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Where do those experiencing sexual violence seek help and is routine enquiry acceptable within a sexual healthcare setting? Findings from a population-based survey

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ABSTRACT

Objectives Most sexual violence (SV) remains undisclosed to healthcare professionals. The aims of this study were to identify where support would be sought after SV and whether routine enquiry about SV was acceptable in a sexual healthcare setting.

Design An online population-based survey collected data on a history of SV and preferences on support after SV, in addition to sociodemographic data. Respondents' views on being routinely asked about SV were sought.

Setting and participants This online survey was based in England, UK. There were 2007 respondents.

Results The police were the most frequent first choice for support after experiencing SV (n=520; 25.9%); however, this was less common in individuals in younger age groups (p<0.001) and in those with a history of SV (17.2% vs 29.9%, p<0.001). For the 27.1% (532 of 1960) of respondents who reported a history of SV, the first choice of place for support was Rape Crisis or similar third-sector organisation. The majority of respondents supported routine enquiry about SV during Sexual and Reproductive Health Service (SRHS) consultations (84.4%), although acceptability was significantly lower in older age groups.

Conclusions and study implications A greater awareness of the influence of sociodemographic factors, including ethnicity, age, gender, disability and a history of SV, when planning and delivering services for those who have experienced SV is needed. A history of SV is common in the general population, and a 'one-size-fits-all' approach to encourage disclosure and access to support is unlikely to be optimal. Routine enquiry about SV is highly acceptable in an SRHS setting and likely to improve disclosure when appropriately implemented.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ The study findings are strengthened through the inclusion of a large and diverse sample of respondents, including those with and without previous experience of sexual violence.
⇒ The study strengthens the evidence base for the use of routine enquiry within sexual healthcare settings.
⇒ The main limitations of the study were that respondents were self-selected and required access to a computer or smart phone to participate.

INTRODUCTION

The nature, extent and level of harm resulting from sexual violence (SV) are increasingly being acknowledged.[1] Consequences of SV include a negative impact on individual physical and mental health, and significant social and economic costs.[2] Research indicates that certain groups such as women, racially/sexually minoritised communities and the disabled are at higher risk of being victims of SV.[1 3 4] An awareness of the magnitude of SV has been accelerated by social movements, for example, #MeToo, where disclosure of SV has been shared widely using social media platforms.[5 6] Despite this increased recognition, SV remains highly stigmatised, and considerable barriers persist for individuals to seek help and redress, which are exacerbated by widespread myths about what defines 'real rape' and the concept of a 'legitimate victim'.[7–9]

Healthcare input after SV is required to address the associated risks to health, including pregnancy; sexually transmitted infections (STIs) such as *Chlamydia trachomatis*, hepatitis B and HIV; genital and other physical injuries; acute and chronic pelvic pain; and psychological ill health. Healthcare settings can also act as a conduit to access further care such as counselling, safeguarding, social and legal support, collection of forensic evidence and police reporting. A National Health Service England survey found that 72% of respondents are unaware of the national network of UK Sexual Assault Referral Centres (SARCs), where forensic and medical care can be obtained after SV.[10] This survey also reported that the most sought-after service after SV was testing for STIs. In the

UK, a national network of Sexual and Reproductive Health Services (SRHS) offers a range of STI and bloodborne virus testing, treatment and management, contraceptive provision, and health promotion and prevention, and provides support to those reporting SV. Despite being recognised as a public health priority, most SV remains undisclosed to healthcare professionals.[11–13] In a national sample of US adult women, Zinzow *et al* reported that only 21% reported seeking medical care after SV.[14] Previous studies suggest that disclosure in healthcare settings is highly acceptable.[15 16] However, the best way for healthcare services to facilitate this disclosure (for example, by routinely enquiring if SV has occurred) and create a safe place to disclose SV and access medical care remains uncertain, although some examples of good practice are emerging.[17 18]

The type of help required, and where it is accessed, are dependent on the specific needs of the individual and other factors, such as the type of SV experienced.[19] People can seek support through specialist voluntary organisations, which offer advocacy, counselling and emotional support. Approximately two-thirds of service users at Rape Crisis (the largest specialist voluntary SV organisation in the UK) are adult survivors of childhood sexual abuse, illustrating the need for a range of support over a prolonged period of time after SV.[20] Due to the variety in the types of SV experienced, and the fact that support needs can change over an individual's lifetime, it is unlikely that a 'one-size-fits-all' approach will be sufficient.

Since most people do not seek formal support after SV, with the barriers to accessing care likely to vary across different groups of people, it remains important that easily accessible support and care is available, especially within healthcare settings. However, there is limited knowledge about how different groups of people who have a history of SV access care and what factors might facilitate engagement.

The current study used data from a national survey to consider healthcare choices, preferences and experiences after SV in adults who had and had not experienced SV.

Study aims and objectives

1. To identify where respondents would seek support after experiencing SV.
2. To explore respondents' views on SRHS as a setting for support after experiencing SV.
3. To understand respondents' views on differing approaches used in SRHS to identify individuals who have experienced SV, including the acceptability of routine enquiry.

METHODS

Study design including patient and public involvement

Consensus-Based Checklist for Reporting of Survey Studies guidance was used during the design, conduct and reporting of the survey.[21] Survey question design and content were based on a review of the literature, interviews with individuals who had experienced SV and the input of an expert advisory group (comprised of patient advocates, researchers and healthcare staff). Input from a statistician was sought at the draft stage to ensure the survey responses could be collated and analysed. Face validity was assessed to ensure understanding of the questions, estimate the length of time required to complete (target <15 min) and assess whether there was unnecessary repetition or response options that were missing or did not make sense. This was carried out using 10 individuals from the advisory group and researchers with expertise in violence and abuse. A 7-day pilot (6–12 January 2022) administered the questionnaire online to 300 people, after which an interim analysis was carried out to assess consistency, completion rate, validity and reliability, with subsequent minor changes made to the wording and question order. Data from the pilot were included in the study.

The online survey was distributed to a panel of English residents made up of approximately 600 000 people. The survey was hosted by a professional marketing and data company (https://www.dynata.com), where panellists are typically paid in e-rewards (a currency awarded in exchange for taking part in surveys that can be used to redeem gift cards) for their involvement. The survey was formatted and designed to be delivered online and to be compatible with smart phones, tablets and desktop computers. The survey opened to the panel on 19 January 2022 and continued until a minimum quota of 2000 respondents was achieved on 31 January 2022.

Respondents

The survey was open to those aged 18 years and above. Open recruitment was used, but with quota sampling targets as follows:

- Age: minimum of 5% to be aged 18–24 years, and maximum of 10% aged 55 years or older (with the aim of ensuring that a variety of age groups were represented).
- Ethnicity: maximum of 85% white British, with a minimum 1% black respondents (to ensure that minority groups were represented, and that the distribution of ethnicities was reflective of national census data[22]).

Confidentiality

The initial survey page outlined the nature and purpose of the survey. Contact details to access support for those who had a history of SV were provided. The data were anonymised before being sent to the research team and the researchers were not able to meet or contact survey respondents before or after the survey.

Survey sections

The survey (online supplemental file 1) contained three sections and completion for all questions was optional: (1) respondents' demographics (as listed in table 1); (2) knowledge of existing services and choice of where to attend following SV; and (3) history of SV, including having no known experience, and opinions

Table 1 Respondents' backgrounds and a history of sexual violence

	Total (% of total respondents)*	History of sexual violence†
Age (years)		**p<0.001‡**
18–24	113 (5.6)	44/106 (41.5%)
25–34	607 (30.2)	234/596 (39.3%)
35–44	634 (31.6)	198/618 (32.0%)
45–54	423 (21.1)	115/413 (27.8%)
55 or older	230 (11.5)	30/227 (13.2%)
Ethnicity		p=0.053
White	1715 (85.5)	532/1678 (31.7%)
Asian	160 (8.0)	38/157 (24.2%)
Mixed	58 (2.9)	24/57 (42.1%)
Black	50 (2.5)	19/45 (42.2%)
Other ethnic group	24 (1.2)	8/23 (34.8%)
Gender		**p<0.001**
Female	1250 (62.3)	452/1216 (37.2%)
Male	742 (37.0)	162/732 (22.1%)
Non-binary	8 (0.4)	4/8 (50.0%)
I describe my gender in another way	3 (0.1)	2/3 (66.7%)
I prefer not to say	4 (0.2)	1/1 (100.0%)
Sexual orientation		**p<0.001**
Heterosexual/straight	1746 (87.0)	496/1712 (29.0%)
Bisexual	116 (5.8)	68/115 (59.1%)
Gay/lesbian	70 (3.5)	24/69 (34.8%)
Pansexual	21 (1.0)	14/20 (70.0%)
Queer	3 (0.1)	1/3 (33.3%)
Asexual	1 (0.0)	1/1 (100.0%)
Prefer not to say or not sure	50 (2.5)	17/40 (42.5%)
Disabled		**p<0.001**
Yes	284 (14.2)	166/275 (60.4%)
No	1723 (85.8)	455/1685 (27.0%)
In an intimate relationship currently?		p=0.092
Yes	1454 (72.4)	468/1424 (32.9%)
No	494 (24.6)	132/481 (27.4%)
Not sure	32 (1.6)	13/31 (41.9%)
Prefer not to say	27 (1.3)	8/24 (33.3%)

*Denominator is the total number of respondents n=2007.
†Denominator is n=1960, as the n=47 who did not wish to respond to the question were excluded; responses of 'not sure' were treated as 'yes' for analysis; data are reported as the n/N (%) of respondents in each subgroup answering 'yes'; p values are from X^2 tests, unless stated otherwise, and bold p values are significant at p<0.05.
‡P value from a Mann-Whitney U test, treating age as ordinal.

on what is, or might be, important for those attending a sexual health clinic after experiencing unwanted sexual activity in order to feel safe and supported. Where respondents stated that they were 'not sure' if they had experienced SV, four options supplied were provided, including a free-text option, to further understand this response. Additional questions focused on the use of routine enquiry (asking about SV whether or not there are any indicators or suspicions of abuse), to assess in what manner and how often those attending a sexual health clinic should be asked about 'sexual activity that was not agreed to'. The survey gave details of four prerequisites that services would have in place prior to use of routine enquiry based on safety, confidentiality, staff training and the option to decline. Where routine enquiry was not supported, five options were given to establish the reason, including the opportunity for a free-text response.

Data analysis

For comparisons between two groups, X^2 tests were used for nominal variables, with Mann-Whitney U tests used for ordinal variables. For the analysis of experiences of disclosure of SV, comparisons with SRHS were performed using Wilcoxon signed-rank tests, which only included those respondents who responded to the questions for both of the healthcare settings being compared. Analyses were conducted in IBM SPSS Statistics V.28.0 (IBM Corp), with p<0.05 classified as statistically significant throughout. Respondents who did not answer a question, or stated that they were 'not sure' or 'preferred not to say' were excluded from the analysis of the affected question, unless stated otherwise. Where exclusions are made, the sample size included in each analysis is reported in the tables.

RESULTS

Sociodemographic characteristics and prevalence of SV

Survey responses were received from 2007 individuals, the sociodemographic characteristics of whom are summarised in table 1. The majority of respondents were of white ethnicity (85.5%), female (62.3%) and heterosexual (87.0%); 14.2% reported being disabled, and 72.4% stated that they were currently in an intimate relationship.

When asked whether they had a history of SV, 47 of 2007 (2.3%) did not give a response. Of the remaining n=1960, 27.1% (n=532) respondents stated that they had a history of SV, with a further 4.5% (n=89) answering 'not sure'. Where respondents were not sure, the most common reasons given for this response were that they could not remember what happened (eg, under the influence of alcohol or drugs n=37 (41.6%)); they used words other than 'sexual violence' to describe what had happened (n=27; 30.3%); or that they had initially agreed to sexual activity then changed their mind (n=21; 23.6%); with the remainder providing other reasons (n=4; 4.5%). As such, for subsequent analysis, the 'not sure' group was combined with the 'yes' group, such that 31.7% (621 of 1960) were deemed to have a history of SV. Of those

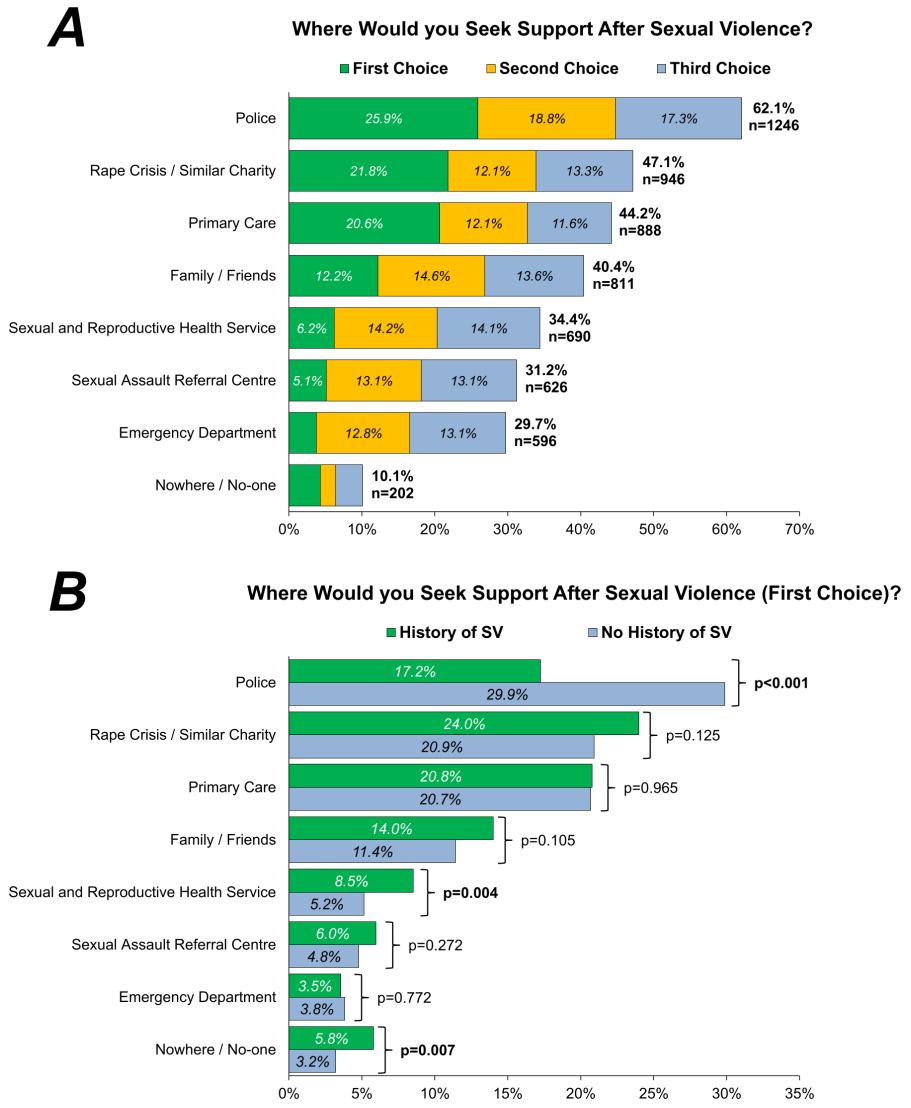

Figure 1 Preferred place to seek support after sexual violence (SV). (A) Based on a denominator of n=2007, unlabelled bars comprise <5% of the cohort, and bold values represent the proportion and number of respondents for whom the stated place was in the top three choices. (B) Based on a denominator of n=1960, the n=47 who did not wish to respond to the question were excluded; responses of 'not sure' were treated as 'history of SV' for analysis. P values are from X^2 tests, comparing between patients with a history versus no history of SV, and bold p values are significant at p<0.05.

reporting a history of SV, 37.0% (210 of 567) stated that they had experienced SV as a child. Comparisons across socioeconomic characteristics found respondents who were younger, female, from sexually minoritised communities or disabled to be significantly more likely to report a history of SV (table 1).

Preferred place of support after SV

In section two of the survey, respondents were asked to rank their top three choices of places to seek support after SV, from the list of options reported in figure 1A. The majority of respondents included the police within their first three preferred places to get support after SV (n=1246; 62.1%), followed by Rape Crisis (n=946; 47.1%). SARCs were in sixth place for seeking support, with n=626 (31.2%) including these in their top three and only n=102 (5.1%) indicating that a SARC would be their first choice. Respondents who reported having experienced SV were significantly less likely to select the police as their first-choice place for support, compared with the remainder of the cohort (17.2% vs 29.9%, p<0.001). This resulted in the police being ranked in third place by those with a history of SV, with Rape Crisis (24.0%) and primary care (20.8%) being the most common first-choice places (figure 1B). Those with a history of SV were significantly more likely to choose SRHS (8.5% vs 5.2%, p=0.004), or to say that they would tell no one (5.8% vs 3.2%, p=0.007) than those with no history of SV; no significant differences between the two groups were observed for other places of support.

Comparisons of first-choice places for support by sociodemographic factors are reported in table 2. This found a range of significant differences; for example, the police were significantly less likely to be the first choice

Table 2 Association between variables of interest and first-choice place of support after sexual violence (SV)

	Rape Crisis/similar charity	Primary care	SARC	SRHS	Emergency department	Police	Family/friends	Nowhere/no one
Age (years)	p=0.200*	p=0.839*	**p=0.001***	**p<0.001***	p=0.263*	**p<0.001***	**p=0.009***	**p=0.003***
18–24	32 (28.3%)	16 (14.2%)	10 (8.8%)	10 (8.8%)	4 (3.5%)	15 (13.3%)	20 (17.7%)	6 (5.3%)
25–34	138 (22.7%)	130 (21.4%)	41 (6.8%)	45 (7.4%)	30 (4.9%)	125 (20.6%)	80 (13.2%)	18 (3.0%)
35–44	128 (20.2%)	143 (22.6%)	28 (4.4%)	45 (7.1%)	18 (2.8%)	163 (25.7%)	83 (13.1%)	24 (3.8%)
45–54	91 (21.5%)	81 (19.1%)	17 (4.0%)	21 (5.0%)	18 (4.3%)	143 (33.8%)	41 (9.7%)	10 (2.4%)
55 or older	48 (20.9%)	44 (19.1%)	6 (2.6%)	3 (1.3%)	6 (2.6%)	74 (32.2%)	21 (9.1%)	28 (12.2%)
Ethnicity	p=0.148	p=0.556	p=0.231	**p=0.002**	p=0.755	**p=0.034**	**p=0.024**	p=0.272
White	364 (21.2%)	350 (20.4%)	83 (4.8%)	94 (5.5%)	64 (3.7%)	459 (26.8%)	221 (12.9%)	77 (4.5%)
Other	73 (25.0%)	64 (21.9%)	19 (6.5%)	30 (10.3%)	12 (4.1%)	61 (20.9%)	24 (8.2%)	9 (3.1%)
Gender†	p=0.426	p=0.105	p=0.936	**p=0.019**	p=0.751	p=0.433	**p<0.001**	p=0.532
Male	168 (22.6%)	168 (22.6%)	38 (5.1%)	58 (7.8%)	27 (3.6%)	200 (27.0%)	49 (6.6%)	34 (4.6%)
Female	264 (21.1%)	245 (19.6%)	63 (5.0%)	65 (5.2%)	49 (3.9%)	317 (25.4%)	194 (15.5%)	50 (4.0%)
Sexual orientation‡	p=0.610	p=0.075	p=0.152	p=0.972	p=0.462	p=0.108	p=0.148	p=0.356
Heterosexual/straight	377 (21.6%)	371 (21.2%)	84 (4.8%)	108 (6.2%)	64 (3.7%)	463 (26.5%)	206 (11.8%)	72 (4.1%)
Other	60 (23.0%)	43 (16.5%)	18 (6.9%)	16 (6.1%)	12 (4.6%)	57 (21.8%)	39 (14.9%)	14 (5.4%)
Disabled	p=0.423	**p<0.001**	p=0.056	p=0.227	p=0.154	**p=0.015**	**p=0.004**	p=0.493
Yes	67 (23.6%)	80 (28.2%)	21 (7.4%)	13 (4.6%)	15 (5.3%)	57 (20.1%)	20 (7.0%)	10 (3.5%)
No	370 (21.5%)	334 (19.4%)	81 (4.7%)	111 (6.4%)	61 (3.5%)	463 (26.9%)	225 (13.1%)	76 (4.4%)
Intimate relationship§	p=0.165	p=0.338	p=0.880	p=0.502	p=0.491	p=0.842	p=0.794	**p<0.001**
Yes	329 (22.6%)	309 (21.3%)	74 (5.1%)	85 (5.8%)	57 (3.9%)	376 (25.9%)	176 (12.1%)	46 (3.2%)
No	97 (19.6%)	95 (19.2%)	26 (5.3%)	33 (6.7%)	16 (3.2%)	130 (26.3%)	62 (12.6%)	34 (6.9%)
History of SV¶	p=0.125	p=0.965	p=0.272	**p=0.004**	p=0.772	**p<0.001**	p=0.105	**p=0.007**
Yes	149 (24.0%)	129 (20.8%)	37 (6.0%)	53 (8.5%)	22 (3.5%)	107 (17.2%)	87 (14.0%)	36 (5.8%)
No	280 (20.9%)	277 (20.7%)	64 (4.8%)	69 (5.2%)	51 (3.8%)	400 (29.9%)	153 (11.4%)	43 (3.2%)

Data are reported as the number and percentage of respondents who indicated that the setting would be their first choice. Analysis are based on n=2007, unless stated otherwise. P values are from X^2 tests, unless stated otherwise, and bold p values are significant at p<0.05.
*P value from Mann-Whitney U test, treating the category of age as ordinal.
†Analysis of gender is based on n=1992, after excluding those who described gender in another way or preferred not to say, due to insufficient sample sizes in these groups.
‡Sexualities other than heterosexual/straight were combined into an 'others' group, due to small within-group sample sizes.
§Analysis of intimate relationship status is based on n=1948, after excluding those who were either unsure or preferred not to say.
¶Analysis of a history of sexual violence is based on n=1960, after excluding those who preferred not to say; responses of 'not sure' were treated as 'yes' for analysis.
SARC, Sexual Assault Referral Centre; SRHS, Sexual and Reproductive Health Service;

in younger respondents (p<0.001), those of non-white ethnicity (p=0.034) and disabled people (p=0.015). Since the police were the most common first-choice place of support after SV, a post hoc multivariable analysis was performed, to assess whether these factors were independent predictors of selecting the police as the first-choice place of support (see online supplemental table 1 for further details of the methodology and analysis). On this analysis, both younger age (p<0.001) and a history of SV (p<0.001) remained significantly associated with a lower likelihood of selecting the police as the first-choice place of support, after adjusting for effects of other sociodemographic factors. However, non-white ethnicity (p=0.105) and disability (p=0.103) did not reach statistical significance on this analysis.

Of the healthcare-related places for support considered, both SARC and SRHS were significantly more commonly chosen by younger respondents (p=0.001 and p<0.001, respectively), with SRHS additionally significantly more likely to be the first choice in male respondents (p=0.019) and those of non-white ethnicity (p=0.002). The proportions of respondents selecting either Rape Crisis or the emergency department as their first choice were not found to differ significantly across any of the sociodemographic factors considered. However, primary care was significantly more commonly selected as the first choice in those with a disability (p<0.001).

Experience at SRHS

Overall, 84.9% (n=1703) of respondents had heard of SRHS and 44.7% (n=898) had attended. Just over half (51.3%; n=1030) of respondents were aware that SRHS offer support after SV. Those who had experienced SV and had attended SRHS (n=183) were asked to rate their experience when disclosing SV in this setting. This was assessed using four questions, with responses on a Likert scale of 1–5 (disagree strongly to agree strongly), the results of which are reported in table 3.

Respondents generally considered that they had been believed when they disclosed SV at SRHS, with 77.6%

Table 3 Experiences of disclosure of sexual violence at healthcare settings

	I felt believed				
Healthcare setting	5 (agree strongly)	4	3	2	1 (disagree strongly)
SRHS (n=183)	86 (47.0%)	56 (30.6%)	31 (16.9%)	7 (3.8%)	3 (1.6%)
Primary care (n=196)	84 (42.9%)	74 (37.8%)	29 (14.8%)	6 (3.1%)	3 (1.5%)
SARC (n=129)	65 (50.4%)	33 (25.6%)	25 (19.4%)	3 (2.3%)	3 (2.3%)
ED (n=133)	60 (45.1%)	49 (36.8%)	16 (12.0%)	4 (3.0%)	4 (3.0%)
	I felt blamed*				
Healthcare setting	1 (disagree strongly)*	2	3	4	5 (agree strongly)*
SRHS (n=182)	25 (13.7%)	13 (7.1%)	33 (18.1%)	53 (29.1%)	58 (31.9%)
Primary care (n=198)	30 (15.2%)	15 (7.6%)	38 (19.2%)	56 (28.3%)	59 (29.8%)
SARC (n=129)	29 (22.5%)	5 (3.9%)	26 (20.2%)	36 (27.9%)	33 (25.6%)
ED (n=133)	14 (10.5%)	7 (5.3%)	27 (20.3%)	49 (36.8%)	36 (27.1%)
	I am glad I told them about what had happened				
Healthcare setting	5 (agree strongly)	4	3	2	1 (disagree strongly)
SRHS (n=182)	70 (38.5%)	64 (35.2%)	34 (18.7%)	7 (3.8%)	7 (3.8%)
Primary care (n=197)	82 (41.6%)	65 (33.0%)	32 (16.2%)	12 (6.1%)	6 (3.0%)
SARC (n=128)	53 (41.4%)	42 (32.8%)	23 (18.0%)	4 (3.1%)	6 (4.7%)
ED (n=134)	55 (41.0%)	48 (35.8%)	18 (13.4%)	6 (4.5%)	7 (5.2%)
	I felt safe and supported				
Healthcare setting	5 (agree strongly)	4	3	2	1 (disagree strongly)
SRHS (n=180)	75 (41.7%)	54 (30.0%)	34 (18.9%)	9 (5.0%)	8 (4.4%)
Primary care (n=200)	82 (41.0%)	65 (32.5%)	33 (16.5%)	9 (4.5%)	11 (5.5%)
SARC (n=128)	49 (38.3%)	42 (32.8%)	18 (14.1%)	7 (5.5%)	12 (9.4%)
ED (n=132)	50 (37.9%)	52 (39.4%)	16 (12.1%)	4 (3.0%)	10 (7.6%)

Data are reported as the numbers and proportions of respondents choosing each option on the Likert scale. Respondents only answered the questions for the healthcare settings where they had reported having experienced disclosing sexual violence; hence, the sample size varies across settings. Respondents who did not give responses for all four questions were excluded from the analysis of the affected question. Comparisons between healthcare settings are reported in online supplemental table 2.
*Categories are reversed so that positive responses are on the left, in keeping with the other questions.
ED, emergency department; SARC, Sexual Assault Referral Centre; SRHS, Sexual and Reproductive Health Service.

(n=142) scoring 4 or 5 on the Likert scale; a similar proportion stated that they felt safe and supported (71.7%; n=129). However, 61.0% (n=111) of respondents reported that they had felt blamed. Despite this, the majority of respondents (73.6%; n=134) were glad to have disclosed SV.

The same questions were also asked relating to respondents' experiences of primary care, SARC and the emergency department, the responses to which were compared with those for SRHS. These analyses included only those respondents who reported having experienced disclosing SV at both of the pair of healthcare settings being compared, and found the majority of respondents with experience of multiple healthcare settings to give the same scores in each case, with no significant differences between healthcare settings (online supplemental table 2).

Views on routine enquiry

Respondents were asked whether they supported routine enquiry regarding experiencing SV, both when attending appointments and telephone consultations, in a scenario where four criteria were met, relating to safety, confidentiality, staff training and the option to decline. The majority of respondents showed support for routine enquiry for SV when attending an SRHS (84.4%; n=1693). For those who did not support this (n=314), the most common reasons given were that: it should be left with the patient as to whether or not they want to bring it up (n=156); the question may be upsetting for the patient (n=102); it is not something relevant to ask in a sexual health clinic (n=30); and that it will take up consultation time and distract from the health issue they had attended for (n=23); with other responses given by the remainder (n=3). Comparisons across sociodemographic factors found respondents who reported a history of SV to be significantly more likely to agree with routine enquiry (87.3% vs 83.6%, p=0.037). Younger respondents (p<0.001), those with a sexual orientation other than straight/heterosexual (p<0.001) and those in an intimate relationship (p=0.045) were also significantly more likely to agree with routine enquiry (table 4).

Although the majority of respondents still indicated they would be happy that routine enquiry took place during telephone consultations, support was lower than for routine enquiry when attending appointments, with 71.8% (n=1441) stating that they agreed with routine enquiry during telephone consultations, and a further 14.0% (n=280) being unsure.

DISCUSSION

Prevalence of SV

The survey defined SV as 'sexual activity not agreed to, like sexual violence or abuse'. Defining and measuring SV are notoriously difficult and the published prevalence varies depending on the definition of SV (some studies include only attempted or completed sexual penetration, whereas others include unwanted sexual contact such as kissing and sexual touching), the tool used for data collection and the sample representativeness.[23] The SV prevalence of 27.1% in this survey is similar to previously published papers.[24–27] We found SV to be significantly more common in those whose sexual orientation was not straight/heterosexual (p<0.001), in whom around half reported a history of SV consistent with other studies.[28] It is not clear why older age groups in our survey reported lower lifetime experience of SV (despite having had a longer exposure time), but this may reflect a reluctance to speak about sexual health matters or SV.[29–33]

Our survey identified that a disproportionally high number of disabled people experience SV (n=284, 60.4%). The majority of published studies suggest disability is associated with an increased prevalence of SV, ranging from 13.9% in men with disability to >40% in women.[34–36] We found health-seeking behaviour also differed for disabled people, who were significantly more likely to choose their primary care provider, and tended to be less likely to select the police, or friends and family, as their first choice for support. We postulate that disabled respondents may prefer their primary care provider because they have an established trusted relationship with them linked to their disability and prefer the holistic approach that primary care providers are able to offer. However, our survey is limited in using self-identification of disability and lacking data with regard to type or severity. It was also not possible to identify disability that resulted from SV, and occurred after the SV or predated it. Despite these limitations, we suggest that healthcare providers need to specifically ensure that their services are designed to identify and support disabled patients who have experienced SV. Future work is needed to understand what factors lead to choosing a primary care provider for initial support, which can then be used to inform the optimal delivery of tailored services and improve healthcare professional training.

Help-seeking behaviour

Most survey respondents indicated they would seek support from the police following SV; however, only 25.9% named the police as their first choice, in keeping with the under-reporting of SV globally.[25 37] It is worth noting that our survey provided a hypothetical choice from most respondents, as two-thirds said they had never experienced SV. Multivariable analysis found younger age and a history of SV to be independently associated with a lower likelihood of selecting the police as the first choice of support, with a similar tendency also observed for disabled people and those from racially minoritised communities. For those reporting a history of SV, the police were superseded by Rape Crisis and the primary care provider as preferred places to access support. This may reflect a previous poor experience with the police, or a change in preference when faced with the reality of experiencing SV. Moore and Baker found an 'underlying belief that the police are trustworthy' was a predictor of

Table 4 Use of routine enquiry in Sexual and Reproductive Health Services (SRHS)

	Agree with routine enquiry	
	When attending SRHS	**Via telephone**
Age (years)	**p<0.001***	p=0.218*
18–24	102/113 (90.3%)	81/113 (71.7%)
25–34	537/607 (88.5%)	437/607 (72.0%)
35–44	534/634 (84.2%)	473/634 (74.6%)
45–54	343/423 (81.1%)	295/423 (69.7%)
55 or older	177/230 (77.0%)	155/230 (67.4%)
Ethnicity	p=0.914	**p=0.005**
White	1444/1715 (84.2%)	1246/1715 (72.7%)
Asian	137/160 (85.6%)	100/160 (62.5%)
Mixed	50/58 (86.2%)	40/58 (69.0%)
Black	43/50 (86.0%)	42/50 (84.0%)
Other ethnic group	19/24 (79.2%)	13/24 (54.2%)
Gender	p=0.659	**p=0.042**
Female	1061/1250 (84.9%)	921/1250 (73.7%)
Male	620/742 (83.6%)	511/742 (68.9%)
Other/non-binary/ prefer not to say	12/15 (80.0%)	9/15 (60.0%)
Sexual orientation (n=1957)	**p<0.001**	p=0.194
Heterosexual/ straight	1463/1746 (83.8%)	1258/1746 (72.1%)
Bisexual/ pansexual	128/138 (92.8%)	104/138 (75.4%)
Gay/lesbian	70/73 (95.9%)	59/73 (80.8%)
Intimate relationship (n=1948)	**p=0.045**	**p=0.016**
Yes	1244/1454 (85.6%)	1078/1454 (74.1%)
No	404/494 (81.8%)	338/494 (68.4%)
Disabled	p=0.257	p=0.990
Yes	246/284 (86.6%)	204/284 (71.8%)
No	1447/1723 (84.0%)	1237/1723 (71.8%)
History of SV (n=1960)	**p=0.037**	p=0.143
Yes (includes not sure)	542/621 (87.3%)	464/621 (74.7%)
No	1120/1339 (83.6%)	958/1339 (71.5%)

Data are reported as the n/N (%) of respondents who responded 'yes' to the question; responses of 'no' and 'not sure' were combined for analysis. Analyses are based on n=2007 respondents with p values from X^2 tests, unless stated otherwise, and bold p values are significant at p<0.05.
*P value from Mann-Whitney U test, treating the category of age as ordinal.
SV, sexual violence.

reporting to the police, with further studies identifying mistrust in the police and the judiciary, particularly among minority groups, affected help-seeking.[38] This is currently pertinent in the UK, with several recent cases highlighting concerns around the relationship between the police, criminal justice system and those who have experienced SV, particularly for the minority groups identified in this survey.[39–42]

The preference for seeking help from Rape Crisis did not differ significantly by ethnicity, sexual orientation, gender, self-reported disability, relationship status or history of SV. These organisations have an established role in resolving issues of trust, improving people's experiences with the criminal justice system and in preventing secondary victimisation.[43 44] SARCs were ranked sixth out of the eight options by respondents. Those attending the police may be referred to the SARC for a forensic examination; however, police involvement is not a prerequisite for attending these centres. To have these dedicated SV services ranking low in the survey raises concerns about their visibility and public awareness, and whether individuals' needs and priorities after SV are being addressed. To go nowhere and tell no one was the lowest ranking option to choose following SV (although becoming significantly

and proportionally higher in those with a history of SV). This suggests that disclosure is important to people, despite mixed evidence of the benefits of disclosure.[5 45–47] We acknowledge the complexities surrounding disclosure, but emphasise the focus should be on the freedom to choose whether or not to disclose, and the process of disclosure should remain within the control of the individual.[48] Where the response to disclosure is one of validation and contains the offer of support, benefits are more likely.[49 50]

Perceptions of SRHS including use of routine enquiry

Almost half of respondents had attended an SRHS in their lifetime, and over one-third indicated SRHS would be in their top three choices for support after SV. Males (vs female), non-white (vs white), younger age groups and those with a history of SV (vs no history of SV) were significantly more likely to choose SRHS. Possible reasons for this are that SRHS are known to routinely deal with sensitive and highly personal information, and are recognised to provide non-judgemental and confidential support.[51] A total of 183 respondents reported experiencing SV and seeking support at SRHS. The majority of this group reported a sense of being believed and safe, but 61% reported feeling blamed. It is possible that this high rate may partly be explained by some respondents misreading the direction of the Likert scale for this question, since it was in the opposite direction to the other questions. However, further work is needed to explore the reasons for this result and identify improvements that could be made to services. Lanthier *et al* found that the most helpful responses by healthcare professionals after disclosure of SV were 'validating the disclosure and providing emotional support (ie, showing compassion, being empathic) and providing tangible aid (eg, assisting with access to medical care, encouragement to seek mental health support)'.[11] Ensuring a good response to disclosure is of particular relevance if routine enquiry about SV is implemented in the clinical setting. There is little pre-existing evidence relating to the use and evaluation of routine enquiry, and that which is available focuses on women and may not be generalisable.[15 16]

When presenting a scenario with four prerequisites for using routine enquiry about SV in place (based on safety, confidentiality, staff training and option to decline), we found a large majority (84.4%) of respondents were supportive of its use when attending SRHS. Younger age groups, those in intimate relationships, those with a sexual orientation other than heterosexual/straight and those with a history of SV were significantly more in favour of routine enquiry. There was no significant difference between genders and support of routine enquiry. Although still supported by a majority, routine enquiry was less acceptable during telephone consultations (71.8% vs 84.4%). Barriers to the current use of routine enquiry in the setting of SRHS are not clear, but may relate to lack of knowledge, cost, limited staff training, absence of onward referral pathways or the perceived need to address other priorities.

Strengths and limitations

The primary strength of the study was the relatively large sample size, with participant demographics that are broadly comparable with national census data in relation to ethnicity, disability and sexual orientation, although a difference was present for gender (females: survey (62%) vs census data (51%)).[52 53] However, respondents were self-selected, and required access to a computer or smart phone, making it likely that they belonged to higher than average socioeconomic groups.[54] Further limitations of the study related to the 'prefer not to say' and 'not sure' categories for some of the questions. While these were used relatively infrequently for some questions (eg, gender), they were a more common response for other variables (eg, history of SV). In an attempt to minimise selection bias, these responses were grouped in with other categories, rather than being excluded, where this was deemed reasonable. For example, responses of 'not sure' for history of SV were grouped in with the 'yes' responses, since the explanations given indicated that SV potentially occurred in the majority of these cases. However, there were other instances where there was no reasonable way to combine responses (eg, those answering 'not sure' when asked if they were in an intimate relationship); hence, these cases were excluded from analysis of the affected question.

CONCLUSION

The survey indicated an SV prevalence of 27.1%, with the vast majority of respondents reporting that they would seek support after SV, and the police being the most commonly selected place to do this. However, those with a history of SV and of a younger age were significantly less likely to select the police as their first choice, instead indicating a preference for Rape Crisis (or similar charity) or primary care. There was also a tendency for those from racially minoritised communities and disabled people to be less likely to choose the police, raising concerns over the levels of trust between the police and these groups. The majority of respondents supported routine enquiry about SV in an SRHS healthcare setting, both for those attending clinics and telephone consultations; however, acceptability of routine enquiry significantly reduced with age. Those with a history of SV were significantly more in favour of routine enquiry than those who had not. The authors believe the findings from this study support the introduction of routine enquiry within these healthcare settings once the necessary training, referral pathways and understanding of how to create a safe environment for disclosure are in place.

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