotiate. Therapy was generally between 6 and 20 sessions, with victim-survivor needs and wishes being reviewed and sessions extended if necessary. With a focus on exploring the impact of abuse, therapy was non-judgemental and empathic and believing victim-survivors was fundamental to the therapeutic approach. Therapy of this nature was said to have the potential to 'change someone's life' (S1.P4), with victim-survivors describing it as impacting 'your life in a way you would never have thought [possible]' (Selasie). Its delivery was also recognised to take 'real skill' (Margot).

The transition of counselling services online to provide support throughout the pandemic, and the option of a more blended approach once services returned in-person, was flagged by all as beneficial in enabling support to continue. While a blended mix offered greater flexibility, practitioners, however, spoke about the emotional challenges of providing online provision:

> *I don't think it's good for anyone to have to do this, any sort of type of this from home, because you are dealing with a lot of trauma in your own home and your home should be your safe place … And for service users, I don't think they should be talking about it in their home …*
>
> *S1.P3*

The Partnership in this site were commissioned to deliver Crisis Talking Therapies to SARC clients. Talking Therapies was up to 12 weeks duration and often delivered very soon after the abuse had occurred. While described as 'valuable' in certain cases, there were multiple practitioner concerns that it did not meet the needs of victim-survivors. This was because the point at which it was offered was 'not the best place in the person's journey … it's not what they're ready for' (S1.P5): a perspective supported by independent evaluation. It was argued that weekly practical/emotional support would be more beneficial, with counselling commencing later. However, as stood,practitioners had little agency to use their expertise to influence the current delivery model.

### Case Site 2

Counselling was provided by Service 1 using a trauma-informed approach, in-house and across three sites (two drug services and a sexual health service - see below). They provide counselling for both children and adults, and to people of all genders. Children receive up to 24 sessions of therapy and adults receive 16 weekly sessions. Service 1 also deliver crisis counselling for the regional SARC. This latter provision was noted for its swift response but was described as 'holding' (S2.P3) the victim-survivor until other services are able to engage, or the victim-survivor can take up other service provision. There is an extensive amount of support and outreach work that happens across the region, mostly provided by Service 1. Support workers provide a broad range of advice and guidance, particularly around housing and benefits. They are often a 'bridge' when there is a counselling waiting list (S2.P4). There are several support workers from Service 1 that are co-located in other services, including sexual health and two drug support services. This co-location has proved important to the overall local sector (S2.P1,4), aiding with referral support and the host service receiving ad hoc advice and support outside of individual situations.

It was specifically noted in interviews that psychoeducation was a useful approach in therapy:

> *The biggest thing for me was education really, they taught me why my body was responding in certain ways and up until that point I just thought I was going mad, so to learn about post-traumatic stress and the effects that trauma has on the body, I even attended training as well while I was there, so that was really helpful.*
>
> *Millie*

This participant's new understanding around the somatic effects of trauma created a reassurance in the victim-survivor that their response was a normal one. Linked to this feeling of 'normalisation' that being part of a VSS service can offer, Gen commented, '… there's other women that are going through this … I'm not on my own … it does make you feel better … So just how important it is to have this community'.

### Case Site 3

Volunteers play an important role in the organisation, primarily as volunteers on the helpline and engaging in fundraising activities. The positive influence of having volunteers, peer support workers and workers with lived experience was noted in relation to a negative experience for one participant in 'other services' they had accessed previously: 'it was different …

I'm not sure if that person had the same experiences or could relate as much as like the volunteers or support workers in the crisis centre' (Victim-survivor 1).

Victim-survivors appreciated the range of therapeutic approaches on offer within the service, reflecting that 'it's not just the support sessions, it was so much different types of support' (Blossom). This recognises, as mentioned previously, that one size does not fit all within VSS service provision and delivery. Counsellors at Local Partner 1 are 'trained to work with trauma and abuse, not as a speciality, but as part of the core training' (S3.P6). Practitioners who do undertake specific SV focused work do, however, receive additional training, for example, about sexual abuse disclosure and pre-trial therapy. Local Partner 1 describes their therapeutic model as an integrative client-centric model that draws on cognitive–behaviour therapy, acceptance and commitment therapy and solution-focused therapy, as well as creative strategies such as play, art and drama therapy.

Like Local Partner 1, Local Partner 2 staff understood their specialism to be in working therapeutically (often in a psychodynamic way) with people who have experienced trauma, rather than working exclusively with victim-survivors of SV. Staff we interviewed were confident about the transferability of their skills and indeed these practitioners did have considerable experience and interest in working with victim-survivors specifically. However, it was acknowledged that, outside of the VSS service, not all staff would be able to work confidently with victim-survivors and we were told that some staff in the patner agencies had opted not to, as they did not consider themselves sufficiently skilled in this area of therapeutic work. Both 'non-specialist' organisations (Local Partners 1 and 2) invested considerable time and resource to support staff working with victim-survivors and talked about this as an ethical imperative. However, it was clear that additional training and supervision to upskill were provided in response to staff need, rather than being required by funding or commissioning bodies.

### Case Site 4

The main support provided and discussed by practitioners was therapeutic counselling and advocacy (i.e. ISVA) services. Therapy was person-centred and compassionate. Therapeutic services provided by one of the services consisted of one-to-one specialist (trained) counselling, a 15-week group therapy programme, or emotional support sessions or alternative therapies if in-depth counselling was not required/appropriate. Counselling comprised up to 10 sessions; however, it was negotiated and reviewed on an individual basis. Practitioners noted the positive benefits of specialist counselling: 'you watch them [victim-survivors] kind of grow' (S4.P5).

With the 'standard' therapy provision offered, Sabir noted how they appreciated the individualised approach to the number of sessions received: 'they said it were 10 sessions, but I needed about six or seven, I felt a lot better in myself after six or seven sessions. That was because they listened to me. I gave him everything I owned basically. They listened to me'.

All the services who took part stressed the importance of flexibility in the nature and content of support offered. The male specialist services in particular emphasised that not all clients wanted to talk specifically about abuse experienced and valued different approaches, such as befriending [offered by (Service 2)] and opportunities for connection: '[victim-survivor] said, yeah, do the befriending, I don't want to talk about abuse, I just want to talk about football' (Service 2). Adopting this tailored approach was crucial to avoid losing clients and for victim-survivors to build trust. In addition to its counselling, Service 3 offered walking groups as a safe space for ethnic minority clients who may lack the cultural language to express abuse experiences and were helpful for wider symptoms such as depression.

### Cross-site analysis

Despite these positive reports, the complex nature of sexual trauma can necessitate longer-term support, in light of which some victim-survivors recommended not putting a limit on support duration because some individuals will need 'so much more than … 20 weeks of support' (Lavinia). It was a comment from one victim-survivor that appropriately summarised the problem with long waiting lists and time-limited support by saying 'recovery takes time' (Tracey). Further, concern was raised by one practitioner about the person-centred counselling modality and how it could sit in tension with the linking back of SV to systemic inequalities and the experiences of multiple women. In focusing in on the individual, the approach could sometimes marginalise the cultural, social and structural – key areas of focus for the SV movement: 'that one-to-one individual focus stops you doing the bigger picture' (S1.P6). In addition to informal support, all levels of participants – victim-survivors, commissioners and practitioners – recognised the benefit of the specialist nature of VSS services, which seemed integral to the service provision.

### *Explore how different principles underlying service provision influence service delivery, including feminist and trauma-informed principles of care*

#### Case Site 1

Services' independence from state-led organisations was further considered central to their ability to engage victim-survivors and, in so doing, provide an alternative to statutory provision. Independence from state bureaucracy was seen as crucial in enabling services' agile and flexible response: '… our partnership work with other agencies, they can't bend because of strategies and things that come down from their national bodies, they're very rigid and fixed' (S1.P1). Although confined by funding pressures, practitioners described VSS services as able to respond quickly. Something commissioners saw as distinguishing: 'I find that there is less flexibility and the opportunity to adapt [with a private provider] than working with the third sector' (S1.F/C2).

#### Case Site 2

Site 2's strengths-based approach attempted to deliberately resolve some of the effects of the medical model response that denotes the individual as flawed:

> *It looks at what is strong with the person rather than what is wrong with you … if we turn that around and look at this is what you're suffering now, it's a positive coping strategy, this is what's strong with you, we can build on this and we can build more strengths.*
>
> *S2.P4*

Here the practitioner explains that, using this strengths-based principle, the mental health responses of victim-survivors to trauma can be identified as reasonable responses to external violence. They went on to discuss that these responses could be, at times, protective mechanisms, and helping victim-survivors identify these strengths is powerful and allows for the identification and development of other behaviours, drawing on these strengths as a base. This method of psychoeducation was appreciated by victim-survivors using the service, as noted in the narrative above. Their model was praised by the commissioners, who stated that, 'They know that the waiting lists are long so they know that people can access the helpline support and they check in with people, so it really is, I would say, the strength of the service is really being that victim-survivor-led, trauma-informed support for people' (S2.F/C1,2).

#### Case Site 3

Service 1 staff in Site 3 were able to make comparisons in underlying principles of service provision due to previous work in the statutory sector. Experiences of working in statutory services were often described through reference to machinery and automation, in the context of a high (pressured) workload. In contrast, there was greater emphasis placed on creativity, 'high-quality work' (S3.P4) and a culture of care in the voluntary sector. Within Service 1, this resulted in an enhanced sense of staff well-being and belonging that fed into a collective commitment to go 'above and beyond' for clients.

#### Case Site 4

Practitioners typically had lived experience of SV and Service 2 described itself as service user led. Having lived experience was seen to bring a 'deeper understanding' (Service 1), commitment and passion to services (although was not a requirement for staff or volunteers). It also contributed to a more 'equal relationship' (Service 2) which was important for victim-survivors who often felt powerless.

#### Cross-site analysis

Across the four sites, there were a number of consistent principles underlying service provision, noted by practitioners and victim-survivors. Services in all sites referenced being led or driven by *feminist principles*, or 'recognising that sexual violence is based in misogyny, patriarchy and having that political perspective' (S1.P1). As part of the feminist work services did, activism and the translating back of victim-survivors' experiences to policy-makers took place. While described as essential for placing frustrations into a tangible outlet, it was noted that this activity had reduced across the sector: 'I'm just thinking about Rape Crisis member groups … a lot of groups are so busy trying to survive that they don't communicate and influence their local structures well enough' (S1. P6). In Site 4, all RC staff and volunteers underwent a 7-week CPD accredited training course which introduced them to theories of feminism, oppression and support skills. Being male-specific services, Service 2 and Service 3 also addressed shame issues within therapeutic services, but did so from a 'humanist' and 'gender-informed' perspective, which recognised the particular challenges for men in sharing sexual abuse/violence experiences and toxic notions of masculinity which may inhibit disclosure, at the same time as recognising that men were more likely to be perpetrators of SV/abuse. Even without specifically being defined as feminist organisations, Local Partners in Site 3 reflected that there were commonalities in how staff at all organisations characterised their commitment to be victim-survivor- (or client)-led. Recognising and responding to individual, sometimes complex needs of victim-survivors were consistently highlighted as a defining feature of each service, rooted in a commitment to relational, ethical practice. As Practitioner 3 commented:

> *I'd like to think we don't treat people as in a sausage factory almost, you know, like next, next, next! There is a level of flexibility … with the feedback we get from clients, they've told us that we are providing them with what they need.*

This ethos around being *victim-survivor-led* and *person-centred* was also reflected consistently across sites. In Site 3, victim-survivors were aware of these inherent underlying principles in use throughout the work, namely in terms of the way the support felt. One description seemed to fit with a holistic and person-centred approach, '… honestly, I just felt so understood and kind of, like, I didn't have to explain things and, you know … that was really helpful as well' (Autumn). In Site 1, service user co-production groups, surveys and focus groups were used to generate victim-survivor insights, with victim-survivors valuing this approach. An 'online victim-survivor service users forum' was highlighted as a way of enabling service users to 'shape and direct and put what they want into the charity and that's just really empowering' (Mandy). In Site 4, the need to respond to individual needs was reflected through the development of the ethnic minority specialist support organisation (Service 3) which sought to challenge racial and religious prejudices that marginalised ethnic minority male victim-survivors experienced and prevented them from accessing statutory support. Identifying as secular and evidence-based was considered to be important for its legitimacy with clients who had different religious backgrounds, and/or who viewed religious institutions as upholding systems of racism. Staff explained that understanding how certain cultural or religious concepts may prevent recognition, awareness or expression of experiences of SV was essential for initiating and developing relationships with clients and engaging with them in a way that mainstream services could not.

Working with and for victim-survivor needs was considered to be very strongly linked to *belief*. Blossom (site 3) reflected that while accessing support from another service, they were told 'well that's not what happened', whereas when they were supported by Service 1: 'I could have told them that I saw a pink elephant walk down the road and they would have been like "yeah OK" and just run with it kind of thing'. This was also echoed by Lucy from Site 2 as they describe how 'you've never had to prove yourself, like … what you've been through, like with the Police and everything else, you've had to prove it, but with [Service] you don't'. The experience of being believed, without providing evidence, held weight: '… when you believe somebody's story then you'll be able to know what kind of help the person needs, where to signpost the person and how the person can go about it.' (Ava).

The *specialism* held by the services across the case sites also cannot be underestimated. VSS services' specialism – or intrinsic, unspoken understanding of sexual trauma – was described by victim-survivors as key in contributing towards positive experiences: 'you didn't have to explain to them, they knew what you were going through' (Lavinia). It is of note also that even when victim-survivor participants may not have recognised 'trauma-informed care' or 'feminist principles' at work, they often recognised and appreciated the specialism of the service:

> *I think my therapists were both very, very good talking about sexual trauma, my relationships with men and my body and how my body responds to triggers and all of these things, that was all very informed and they clearly knew everything about that.*
>
> *Gen*

Perhaps it was the coming together of these values and approach that produced in staff a willingness to go ‘above and beyond’ (S1.P2). Multiple practitioners spoke about their commitment, care and passion for their work, albeit hard work. Features that show up in the interaction with service users: ‘clients, they get that people are passionate, they feel that they know people care’ (S1.P2). The coming together of these unique ways of working, combined with a primary focus on, and deep-seated expertise in SV, underpinned the meaning of the term ‘specialism’. It was this combined approach which differentiated VSS services from the support offered by statutory, private or more generic organisations and why, budgets permitting, certain commissioners expressed a commitment to the future investment in specialist services.

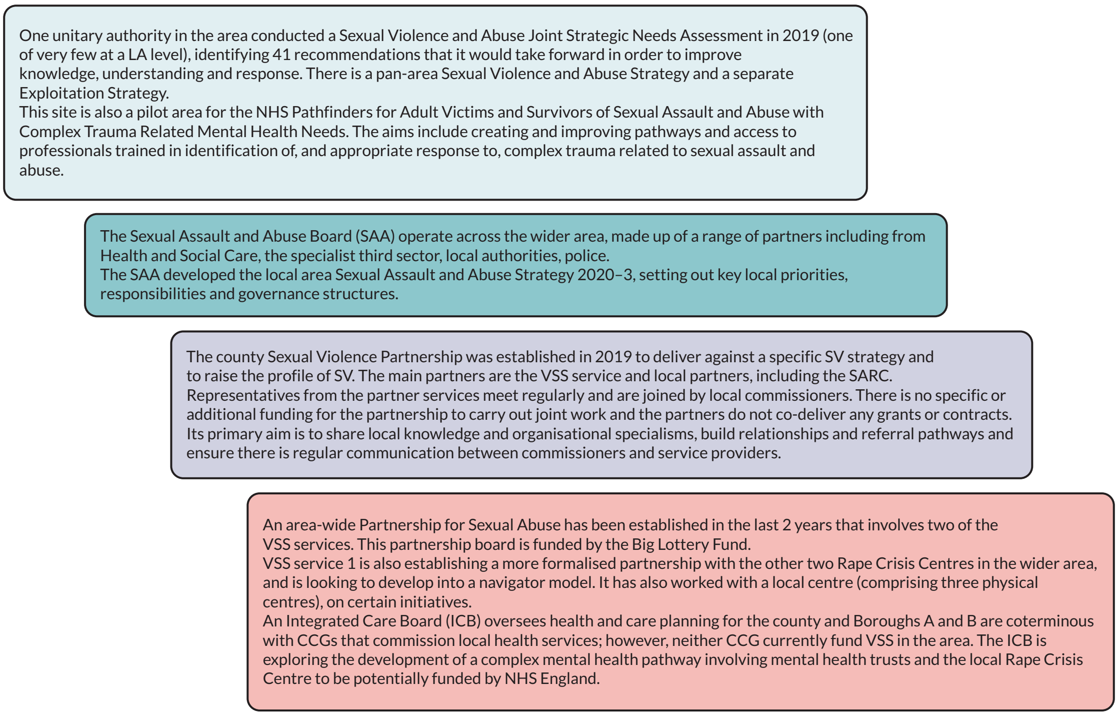
### *Investigate referral patterns and pathways, and how voluntary sector specialist services fit with each other and link to the wider network of services for victim-survivors*

*Figure 18* shows an overview of the local structures and partnerships across the sites.

### Case Site 1

As discussed, the three services in this area had formed a formal Partnership. While born out of necessity, there was overwhelming agreement that it had been a positive change in terms of operational practice and support provision. It was argued that it was now possible to ‘offer a quality, uniform service across the whole county’ (S1.P1), with commissioners/funders stating that they did not have ‘to worry about a postcode lottery’ (S1.F/C6) of different levels of care.

Operationally, partnership working had allowed VSS services to share their skills, have a collective voice and ‘much more clout when it comes to asking for funding’ (S1.P7). It was recognised that funders/commissioners preferred and, in this area, expected a partnership approach: ‘… what we recognised was that commissioners preferred to work with one representative, so they don’t like it if they’re having to talk to different partners …’ (S1.P9). Due to these collective practices, the Partnership had developed, as outlined, a cross-service initial point of contact or ‘triage’ model. Inspired by international practices, this approach had helped mitigate certain risks of having small teams working purely within one service. The triage model had also supported improved response times and a seamless approach to referral. Indeed, referral into VSS support via the police, for those victim-survivors who had come through this route, was reported to be very effective. However, certain victim-survivors stated that the VSS services ‘can be hard [to find]’ (Selasie) if self-referring. Indeed, few victim-survivors had awareness of their existence prior to being subjected to abuse and this is



One unitary authority in the area conducted a Sexual Violence and Abuse Joint Strategic Needs Assessment in 2019 (one of very few at a LA level), identifying 41 recommendations that it would take forward in order to improve knowledge, understanding and response. There is a pan-area Sexual Violence and Abuse Strategy and a separate Exploitation Strategy.
This site is also a pilot area for the NHS Pathfinders for Adult Victims and Survivors of Sexual Assault and Abuse with Complex Trauma Related Mental Health Needs. The aims include creating and improving pathways and access to professionals trained in identification of, and appropriate response to, complex trauma related to sexual assault and abuse.

The Sexual Assault and Abuse Board (SAA) operate across the wider area, made up of a range of partners including from Health and Social Care, the specialist third sector, local authorities, police.
The SAA developed the local area Sexual Assault and Abuse Strategy 2020–3, setting out key local priorities, responsibilities and governance structures.

The county Sexual Violence Partnership was established in 2019 to deliver against a specific SV strategy and to raise the profile of SV. The main partners are the VSS service and local partners, including the SARC. Representatives from the partner services meet regularly and are joined by local commissioners. There is no specific or additional funding for the partnership to carry out joint work and the partners do not co-deliver any grants or contracts. Its primary aim is to share local knowledge and organisational specialisms, build relationships and referral pathways and ensure there is regular communication between commissioners and service providers.

An area-wide Partnership for Sexual Abuse has been established in the last 2 years that involves two of the VSS services. This partnership board is funded by the Big Lottery Fund.
VSS service 1 is also establishing a more formalised partnership with the other two Rape Crisis Centres in the wider area, and is looking to develop into a navigator model. It has also worked with a local centre (comprising three physical centres), on certain initiatives.
An Integrated Care Board (ICB) oversees health and care planning for the county and Boroughs A and B are coterminous with CCGs that commission local health services; however, neither CCG currently fund VSS in the area. The ICB is exploring the development of a complex mental health pathway involving mental health trusts and the local Rape Crisis Centre to be potentially funded by NHS England.

**FIGURE 18** Site overview diagram – local structures and partnerships.

where signposting by key organisations can become crucial. As Selasie stated, ‘they would never have gone to [service]; it was only because the police referred’.

### Case Site 2

There were strategic projects and cross-area aims to aid strong service provision in this site. For example, the area had a newly developed SV consortium, comprising Service 1, two other SV services, the police and NHS. This has encouraged more connection and discussion between SV services and statutory services. For example, Service 1 was contracted to provide SV training to the police, and to provide critique and feedback on new SV-related policies. The region also includes a Domestic and Sexual Abuse Board that meets bimonthly, including VSS and statutory services, as well as commissioning representatives. The commissioning group is aiming to drive forward the local SV agenda and improve patnership working and collaboration. The CAMHS practitioner in this site also explained that a few years ago, the DH funded a review into connections between CAMHS, SV services and the LA. This review found that most CAMHS clinicians did not have the knowledge about SV to adequately identify and treat. The outcome was a substantial training package that has improved the skills and confidence of the CAMHS workers, alongside positively influencing the collaboration and pathways between services.

Trust and familiarity between services is key to good referral pathways and maintaining confidence in those services. Many of the key individuals across services (both VSS and statutory) in this area have been in post for a decade (some for much longer) supporting a strong sense of stability andreliability. One practitioner stated that:

> *These services were set up years and years and years and years ago … these links have been in place for years … and the main players don’t really change. And I think that possibly adds to some of the stability … of how we worked together.*
>
> *S2.P3*

### Case Site 3

The three voluntary sector services that provide specialist support to victim-survivors are independent organisations, with no connecting formal partnerships or agreements. A perceived advantage of this was that each service retains its unique identity and service remit. In addition, the services are not, in the main, in direct competition with one another for contracts or pots of funding when it comes to SV-related work. In 2019, the OPCC established the County’s Sexual Violence Partnership to help deliver its SV strategy and to raise the profile of SV in the county. The Partnership was set up to enhance joint-working, referral pathways and professional relationships between organisations with shared interests. The main partners are Service 1, Local Partner 1 and Local Partner 2 and the SARC. Practitioners described the Partnership as a useful forum to share knowledge and learn about one another’s services and areas of specialism. As Practitioner 6 described: ‘… we get together and share information, providing we’ve got client’s consent to get them the best possible support, yeah, which works really well’ (S3.P6). The Partnership also provides a regular space for communication between commissioners and service providers and was valued by all parties for helping to raise issues in a timely way and to increase transparency about funding and commissioning decisions.

It was reflected that SARCs in this area regularly work alongside the VSS services and often represent the entry point for victim-survivors: ‘so I went to SARC, saw [SARC Staff] and then I think it’s through Service 1, they do the twenty-four-week counselling that I did with [Service Staff]’ (Mia). Both SARCs and VSS services work closely with the criminal justice system if a victim-survivor should wish to pursue this option: ‘And with [VSS service] as well, I appreciated the fact they don’t push you to contact the Police at all … if you want to report it – they offer, like, different ways of reporting it’ (Blossom). Reasons for not reporting are varied but may include Blossom’s experience: ‘… I just know for a fact that I wouldn’t have a leg to stand on in the justice system’. The reality for many victim-survivors is that few SV cases reach the stage of prosecution and then conviction, making some very reluctant to report.

### Case Site 4

Organisations in this site described ‘reciprocal’ relationships that involved referring or linking victim-survivors to other VSS services and collaborating to hold one-off joint activities around specific initiatives or issues. These informal relationships were vital for managing victim-survivors’ needs at different points in their journey and being able to signpost appropriately.

There were also more ‘formalised’ relationships and partnership arrangements in place. For example, an action partnership for SV existed between Service 1 and Service 2 to raise awareness and provide a platform to work with commissioners; however, differences in priorities for different victim-survivor groups (girls and women, and men) had so far prevented further formalisation of the partnership and any specific joint commissioning arrangements.

Both Service 2 and Service 3 were members of the Male Partnership Board which provided a link to policy-makers and connections with other organisations. However, Service 3 was cautious in its relationships with other VSS and statutory organisations to preserve its acceptability to victim-survivors:

> *if we’re going to support people from these communities one of the things you have to be careful of is delegitimising your service. So, one of the things that we certainly don’t want to do is overly befriend [statutory organisations] …we keep it to a minimum.*
>
> *S4. Service 3*

### Cross-site analysis

Referrals to VSS services across all four sites were either self-referrals or agency referrals. Self-referrals were particularly common for the male specialist support organisations in Site 4, but both had received some referrals from Victim Support, GP networks and local homelessness, drug and alcohol agencies. Service 2 attributed a large number of self-referrals to its digital outreach work.

Exploring referral patterns and pathways into VSS services with victim-survivors exposes a diversity in the journeys that people have taken to arrive there. In Site 3, Autumn’s reflections demonstrate one type of journey into specialist support: ‘I got support through my private insurance company … probably … ten sessions … I was on the waiting list with [Service 1] and then I had these sessions …’. Long wait times for VSS services may mean that victim-survivors need alternative sources of support as they wait, as it was for Blossom who ‘also paid a private counsellor’.

For practitioners and victim-survivors, however, referrals were not always straightforward. Experiences when initially accessing VSS support can be varied. Those victim-survivors who reflected positively cited how it was an ‘easy process’ (Brian), and how they ‘very quickly [got] through to the right people’ (Aadava)). The latter experience, however, was considered by the victim-survivor to be based on luck and not necessarily what they thought would be the norm: ‘I think I’m just one of those fortunate ones … I was one of the lucky ones, because it wasn’t really directed from the GPs either’ (Aadava)). This perception was mirrored by a different participant who described the systems around accessing support as not ‘completely broken – but it’s not joined, you know, from one service to another and it’s all higgledy piggledy’ (Toby). In Site 1, concerns were raised by practitioners in relation to certain referring organisations and practices. For example, with mental health, while there was a reported ‘willingness … to work very constructively together’ (S1.P5) in certain areas of the county, it was argued that VSS services were receiving many referrals from mental health – ‘not all of them are appropriate’ (S1.P5) – and often without any remuneration: ‘… Health, they make 17% of referrals into [Partnership] but pay for 1.6% of those referrals’ (S1.P1). Practitioners argued that a funded pathway and a better understanding of each services’ thresholds of work could potentially improve these relationships.

## *Explore victim-survivors’ experiences of accessing and using voluntary sector specialist services, identifying what needs are being met for which groups of victim-survivors and what encourages victim-survivors to take up services*

### Case Site 1

Victim-survivors had positive experiences when accessing and using VSS support and noted services’ propensity to go ‘above and beyond for every single person they meet’ (Margot). Victim-survivors’ relationships with their practitioners, the physical environment and specialism of workers were all factors identified as contributing towards positive outcomes.

Certain victim-survivors described their workers as having ‘probably saved [their] life’ (Margot), reinforcing the integral nature of the relationship/connection between the worker, service user and recovery process. Described as ‘almost like talking to a friend’ (Pippa), the positioning of the practitioner on a level equal to that of the service user facilitated the growth of a connection that transcended the power imbalances that can underpin certain client/professional interactions.

### Case Site 2

Accessibility of services was specifically discussed by several participants. Gen reflected that 'I've never done therapy before … I don't feel like working class people have that opportunity'; furthermore, they stated, 'I think the world of therapy in general is just so inaccessible'. Lack of knowledge of service provision was also considered a barrier: 'So I initially just started looking for therapy … in general … I just had no idea where to start … the priority for me is the sexual violence', explaining, 'they seemed to be much more experienced in dissociation and things like that' (Millie). The cost of a service is often a consideration: 'one of my friends said to me "I can't afford therapy" … and I said, "I've just had … sixteen sessions at [Service] and it was free"' which encouraged their friend to access VSS support. The same participant explained, 'I am in a privileged position where I could pay for [pay-to-access service], but a lot of people aren't, especially in the current financial climate' (Gen). Importantly, though, Gen reflected how the quality and experience through the VSS (free-to-access) service and the pay-to-access service were as good as each other.

### Case Site 3

Even with awareness of services, victim-survivors' personal reasons for accessing support can vary considerably. Engaging with VSS services may be the result of a chance comment to the right person: 'the first time when I actually was able to say out loud to someone that asked what happened … they suggested the women crisis centres and this is how I found [Service]' (Autumn). This may be especially valuable when victim-survivors do not feel as though they can or should address what has happened, until perhaps there is a trigger for them:

> *throughout my whole life I suppressed it so much that I think I also convinced myself like nothing ever happened. And so I never even thought about it, like, I never told anyone about what happened … only when I was kind of already in my, I don't know, like 20s, and I started dating and then sometimes something would kind of, like, a memory comes up.*
>
> *Autumn*

If participants were more aware of the services on offer, they could not only be involved in decision-making about the most appropriate form of therapy/support, but for services themselves, it may create a more seamless and timelier journey through the VSS system:

> *And so if you suffer from this, we've got this kind of thing, if you suffer from this we can offer you this … I'd never heard of EMDR until last year and it took me about six months to understand what EMDR stood for.*
>
> *Mia*

### Case Site 4

What supported victim-survivors to reach out to VSS services included seeing 'an advert, and it was about mental health and stuff and [they] just really related to it' (Karl) and hearing 'on the radio … "are you a male victim-survivor of sexual abuse and, if so … we can help" … it was surreal when it came on' (Sam). Aadava spoke to the importance of an accessible service, related to paying for support, comparing a national service that charges a nominal fee – 'I just didn't bother going in' – with their local VSS service who responded quickly and with 'no cost involved at all'. Karl also reflected that the fact the VSS service 'didn't cost £50 a session' was a strong motivating factor for their engagement with the service. For Brooklyn, it was a friend's father having 'gone through a similar thing when he was younger' so their friend was aware of a service that could help.

There were positive experiences and outcomes from VSS support also reflected by victim-survivors, including 'the biggest takeaway would be like an increased self-awareness and ability to look at [themselves] objectively and manage [their] behaviour' (Brooklyn). For Brooklyn, the gravity of the experience and outcome of support could not be underestimated: 'I'd say, to some degree, it saved my life getting help from them'. In this case study site specifically, there was a larger proportion of male victim-survivors compared with female. Given this, it was interesting to see reflected the extent to which some male participants considered the needs of other male victim-survivors as having been met, or not, as influential to their decisions to seek support. Findlaigh reflected how he 'wasn't even sure there would be support available as a male victim-survivor'. He considered the perceived 'skew' towards female victim-survivors to be understandable, and not upsetting to him, but he reported that there at least needed to be more awareness for services and support 'in whatever form it takes' for men. Findlaigh considered himself to have ended up with a positive outcome, but was concerned that for other people, 'that might not be the case'.

### Cross-site analysis

Most participants reported waiting several months between referral and commencing counselling provision, although a minority accessed it 'pretty much straight after' referral and 'within about six weeks, six to eight weeks of applying' (Lottie). This underscores the mixed experiences that can be based on waiting list times. While having to wait was understood by victim-survivor participants, it does highlight, again, the risk around delayed access. For one participant from Site 4, a point of crisis was a motivating factor for accessing support: 'it wasn't until one Sunday there I found myself popping my pills and again trying to commit suicide, so my wife brought me back home and said, "Look, you're going to have to get help"' (Levi).

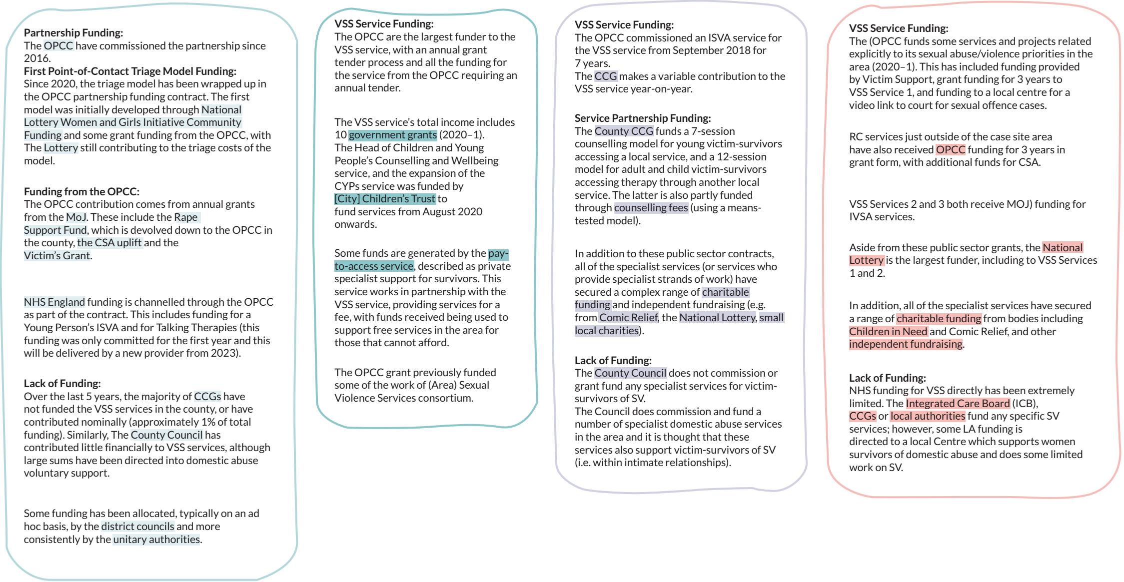
Therefore, victim-survivors were cognisant of the effect of decision-making from commissioners and the influence of their funding decisions for the service users. The main impact of funding for all participants appeared to have been in wait times for a service, with a sometimes-significant impact on victim-survivors. While there was an appreciation that 'the waiting list is very long' and that the financial constraints the service worked within caused the staffing issues, it nevertheless had an impact.

## *Explore how arrangements for commissioning and funding services for victim-survivors across health, local authorities and criminal justice have evolved over the last 3–5 years and how they have impacted on voluntary sector specialist service provision*

### Case Site 1

Perhaps unsurprisingly, the problems of short-term funding were raised by all practitioners. Such funding was said to not recognise that 'to embed other services, drop-ins, social groups … they need to be given a long time to actually embed and grow' (S1.P8). Short-term funding produced a context of living 'hand to mouth' (S1.F/C3) and distracted from activity focused on developing services. The stress this context engendered cannot be underestimated: 'I can't express enough how terrifying it is each year or each couple of years when we know funding is running out or ending, can we sustain the service' (S1.P2).

Despite good relationships with engaged local commissioners/funders, there was broad criticism of the commissioning agenda, which was said to have introduced generic and private providers and the treat of 'takeover by bigger, more funded organisations' (S2.P6). With commissioning came the work associated with writing tender responses and going



**Partnership Funding:**
The OPCC have commissioned the partnership since 2016.
**First Point-of-Contact Triage Model Funding:**
Since 2020, the triage model has been wrapped up in the OPCC partnership funding contract. The first model was initially developed through National Lottery Women and Girls Initiative Community Funding and some grant funding from the OPCC, with The Lottery still contributing to the triage costs of the model.

**Funding from the OPCC:**
The OPCC contribution comes from annual grants from the MoJ. These include the Rape Support Fund, which is devolved down to the OPCC in the county, the CSA uplift and the Victim's Grant.

NHS England funding is channelled through the OPCC as part of the contract. This includes funding for a Young Person's ISVA and for Talking Therapies (this funding was only committed for the first year and this will be delivered by a new provider from 2023).

**Lack of Funding:**
Over the last 5 years, the majority of CCGs have not funded the VSS services in the county, or have contributed nominally (approximately 1% of total funding). Similarly, The County Council has contributed little financially to VSS services, although large sums have been directed into domestic abuse voluntary support.

Some funding has been allocated, typically on an ad hoc basis, by the district councils and more consistently by the unitary authorities.

**VSS Service Funding:**
The OPCC are the largest funder to the VSS service, with an annual grant tender process and all the funding for the service from the OPCC requiring an annual tender.

The VSS service's total income includes 10 government grants (2020–1).
The Head of Children and Young People's Counselling and Wellbeing service, and the expansion of the CYPs service was funded by [City] Children's Trust to fund services from August 2020 onwards.

Some funds are generated by the pay-to-access service, described as private specialist support for survivors. This service works in partnership with the VSS service, providing services for a fee, with funds received being used to support free services in the area for those that cannot afford.

The OPCC grant previously funded some of the work of (Area) Sexual Violence Services consortium.

**VSS Service Funding:**
The OPCC commissioned an ISVA service for the VSS service from September 2018 for 7 years.
The CCG makes a variable contribution to the VSS service year-on-year.

**Service Partnership Funding:**
The County CCG funds a 7-session counselling model for young victim-survivors accessing a local service, and a 12-session model for adult and child victim-survivors accessing therapy through another local service. The latter is also partly funded through counselling fees (using a means-tested model).

In addition to these public sector contracts, all of the specialist services (or services who provide specialist strands of work) have secured a complex range of charitable funding and independent fundraising (e.g. from Comic Relief, the National Lottery, small local charities).

**Lack of Funding:**
The County Council does not commission or grant fund any specialist services for victim-survivors of SV.
The Council does commission and fund a number of specialist domestic abuse services in the area and it is thought that these services also support victim-survivors of SV (i.e. within intimate relationships).

**VSS Service Funding:**
The (OPCC funds some services and projects related explicitly to its sexual abuse/violence priorities in the area (2020–1). This has included funding provided by Victim Support, grant funding for 3 years to VSS Service 1, and funding to a local centre for a video link to court for sexual offence cases.

RC services just outside of the case site area have also received OPCC funding for 3 years in grant form, with additional funds for CSA.

VSS Services 2 and 3 both receive MOJ) funding for IVSA services.

Aside from these public sector grants, the National Lottery is the largest funder, including to VSS Services 1 and 2.

In addition, all of the specialist services have secured a range of charitable funding from bodies including Children in Need and Comic Relief, and other independent fundraising.

**Lack of Funding:**
NHS funding for VSS directly has been extremely limited. The Integrated Care Board (ICB), CCGs or local authorities fund any specific SV services; however, some LA funding is directed to a local Centre which supports women survivors of domestic abuse and does some limited work on SV.

**FIGURE 19** Site overview diagram – funding structures.

through recommissioning processes, with a lack of flexibility with the latter being noted. For example, despite being the only large-scale specialist provider in the area, one with a track record of delivering, procurement wavers were infrequently used to support services from having to re-engage with the recommissioning process: ‘so it’s like OK well there’s a quality service, there isn’t a competitor that is specialist in the area, why are you putting it out to tender, why are you putting us through that!’ (S1.P1).

Despite commissioning becoming embedded into local infrastructure – and the necessity to comply – questions in this area existed as to whether sexual abuse was a crime ‘problem’ and the responsibility of the PCC to fund, a public health priority, implicating the LA, or a long-term health concern necessitating NHS or CCG input. In a context of squeezed commissioner budgets, this ambiguity had resonance. However, improving clarity on this point will not necessarily be enough to shift this situation, with a failure to understand the potential long-term trauma of sexual abuse, what VSS services do or their complementary approach to ‘a clinical service provider’ (S1.F/C2), also driving investment decisions.

### Case Site 2

Arrangements for commissioning and funding across the region were described as having a significant effect on the services provided, both intended and unintended. The annual cycle of commissioning was identified by most of the practitioners, and described as a huge challenge, as it does not encourage planning or embedding service in a community (S2.P1,2,4,5, F/C1,2). A practitioner in Service 1 was frank about the chilling effect of this cycle on innovation and sustainability:

> *So the PCC, for example, give us large funds, but every year we’ve got to bid for them, at the end of every year, I’ve explained this uncertainty, a year is not enough to launch a new service or to embed an existing service or grow and develop it.*
>
> *S2.P4*

Commissioners agreed with this sentiment, stating that ‘at least if they [SV services] know that they have two- or three years’ worth of funding it gets into a system and it is that stability then for the staff and for the actual support as well, it would be much better’ (S2.F/C1,2).

Practitioners identified that austerity measures substantially contributed to the challenges for all services, both statutory and voluntary. One practitioner noted that, *‘I think we’ve lost an enormous amount of capacity in the specialist services because of the economy and because of cuts’* (S2.P2), with another arguing that one of the reasons services did not get enough funding to provide support was ‘due to funding cuts’ (S2.F/C1,2), and a further suggesting that austerity has reduced their funding by ‘about 20%’ (S2.P4). Services have deliberately diversified their funding model to address these issues. In order to facilitate this more diverse funding approach, grant bidding and fundraising has become ‘a significant element of the organisational model’ (S2.P4), with the introduction of dedicated staff posts that had specialist skills in identifying, applying for and winning awards.

### Case Site 3

Unusually in Site 3, while several services were commissioned (e.g. ISVA and some counselling provision), other aspects of therapeutic and emotional support work remained grant funded, although there were indications that this may change in the coming 5 years. Practitioners and commissioners underlined the positive nature of their working relationships, characterised by an understanding of their respective roles, regular communication and the ability to work cooperatively within the Sexual Violence Partnership: ‘We have a very good relationship with them (commissioners), yes, we get on really quite well. We meet the deadlines, we meet the spec, we do what it is what we’re asked to do … I think it’s about communication with people and picking up the phone’ (S3.P4).

### Case Site 4

Concerns were expressed that funding pressures prevented more collaborative working as organisations were forced to compete with each other over limited funding. This was particularly pronounced in this case study area because organisations were focused on distinctive victim-survivor groups and priorities. Service 2 explained it experienced particular difficulties in negotiating with commissioners because it identified as victim-survivor-led and was therefore seen as too ‘subjective’. Victim-survivor-practitioners could, in turn, find these dynamics personally triggering and retraumatising. Relying on grant-making foundations was not considered to be sustainable, but both Services 2 and 3 struggled to access statutory funding. Service 3 considered itself limited in available funding sources, due to concern over its legitimacy with clients. It furthermore reported that minoritised services had only recently been recognised within government priorities and were an ‘after-thought’ (Service 3). Funders were perceived to lack a genuine understanding or commitment to support ethnic minority victim-survivors.

In addition, the main commissioner in this case study area (NHS practitioner) echoed the challenge that the lack of a national strategy for SV presented:

> *… if it’s something like sexual assault and violence there is no expectation. There is no funding allocation. There is no metric associated with it. So even having the transparency as to whether we’re good, bad or indifferent, doesn’t exist really.*
> *NHS practitioner*

### Cross-site 5

Short-term funding underpinned the status quo for the VSS services. A picture that had worsened in the last 5 years due to applying for more money, from different sources, to meet the shortfall left by increased demand. For clients, the closure of services could result in discontinuity in support and the extension of waiting times for available services, both of which could come at a psychological and practical cost to the victim-survivor: ‘I’m just like “when that project runs out what about those people?” – I think that’s really, yeah, unsettling’ (S3.P2). Practitioners likened the challenges of short-termism to ‘running around on a hamster wheel of grants’ (S4. Service 1.P3) and uncertainty and insecurity were normalised. Practitioners also highlighted how the precarious nature of multiple, short-term funding limited practitioners’ job security and, concomitantly, sense of well-being. This was a particular concern at Service 1 (in Site 3) – the only dedicated specialist provider – who employed very few staff on permanent contracts and who had an exclusively female workforce, many of whom were the primary wage earners in their household. A situation, Practitioner 4 described as one that was ‘difficult to swallow’ and made employee terms and conditions a priority in contract negotiations with commissioners: ‘I think that’s sort of, my job is to be concerned about all the staff here’s mortgages and livelihoods without looking like it’s what I’m thinking about’ (S3.P4).

The most significant funding and commissioning issue identified across the participants was that there was not enough funding to cover the demand for services, and the struggle to fund long-term counselling:

> *There’s just not enough funding and not enough to be able to provide for everybody that really needs it. The bits of funding that we can get are a drop in the ocean compared to what is really needed in terms of that long-term specialist support.*
> *S2.F/C1,2*

## Key messages from work package 3

- There needs to be a greater recognition of the unique value of independent, VSS services in providing flexible and responsive support, using a victim-focused, trauma-informed approach and representing the voices of victim-survivors.
- For victim-survivors, there needs to be more effective promotion of VSS services for the benefit of enabling them to become aware of the services and make informed choices about engaging with them.
- There should also be a genuine commitment to work with victim-survivors to co-produce services to avoid retraumatisation.
- Referral pathways between services must be clear and effective.
- Partnerships appear to work well in terms of connecting the VSS services and statutory (e.g. NHS) services with each other, and with commissioners. Partnerships should offer a space to share knowledge and resources, dedicate time to think through ‘complex’ individual cases and to work collaboratively on strategic and financial issues.
- Partnerships should offer a layer of support, accountability and structure to existing ‘good’ working relationships and should raise the profile of SV across the area. However, relationships between services can break down when there is competition over funding provision.
- Resources for supporting victim-survivors with ‘complex’ needs must be better understood and provided, to support partnership working.

- Long-term sustainable funding for the sector is required. Not only would this reduce waiting lists and increase the speed of service access, but it would also allow for longer-term support where needed.
- Commissioning in ways that understands and favours specialist services, is needed for example, by scoring weighting to recognise the importance to specialism and local knowledge, would support services to grow their provision in line with demand, and would ensure victim-survivors were accessing the most specialist support.

# Chapter 6 Work package 4: being a co-researcher and doing co-research on the PROSPER study

## Context of work package 2

Drawing upon a 'collective autoethnographic' approach, this chapter attempts to convey the realities of a co-researched project and offer reflective perspectives on that experience. It is co-authored by the five PROSPER co-researchers. We explore some of the contemporary discourse around research co-production while describing how lived-experience co-research was implemented in practice. How well the PROSPER co-research endeavours went – the good and the not so good – are considered and recommendations made for future co-production projects involving those with lived experience of SV. We draw upon the work of Survivors Voices (https://survivorsvoices.org), a national survivor-led organisation which offers insights, principles and guidance for best practice when engaging those with lived experience of interpersonal abuse and trauma. The chapter is infused with first-hand accounts from the co-researchers that capture the personal experiences of *being* a co-researcher and the act of *doing* co-research.

> *When I joined the PROSPER team as a co-researcher, I quietly held on to the hope that I would be seen and heard, valued, and respected, for all the unique things I am beyond my trauma. I had no interest in being an added element of the project to simply fulfil a PPIE remit or to be there to demonstrate a progressive research approach.*
> *I am pleased to say I felt heard and understood, and I was met as a whole being. Perhaps because of this, I believe the co-researchers were able to honour and amplify the voices of study participants – by being able to meet them where they were, and to holistically welcome and hear and heed their experiences.*
>
> *My hope is that co-researchers can now play a part in ensuring that participant voices are heard way beyond the research team, peer-reviewed articles and academia ... by those using sexual violence support services and those who have the power to improve them.*

## Hidden in plain sight

Given the prevalence of SV as detailed elsewhere in this report, it is likely that most research teams will, knowingly or otherwise, have team members who have been subjected to SV. However, talking openly about such experiences remains taboo and is both explicitly and implicitly discouraged. Revealing lived experience to colleagues within a professional context, risks altered perceptions of ability, pre-conceptions around 'victimhood', expectations of vulnerability and mental health instability. An 'othering' can quickly ensue, which is known to be damaging: 'The othering has the effect of reinforcing the sense of injustice you feel ... You find yourself positioned as "damaged"'.[74]

Thus, many lived-experience researchers remain hidden in plain sight. Some may consciously choose this, but for many it may be the fear of 'othering' that perpetuates silence. Articulation of lived experience often remains unheard out of necessity and while the impact of lived experiences on research design, delivery, analysis, dissemination and translation may quietly infuse and impact the work that many researchers undertake, it frequently goes unnoticed, uninvited, unappreciated, undervalued and unrecognised. The voice of lived experience within research is, it would seem most often, 'by invitation only'.

## The patient and public involvement and engagement in research imperative

It is increasingly accepted that more participatory, collaborative lived-experience involvement within research is not only fundamental to the integrity of that research, but is a moral, ethical and social imperative. There remains an ongoing debate, however, regarding exactly how that lived-experience participation is best facilitated. The discussion around this is not new. In 2009, Sweeney *et al.*[75] explored the history and evolution of service user research (including co-production and co-researchers); the different forms of user participation in research; the methodological and epistemological approaches underpinning participatory research; and the relative merits of the data and evidence emerging from these.

Thirteen years on, the discussion continues. Co-production, and the embedding of lived-experience co-researchers within research teams, is gathering favour as the preferred 'way to go' and is advocated by research stakeholders, policy-makers and funders:

> *But the future is not simply about doing more of the same … The practice of co-production which is more often applied to service design and improvement merits further exploration in relation to research as a way to foster partnership, reciprocity and openness.*[76]

The drive towards co-research has emerged in response to concerns that the engagement of 'the public' has often been restricted to tokenistic advisory or consultative approaches, to sensationalist testimonials and to invitations to 'tell your story to help us understand'. Even mandated allocation of project funds to PPIE, despite its best intention, carries the risk of perpetuating box-ticking public involvement – researchers cognisant that this may be the difference between successful/unsuccessful funding applications.

Sustained concerns around the potential for, at best tokenistic, and at worst, harmful, PPIE, were addressed by The National Institute for Health and Care Research (NIHR) within their strategic review of public involvement in research.[76] Their report recommended that a research culture shift towards more inclusive, authentic and fully participatory 'co-production' could become a means of evolving and improving the nature of public involvement in research:

> *Co-producing a research project is an approach in which researchers, practitioners and the public work together, sharing power and responsibility from the start to the end of the project, including the generation of knowledge.*[77]

## Evaluation of co-produced research

While the appetite for co-production is growing, there is still much to learn. Evaluation of co-produced research must therefore be integral to the project, while not detracting from the day-to-day implementation of that co-production. Robust and relevant, but not cumbersome and distracting, valuation tools and processes are required to support the development of a body of evidence around best co-production practices. It is incumbent upon research teams to offer up honest and transparent reflections on how the co-production project was implemented, what went right, what went wrong and how to do things next time. Intentional, creative, far-reaching dissemination of evaluation outcomes and the sharing of co-producer experiential reflections are key to closing the gap between co-production ambitions and co-production realities.

In the spirit of the PROSPER team's ambition to enlist in a meaningful way the knowledge and expertise of those with lived experience at every stage of the project, it seems relevant and appropriate in this chapter to utilise the work of a victim-survivor-led organisation – Survivors Voices – to aid the discussion of PROSPER co-research endeavours.

In 2018, Survivors Voices developed a charter for engaging victim-survivors in projects, research and service development.[78]

The Charter's central tenet is that:

> *All work with all people affected by abuse and trauma needs to look unlike and be the opposite of abuse – otherwise it can inadvertently replicate the dynamics of abuse and cause harm.*

The charter offers seven principles for good victim-survivor engagement which expand upon and illuminate this 'antithesis of abuse' and identify how organisations can ensure that victim-survivor engagement:

- is safe
- is empowering
- amplifies the voices of victim-survivors
- promotes self-care
- is accountable and transparent
- is liberating
- is creative and joyful.

The expectation to meet criteria such as these is neither novel nor revolutionary. For example, Turner and Beresford[79] identified five dominant principles of empowerment, emancipation, participation, equality and antidiscrimination that are fundamental to victim-survivor research.

What is insightful about the charter, and what renders it so pertinent to PROSPER co-research, is the delineation of harmful dynamics of interpersonal abuse as a means of guiding research teams in the provision of co-production opportunities that are intrinsically and intentionally the polar opposite of abuse dynamics. An abuse and trauma-sensitive approach of this nature has the potential to increase the integrity of interpersonal violence research and to improve the safety of co-researchers, researchers and research participants alike. It also holds a gift: a restorative and healing potential for co-researchers.

Utilising the principles of the charter, Survivors Voices then went on to develop an assessment and evaluation tool.[80] The Survivor Research Ladder provides an evaluation framework for organisations to measure the level of engagement of victim-survivors across the life of a research project. The 'rungs of the ladder' outline the potential roles of victim-survivors in research. How this might look in practice is considered in terms of degrees of involvement in planning and decision-making; the proportion of researchers that are victim-survivors; the proportion of study data that are elicited directly from victim-survivors; to what degree victim-survivors contribute to data analysis; and what level of involvement victim-survivors have in the dissemination of research findings. We will return to this ladder towards the end of the chapter as a means of assessing the level of engagement as perceived by the PROSPER co-researchers within the study.

## Rationale for co-researcher involvement in the PROSPER study

The notion of co-production as an integral aspect of PROSPER was mooted early in the study development process. PPIE consultations took place and two lay advisor PPIE representatives were engaged as co-applicants – one of these identifies as a survivor of SV. During early discussions between the original study team and PPIE representatives, the desire to further engage individuals with lived experience beyond lay advisory roles – this time as co-researchers – gathered momentum. The desire to meaningfully employ the voice of lived experience became an essential aspect of the PROSPER study. In the original proposal, the research team expressed an aspiration that co-research would be an embedded element of the research design, offering the following benefits:

- meaningful co-production wherein the voices of victim-survivors are heard
- empowering to victim-survivors
- obtaining meaningful data
- promoting learning and development of new skills among co-researchers.

While these intentions implied shared benefit, they came with an inherent risk: presumption, paternalism and patronisation. The presumption that the co-researchers had not already had their voices heard and that they needed empowerment, new skills, development and learning. The paternalistic risk that the researchers knew 'what was best' for the co-researchers. The risk of patronisation wherein apparently kind or helpful intentions of meaningful involvement betrayed a perceived superiority. The challenge for, and the expressed intentions of the research team, was to avoid these risks. Those with lived experience of SV are, after all, and contrary to prevailing reductionist stereotypes, much more than those lived experiences. Victim-survivors are three-dimensional human beings who bring with them a multitude of personal and professional experiences and skills. It was entirely possible that those responding to the call for applications to become co-researchers were already feeling empowered, knowledgeable, skilful, seen and heard. Research informed by the lived expertise of victim-survivors should recognise their multilayered abilities beyond their abuse experiences.[81,82]

## Co-researcher recruitment

Fuelled with the acknowledgement of potential risk, and the intention of avoiding it, in November 2020, the research team set about recruiting the PROSPER lived-experience co-researchers. The team aimed to recruit four, one for each of the project case study sites. The posts were advertised using the research team's extensive networks in the third sector and within NHS and social services. The COVID pandemic moved all interviews online. The service user co-applicant was closely involved at all stages of recruitment and was a key member of the selection panel.

The advertisement detailed that the co-researcher role would include:

- offering knowledge and experience of the issues being researched
- co-facilitating interviews with victim-survivors of SV
- helping to recruit victim-survivors to the study
- assisting in the development of research materials and tools
- assisting with data analysis
- attending some research meetings
- helping to develop publicity around the research
- helping to support/attend activities to promote the study findings.

### *Remuneration*

The role was advertised as a paid position, lasting approximately 18 months with the desired commitment of 1–2 days per month, with flexibility around time worked. The remuneration was confirmed as meeting the contemporary NIHR INVOLVE guidelines (with the hourly rate subsequently being increased mid-project to reflect inflationary increases) and all travel and incidental expenses would be met.

### *Appointments*

Such was the calibre of applicant pool that out of the 13 candidates who reached interview, 6 were offered a co-researcher post. One of these was unable to proceed with the post due to competing commitments. The five remaining co-researchers remained as active members of the project through to completion. The co-researcher post was open to men and women. However, despite efforts to ensure the invitation was accessible to all, including extensive links to specialist support services for men, all appointees were female – four white women and one black woman.

The range of professional and personal experiences of the appointed co-researchers was extensive and varied (see *Appendix 3*).

## Co-researcher training

Training and regular supervision/mentorship were built into the project design. Co-researchers received bespoke and generic training. A draft training plan was developed in collaboration with the co-researchers once they were appointed in recognition of co-researchers being able to identify their own knowledge gaps and training needs.[83] The service user co-applicant was also actively involved in the development and delivery of the training.

### *Mentorship*

Each co-researcher was allocated a mentor and monthly optional meetings between co-researcher and mentor were scheduled. The overarching desire was to provide regular opportunities for debriefing and ongoing support to encourage the emotional and physical well-being of the co-researchers. The intention for the mentor–mentee relationship was that it would be an egalitarian and mutually beneficial one (the mentor perhaps gaining enhanced empathetic listening skills, insight, scope for self-reflection, sense of achievement and development of leadership and mentoring skills). It was encouraged that the relationship and mentoring activity should be owned and driven by the mentee and that she was regarded as an equal partner in the process. Guidance was provided to mentors regarding the establishment of a trusting relationship, appropriate boundaries, practical action planning and learning support for the mentee and the safe and timely management of ending the mentorship relationship.

## Co-researcher roles/activity

### *Team meetings*

Monthly, remote, hour-long reflexive team meetings for researchers, the PPIE representative, project administrator and co-researchers were well attended throughout the project. Co-researcher participation in discussion at these meetings was voluntary. Practical and project administration topics were tabled as required, but these meetings soon established themselves as a space for all manner of discussion and reflections – at times project related, at times related to other national and international research activity and engagement opportunities. These online meetings became an important opportunity for personal and collective check-ins about well-being and 'life in general' – elements of team relationship building that would ordinarily take place within a workspace, but that were conspicuously absent from the project due to the wide geographic spread of the co-researchers and the impact of COVID on in-person meetings.

### *Away days*

Coronavirus restrictions somewhat hampered the establishment and nurturing of relationships within the team for almost a year. Once permitted, meeting in person was considered a vital opportunity to catch up on lost time and missed connection. Four overnight opportunities in Birmingham were provided for the research team and the co-researchers to come together in person. Each event combined focused, pre-determined project work with down-time opportunities to build and nurture relationships within the team. Each in-person event was purposeful, task oriented and with a pre-defined agenda (see *Appendix 4*).

### *Research activities*

Co-researchers were offered opportunities to undertake multiple research tasks. Participation remained the choice of the co-researchers who were free to decide with which elements of the project they felt able to engage. An appreciation existed regarding co-researcher competing time commitments, varying degrees of confidence in personal skills and research knowledge, current states of well-being and personal life responsibilities. There was an ever-present understanding that choice prevailed. Implicit in this approach was that the co-researchers' membership of the team, and their engagement in meetings and discussions, was enough. All additional work was a bonus and an asset. Training, support and encouragement were on offer to assist co-researchers to undertake tasks that may initially have felt 'out of their comfort zone'.

The tasks undertaken by the co-researchers included, but were not limited to:

- reviewing and editing participant-facing documentation
- reviewing plans and contributing to shaping the victim-survivor-focused recruitment approach, interviewing structure and methods
- working on victim-survivor-focused engagement – informing and assisting development of timeline and agreed approach about how to better use social media and other networks to engage victim-survivors in the study
- discussing and shaping the strategy for engagement of different groups (e.g. people who have not used services, people with communication needs)
- conducting interviews with victim-survivor participants

- interview transcript data coding, thematic analysis, mapping project objectives, using descriptive statistics and qualitative analysis of open text responses
- authoring elements/chapters of the NIHR report and case study write-up
- preparing and presenting to the team an early indicative analysis of provider survey data
- designing and delivering training on trauma, keeping participants safe and how to work with someone who has been triggered into a trauma response
- producing a video representation of example victim-survivor ‘journey’ through services
- disseminating and presenting findings at conferences
- monthly attendance and contributions to team reflexive meetings
- attending in-person task-oriented ‘away days’
- attending other meetings, for example, steering group
- engaging in the co-researcher evaluation creative project.

### *Co-researcher involvement in victim-survivor interviews*

Mid-way through delivery of the project, interviews with victim-survivor participants commenced in each of the four case study areas. While some interviews took place in person, many moved online because of COVID. Appropriateness of co-researcher involvement was assessed regarding any conflicts of interest and, while offered to all, participation remained the choice of each co-researcher. Members of the research team provided teaching on qualitative methodologies, theoretical principles and interviewing techniques. A researcher/co-researcher pair held a mock interview, which was video-recorded and shared with the team. Mentors were also available pre interview to help with preparation for the interviews and respond to any queries regarding the interview process.

Of 31 victim-survivor interviews, 16 of these involved co-researchers. Timing and other commitments precluded the involvement of co-researchers in all interviews.

Prior to all victim-survivor interviews, time was allocated for co-researchers to meet with the researcher for pre-interview preparation. This included a mutually negotiated decision regarding who would lead the interview, and which questions the co-researcher would ask, if any. The option for the co-researcher to simply be present but not actively questioning the participant was always an option – albeit this did not happen in practice. The choice remained as to whether the co-researcher declared her lived-experience status, but all research participants were aware that one of their interviewers had lived experience of SV. Time was made available for a post-interview debriefing between the researcher and the co-researcher and opportunities for further debrief and support were available via fellow co-workers, other team members and mentors. Victim-survivor interview successes, concerns, points of interest and recommendations were often part of monthly reflexive meetings during the interviewing period.

### *Additional creative co-researcher evaluative work*

Throughout the course of the PROSPER project, the impact that becoming a co-researcher was having on the individuals concerned was often discussed. It seemed that the co-research experience was taking on a ‘life of its’ own’ alongside the main PROSPER study. Insights were being revealed that could potentially help inform and enlighten the landscape of lived-experience co-production – enriching future research design and delivery, the engagement of participants, the analysis of data and the dissemination of outputs. In recognition of the unique opportunity that was evolving, additional funds were successfully applied for to enable the co-researchers – using a broadly autoethnographic approach – to capture their lived experience of working on PROSPER. The additional funding was secured through the Social Care: Opportunity for additional work call in October 2021 that was open for competition to NIHR award holders for projects funded by the Efficacy and Mechanism Evaluation, Health Technology Assessment, Health and Social Care Delivery Research and Public Health Research programmes.

Co-researchers received an honorarium payment and project monies granted to cover employment of a project co-ordinator, engagement and payment of artists, dissemination events and interactive workshops. Co-researchers were offered full autonomy to select their creative method and to engage their chosen artist/s, thereby maintaining agency and control over the personal information incorporated into the artwork and the production process. All creative outputs would be brought together, along with a series of process narratives, into a suite of resources to be made widely available to researchers, would be co-researchers, victim-survivors, service providers and funders.

A highly regarded expert in the field of violence against women and girls (Lisa Ward), currently working, amongst other things, as a lived-experience consultant, was appointed as Research Associate (RA) to co-ordinate this discrete part of the PROSPER study (see Lisa's website for profile: www.iamlisaward.com). All co-researchers were involved in and agreed with the appointment. The RA rapidly settled into the post and fostered supportive working relationships. Project ideas were gathered, a call-out to artists was placed and a time – and budget – to target plan was set out. Project timelines were agreed, budgets shared and explained with transparency and a weekend retreat was organised for the co-researchers to come together, discuss, share and offer narratives regarding their creative processes. A variety of artists and creative process were chosen by the co-researchers, including one collage artist, a textiles artist and two multimedia artists. One co-researcher felt unable to engage with the creative process or an artist and instead wrote a narrative piece. A prize-winning author was engaged to attend the reflective retreat to explore and listen to the reflections of the co-researchers and create a narrative piece around the co-research experience. A two-person dance company also attended the retreat and, working with a documentary film maker, created a visual, lyrical, storytelling performance piece as a novel evaluation output for dissemination events.

## How well did we do? The voice of the co-researchers

We now return to the seven principles of good engagement iterated in the Survivors Voices Charter[78] and the PROSPER co-researchers offer up their perspectives regarding how closely these principles have been honoured within their co-research journeys:

> **Safe:** … *the first priority for engagement is a safe environment that begins with providing attentive listening and connections that are warm, collaborative and relational, which recognise and minimises triggers and may include safety protocols. Dedicated time is given to building trust and safety with individuals and victim-survivor groups.*

The PROSPER environment – team members, ethos and co-research ambitions – was largely (indeed overwhelmingly) – experienced by the co-researchers as a very safe environment. There was an explicit emphasis on the importance of trust and safety from most team members. Nevertheless – and perhaps inevitably – in any space involving a collection of humans, especially those unknown to each other – there were moments where some co-researchers felt this safety was compromised either by circumstance or by less trauma-sensitive individuals. At best, these interactions were insensitive and at worst potentially retraumatising. Fortunately, these were very few and far between and ultimately offered a chance for reflection, learning and training opportunities.

The biggest circumstantial compromise to a sense of safety for some of the co-researchers was caused by COVID pandemic restrictions on travel and in-person meetings. Restrictions that were perhaps exacerbated by budget limitations. For some, the enforced reliance on online meetings made it difficult to feel completely safe within a large, unknown and geographically widespread team. It left one co-researcher initially unable to feel 'anchored' within the team and unable to access the full warmth and safety of colleagues until such time that in-person meetings became possible. While there are many known benefits of remote working – convenience, cost, environmental friendliness and flexibility – COVID-enforced remoteness reinforced the importance of safe connection and in-person relationship building for those with lived experience of interpersonal violence (which is intrinsically disconnecting, unsafe and relationship-damaging).

Co-researchers reflected that their experience of facilitating the victim-survivor interviews depended on the person conducting the interview from the research team. Mostly they felt fully integrated and almost leading the interview process, with autonomy over which questions to ask and when. However, a couple of the co-researchers experienced a suboptimal level of trauma awareness on occasions. Those affected felt that the lived-experience engagement fitted neatly into the realms of box-ticking tokenism, leaving them questioning the purpose and value of their involvement. One event left the co-researcher feeling like '*a bit of a spare part*'.

Safety within a team can also be compromised by the inherent risk within any project whose core purpose is to explore aspects of SV, and which necessitates engagement with other people with lived experience. A tension exists between the desire to *'minimise triggers'* while simultaneously creating a space that welcomes and encourages *'release and* *amplification of victim-survivors' voices, experiences and expertise'*.[78] During the study, there were occasions where sharing experiences could be triggering and hugely distressing for those listening, with the consequent potential for those sharing to experience shame and guilt for speaking out. Such events are destabilising and require sensitive reparation. Within the PROSPER project, this highlighted that such experiences can feel especially painful within a space that has been explicitly defined as safe and where sharing of experience has been welcomed. These events prompted reflections by some co-researchers surrounding their own emotional and 'place-in-the team' safety. However, the core team encouraged honest experiential reflections, were receptive to criticism and demonstrated a willingness to learn. The positive connection and unity between most of the core team and the co-researchers enabled successful navigation through these challenging experiences that was validating and provided opportunities for individual and team development.

> **Empowering: …** *good engagement should be collaborative and must empower victim-survivors to have control of decisions about their own involvement. This includes the decision about their capacity to participate in events, research or projects (within boundaries of being able to keep themselves safe and support the maintenance of safety for other participants). Research, events or training may be victim-survivor-led or co-produced … Victim-survivors should have a significant influence from the outset on the process of a victim-survivor-engagement project e.g. setting agendas, scoping courses of action, terms of reference, devising research questions, event schedules, evaluations.*

Co-researchers report that their PROSPER experience was an empowering one within which the retention of agency and control over their level of involvement was supported and encouraged. Co-researchers valued maintaining the power to decline, reflecting upon the significance of maintaining control and choice for those who have experienced SV.

> *Being part of this project has been incredibly empowering. The core team were skilled at asking, listening, hearing, and taking my views on board. I felt both individually and collectively, the Prosper Team were value-driven – and empowerment being a core value.*

Opportunities for learning, access to training and hearing the experiences of others with lived experience were all reported to be empowering. Feeling valued, heard and made to feel 'more than' were also a source of empowerment by altering those scripts from the past which included being silenced and being dismissed.

There was some disappointment for the co-researchers that they were not engaged earlier in the project. That said, once appointed, engagement was inclusive and meaningful and co-researchers valued playing an active part in refining study documentation, being present in participant interviews and having a proactive role in dissemination events. However, earlier appointment would have enabled a much greater opportunity to shape the project from the start. By the time the co-researchers were on board, the project, its design, methods and outcomes were pre-determined.

> **Amplifying the voices of survivors:** *Engagement should help release and amplify victim-survivors' voices, experiences and expertise. Good engagement will make it ok for victim-survivor issues and viewpoints to be on the agenda. It creates intentional space for dialogue with victim-survivors, gives and shares organisational platforms with victim-survivors and evaluates projects, events and research findings with victim-survivors' voices as a key input, allowing them to be the 'experts by experience'.*

There is little value in the voice of lived experience being heard if it not also heeded. To heed is to amplify and to amplify validates and values those voices. PROSPER co-researchers felt the role did amplify their voice, that there was a genuine desire from most of the team to embrace the expertise of lived experience as a means of both enriching the research and eliciting authentic data. A continuous dialogue was opened within which co-researcher voices were met with appreciation and compassion. It was a shared hope within the team that heeding the voices of the co-researchers held multiple benefits – for the research, for future research, for researchers and co-researchers, for study participants, service commissioners and providers and victim-survivors watching from afar.

> *We are also survivors informing, shaping, honing and analysing information provided by, and about survivors. We know best how that might feel and how to approach the research. We have helped to amplify the voices of those that have sought sexual violence services and we have had our voices heard too.*

> **Promoting self-care**: *Many who have been abused experience times of fragile mental and physical health and may find it hard to practice self-care. Engagement in research-activism can impact coping mechanisms – thus radical self-care should be normalised by example as well as in organisational processes. This includes recognising that many victim-survivors are both 'ok' and 'not ok' at the same time (often masking distress). Organisations should support and not pathologise workers and participants who are survivors, enabling them to be real about struggles and 'not-ok' days and ensuring sufficient 'back-up'.*

Co-researchers reflected that during interviews for the role, the decision to take part was articulated in terms of self-care. The framework for engagement outlined and promoted self-care as a priority: *'self-care was encouraged (and even felt celebrated)'*.

Co-researchers experienced a genuine interest in their well-being from other team members. Self-care, by definition, remained the preserve of the individual, but the collective encouragement of prioritising self-care was welcomed by all co-researchers. The sense of shared and 'collective care' was palpable. Some co-researchers experienced this 'collective care' as a welcomed contrast to *'coping with the impacts of trauma alone and behind closed doors'*. In a society that lauds overworking, deadlines and meeting the expectations of others, an environment that fostered, celebrated and made room for self-care felt empowering and liberating. Self-care was seen as an investment both in the individuals involved in PROSPER and in the project itself, holding the power to revive and restore while simultaneously enabling sustained, active, productive and healthy participation.

> **Accountable and transparent:** … *Engagement with victim-survivors must have clear lines of communication and accountability, including to victim-survivor-participants and victim-survivor communities. Processes and decision-making should be relational, honest, real, transparent and open to feedback and dialogue.*

Decision-making within the co-researcher role felt authentic, honest, relational and transparent – positive and negative feedback was welcome and open dialogue maintained. However, engagement of co-researchers when project design, delivery and outcomes had already been decided created a certain opaqueness to what had gone before. There were also periods throughout the project when communication and updates lessened leaving some co-researchers feeling disconnected and a little lost in terms of what they were meant to be doing. Conversely, times of intense activity and updates felt overwhelming for some when set against their other commitments.

One co-researcher expressed that sometimes a tension appeared to exist between the full inclusion of co-researchers and a fear from the core team that they might be 'asking for too much'. This demonstrates a difficult balance between full inclusivity of co-researchers, while acknowledging that they are not fully employed and cannot devote as much time to the project. This appears to be a perennial issue. Openness of dialogue within the team enabled freedom to raise these potentially problematic matters and offer opportunities for redress. This begs the question, however, whether these matters are inevitable within co-research and can only be resolved, day to day in a dynamic way by highlighting the tensions each time they surface or whether in fact that can be avoided and minimised by implementing fundamental changes to research infrastructures and funding.

> **Liberating:** *Engagement must be a totally voluntary process and easy to withdraw from at any point (without fear of permanent exclusion). Good engagement is liberating, dynamic, life-giving and helps victim-survivors experience a sense of possibility and life beyond the aftermath of abuse.*

Aside from individual feelings of not wishing to 'let anyone down', PROSPER co-researchers felt it was easy to withdraw at any point or to 'temporarily take a step back'. This was reiterated and explored often by the core team in the early stages of the project. Maintenance of this level of agency and choice, without fear of judgement or consequence, was welcomed and liberating for some of the co-researchers. The research team frequently demonstrated an understanding of co-researcher lives, and commitments, both within and beyond PROSPER.

Co-researchers were engaged in PROSPER by virtue of their lived experience. That, after all, was *'the whole point'*. However, what was oft spoken of as the most liberating aspect of being a PROSPER co-researcher, was that a reductionist perspective was liberatingly replaced with a holistic one. Co-researchers, contrary to the appointment brief, were not defined by their experience, but rather were consistently seen in what we refer to as '3D'.

> *It was an exercise in freedom to be part of the research … I felt liberation was lacking when I initially constrained my interaction within the team to 'just my experience' but after voicing that concern, we all acknowledged that we are so much more. It felt liberating to hear that from others.*

On the point of liberation though, it is important to pause to consider what this means in the context of inclusion and diversity. A reflective point is that four out of the five co-researchers are white (they are also all women, although we made deliberate attempts to recruit men to the role). From the words of the one, black co-researcher (who also identifies as being neurodiverse), there are clear lessons about the need to address matters of intersectionality in a co-research project such as PROSPER:

> *I'm neurodivergent. I'm not sure if it's because the more I'm learning about me, and the way I receive, read, process, retain, and present information, that how different that is to everyone else. But it became quite apparent to me on this project, and I let it hinder me, massively. I actively didn't participate in a lot of the academic writing because of inferior complex … I recognise that the amount of support I wanted and potentially needed would have been a lot, so I didn't participate, which I'm really now frustrated about that I let an opportunity to get involved that way, pass me by because of it. I wish I would have been more confident in saying how I would of wanted to be developed!*
>
> *When you are not a part of that 'typical white, heteronormative space', you become conscious about how and what you are going to do, to have a seat at the table. I'm black. You can see I'm black … I've found myself on this project, having to carefully navigate my experiences as a black woman, between making sure I've hopefully given a space for black women to talk about their experiences of SV, but also knowing, (and not wanting to be) the spokesperson of every black woman.*
>
> *Co-research, co-production, co-creation it's vital. Within this, the need for an intersectional approach is absolutely vital! There needs to be the time, the care, the resources and the finances to be able to execute this in a way that is positive, meaningful, enriching and impacting. Reflecting back, there should have probably been a lot more thought and opportunities to provide a space on how we embody intersectionality approaches, what that looks like, and what that means. Having honest and open conversations about the limitations about this also.*
>
> **Creative and joyful:** *Engagement should be a creative process. Good engagement focuses on positive experiences and strengths as well as negative ones and can increase capacity for joy, creativity and imagination. Where appropriate, projects should include elements of fun and celebration of achievements and landmarks in the lives of individuals and in victim-survivor groups and wider social justice movements for survivors.*

Creativity was honoured throughout the experience, and co-researchers were actively encouraged to bring alternative approaches to supplement and challenge 'more traditional' elements of the study. This was seen within regular meetings and the team away days where creative expressions of experience were welcomed. Co-researchers identified creativity to be of great importance to them – being representative of 'wholeness' and contributing towards holistic healing. It was expressed many times that joy was being found in the connection and unity between the core academic team and co-researchers, in the opportunities for new learning and new skills and joy in feeling part of a project whose intention was to make a difference to the lives of victim-survivors.

An early invitation from the core team to imaginatively evaluate the co-research experience (as referenced earlier) quickly gathered momentum and favour. The additional creative evaluation work was fully embraced by the co-researchers who identified its potential value to others often articulating a desire for the work's outputs to become far-reaching, creative and offer novel insights into routes to healing. Outputs and accompanying narratives that funders, service providers and service users alike will hopefully be brave enough to draw inspiration from.

> *Yes, yes, yes! Being part of PROSPER has brought me great joy and opened up additional creative opportunities. I feel truly grateful for being part of an important piece of research.*

## Whose benefit?

Much of what has been written in this chapter reflects on the experiences of and benefits to the co-researchers, but 'good co-research' must not just be good for the co-researchers. Despite the plethora of commentaries around co-production, it is difficult at times within a project to uncover the immediate and future benefits. The subtleties of benefit may be difficult to identify – and perhaps only gradually revealed over time as the ripples of co-production spread outward, albeit obvious cause and effect may remain elusive.

Oliver *et al.*[84] comment on the importance of far-reaching translational research evidence: *beyond the standard academic journal article into some format which can be easily absorbed by policy-makers, practitioners or other 'users', if it is to have influence outside the academy.*

They also offer four key justifications for undertaking co-production:[84]

**Substantive:** to improve the research quality and enable a fuller, more holistic understanding of the issue being researched and in doing so making the research more relevant with the potential to discover *'unknown unknowns'*.

**Instrumental**: which sees co-production as a means to ensure that the results of research are used in effective ways – collaboration helps to identify these innovative methods of output and translation. Integral to this is the upskilling of non-academics, creation of a trust and greater evidence sharing**.**

**Normative**: draws upon the intrinsic value of co-production, whereby democratic engagement is transformative in both research and social terms.

**Political**: wherein co-production offers a greater sense of ownership, empowerment and inclusion to users/those with lived experience which translates into a greater likelihood of research findings being acted upon and received as more credible.

Co-research 'well done' may not only assist co-researchers in their ambitions to be agents of change but may also translate into a far more nuanced lived-experience voice within commissioning spheres and service provision than there is at present. Reflections by some members of the PROSPER core research team offer their perspectives on the benefits of co-research:

> *I am proud to have been part of a project that was able to learn so much from five co-researchers each with their own expertise and strengths. On more than one occasion in a victim-survivor interview with a co-researcher, the interview participant specifically referenced the experience of the co-researcher and seemed to feel supported in knowing that there were others who could understand and validate their experiences to a greater extent.*
>
> *The co-researcher contribution to PROSPER has been vast. It has resulted in a more sensitive and attuned approach to the subject matter and interviewing of victim-survivors specifically. I asked all victim-survivor participants if they would be happy to be interviewed by a co-researcher. All said yes, indicating that having someone with lived experience involved in the process was wanted and considered important. PROSPER as a whole was more informed, critical and insightful care of co-production.*
>
> *As a long-standing researcher of gender-based violence, I have also had some of the most powerful conversations of my career with the co-researchers, focused on topics of trauma, recovery and its messy, non-linear trajectory. We have also had fun as a group, despite the gravity of what we were researching, and that has been essential for everyone's well-being and morale.*
>
> *The PROSPER co-researchers have enriched the project through their insights, critical questions and sharing of their personal and professional experiences … the group both individually and collectively have had a significant impact on the course of the study and the ways its findings have been (and will be) communicated. Victim- survivor participants welcomed the presence of co-researchers in all the interviews that I carried out. Moreover, I think that the presence of*

> *co-researchers is likely to have increased participants' tacit confidence that they would be treated with sensitivity and respect and, more broadly, feel that they were taking part survivor-centred research.*

Core research team members commented upon the potential for research teams and research leadership, which is created by co-research. This is the potential for a deepening of understanding of, and respect for, the realities – and messiness – of lived experience – an understanding that will hopefully infuse their future research endeavours and their interactions with victim-survivors.

## Use of Survivors Voices Charter and Engagement Ladder

A growing number of co-production evaluation tools and frameworks are available. What became clear for the co-researchers when reflecting upon the PROSPER co-research experience was the importance of employing a framework that held meaning and resonance for them. The Survivors Voices Charter[78] was regarded as a bespoke framework which completed the circle of lived-experience involvement, a resource created by victim-survivors which offered great authenticity to the evaluation process.

The co-researchers acknowledge inherent limitations in using the Survivor Research Involvement Ladder[80] as an evaluation tool. Its meritocratic ranking of different forms of engagement such that victim-survivor-led and victim-survivor co-produced projects are portrayed as the 'gold-standards' for engagement, offers little credence to the benefits of 'less inclusive' yet potentially insightful methods of utilising lived experience. However, the simplicity of the ladder as a method of assessing where the PROSPER co-research sits within the matrix – as ranked by co-researchers and core researchers – provides insight into the PROSPER co-research endeavours, which, when considered alongside the Charter, may offer clarity on where and how to improve future co-production endeavours.

## Summary and key recommendations

The PROSPER co-researchers collectively express that their engagement in the project has largely reflected the Survivors Voices Charter[78] principles, and that the University of Birmingham academic team has honoured the Charter's 'Good Practice' guidance. The co-researchers conclude their level of engagement, according to the indicators within the Engagement Ladder, falls somewhere between 'victim-survivors co-produce the research' and 'victim-survivors act as advisors to the research project'. PROSPER co-researchers feel that much has indeed been 'done right'. However, improvement is always possible and honest reflections provide points of learning to be taken forward into future projects:

- Avoid the presumption that co-researchers may be less interested in the early parts of research – such as funding applications and ethical approvals.

> *Co-production of a research project should begin from the collective production of research aims and questions. This allows non-academic co-producers to address issues they consider to be of direct importance for their lives; and to frame them in ways appropriate to their knowledge and lived experiences.*[85]

- Do not underestimate the power of in-person connection for those who have experienced interpersonal violence. Interpersonal violence is inherently isolating. Avoid succumbing to a reliance on remote working as a means of convenient, economical engagement of co-producers. This potentially creates isolation and disconnect and hampers the development of safe and trusting relationships.
- The Survivors Voices Charter offers guidance to organisations to *'seek workers who understand nuances about abuse and safety, e.g. victim-survivor-researchers/speakers or people who have accompanied victim-survivors as "enlightened witnesses" and are victim-survivor-sensitive'*. It is inevitable that some researchers, despite their protestations to the contrary, will fall short of this. It is incumbent upon all team members to act quickly when concerns are mooted regarding an individual's level of awareness, trauma-sensitive practice and their commitment to the project. Clear lines of responsibility in managing individuals who fail to meet their responsibilities to the co-researchers and to the

project are required, including written and agreed processes and procedures for escalation of concerns. There must be provision of safe opportunities for such concerns to be raised and the identification and articulation of training needs for the individual/s concerned.

- Have robust protocols, clear lines of communication and defined areas of responsibility in place to manage and minimise destabilising incidents. Wherever possible and safe, ensure that reparative discussions are open and collective and ideally avoid the provision only of 'behind the scenes one to one support'. While potentially of benefit to the individuals concerned, the exclusion of team members from discussions may be fragmenting of collective responsibilities and replicate harmful 'secret keeping' dynamics. Keep in mind the:

> *intertwined nature of the transformative power and pain of breaking the silence of abuse … acknowledge that individual and organisational fears about the risks of 'opening Pandora's Box' can silence victim-survivors and prevent meaningful dialogue, engagement and partnership with victim-survivors. Enabling dialogue about abuse may cause distress, however, distress does not automatically lead to damage. Instead of avoiding the subject of abuse, we will learn to ask well, work collaboratively, and give choice in a safe and supportive atmosphere.*[78]

- Explore and mitigate the fine balance that exists between honouring other commitments held by co-researchers and the avoidance of well-intentioned but potentially paternalistic and patronising expressions of *'we don't want to overload you'*. It is indeed a difficult balance to reach, yet the recognition of commitment offered and the expectation of co-researchers to meet this commitment is respectful and empowering and goes some way to avoiding the presumption of vulnerability.
- When constrained by tight co-research budgets, acknowledge that employing more co-researchers than originally budgeted for may be counterproductive and lead to monies having to be spread rather thin. Allocation of research funding to PPIE and piecemeal co-production payments may ultimately be a limitation to ambitions for comprehensive co-production. A shift is recommended – wherein *'Expertise by experience must be incorporated into professional practice, not silenced by it'*.[74] Challenge the status quo of research funding and a research landscape that promotes hearing and lived-experience voices 'by invitation only'. Acknowledge that those with lived experience are found within all professional spheres. This requires the creation of safer environments which openly embrace these individuals and their experience without fear of censure, discrimination or othering. Actively work against the prevailing force that perpetuates silence.
- Remain open to novel and unexpected benefits and respond to these in creative ways so that insights are harnessed for future use – in particular, recognise how the discovered benefits to co-researchers within a project can be translated to those with lived experience outside the project. A potential mirroring of benefit is available to those watching carefully, whereby experiences within can be applied without.

> *It is as important to value the impacts of working co-productively that come from the research process as it is of the research findings or outputs. For the research process, some of these impacts will emerge rather than be planned: new relationships, expanded social networks and increased confidence of members of the public may be some examples. In terms of the research findings or outputs, working co-productively will produce knowledge and an end result that will often be different from that produced by a conventional academic process.*[77]

- Many research projects regarding victim-survivors of sexual and interpersonal violence have the ultimate goal of improving routes to recovery and enabling victim-survivors to live lives full of potential and joy. It is important within this endeavour to embrace the transformative and healing power of creativity – to recognise it as a credible area for financial investment and challenge attitudes that dismiss creative research approaches and outputs as 'flights of fancy' requiring greater justifications that 'tax-payers money is being well spent':
- *'It is the presence of the creative process that transforms life. If we imagine healing as an energy of creative transformation, then our goal becomes the cultivation of the salubrious force that finds its way to people in different ways'*[86] (p. 18). For those requiring greater scientific evidence of the power of creativity, the body of knowledge around this is rapidly growing within the neuroscience and trauma spheres and can be found if one is willing to look. Bolwerk *et al.*[87] report that using real-time magnetic resonance imaging of brain concluded *'Our findings are the first to demonstrate the neural effects of visual art production on psychological resilience in adulthood'*.

- When planning and delivering a co-researched project involving those who have lived experience of sexual and/or other interpersonal violence, consider the Survivors Voices Charter[78] – its seven principles and guidance for safe, empowering, liberating and joyous engagement.
- As regards intersectionality, there needs to be the time, the care, the resources and the finances to be able to execute this in a way that is positive, meaningful, enriching and impacting. Critical reflection is crucial on how to embody intersectional approaches into co-research and the limitations associated with such attempts.

It has been a revelation and a privilege for the PROSPER co-researchers to have been part of a project, and a team, committed so wholeheartedly to delivering a co-research experience that honoured the insightful principles articulated within the Survivors Voices Charter. However, the co-researchers are realistic and cognisant of human fallibility as an inevitability, the avoidance of risk as impossible and the unlikely creation of a 'perfect' co-production experience. What is most important is hope and intent.[85]

# Chapter 7 Work package 5: data integration

## Context of work package 5

*Chapters 3–5* presented the quantitative data from the survey and the qualitative data arising from the interviews and focus groups in WP1 and the deep-dive qualitative analysis of the case study analysis in WP3. The purpose of this chapter is to draw together the different strands into a cohesive whole in order to arrive at a comprehensive synthesis of findings. It is noteworthy here that the focus of this chapter is on the empirical findings, not the extensive largely autoethnographic work with co-researchers. This integral part of PROSPER is revisited in the next chapter.

## Revisiting the key findings from the PROSPER study

A useful starting point to inform this integrative stage of the analysis and synthesis process is to revisit the findings presented so far in the report. *Table 9* displays the findings from WPs 1–3 as presented at the end of each relevant chapter. These form the basis of the rest of this report.

## Insights from each work package juxtaposed with the study objectives

An important part of the integration process is to consider how each of the WPs has responded to the PROSPER study objectives. We undertook a mapping exercise to create a matrix showing the relationship between the different WPs and the study objectives (*Table 10*). The red domains show a weaker contribution to addressing the objective on the same row and the green show the strongest. There are shades of orange and yellow that indicate a partial contribution. For example, for objective 1, which was concerned with capturing the experiences of victim-survivors, unsurprisingly, the victim-survivor interviews that took place in WP4 provided rich insights. Conversely, again, for example, the

**TABLE 9** Key findings from each WP of the PROSPER study

| WP1 key findings | WP2 key findings | WP3 key findings |
|---|---|---|
| • The specialist nature of VSS services is highly valued by victim-survivors. In the voluntary sector, specialism relates to the knowledge and expertise of staff and the historic role many organisations have played in shaping responses and understandings of SV. | • Huge variety of service scope, organisation, funding, delivery.<br>• Complex patchwork of services often working closely with each other to support victim-survivors. | • There needs to be a greater recognition of the unique value of independent, VSS services in providing flexible and responsive support, using a victim-focused, trauma-informed approach and representing voices of victim-survivors. |
| • VSS services offer a dedicated, protected environment for victim-survivors where the shame and stigma of SV is understood and challenged.<br>• Challenges arise from working with 'complex' clients in a pressurised environment (e.g. high caseloads, rising demand, higher client need). | • Service configurations may reflect a legacy of historical funding and commissioning arrangements but evidence of effective, needs-led practice.<br>• Many VSS service providers offer support that no other services do, and often to under-represented groups, for example, sex workers. | • For victim-survivors, there needs to be more effective promotion of VSS services for the benefit of enabling them to become aware of the services and make informed choices about engaging with them.<br>• There should be a genuine commitment to work with victim-survivors to co-produce services to avoid retraumatisation. |

continued

**TABLE 9** Key findings from each WP of the PROSPER study (*continued*)

| WP1 key findings | WP2 key findings | WP3 key findings |
|---|---|---|
| • Demands also centred on the challenges of competing for funding and contracts and the insecurities generated by short-term and innovation-focused funding.<br>• Practitioners were reported to be leaving VSS services, with an attendant loss of specialism and expertise from the sector. | • Most services work with a variety of commissioners, with varying satisfaction with these arrangements.<br>• Complex funding landscape: most services rely on multiple funders, but a dynamic and evolving picture. | • Referral pathways between services must be clear and effective. |
| • (Most) statutory services were seen to work in a different way with victim-survivors compared to those in the voluntary sector. Victim-survivors were seen to benefit from (and prefer) the independent and needs-led approach of the voluntary sector. | • Providers competing for same funding, an inconsistent/unstable funding, clarity needed around funding context. | • Partnerships appear to work well in terms of connecting the VSS services and statutory (e.g. NHS) services with each other, and with commissioners. Partnerships should offer a space to share knowledge and resources, dedicate time to think through 'complex' individual cases and to work collaboratively on strategic and financial issues. |
| • Good relationships existed between many statutory and voluntary sector services and there were examples of innovation and close partnership working. | • Substantial unmet need which restricts responsiveness to client need, waiting lists growing over time. | • Partnerships should offer a layer of support, accountability and structure to existing 'good' working relationships and should raise the profile of SV across the area. However, relationships between services can break down when there is competition over funding provision. |
| • Over the past 10 years, statutory and voluntary sector services have faced increased demand for their services at time of widespread reductions and changes in funding streams. This has led to pressures on both sectors, and it was widely recognised that VSS organisations are now working with more 'complex' clients who in the past would have received statutory support. This transition has occurred without a commensurate realignment of funding. | • Service users with complex trauma, restricted duration of support, worries about not meeting victim-survivors' needs, in some areas a need to expand support for under-represented groups.<br>• Difficulties due to funding competition, problems with referral processes, good links support certain under-represented groups, enhanced working with NHS and statutory services. | • Resources for supporting victim-survivors with 'complex' needs must be better understood and provided, to support partnership working.<br>• Long-term sustainable funding for the sector would reduce waiting lists and increase the speed of service access. It would also allow for longer-term support where needed. |
| • While longer-term investment is welcomed, VSS services expressed concern that the move towards joint-funded, large contracts is likely to favour larger, often generic providers. This threatens the survival of smaller, bespoke VSS services who provide valued support to victim-survivors. | • Need for greater capacity and efficiency.<br>• High turnover, stressful, difficulties funding specialist team staff members. | • Commissioning in ways that understands and favours specialist services is needed, for example by scoring weighting to recognise the importance to specialism and local knowledge, would support services to grow their provision in line with demand, and would ensure victim-survivors were accessing the most specialist support. |
| • Developing partnership or consortia arrangements between VSS services can help services to share their resources and expertise. In turn, this can help them to compete alongside larger providers for bigger (often longer-term) contracts. This was the case for some of the practitioners we interviewed. | • Need for more holistic support, increasing provision of wraparound projects that add value to core services. | |

**TABLE 9** Key findings from each WP of the PROSPER study (*continued*)

| WP1 key findings | WP2 key findings | WP3 key findings |
|---|---|---|
| • In some areas, short-term and/or innovation-focused funding resulted in 'good', established VSS services struggling to survive. The associated precariousness negatively affects staff morale and retention and can undermine sector leader's ability to work in a strategic and creative way. Uncertainties about how VSS services are delivered can also undermine victim-survivors' trust and the quality of support they receive. | | |

commissioner survey of WP1 and the commissioner interviews of WP3 contributed very little to the overall findings in relation to objective 3, which is concerned with service delivery. It was the victim-survivor and practitioner interviews of WP3 that helped most in responding to this particular objective. In terms of integration, the matrix is a useful tool to demonstrate patterns and degrees of how methods relate to objectives. Moreover, in relation to the PROSPER study, the green segments in every row demonstrate overall success in achieving each of the study objectives through the combined findings across the WPs.

## Data integration and the PROSPER theoretical framework

Billis and Glennerster's[50] theory holds that the unique feature of voluntary sector services are:

- flatter organisational structures with less distance and distinction between senior or decision-making staff and those on the front line
- closeness to communities
- being mission-led and driven by core values and purpose.

As explained in *Chapter 2*, we revisited this theoretical framework frequently throughout the progress of the PROSPER study to ensure that our findings were grounded in the study's theoretical underpinnings. We had intended from the outset that the three domains of the framework would form the basis for organising the findings at integration stage. Once we began the process of mapping the findings from WPs 1–3 to the framework, however, we discerned some limitations that necessitated an adaptation to meet the specific needs of the PROSPER study.

## Adapting Billis and Glennerster's theory to meet the needs of the PROSPER study

According to Bradbury-Jones *et al.*,[73] there is a legitimacy in adapting a theoretical framework to meet the needs of a study because it avoids the unhelpful practice of 'squeezing' data into a framework where there is a poor fit. They caution though, that this needs to be undertaken carefully and transparently. We had selected Billis and Glennerster's[50] theory because it is concerned with the voluntary sector. To that end, its three broad domains were relevant and appropriate in shaping our findings. However, it was not developed specifically in the field of SV, nor was its focus on *funding and commissioning* of voluntary services. While the focus on SV was unproblematic, we encountered challenges in contextualising the PROSPER findings regarding funding and commissioning. As discussed in the relevant chapters, conceptually, our findings went beyond values, communities and organisations, to a broader commissioning context. This is understandable given the aim of the PROSPER study. However, rather than abandon our theory on the basis of its limitations, we chose to adapt it and add a broader, macro level that encompasses the commissioning level. We also pared back the language used by Billis and Glennerster to shorter statements, while retaining the essence of the theory. Data integration was thus achieved with reference to four theoretical domains:

**TABLE 10** A matrix showing the relationship between WPs and study objectives

| Less relevant 🟥 🟧 🟨 ▨ 🟩 Most relevant | Stage 1 | | | | Stage 2 | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | WP1 | WP2 | | | WP3 | | | WP4 | WP5 |
| | Practitioner/ commissioner interviews | Commissioner survey | VSS survey | SARC survey | Survivor interviews | Practitioner interviews | Commissioner interviews | Co-research with survivors | Data integration |
| Explore survivors' experiences of accessing and using VSS services, identifying what needs are being met for which groups of survivors, and what encourages survivors to take up services | 🟨 | 🟨 | ▨ | 🟨 | 🟩 | ▨ | 🟧 | ▨ | ▨ |
| Analyse the range, scope and funding of VSS services and how demand is managed | 🟨 | ▨ | ▨ | 🟥 | ▨ | 🟩 | 🟨 | ▨ | ▨ |
| Explore the usefulness of different approaches to service delivery (including peer support and delivery by volunteers) and different therapy models | 🟨 | 🟥 | 🟨 | 🟧 | 🟩 | 🟩 | 🟥 | ▨ | ▨ |
| Explore how different principles underlying service provision influence service delivery, including feminist and trauma-informed principles of care | 🟨 | 🟥 | 🟨 | 🟧 | ▨ | 🟩 | 🟥 | ▨ | ▨ |
| Investigate referral patterns and pathways, and how VSS services fit with each other and link to the wider network of services for survivors | 🟨 | 🟨 | 🟩 | ▨ | 🟨 | 🟩 | 🟧 | ▨ | ▨ |
| Explore how arrangements for commissioning and funding services for survivors across health, local authorities and criminal justice have evolved over the last 3–5 years, and how they have impacted on VSS service provision | 🟨 | 🟩 | 🟩 | ▨ | 🟧 | 🟩 | 🟩 | 🟨 | ▨ |
| Develop a taxonomy of the VSS services/service models being commissioned and provided | 🟨 | 🟩 | 🟩 | ▨ | 🟧 | 🟩 | 🟩 | 🟨 | 🟩 |
| Make recommendations for the commissioning and provision of VSS services at practice and policy levels, in order to strengthen overall service provision for survivors of SV | 🟨 | ▨ | ▨ | 🟧 | 🟩 | ▨ | ▨ | 🟩 | 🟩 |

1. macro commissioning context
2. organisational structures
3. relationships and people
4. values and principles.

## The data integration process

Data integration is the process of bringing data together from different stands of a study to draw out new insights beyond those gained from separate quantitative and qualitative results.[88,89] In the context of the PROSPER study, integration of data was led by the lead author and verified through a number of iterations with the rest of the team until consensus was achieved. The first part of the process involved a deductive approach.[90] By this, we mean that we used the broad statements that were held within the data as the starting point and made sense of them with reference to the specific details of our theoretical framework. In practice, this involved taking the findings from each WP and mapping them onto the (adapted) theoretical framework, seeking the closet fit to either one of the four domains. Once this stage was complete, verification and agreement with the rest of team took place. This was a relatively simple communication using e-mail and no revisions were made as a result.

## Integrated PROSPER findings

*Table 11* shows the integrated findings from the three empirical WPs presented in accordance with the amended theoretical framework. While these are presented as four discrete areas, we emphasise their interconnection and the influences of one domain upon others. In the following, concluding chapter, we highlight this interconnectivity by presenting a diagrammatic representation of the overall PROSPER findings.

**TABLE 11** Integrated PROSPER findings

| Macro commissioning context |
|---|
| • Complex (and precarious) funding landscape<br>• Service configurations may reflect a legacy of historical funding and commissioning arrangements<br>• National government and centralised funding policies not reflecting local needs and the reality of demand<br>• Challenges of competing for funding and contracts<br>• Joint-funded, large contracts favour larger, often generic, providers which potentially squeezes smaller services out of the ecosystem of support<br>• Formal collaborations through consortia or joint-partnership arrangements are complex but well-received by commissioners (and practitioners, if done well)<br>• Short-term funding that rewards innovation<br>• The commissioning agenda might act to move services away from being truly victim-survivor-led |
| **Organisational structures** |
| • Increasing range of services providing support to victim-survivors through the commissioning process<br>• Voluntary sector specialist services ‘upskilling’ staff to provide support to victim-survivors<br>• Voluntary sector specialist services working closely with each other to support victim-survivors<br>• Complex patchwork of services often working closely with each other to support victim-survivors<br>• Pressurised environment (e.g. high caseloads, rising demand, higher client need)<br>• Working with complexity in clients’ lives<br>• Practitioners leaving VSS services, with an attendant loss of specialism and expertise from the sector<br>• Unmet needs and under-represented groups vs. good links to support under-represented groups |

continued

**TABLE 11** Integrated PROSPER findings (*continued*)

| Relationships and people |
|---|
| • Good relationships do exist between many statutory and voluntary sector services with examples of innovation and close partnership working<br>• Most services work with a variety of commissioners, with varying satisfaction with these arrangements<br>• Services can be hard for victim-survivors to navigate and access<br>• Uncertainties about how short-term VSS provision is delivered can undermine victim-survivors' trust and perceptions of the quality of support they receive |
| Values and principles |
| • Voluntary sector specialist services are highly valued by victim-survivors<br>• Voluntary sector specialist services offer a dedicated, protected environment for victim-survivors where the shame and stigma of SV are understood and challenged<br>• Needs-led services are important, that focus on survivor empowerment<br>• Feminist and trauma-informed approaches are valued within the VSS sector<br>• Gender awareness is also important, within a broad framework that takes account of intersectionality<br>• Detailed understanding of sexual abuse constitutes what it means to be a specialist SV service |

# **Chapter 8** Discussion, conclusion and recommendations

## Introduction

In this concluding chapter, we draw on the integrated findings from the combined WPs and discuss the primary implications and limitations of the PROSPER study. Drawing on ecological systems theory (Bronfenbrenner, 1979),[91] the delivery, funding and commissioning of VSS services are conceptualised as a series of interconnected 'systems'. We anticipate that the model set out in this chapter might be useful as a resource for training and education or as an aid to communications in any interactions that are concerned with the delivery, funding and commissioning of VSS services, or it might be developed further or tested in future research. The model offers an orientation point to discuss the key recommendations from the PROPSER study and this is the second focus of this chapter. Our principles and practice of close partnership working with VSS services, commissioners and policy-makers throughout the study and, indeed, in the development of the recommendations mean that the chances of implementing the findings are augmented. In turn, it is hoped the PROSPER study findings can have a positive impact on service delivery and the support of victim-survivors of SV – the PROSPER study raison d'être.

## Development of a new model

The data integration process discussed in the previous chapter led to the organisation of key findings around the following four areas: macro commissioning context; organisational structures; relationships and people; values and principles. Given that these four domains are broadly concerned with micro through to macro level, we saw the potential for them to be understood through a socioecological lens. Inspired by Urie Bronfenbrenner's ecological systems theory,[91] we therefore captured the integrated findings conceptually and diagrammatically into a new model (*Figure 19*). Bronfenbrenner's ecological model holds that an individual is influenced by the reciprocal relationship between them as a person and their environment (and the different 'systems' in that environment). Presented as a pattern of concentric rings, the individual exerts influence on and is influenced by the different systems. In the context of PROSPER, the model shows the influence of micro- and macro-level factors associated with SV and how a victim-survivor might operate and interact with the five systems, from proximal to distal. Most models evolve over time and the model presented may be modified once it has been subject to peer scrutiny and feedback, but in the iteration presented in this report, it comprises the six prominent themes developed to capture the recurring, overarching issues at the heart of our integrated findings, detailed below:

- The complex and precarious funding landscape.
- The challenge of competition for funding and contracts.
- The importance and success of partnership working with organisations.
- The pressured environments within which VSS services work.
- Different roles, scope and eligibility of voluntary and statutory services within an area.
- The ways services are organised and delivered, underpinned by services' values and philosophies.

*Table 12* sets out a brief description of each theme and how the themes link to findings within each of the three WPs in the PROSPER study. The table does not provide an exhaustive account of the links between themes and the empirical data; however, it is intended to help trace which of the study's key findings support the key, overarching themes. The table is followed by *Figure 20*. *Figure 20* adapts Bronfenbrenner's ecological model to map how the organisation and funding of VSS services shapes the experience of victim-survivors.

The intention of presenting this adapted model is to promote greater recognition of (1) the centrality of local geographic and political contexts shaping VSS delivery and organisation (2) the intricate, yet impermanent, ties that bind together the various layers of the VSS 'commissioning ecosystem'. While these findings in many ways reiterate previous literature

**TABLE 12** Table of key findings and linkages to the empirical data

| Key theme | Theme overview | Links to WP (key findings/themes) |
|---|---|---|
| **The complex and precarious funding landscape** | Funding for VSS services is not secure or sustainable. Services rely on a complex mixture of contracts, grants and, increasingly, independent fundraising. The nature of these funding streams is subject to constant changes | Stage 1a interviews: *Funding issues*<br>Surveys: *Consequences of funding/commissioning arrangements*<br>Case studies: *Arrangements for funding and commissioning* |
| **The challenge of competition for funding and contracts** | Public sector bodies' competitive tendering processes require that VSS services bid for contracts, which can put them in opposition to other local and/or specialist services. VSSs have developed considerable expertise in developing and engaging with commissioning processes, but the practice is often relationship-based and characterised by precarity. Knowledgeable and committed commissioners can play a key role in making these processes and practices work in a way that benefits local services and populations | Stage 1a interviews: *Consortia, collaboration and competition*<br>Surveys: *Service funding; Service commissioning*<br>Case studies: *Arrangements for funding and commissioning* |
| **The importance and success of partnership working with organisations** | Partnerships between VSS organisations (formal and otherwise) may be time intensive to establish, but can facilitate the pooling of expertise, institutional knowledge and resources. This can enable VSSs to 'compete' against larger providers and/or for large-scale (i.e. longer, higher award) contracts. At a local level, partnership working between organisations (referral pathways, collaborative working, sharing of knowledge) can play a key role improving what is often a difficult and long process for victim-survivors' seeking the right support at the right time | Stage 1a interviews: *Co-production and partnership in the commissioning process*<br>Surveys: *Partnership working*<br>Case studies: *Range, scope and funding of VSS services* |
| **The pressured environments within which VSS services work** | In the context of managing multiple strands of short-term funding and/or contracts (including monitoring and reporting requirements) and rising demand for services (e.g. waiting lists, increased 'complexity' of clients), senior staff are often navigating multiple strategic and operational demands with limited support. This context also affects practitioners, many of whom are employed on insecure contracts. It is important to note the gendered nature of precarity in a female-majority workforce | Stage 1a: *Consortia, collaboration and competition*<br>Surveys: *Working with commissioners*<br>Case studies: *Range, scope and funding of VSS services* |
| **Different roles, scope and eligibility of voluntary and statutory services within an area** | Victim-survivors often do not know how or where to access support, or what support is available (from statutory or voluntary services). Gaps in provision (e.g. restricted access for certain population groups) coupled with increasingly long waiting times for therapeutic support (due to limited staff/capacity) further increase victim-survivors' challenges accessing the right support at the right time | Stage 1a interviews: *Accessibility and duration of support*<br>Case studies: *Referral patterns and pathways; Experiences of accessing services* |
| **The ways services are organised and delivered, underpinned by services' values and philosophies** | Services' philosophies and approaches plays a critical role shaping the nature of support offered and, in turn, the experience of victim-survivors. These differences can be overlooked if people do not have specialist knowledge of the field and the history and experience of SV provision within the voluntary sector. Differences include, for example, the degree to which the political, social and economic dimensions of SV are recognised and engaged with, versus more clinically led models of therapeutic support. These differences enable 'choice' of provision for victim-survivors | Stage 1a interviews: *The uniqueness of specialist services*<br>Surveys: *Innovative practices to engage under-represented groups*<br>Case studies: *Different approaches to therapy models; Different principles underlying service delivery* |

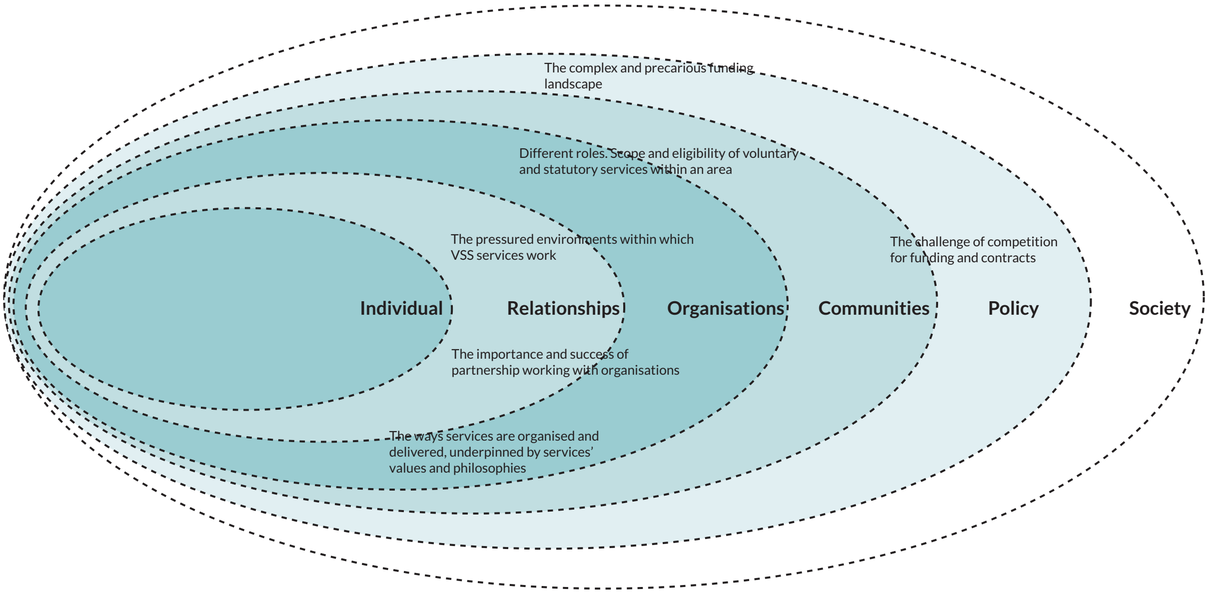


**FIGURE 20** The delivery, funding and commissioning of VSS services to support victim-survivors of SV.

(much of it developed by the VSS sector), the degree of interconnection and complexity is likely to be unknown to those not immersed in the processes, politics and partnerships that have been so carefully and often laboriously navigated over recent years; that is, those people who are not VSS senior practitioners or commissioners. We argue that it is important to make visible the sophisticated work that takes place to forge connections and alliances across these social, political and relational spaces, which in turn challenges conceptualisations of commissioning as a primarily evidence-based and/or 'rational' process. The model in turn helps to explain the precarious and at times desperately long journey that some victim-survivors are forced to navigate when seeking specialist support. It also indicates that while there is little doubt that increased investment could change if not transform some aspects of service delivery, other factors – such as the way that decisions are made, partnerships forged and 'on the ground' practice developed – also shape the sustainability and quality of services for victim-survivors.

## Contextualising the findings in a broader context

In many respects, the PROSPER study has confirmed what is already known about the complexity and precariousness within the VSS sector, with short-term funding from state and independent bodies generating considerable instability for VSS services. Concern over existing practice has changed the range and type of support available to victim-survivors of SV. As described by Robinson and Hudson, there has been the introduction and expansion of SARCs to provide a range of immediate, short- and longer-term support and assistance to victim-survivors of SV. Over the same period, however, there has not been a similar development and support of VSS services, prompting concern over the long-term sustainability in the sector.[36] As others have highlighted, such precariousness negatively affects staff morale and retention and can undermine sector leaders' ability to work in a strategic and creative way.[92] The problem is exacerbated by the introduction of SARCs,[93] which increase the number of referrals received by VSS organisations, not always with supporting financial remuneration (Survivors Trust, 2010).[94]

The PROSPER study findings have shown the considerable challenges of competition across the sector as regards competition for funding, balanced with insights into positive models of partnership working. Our findings regarding the problems of short-term funding have been acknowledged previously as an undermining factor for organisational stability, particularly in respect of staffing.[95] There is some evidence that size matters. Large organisations are likely to do relatively well as regards funding,[95] whereas smaller VSS organisations often have fewer resources to dedicate to the tendering process.[96] Robinson *et al.* (2008) report how one of their interviewees commented that 'agencies subsume their mutual hatred in a desire to secure funding'. While they acknowledge that the situation is not quite so bad as to instil hate between agencies, they do acknowledge that services are frequently 'scrabbling for small scraps of money'.[5]

Resonating with the PROSPER findings, we found considerable challenges and competition in terms of funding, but far from 'hatred', a significant respect between organisations in the sector, who ultimately share the same goal of supporting victim-survivors of SV.

In terms of partnership, as stated above, the PROSPER study has highlighted clear examples of best practice in services and agencies working together. The Women's Resource Centre (2023)[101] argue that working in partnership is the primary response to competitive tendering, including working in alliance with specialist services run by and for minoritised women and girls (services that are often ignored in discussions of SV, yet being best placed to elucidate how processes of racialisation add to the trauma of SV). It is important, they contend, that services remain complementary because working within the system can force the change that is needed.[96] The Women's Resource Centre argue that women's services generally know what their communities need, but through commissioning, they go through processes that dilute their services, while also competing against other organisations.[96] Arutyunova (2018) also talks about complementarity, suggesting that the way ahead is to move away from thinking about funding in terms of compartments and siloed thinking and instead focus on interdependence, correlation, complementarity and value added.[100] Moreover, this can be achieved through a feminist funding 'ecosystem'. This way of conceptualising funding shifts from a 'funding landscape' (where power is held/retained at the top, typically by funders and commissioners) to a 'funding ecosystem', whereby people and resources become more connected, coherent and complementary.[100]

In line with the study objectives, the PROSPER study provided rich insights into VSS organisations' responses to the commissioning landscape – or perhaps we might now call it the *commissioning ecosystem*.[97] This study evidences the pressured environment in which practitioners operate across the VSS sector, associated with complexity in the lives of those they support. Similarly, interviewees in the study by Hester and Lilley (2018) described the specialist ISVA role as one that is varied and complex.[38] More recently, Horvath and colleagues (2021) reported how ISVAs and ISVA managers who completed their survey were experiencing some psychological distress and moderate to high vicarious trauma.[103] The same study showed how ISVAs holding high caseloads experienced more psychological distress than ISVAs with lower caseloads.[98] In addition, the longer the ISVA spent working with clients who have experienced SV, the more likely they are to experience vicarious trauma.[98] Like those from the PROSPER study, these findings show the human cost of pressured VSS environments, discussed here in relation to VSS staff.

Victim-survivors are also impacted by pressured environments. Echoing wider findings, the PROSPER study heard consistent testimony from victim-survivors about the challenges finding the right support and, moreover, accessing this support at the right time for them. Furthermore, victim-survivors' trust in services can be threatened by uncertainties about the way services are/might be delivered and the time taken to be able to access them. As members of the PROSPER team have reported, trust is undermined by uncertainties about VSS services' future and sudden changes in how services are delivered (or ended). This can have a particularly detrimental impact on victim-survivors who have 'complex' needs.[92] There is evidence though that some of this can be mitigated through harnessing the advantage of being a VSS organisation, where independence and flexibility are perceived as a strength for gaining access to victim-survivors and maintaining their confidence.[36]

The PROSPER study has provided clear evidence of the value that victim-survivors place on VSS services. This is a finding that we had expected and it is one that has been highlighted by others.[99] It is a finding that needs to be reinforced however, given the challenges that the sector continues to face in providing sustainable, specialist provision to all victim-survivors. VSS services are seen to provide a space where victims can tell their story without fear of judgement.[36] They often provide the only 'safe space', where disclosure and support tend to be consistently positive and where victim-survivors are 'held' in that safe space.[38] It is of course important to recognise that disclosure is a choice. Coupled with empowerment and boundaries, choice is an important principle of a trauma-informed approach and all such principles require careful balancing. For example, a victim-survivor may make an informed choice to stay silent and this choice needs to be respected. However, if staying silent creates more risk/harm, then boundaries need to be put in place around what happens next. Next steps may not require an individual to speak up on their own, but next steps may need some action to be taken to prevent or disrupt the escalation of further harmful behaviours. According to the Women's Resource Centre, commissioning needs to change to recognise grassroots organisations that have risen from the communities they serve, in order to get what they need, rather than what commissioners say they need.[96] This links us back to the commissioning landscape and its impacts on the direct support to victim-survivors. It also leads to reflection on the approaches that underpin such support. Like earlier research that has shown the value of survivor-centred, trauma-informed approaches,[100] the PROSPER study has highlighted the importance of SV support being needs-led, feminist and trauma-informed, encompassing survivor empowerment and gender awareness.

The important role played by VSS organisations helping victim-survivors overcome the trauma of SV, and in getting SV recognised as a significant social problem, cannot be overstated.[93] Trauma-informed support involves identifying survivors' strengths, prioritising their autonomy and considering how identity and context influence their experiences and needs.[100] Becoming a trauma-informed organisation requires organisations to move away from traditional models of support and to re-evaluate their practices and policies so that they operate through a trauma-focused lens.[101]

Pemberton and Loeb (2020) argue that given that SV impacts women at disproportionate rates compared with men and that SV results from power inequities, the healing journey for survivors must take such issues into account.[92] Feminist therapy specifically acknowledges the mental health risks associated with living in a patriarchal and hegemonic environment.[103] There is no one feminist therapeutic way of practice and, therefore, practitioners are connected through shared values,[104] with feminist values premised on the idea of believing women and respecting their confidentiality and autonomy.[5] The PROSPER study has also shown the importance of survivor empowerment and gender awareness within VSS service delivery. Kulkarni (2019) talks of intersectional trauma-informed services,[93] which aligns well with our study findings. Intersectional approaches underscore the ways in which social categories, such as race, class, ability, gender and sexuality, interact to shape victim-survivor experiences and how individuals frequently contend with multiple oppressions.[105] It is this complexity in the lives of many victims-survivors of SV that mirrors the complexity of the commissioning landscape. *Figure 20* is intended to capture this complexity in a representation that shows simplistically the relationship between micro and macro and how crucial the impacts of commissioning are on individual victim-survivors.

## Co-producing the PROSPER recommendations

There is an increasing imperative in health research to focus on knowledge exchange through engaging with those who will be the users of the research.[94] The overarching goal of knowledge user engagement is to co-produce knowledge that is relevant and useful to those making real-world decisions.[94] With this in mind, we took deliberate action to engage with key knowledge users at the dissemination event held near the end of the study. It was an attempt to create what has been termed evidence informed policy-making.[95]

On 28 November 2022, during the final full month of the PROSPER study, the study team hosted a dissemination/engagement event to which local and national stakeholders were invited. The intention was to use the integrated findings as the springboard for discussion regarding how they inform the recommendations. This activity arose from the team's philosophy that maximum impact from research findings can only be achieved through meaningful engagement with those who are likely to be affected by or implement such findings. There were over 30 attendees, including representatives from the Home Office, NHSE, Rape Crisis England, OPCC, Survivor Alliance, The Survivors Trust and one victim-survivor participants who had taken part in the case study analysis.

The event was utilised to present a first draft of the integrated findings and to provide opportunity for feedback and revision to any aspects of the findings at that stage. We received no requests for revisions and therefore used the opportunity to work with the findings to formulate the key recommendations. Using four round-table discussions that were chaired by a member of the PROSPER team, the attendees were asked to consider the final PROSPER objective: make recommendations for the commissioning and provision of VSS services at practice and policy levels, in order to strengthen overall service provision for victim-survivors of SV.

Each table was allocated one of the four areas as per our theoretical framework: macro commissioning context; organisational structures; relationships and people; values and principles. A structured discussion took place and scribed by the chairperson in relation to the following questions:

- What recommendations do we need to make for the commissioning and provision of VSS services at practice and policy levels?
- Based on PROSPER findings, how can we strengthen VSS service provision for victim-survivors of SV?

The event was instrumental in developing the recommendations presented in this report. In addition, post event, we have had the opportunity to elicit further feedback from colleagues from VSS organisations and we are confident that this co-production process has resulted in recommendations that are both usable and relevant.

## Recommendations

*Table 13* considers each of the six key themes identified in *Figure 20* and the concomitant recommendations that we have developed. We aim to highlight the linkages between the data, our analysis and our co-produced recommendations. We acknowledge that in certain areas of England (some of) these recommendations are being implemented or are in operation. However, we know that such adoption tends to be the exception rather than a standard approach.

The recommendations do not appear in a priority order. Instead, we draw attention to their interconnection and hope, long term, that if not all, a minimum of one to two recommendations per key theme be adopted. As already described, the recommendations are firmly grounded in the empirical and co-produced elements of PROSPER and we regard them as important, if not crucial guidance. As our data imply, failures to invest in the ways recommended here runs the very real risk of losing the specialism, difference and life-saving work that VSS services contribute. Failure to invest will also sustain the current status quo (which will become further entrenched) in terms of unequal access to services for victim-survivors, a lack of choice in provision, failure to build upon examples of effective practice, a failure to foster improved relationships, partnerships and expedient ways of working and a failure to ease the debilitating pressures of high-intensity work environments.

In addition to the recommendations relating to the empirical WPs on the PROSPER study, we also have some recommendations arising from the experiential, co-research work, as follows:

Working with co-researchers:

1. Begin the process as early in the research cycle as possible.
2. Avoid piecemeal co-production payments.
3. Do not underestimate the power of in-person connection and support.
4. Robust protocols, clear lines of communication and defined areas of responsibility need to be in place to manage and minimise destabilising incidents.
5. Principal investigators need to be alert to how power dynamics can affect the team, particularly in relation to the need to disrupt the presence or escalation of unacceptable or unhealthy behaviours.
6. Principal investigators are pivotal in fostering a culture of co-researchers being seen in ‘3D’, that is, seeing a co-researcher’s skill set beyond their lived experience.
7. Research leaders and funders need to remain open to novel and unexpected benefits and respond to these in creative ways so that insights are harnessed for future use.
8. Research leaders and funders need to embrace the transformative and healing power of creativity – to recognise it as a credible area for financial investment.
9. Critical reflection is crucial on how to embody intersectional approaches into co-research and the limitations associated with such attempts.

**TABLE 13** PROSPER recommendations mapped against the six core themes

| Key theme | Theme overview | Recommendations |
|---|---|---|
| **The complex and precarious funding landscape** | Funding for VSS services is not secure or sustainable. Services rely on a complex mixture of contracts, grants and, increasingly, independent fundraising. The nature of these funding streams is subject to constant changes | The study indicates the need for a sustainable funding framework for VSS services (e.g. a minimum 5-year funding period) with joined-up commissioning (and funding) from all statutory bodies whose services refer into specialist SV services<br>The findings highlight the need for contracts and grants to cover core service costs (e.g. contribution to employee pensions, sickness pay, rent, overheads, clinical supervision, etc.). In addition, innovation activities should be funded separately to core funding. It would be helpful for any statutory or non-statutory guidance issued by government to reflect this expectation<br>The findings indicate that VSS providers would benefit from being entrusted with greater autonomy and discretion in how they use allocated funding. VSS services know their local area and population and are the best placed to know where to allocate resource. Similarly, we suggest that commissioners need to have the ability to operate flexibly as regards movement of funds to respond to local needs |
| **The challenge of competition for funding and contracts** | Public sector bodies' competitive tendering processes require that VSS services bid for contracts, which can put them in 'opposition' to other local and/or specialist services. VSS services have developed considerable expertise in developing and engaging with the commissioning process, but it remains precarious and relationship-based. Knowledgeable and committed commissioners can play a key role in making these process and practices work in a way that benefits local services | The study findings show the importance of grants within the funding landscape and how there should not be an exclusive focus on contracting/tendering services. We suggest that funding for grants should be increased substantially We recommend that commissioners are trained (where they are not already) and supported to develop requisite specialism in the field of sexual and gender-based violence. They would be required to do so in other areas of specialist and clinical commissioning. This is crucial for the strategic and decision-making aspects of their role. Similarly, senior VSS practitioners need support and 'upskilling' to manage roles relating to grant funding and engaging with commissioners (e.g. training workshops, mentor relationships, etc.)<br>Evidence from the study suggests the need for a closer relationship between commissioners and the services they fund, to ensure a greater understanding of the realities, complexities and needs of service provision. This could involve time spent shadowing within the VSS service |
| **The importance of partnership working across organisations** | Partnerships between VSS organisations can facilitate the pooling of expertise, institutional knowledge and resources. This can enable VSS to 'compete' against larger providers/for large-scale delivery contracts. At a more local level, partnership working between organisations (referrals pathways, collaborative working, sharing of knowledge) enhances victim-survivors' service journeys | Based on the study findings, commissioners should support the development of local partnerships, through the allocation of funding, space to host meetings and facilitating introductions between key service staff. However, the study has also shown how partnerships work best when bottom-up and can develop without commissioners specifying who the key agency partners should be |

continued

**TABLE 13** PROSPER recommendations mapped against the six core themes (*continued*)

| Key theme | Theme overview | Recommendations |
|---|---|---|
| **The pressured environments within which VSS services work** | In the context of managing multiple strands of short-term funding and/or contracts and rising demand for services (e.g. waiting lists, increased 'complexity' of clients), senior staff are often navigating multiple strategic and operational demands with limited support. This context also affects practitioners, many of whom are on insecure contracts. The gendered nature of precarity in a female-majority workforce | The study findings point to the need for commissioners to commission services with a consideration of the needs of the workforce (competitive pay reflective of the trained workforce, resource to support staff training, job stability, manageable workloads, to foster wellbeing and combat vicarious trauma). There is currently a disproportionate burden on commissioners and practitioners regarding reporting and monitoring requirements which needs to be reduced, for example, through use of similar/the same reporting/monitoring templates. What is consididered 'good' in these key performance indicators must also be contextualised with an understanding of sexual violence recovery |
| **Different roles, scope and eligibility of voluntary and statutory services within an area** | Victim-survivors often do not know how or where to access support, or what support is available. 'Gaps' in provision (e.g. restricted access for certain population groups) coupled with increasingly long waiting times for therapeutic support (due to limited staff/capacity) further increase victim-survivors' challenges accessing the right support at the right time | Victim-survivors need 'choice' and different options at different time points. We suggest that there needs to be recognition of the value of a range of VSS services – peer support, counselling, advocacy, etc. – and resistance to promoting overly medicalised models of support. The current focus on short-term counselling often fails to meet need and can overshadow other linked types of support (e.g. creative or systemic therapeutic work, political engagement, etc.) |
| | | Sustainable, long-term design and organisation of services could help to eradicate the current hierarchies or 'tiers' that can exist within the VSS support system (i.e. referral pathways restricted by funding/criteria controls). This would mean that services can be accessed irrespective of how victim-survivors report/or to whom, how recent their experience of SV or based on demographic characteristics |
| | | Training of front-line health professionals (e.g. GPs, health visitors) is important as they are often the first entry/disclosure point to services, as is making it possible for health professionals to refer and signpost victim-survivors into specialist SV services. There is an opportunity to consider learning from pilot and/or localised schemes that are currently in operation in some areas of England |
| **The ways services are organised and delivered, underpinned by services' values and philosophies** | Service philosophy and approach plays a critical role shaping the nature of support offered and the experience of victim-survivors. For example, the degree to which the political, social and economic dimensions of SV are recognised and engaged with, versus more clinically led models of therapeutic support | Recognition of the unique value of VSS services – and the different modalities that they offer – is currently patchy and the expertise of practitioners and senior leaders is not consistently understood amongst all commissioners and/or statutory services. The findings point to the need for a cultural change and a shifting of the recognition of what expertise 'looks like' when it comes to the provision of practical, therapeutic and social support for victim-survivors of SV |
| | | The study shows how victim-survivors (especially those from under-represented groups) need to be authentically involved in the decision-making around and development of SV services/provision. This should include involvement at various stages of the commissioning cycle. It should also include involvement at the points at which VSS services conceptualise/develop SV service provision |

## PROSPER limitations

### *Methodological limitations*

The study was limited by its reliance on one theoretical framework, rather than drawing on multiple perspectives. While Billis and Glennerster's[50] theory provided a useful structure, particularly in synthesising the findings, we may have derived different insights from using another approach. Similarly, we may have been constrained by imposing the structure of a theoretical framework and mapping the findings to its four domains. A more open, inductive approach might have led to insights that fall outside the rigid structures of a theoretical framework. In addition to these broad methodological limitations, the specific areas of recruitment for the survey and case study phases are worthy of discussion.

As already discussed, it was anticipated initially that the survey responses (WP2) would identify variations in the national picture which could be explored further in four in-depth case study sites, and as such, the survey data would be instrumental in helping to identify and select case study locations. However, changes to project timelines (and the influence of the COVID-19 pandemic) meant that case study locations had to be selected and work initiated at those sites prior to the survey data being analysed. Nevertheless, the survey data provided a useful post hoc justification for the case study sites that were selected.

In relation to the case study work, the figures for participant recruitment were lower than projected figures for a number of reasons. First, from a study design perspective, much of the recruitment and interviewing took place at a time where the country was going into/coming out of various COVID-19 lockdowns and restrictions. This impacted on the timeline for the project and inevitably had an impact on individuals' ability and willingness to engage in the study. Second, in terms of service demand, a large proportion of the recruitment took place over the year-end period which is a particularly busy time for organisations especially within the voluntary sector, again likely impacting engagement. Finally, projected figures, determined towards the beginning of the project – around 4 years before the case study phase – became less representative of the true number of services as time went on, and services nationally were closed. While the final number of participants was lower than anticipated, we believe there was more insight gained from the WP1 interviews than originally intended, thus bolstering understanding and latter stages of the PROSPER study data.

### *Limitations of our definition of a 'specialist' service*

During the PROSPER project, we grappled with how best to define and operationalise the concept of *specialist services* for victim-survivors of SV, cognisant of the different ways that services can provide valuable care and support to victim-survivors. We sought to differentiate between services who can and do support victim-survivors but who do not 'specialise' in SV, that is, staff do not receive bespoke training or are required to have specific knowledge, and/or services are not designed primarily or exclusively with the needs of SV victim-survivors in mind. Given that a primary aim of the PROSPER study was to identify, map and explore the implications of the limited, often precarious, nature of support for victim-survivors of *sexual violence specifically*, we judged that this distinction was important to uphold for reasons of conceptual clarity. An unintended result of this definition was, however, that it may have led to a narrow definition that excluded the contribution of services with multiple specialisms and/or services for whom victim-survivors are likely to turn to but who may not offer a 'traditional' model of a specialist SV service. This exclusion seems most apparent in terms of not including black and minoritised VAWG women's services who did not state that they provided specialist support around SV (e.g. 'women's services' may not have specifically identified strands of specialist SV-orientated support or therapy), but also extends to victim-survivors who are minoritised by virtue of their disability and/or sexuality. The predominately white British ethnicity of our practitioner and victim-survivor participants likely reflects these limitations of recruitment strategy. However, as noted, the disability status of victim-survivors may have been relatively unimpacted (see *Table 8* earlier in the report).

## Deviations from original application and impacts of the COVID-19 pandemic

The pandemic negatively impacted on obtaining ethical approval for the case study work due to the disruption to services and their ability to take part in the study. This in turn delayed the start of the case study phase of the project. Throughout the 'active' period of the pandemic, we had to reflexively review the specific mode of data collection and engagement in response to social distancing (e.g. conducted online instead of face-to-face), but this did not impact the quality of the study, nor did it significantly impact the timeline for data collection and analysis.

The deadline for completion of the surveys was extended by 3 months to the end of June 2021 due to challenges and pressures on time commitment faced by the sector during the pandemic. Initially, a variety of avenues were available to disseminate the survey to commissioners; however, a number of the options became unavailable due to prioritisation of the COVID-19 vaccine roll-out, especially amongst CCG and public health commissioners. The survey response rate was approximately 25%, which is in line with expected totals using this method. The uptake of the VSS sector survey was higher than this average, while the uptake of the commissioner survey was lower. All participants who undertook the surveys completed the questions and many provided in-depth free-text answers, thus adding an unanticipated layer of depth to the data.

The planned start to the case study phase was October 2021, which was later than originally anticipated. This delay was in part a knock-on effect of delays completing the survey phase. However, the study team began concurrent planning for the case study phase in late 2020 and thus have minimised the impact of these delays. As regards the planned case study sites for WP3, making contact with and creating networks in a couple of the initial candidates for potential case study sites were difficult and time-consuming. After reviewing the initial work carried out in these areas, we elected to identity and develop two new case study sites, again, impacting time frames.

Finally, the recruitment of co-researchers was initially expected to be in January 2020; however, the co-researchers were not recruited until just before the case study work began in 2021. The justification was that the co-researchers' primary contribution would be to the case study work by undertaking victim-survivor interviews jointly with the academic researchers. We also planned that they would contribute to the interpretation of results, report/article writing and dissemination. At the time, we believed that involvement of co-researchers prior to these activities ran the risk of holding limited relevance to them. On reflection, however, this was a misjudgement and we should have involved them earlier (as discussed in *Chapter 6* and indicated in the study recommendations).

**PPIE activities:** The PPIE activities associated with the PROSPER study are multiple and pervasive. Victim-survivors' views fed into early iterations of the proposal prior to application through: the NIHR CLAHRC-West Midlands PPI group, which includes a victim-survivor who has used VSS services; engagement with The Survivors' Trust; and staff working directly with victim-survivors, some of whom were victim-survivors themselves. There were two PPIE co-applicants, one of whom is a survivor of SV. The second was a PPIE representative with an interest in services to support victim-survivors. Both these individuals are experienced PPIE representatives who played an active role in steering group and study team meetings. Moreover, the PPIE survivor was part of the interview panel for the appointment of the co-researchers and has played an important role in their support. A reflective account of her role and experience working on the PROSPER study as a PPIE representative with lived experience of SV is included in *Appendix 5*. This should be read in conjunction with insights from *Chapter 6*, to gain a comprehensive understanding of the combined, rich, multifaceted experiential insights brought to bear on the PROSPER study.

## Equality, diversity and inclusion and the PROSPER study

There are several issues that need to be acknowledged in relation to equality, diversity and inclusion (EDI). We consider these in terms of strengths and limitations, focusing broadly on EDI in relation to (1) research participants and (2) the study team.

### *Equality, diversity and inclusion and research participants*

We sought diversity and maximum variation sampling in the qualitative work. The case study sites in WP3 were selected on the basis not only of the different models of VSS service delivery, but also on geographical and demographic differences. Women are disproportionately represented among victim-survivors of SV, and this is reflected in our samples (as presented in earlier chapters, see *Table 8*). However, one of our case study sites offered VSS services specifically for men. This led to insights from the perspectives of male victim-survivors and the services that support them, that would likely have been missing otherwise. In addition, in WP3, the proportion of victim-survivor participants who identified as people with disabilities was far greater than the proportion of practitioner/commissioner participants. These demographic findings point to a relationship between experiences of violence and abuse and physical and mental health issues that may be casual or associative (i.e. that disabilities are associated with greater 'vulnerability' to violence and abuse) of which there is evidence in the wider literature.

### *Equality, diversity and inclusion and the study team*

The co-researcher component of PROSPER has been at its core. In *Chapter 7*, we highlighted some of the strengths and limitations of the recruitment processes – and, crucially, practices of working with the co-researchers in *Chapter 6* – and how these practices are likely to have shaped who took part in PROSPER, and how. For example, as shown in the co-researcher profiles, there were no male co-researchers. This is in spite of our efforts, which involved advertising the role through a number of VSS services for men. The co-researchers' profiles also demonstrate lack of diversity in terms of ethnicity, with only one identifying as Black Caribbean. A significant benefit of working with the co-researchers has been their connections with and for most, their employment within, VSS organisations in England. While this has been an overwhelming asset, it might mean that potential co-researchers from different socioeconomic backgrounds were excluded from the application and selection process because we were unable to reach them. Finally, as regards the authorship team, we are majority white women; highlighting lack of diversity as regards ethnicity and gender. This is offset in other areas however, with (as far as we know) four people in the team identifying as gay and others being people with disabilities, neurodivergent and/or living with a range of mental health conditions.

## Conclusions

The PROSPER study has provided hitherto missing evidence regarding the funding and commissioning of SV services in England. It has also presented some unexpected opportunities for learning that had not been conceived in the planning or early stages of the study. Theoretically, PROSPER was informed by Billis and Glennerster's[50] theory in relation to the voluntary sector. As discussed in the previous chapter, it proved to be a useful framework, but we adapted it to meets the specific needs on the PROSPER study. As described, we added a broader dimension that allowed us to capture the PROSPER findings about the commissioning context, which are at its core. Theory is not static; it is constantly evolving. With this in mind, we can claim an advancement of theory in the field of research in the voluntary sector. Even if the focus of future research is on voluntary sector service *delivery* (as is the case with a great deal of research in this field), it is likely that the wider lens of commissioning of such services will have relevance. We had not intended to adapt the work of Billis and Glennerster,[50] but it was necessary to meet the unique needs of the study. We will capitalise on having done so, by sharing the unexpected new insights in forthcoming academic publications.

Further, the co-research component took on a life of its own. We had anticipated that the co-research would be a vehicle to obtain the best insights possible from the victim-survivor interviews. We are confident that this was the case. However, we had not expected the significant learning that would arise from the co-research itself as a practice; the 'doing' of co-research that we described in *Chapter 6*. This has unexpectedly led to new knowledge about the undertaking of co-research in the field of SV. We are now in a position to make an important contribution to the field of co-production and co-research literature and practice. Much of the learning can be extrapolated to co-research studies quite broadly. However, we have learnt that there are very specific and crucial lessons in relation to research about violence and abuse that are specific and critical, primarily regarding personal safety and risks of retraumatisation. We have already begun to disseminate these important insights so that the unexpected new knowledge we have generated can benefit other researchers and (potential) co-researchers.

# Additional information

## CRediT contribution statement

**Caroline Bradbury-Jones (https://orcid.org/0000-0002-5237-6777):** Conceptualisation (equal), Formal analysis (lead), Funding acquisition (equal), Investigation (lead), Methodology (lead), Project administration (lead), Visualisation (equal), Writing – original draft (lead), Writing – editing and reviewing (lead).

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**Kirsten Fruin (https://orcid.org/0000-0002-5018-1052):** Methodology (supporting), Writing – editing and reviewing (supporting).

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**Lucy Hebberts (https://orcid.org/0000-0002-8568-2973):** Formal analysis (supporting), Methodology (supporting), Writing – editing and reviewing (supporting).

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**Laura Patterson (https://orcid.org/0000-0001-7586-8080):** Formal analysis (supporting), Methodology (supporting), Visualisation (equal), Writing – original draft (lead), Writing – editing and reviewing (supporting).

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**Julie Taylor (https://orcid.org/0000-0002-7259-0906):** Conceptualisation (equal), Funding acquisition (equal), Methodology (supporting), Project administration (supporting), Supervision (lead), Writing – original draft (supporting), Writing – editing and reviewing (supporting).

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## Patient data statement

This work uses data provided by patients and collected by the NHS as part of their care and support. Using patient data is vital to improve health and care for everyone. There is huge potential to make better use of information from people's patient records, to understand more about disease, develop new treatments, monitor safety, and plan NHS services. Patient data should be kept safe and secure, to protect everyone's privacy, and it's important that there are safeguards to make sure that it is stored and used responsibly. Everyone should be able to find out about how patient data are used. #datasaveslives You can find out more about the background to this citation here: https://understandingpatientdata.org.uk/data-citation.

## Data-sharing statement

All available, anonymised data can be obtained from the corresponding author on reasonable request.

## Ethics statement

The PROSPER study was subject to the following ethical approvals:

The University of Birmingham Science, Technology, Engineering and Mathematics ethics committee. February 2020 (ERN_19-1152A) and October 2020 (ERN_19-1152B).

Ethical approval from the University of Birmingham and research governance approval from the Health Research Authority (HRA) and Health and Care Research Wales (HCRW) January 2021 (REC reference: 20/HRA/6042). The Association of Directors of Children's Services (ADCS) (Ref: RGE201005), and Association of Directors of Adult Social Services approved sharing the survey weblink(s) amongst their members. Data that underlie the findings will be available immediately following publication with no end date from the Principal Investigator, on reasonable request and following deidentification.

## Key ethical issues identified and mitigated

The principal ethical considerations involved in carrying out qualitative work with victim-survivors in the PROSPER study were: to protect participants' confidentiality and the safe storage of their data; to protect and promote their welfare, ensuring that participation does not cause unnecessary distress or retraumatisation; to ensure that participants meaningfully consent to taking part and that their consent is understood as dynamic and conditional. Broadly, the following ethical issues were anticipated with associated mitigating actions:

1. Exiting the researcher–participant relationship

   Previous experience suggests that researchers and co-researchers may find it difficult to exit the research relationship with a participant, particularly when discussing sensitive topics such as SV. Participants may inadvertently develop an attachment to the interviewer, particularly if good rapport is developed during an interview. This can be challenging for the researchers to handle, particularly with participants to whom they may feel a duty of care. This was a potential ethical problem for WP 1 and 3 interviews.
   Mitigating actions: Researchers' and co-researchers' contact details were not shared with participants, who were provided with the study office number only.

2. Overinvolvement of the researchers/co-researchers

   Operating somewhat in reverse to point 1, researchers may likewise feel drawn into participants' lives, particularly co-researchers, who, as victim-survivors of SV themselves, are likely to identify with, and feel empathy for the victim-survivors they interview. Researchers may find it upsetting to hear about participants' experiences and may not always feel they know how to react.
   Mitigating actions: A distress protocol for the study set out how this risk would be minimised and covered in detail in initial training for co-researchers and any members of the academic team who required such training. As per the Participant Information Sheet, it was made clear that researchers would not take on any ongoing role with a research participant, but rather, would signpost participants to sources of support and advice, where relevant. It is noteworthy that most of the research team had significant experience of practice and research in the field of SV and were brought onto the project for these skills. This was an important mitigating factor.

3. Confidentiality

   There was a risk, albeit a low risk, that one of the research team might live or work in one of the areas selected as a case study site, raising important issues of confidentiality (WP3).
   Mitigating action: Researchers/co-researchers did not undertake victim-survivor interviews in an area where they lived or worked and/or were likely to have a connection to one of the victim-survivor participants or an associated VSS service.

4. Consent

   Some participants may have found it challenging to decline the opportunity to participate and we needed to draw on our extensive experience to design materials that enabled victim-survivors and those with special educational needs to participate safely.

   Mitigating actions: We developed pictorial materials to explain the research in accessible terms and ensured that sufficient time was given to explaining the research. Consent was treated as a dynamic process and researchers remained alert to signs that a participant may have wished to stop the interview or move to a new topic. Written informed consent was taken for all participants in WPs 1 and 3. Researchers explained with every participant, what taking part involved, their right to withdraw, how data are stored and how confidentiality and anonymity were to be maintained. All interviews were followed by a short debriefing discussion, ensuring the participant could reflect on the interview and any further questions. Audio-recorded or written consent was collected from all participants in line with the ethical permissions. We briefed VSS organisations regarding our eligibility criteria for recruitment (which had been designed to minimise distress/risk of retraumatisation) and the need for the organisations to exercise sensitivity and reassurance when approaching potential participants. We requested that they reassure all potential participants that if they did not wish to take part, it would not affect any future care/support they may need from that service.

5. Disclosure of SV experiences

   In any study such as PROSPER, there is the risk of disclosure of non-recent or ongoing SV, for participants and researchers, plus a risk that team members may experience vicarious trauma.
   Mitigating actions: A clear and comprehensive safeguarding policy ensured that potential issues were dealt with swiftly and effectively. The team were fully briefed on the policy and the importance of adhering to it, although fortunately, no significant safeguarding or disclosure matters arose.

6. Well-being and safety of the co-researchers

   The co-research component of PROSPER was strong in terms of effort, time, contribution and potential impacts. It carried with it several ethical issues, most of which have been alluded to in *Chapter 6*. We adopted the following practices to ensure the ethical conduct of this integral part of the study:

   a. We worked in line with the NIHR guidance for involving the public in research[106] and specifically to help us deal with some potentially thorny ethical issues such as payments.[107]
   b. We advertised the opportunity for the co-researcher roles widely, via national networks such as People in Research, The Survivors Trust, Rape Crisis England and Wales and Male Survivors Partnership. This was in an attempt to recruit people from as diverse backgrounds and experiences as possible.
   c. We ensured that co-researchers had a full and informed understanding about the research and what it involved as part of the recruitment process.
   d. Training and mentorship were provided to equip co-researchers with the required support and skills to undertake the role.
   e. Reflective sessions (online) were held regularly as a forum for ongoing support and mentoring of the co-researchers and a sharing of experiences and learning across the team.

7. Well-being and safety of the whole team

   During the WPs that involved interviewees (victim-survivors and staff), we were aware of the potential for participants to become distressed as a result of taking part. We followed the principles of the McCosker *et al.*[108] distress protocol and that of Drauker *et al.*[109] to guide decisions about appropriate action in the event of such distress. Information about local sources of support was included in the written documentation about the study and interviews were halted if the interviewee became upset. Support for research team members followed recommendations developed by two of the team's co-applicants as regards managing risks for vicarious trauma.[110] For example, we embedded regular supervision for researchers, PPIE co-applicants and the co-researchers in which we addressed the potential for vicarious distress. We endeavoured to create an environment in which the difficulties of listening to and engaging with people's experiences of SV could be acknowledged as upsetting. This, we hope, helped to build resilience and compassion across the whole team.

## Information governance statement

### *Risks to confidentiality of information in WP3*

Documents provided by organisations in case study sites did not include any service user identifiable information. VSS organisations sharing performance/outcome data with the research team did so in aggregated form only. Data were shared and transported on encrypted secure data sticks. Contact information for participants was stored securely at the University of Birmingham and destroyed on completion of the project.

### *Data protection*

With prior consent, all interviews (WP1 and 3) and focus groups (WP1) were digitally recorded on encrypted devices. The recordings were transferred directly to the secure study folder and then deleted from the recording device. Recordings were transcribed using a professional transcription firm which is registered with The Information Commissioner. The transcripts were anonymised and uploaded to NVivo (a qualitative data analysis software). All personal and signifying data were kept confidential. Participants were assigned identifying numbers and these numbers were used to ensure transcripts, field notes and communication records were appropriately stored and categorised. The index for these identifying numbers was stored on the study secure folder.

Data were stored electronically on a secure folder using the University of Birmingham's Research Drive which provides secure, backed-up storage of research data. The secure study folder can only be accessed by named members of the team and was password protected. The folder is protected by the University's high level of security that protects against spam and virus scanners. The data will be stored for 10 years. Using the BEAR Datashare 'sync and share' tool ensures central replication and back-up to a central data store. The system provides the mechanism for securely sharing data with collaborators. The University of Birmingham has established systems for data storage and back-up (every 24 hours) which safeguard data. The study data will be held for 10 years.

The BEAR Archive provides a secure and resilient service, available to researchers from all disciplines for the long-term storage of valuable data from completed research projects or data where access is not required in the short or medium term. On request, a default allocation of working data storage is provided to each principal investigator for the duration of 'live' projects. Long-term storage for other valuable data which are not currently in use, including from completed research, is provided in the BEAR Archive.

The appointed research fellows had day-to-day responsibility for the management and curation of the data sets, and preparation of the data and the technical report for archiving. Strategic and managerial responsibility for the data sets was with the principal investigator who in turn is responsible to the University. The anonymised data set will be stored in strict accordance with the revised General Data Protection Regulations (2018)[96] and the Data Protection Act (2018).[97]

## Disclosure of interests

***Full disclosure of interests:*** Completed ICMJE forms for all authors, including all related interests, are available in the toolkit on the NIHR Journals Library report publication page at https://doi.org/10.3310/WWKT3077.

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## Publication

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# Appendix 1 Scoring methods

Explanation of scoring for presentation of data based on agreement with Likert scale response options.

In a number of survey questions, a series of statements was provided to survey respondents, describing various aspects of the provider–commissioner relationship. Respondents rated each issue on a Likert scale of perceived importance (‘very important’, to ‘important’, to ‘neutral’ to ‘slightly important’, to ‘not important’), or perceived agreement (‘strongly agree’, ‘agree’, ‘neither agree nor disagree’, ‘disagree’, ‘strongly disagree’).

To standardise responses for direct comparison, each response on the scales was converted to a numerical value (very important/strongly agree = 100; important/agree = 75; neutral/neither agree nor disagree = 50; slightly important/disagree = 25, and not important/strongly disagree = 0). The scores were added, and the overall importance of each factor expressed as the proportion of the ‘ceiling’ score it achieved. The ceiling score relates to the maximum value that would have been given to a specific factor if all respondents had scored it as ‘very important’ or ‘strongly agree’.

For example: If 10 participants had answered a question in which they rated the importance of partnership working with commissioners, and all 10 individuals considered this to be ‘very important’, the ceiling score for that issue would be 10 × 100 = 1000. However, if in practice 5 individuals considered the issue to be ‘very important’ and 5 considered it ‘slightly important’, the true value would be (5 × 100) + (5 × 25) = 625. Expressed as a percentage of its maximum ceiling score, this would mean that the overall agreement with this statement would be 625/1000 × 100 = 62.5%. Scoring each of a series of statements in this way allows the relative overall importance of each one to be assessed and compared to each of the others, taking into account the number of participants who provided a response to each statement.

# Appendix 2 Victim-survivor participant pseudonym key

| Site | Participant | Pseudonym |
|---|---|---|
| 1 | 1 | Mandy |
| 1 | 2 | Jack |
| 1 | 3 | Selasie |
| 1 | 4 | Kylie |
| 1 | 5 | Margot |
| 1 | 6 | Lottie |
| 1 | 7 | Pippa |
| 1 | 8 | AJ |
| 1 | 9 | Lavinia |
| 2 | 1 | *Participant requested removal of data* |
| 2 | 2 | Gen |
| 2 | 3 | Asha |
| 2 | 4 | Cleo |
| 2 | 5 | Millie |
| 2 | 6 | Ginger |
| 2 | 7 | Ava |
| 2 | 8 | Lucy |
| 2 | 9 | Tracey |
| 2 | 10 | Alice |
| 2 | 11 | Parker |
| 3 | 1 | Autumn |
| 3 | 2 | Blossom |
| 3 | 3 | Mia |
| 4 | 1 | Findlaigh |
| 4 | 2 | Brian |
| 4 | 3 | Aadava |
| 4 | 4 | Sabir |
| 4 | 5 | Sam |
| 4 | 6 | Levi |
| 4 | 7 | Brooklyn |
| 4 | 8 | Toby |
| 4 | 9 | Karl |

# **Appendix 3** Co-researcher summary biographies

| Age and ethnicity | Gender | Other self-identified elements of self | Work/professional/areas of interest experience |
|---|---|---|---|
| 56<br>White British | Female | Mother<br>Sister<br>Living with cPTSD<br>Creative<br>Sports enthusiast | Midwife. 22 years. Experience in maternity settings and neonatal intensive care. Clinical research since 2012. Volunteered and worked within RC affiliated services. Qualified ISVA, mainly supporting CYP |
| 24<br>White British | Female | Daughter, sister, partner<br>Colleague<br>Feminist<br>Activist<br>Pianist<br>Any ally for young women<br>Artist/creative<br>Coffee and chocolate enthusiast | Worked in the specialist SV sector since 2019, including being the head of a specialist SV organisation. Specialising in violence against women and girls. University of Birmingham Business Management Graduate. Published academic author: research surrounding female objectification and sexualisation in marketing |
| 58<br>White British | | Lesbian, Feminist | Social work trained and experience of working with vulnerable, silenced and excluded people over 30 years.<br>History of involvement in the RC movement, as a volunteer, Trustee and CEO.<br>Currently Trauma Therapist, Clinical Supervisor and Tutor of counselling students |
| 48<br>White British | Female | Heterosexual<br>Developmental trauma<br>Researcher<br>Social worker<br>Mother | Sensitive PhD research undertaking interviews with young people who have made a suicide attempt, social worker with children and families for 20 + years. Also worked as a youth worker and pastoral support officer. Also run a Wellbeing Café on the high street where I live and an active Christian in a local church |
| 35<br>Black Caribbean | Woman | Sister, auntie, great auntie. An advocate for women and girls, in particular black/women of black heritage.<br>A lover of music and all things creative | Worked in the VAWG sector for a number of years, having a particular focus on young women within racialised communities.<br>Passionate in advocating and reaching young black women in urban areas, in particular challenging the sexualisation of black women and girls as a whole. Hoping to spread awareness of SV within the black community and is particularly to share her experiences around neurodiversity, identifies as being neurodivergent |

cPTSD, complex Post Traumatic Stress Disorder.

# Appendix 4 Away day agenda

| PROSPER in-person team events | | | |
|---|---|---|---|
| September 2021 | March 2022 | April 2022 | July 2022 |
| Introductions and setting the scene – agreeing the day<br>Co-researchers and forcefield analysis<br>Team exercise<br>Survivor interviews – Training materials<br>Parallel funding<br>Co-researcher walk and talk time | Overview of participant demographics<br>Authorship and publication protocol and etiquette<br>Draft abstract and survey findings<br>PROSPER dissemination and publication planning,<br>Example Survivor Journey Timeline (Co-Researcher) | Survivor interview transcript coding | Survivor interviews – post-transcript data coding – next stages and thematic analysis – training and task allocation |

# Appendix 5 Reflective account by patient and public involvement and engagement representative Debs Smith

I was originally made aware of the research project that was to become PROSPER when its original principal investigator was first designing the project and looking to get it funded. I was at that time a public contributor for CLARCH West Midlands for which I was both on the programme steering committee and one of five lay advisors for the chronic diseases theme. We would regularly have meetings to which the research team would present current and new projects in order for us to give input. It was to one of these meetings that the lead researcher first presented her idea to conduct research into how the third sector were supporting victim-survivors of sexual violence across the UK.

I expressed my interest in continuing to support this project into the future and disclosed that I, myself, am a victim-survivor of sexual violence. It was after this that it was decided that I and one of the other lay advisors who did not consider herself a victim-survivor of sexual violence would be the patient and public co-applicants on this project (later named PROSPER). This began an interesting journey towards first of all becoming funded in the first place. The funding does not come without many revisions being made to the application, and it was during one of these revisions that the idea was conceived of having co-researchers, who had their own lived experience. At the time we made this decision, it was felt to be a somewhat risky move as to do it and do it well required asking for more funds than we would otherwise have needed and that in needing more funds to have these co researchers it might mean that we did not receive any funding and the project would end up not happening.

However, we did get funding and so began work on PROSPER. The first task I was involved in was to help in the recruitment of our second research fellow onto the project and as well as helping with the short listing I facilitated two tasks in which the applicants were asked to participate and these tasks were done with victim-survivors from the Victim-survivors Trust. Other members of the research team interviewed the candidates and the feedback from myself and the other victim-survivors was fully taken on board in terms of the selection of the successful candidate. Over the course of PROSPER, I was also fully involved in the recruitment of all the lived experience co-researchers and in the recruitment of the third research fellow when our first research fellow took up another position within the university. I feel this involvement showed a massive commitment to the importance of patient and public involvement in PROSPER and I am very grateful for this.

The first team meeting was in September 2019 and by then the original principal investigator and the researcher that I knew best (at that time) was on sick leave and never returned to PROSPER. This was at the time a huge blow to me and made worse by the fact that I was just about to undergo major surgery and so was unable to travel into the university to attend meetings in person but attended them remotely. Of course, we were all forced into that way of working in March 2020 due to the pandemic. After much reflection I feel that these factors, when taken together, did make building relationships with other members of the research team much harder and had a lasting effect on my fully gelling into the research team as a whole. The original intention has been that there would be support available should my own experience be triggered by anything to do with PROSPER. In hindsight, had the mentoring that was offered from the beginning to the co-researchers been offered also to the lay co-applicants from the beginning, my experience on PROSPER would have been easier and richer. So that is the first learning point that comes out for me from my time on PROSPER. I was given mentoring in the last year of PROSPER, but it was after I had struggled a lot with everything and had to ask for support. I am deeply grateful that I was given a mentor and for the support given, but would have preferred not have  struggled before getting it.

At some point before the last year of PROSPER, the other lay co-applicant stopped attending any meetings and I had no contact with her. This left me in a position that I had not been in before as the only lay co-applicant on the project. I am an experienced public contributor of a number of years standing and have worked on many projects in many roles. I am used to sitting on trial steering committees as the only lay person but being on a research project as the only lay person left standing so not a researcher or a co-researcher felt so very different. I felt very alone and very unsure of what my role was or could be. In later months having a mentor helped with this and in processing things, but I would very much in future always recommend a larger lay pool to draw from so that no lay person finds themselves in this position being the only one active with their particular role.

Since the beginning of PROSPER I have had involvement in other projects where the public contributors have helped as service-user researchers in analysing data and am aware that this is becoming more and more the norm in some projects. I was involved in PROSPER in looking at and commenting on analysis that has been done and there was at one point an intention for me to help in the initial analysis only for me to be unwell when that analysis began. There are other projects now training their public contributors to help work the interviewing in the first place. I recognise that when funding was applied for PROSPER and when PROSPER began co-production in such things with public contributors was not the norm and that having separate lived experience co-researchers probably felt like the only way it could be done. However, my experience on PROSPER and on my other research projects lead me to favour a model of a greater pool of public contributors with their own lived experience from the beginning who can then help with things like interviewing and data analysis rather than PROSPER's model of separate public contributors and co-researchers. As we know hindsight is a great thing but a pity that we have it after the event rather than before it and so I cannot say that I or the rest of the team on PROSPER could or should have made different decisions: at the time we made then without knowing either how things would play out or how the role of public contributors would move on in other projects across the UK. I am, also, very aware that in what I have written I have given my perspective and experience and mine alone and what I feel I have learnt about how projects may do public contribution differently. What I have written should, therefore, be read as just that, bearing in mind the other experiences and views in this report.

Thanks. Debs Smith, lived-experience lay co-applicant on PROSPER. September 2022.

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