BORDER COUNTIES SEXUAL VIOLENCE NEEDS ANALYSIS PROJECT

1 JUNE 2019

Susan Miner PhD

ACKNOWLEDGEMENTS

The first and primary acknowledgements are to the sexual violence survivors who agreed to participate in this project and provided thoughtful input in completing surveys. Advisory Group members provided information and feedback as well as assisting in setting up focus group and consultations. The membership list is in Appendix 1. The specialist sexual violence services facilitated survivor input, provided data, engaged in focus groups and answered endless questions. Thanks also to the stakeholders in other organisations who actively and keenly participated in focus groups, consultations and surveys, as well as providing data and information. They are named in Appendix 2, along with their methods of engagement.

EXECUTIVE SUMMARY

This needs analysis project about sexual violence services for victim/survivors in the border counties of Donegal, Leitrim, Sligo, Cavan, Monaghan and Louth is to:

- **Look at survivor-centred best practices for services for all sexual violence survivors;**
- **Provide an overview of existing services;**
- **Document who is and who is not using existing services, specifically LGBTI persons, young people age 14+, Travellers, Roma, immigrants and refugees and asylum seekers;**
- **In comparison with best practices, reflect on the adequacy for purpose of existing services; and**
- **Make recommendations for the future direction and development of services.**

RESEARCH PROCESS & METHODOLOGIES

The process for this project is:

GOVERNMENT OBLIGATIONS

The Irish government itself, as well as individual government departments, all have obligations under a Council of Europe (COE) Convention, an EU Directive, national strategies and national reviews. The most relevant for this needs analysis project are:

⇒ The COE Convention on Preventing and Combating Violence Against Women and Domestic Violence known as the Istanbul Convention

⇒ EU Directive 2012/29/EU known as the Victims Right's Directive

⇒ The Second National Strategy on Domestic, Sexual and Gender-Based Violence (DSGBV)

⇒ The National Traveller and Roma Integration Strategy
⇒ The HSE Second National Intercultural Health Strategy
⇒ LGBTI+ National Youth Strategy
⇒ Safe, Respectful, Supportive and Positive: Ending Sexual Violence and Harassment in Irish Higher Education Institutions
⇒ HSE National SATU Review.

BEST PRACTICE RESEARCH

Research on best practice, commissioned by the European parliament and conducted by Sylvia Walby and others, determined that specialist sexual violence services need to contain the following elements:

- **Victim/Survivor-centred,**
- **Gender expert/gender/sensitive,**
- **Survivor participation**
- **Trained personnel**
- **Skilled specialist centres to act as beacons to mainstream services,**
- **Built-in monitoring and evaluation**
- **Part of strategically-coordinated comprehensive package of policies.**

Rape Crisis Centres (RCC)s are defined, in COE minimum standards and Rape Crisis Network Europe documents, as NGOs that provide some combination of helpline, counselling, advocacy and self-help in supporting those who have been assaulted recently or in the past. Overall services are delivered using a survivor-centred and trauma-based model. Survivor identified indicators of recovery and healing inform the way in which services are delivered and developed. A trauma-based model means services are offered with the understanding that a survivor's reactions are a normal response to trauma.

Specialist services, such as those provided by RCCs are intrinsic to the necessary culture shift. Not only do they provide what survivors need and want, they also challenge norms. This is according to 2009 research on RCCs conducted by Martin (Human Services Organisations. 2nd Edition. New York, Sage). Having a diversity of services and different 'entry points' is important as it increases the likelihood of survivors finding the help they need. The UK Map of Gaps 2 research examined what and where the gaps in violence against women services were in the UK. It recommends that the government should aim for the diversity of services with multiple entry points in order to 'ensure multiple routes into support as well as providing targeted services to meet specific needs.'

The COE minimum standards note:*"in order to fulfil their responsibilities NGOs need to have skilled and knowledgeable staff, sufficient resources and work within a set of philosophical principles. It is the responsibility of states to ensure that sufficient resources are made available to sustain NGOs in providing quality services to all women who seek support. Such resources should also enable NGOs to continue to innovate, including putting into practice recognised international good practices."* While the standards clearly articulate the need for specialist services primarily provided by specialist NGOs, the report also indicates that there are elements of any an effective support system which are the direct responsibility of the state. The two most emphasised are law enforcement and health services in the immediate aftermath of sexual violence. It is also important to note that there is an overlap between sexual violence and domestic violence, with some survivors experiencing sexual violence from their intimate partner or ex-partner.

SEXUAL VIOLENCE PREVALENCE

In Ireland, detailed population-based research on sexual violence experienced by females and males was carried out in 2002 (SAVI-Sexual Abuse & Violence in Ireland). Overall, 42% of women reported experiences of sexual violence during their lifetimes. For men the rate was 28%. In more recent research the EU Fundamental Rights Agency (FRA) found that 8% of Irish women had experienced sexual violence since the age of 15 and 48% of Irish women had experienced sexual harassment since the age of 15. An individual woman may have experienced both and therefore there may be an overlap between the two.

Research into sexual violence perpetrated against men is more rare than that regarding women. US research results suggest that approximately 90% of sexual assaults were perpetrated against men before they reached the age of 19. Forcible fondling and sodomy were the two most commonly reported types of sexual assaults. Additional research based on the same dataset found that 17% of men experienced some form of contact sexual violence in their lifetimes.

LGB experiences of sexual violence have been even less frequently examined, with trans and intersex people's experience almost non-existent in published research. US LGB research, based on the same national dataset named above, found that bisexual women and men were significantly more likely to experience rape and sexual violence other than rape. The UK government conducted an online LGBTI+ survey. Six percent of the respondents reported threats or actual physical or sexual harassment in the previous year because they were LGBTI+.

In 2009 the Irish Women's Health Council (subsumed into the Department of Health in 2009) researched ethnic minority women's experiences of gender-based violence (GBV). For Traveller women, the discrimination they experienced meant an extra risk factor for domestic violence. According to this research, Traveller women also lacked trust in GPs and social services. Some women who came to Ireland from other countries experienced GBV including harmful traditional practices such as female genital mutilation (FGM) The WHO and other international organisations report that rape and other forms of sexual violence are used as strategies in many conflicts and wars.

The FRA research found that, as a group, young women are particularly vulnerable to violence. Overall, 16% of the third-level students in 2013 research commissioned by the Union of Students in Ireland reported experiencing some type of unwanted sexual experience at their current third-level institution. In 2018 an NUIG research team survey with third-level students found that by the third year about 70% of the women and 40% of the men had experienced sexual hostility or crude harassment.

The under-reporting of sexual violence to police authorities is recognised internationally. There has been a 60% increase in sexual crimes reported to An Garda Síochána between 2014 and 2018. This does not mean the rate of sexual violence has increased. It may mean that more of the sexual crimes which have been perpetrated are being reported.

BORDER COUNTIES

The population of the border counties (Donegal, Leitrim, Sligo, Cavan, Monaghan and Louth) is 11% of the population as a whole, according to the 2016 Census. With the exception of Louth, all of the counties are primarily rural. Louth is the most densely populated county outside of the Dublin counties. This has implications for the location and extent of required services.

According to the 2016 Census there are 212,816 females age 14+ and 206,505 males age 14+ in the border counties. Youth age 14-24 account for 16.6% of that population. Almost one in ten (9.8%) have a nationality other than Irish. The Census recorded a Traveller population of 0.4%, however local reports place that figure much higher. According to the CHO (HSE Community Health Organisation) Region 1 reports, this is likely due to incorrect information being given to Travellers about how to complete the form, the potential reluctance to identify as a Traveller because of discrimination and literacy challenges.

There is no accurate information about the number of Roma living in Ireland. The Census did not ask for information about Roma ethnicity and Roma people have a variety of nationalities. The 2016 Census did not record gender identities other than female or male and did not ask about sexual orientation.

The Department of Justice and Equality Refugee Integration Agency (RIA) statistics for October 2018 (the latest available at time of writing) indicate that 549 people were living in direct provision facilities in the border counties. According to information obtained by RTE there was a dramatic increase in the number of asylum seekers in emergency accommodation between October 2018 and March 2019.

Using SAVI calculations, 89,383 females and 57,821 males living in the border counties have experienced sexual violence. Using FRA figures, 16,784 women have experienced sexual violence since the age of 15 and 18,884 have experienced sexual violence before the age of 15. There may well be an overlap between these two groups of women. It is important to note that the two different pieces of research used different definitions of sexual violence. Neither of these pieces of research specifically examine the different vulnerabilities of different groups of people based on ethnicity, gender identity or sexual orientation.

BORDER REGION SPECIALIST SERVICES

DONEGAL
1 SATU
1 RCC
1 DV Support Service/Refuge
1 DV Support Service
1 Women's Centre with DV Counselling
Male DV outreach
NCS

BELFAST & FOYLE
Male DV counselling

BELFAST
RCC

BELFAST DERRY ENNISKILLEN & outreaches
SV counselling & support - NI address only

ANTRIM
SART – crime committed in NI

DERRY ENNISKILLEN OMAGH NEWRY
DV Service/Refuge

LEITRIM
1 shared RCC/DV Support Outreach
RCC outreach
DV outreaches
NCS

CAVAN
1 DV Support Service Outreach
NCS

MONAGHAN
1 RCC Outreach
1 DV Support Service
NCS

LOUTH
1 RCC
2 DV Support Service/Refuge - 1 with Meath
NCS

SLIGO
1 RCC
1 DV Support Service
RCC Outreach
DV Outreaches
NCS – National Counselling Service

In addition to this local specialist service provision, there are also three SATUs close by in Galway, Mullingar and Dublin. Dublin Rape Crisis Centre operates the nation 24 hour sexual violence freephone helpline and Women's Aid in Dublin operates a 24 hour domestic violence helpline. Connect offers a helpline and telephone counselling for adults who experienced trauma, abuse or neglect as a child. Amen, based in Co. Meath, provides an office hours helpline for men who are experiencing domestic violence, along with support, counselling and court accompaniment. In May 2019 the Men's Development Network launched a 37 hour per week helpline staffed by counsellors for men experiencing domestic violence.

RESEARCH FINDINGS: SURVIVOR INPUTS

Twenty survivors who are using RCC, DV services and/or Family Resource Centres (FRC) participated by completing a questionnaire. All could understand English (the only language in which the survey was available), most were female and white/settled/Irish and the most common age is between 41 and 60. For the most part victims/survivors found the services they used to be helpful. Their comments indicate building/rebuilding self-worth and self-trust, safety, helping to understand feelings, a non-judgemental attitude, starting of recovery and saving lives when suicidal.

Counselling is the most commonly used service and half of those who availed of that support had been on a waiting list to begin varying from three weeks to six months. Half of the participants were also referred to other organisations/agencies. This is indicative of the variety of needs an individual survivor may have. More than half think that additional access to supports/counsellor by telephone, text, skype or other internet facilities is needed in order to improve accessibility. For RCCs specifically, additional counselling times on weekends or in the evenings were named. One quarter see a need for family counselling or group counselling. One-quarter think that education prevention programmes should be available/more available, with a few mentioning that it should be for all age ranges.

Some participants also shared negative experiences; being overwhelmed by being referred too soon for them, not feeling they got enough assistance with coping mechanisms and feeling they were taking someone else's spot.

RESEARCH FINDINGS: ORGANISATION IDENTIFIED ISSUES

Information was obtained from specialist services, general services and stakeholder agencies/groups through an online survey, focus groups, individual interviews, telephone interviews, electronic communications and a data review. Participants came from a variety of government and NGO

organisations including those working with and for Travellers, Roma, immigrants, refugees and asylum seekers, youth and LGBTI persons.

PRIORITIES

The **priorities** identified include:

- **Provision of sexual violence services in Cavan**. This was identified by a significant number of stakeholders. It is also notable that none of the participant survivors live in Cavan.
- **Increase level of sexual violence services in Monaghan** – at present there is only a limited outreach. It was noted that Family Resource Centres (FRC) cover areas in which there are not specialist sexual violence services but that victim/survivors may not go to them.
- **Increase in specialist NGO services capacities across the board, both for direct services provision that is accessible to minority groups and for preventative/social change work.** This area got significant attention. The provision of culturally appropriate services is seen as a gap across all of the counties. In addition, the lack of services in languages other than English is also a problem for a number of people needs to access supports.
- **Equality and specific violence issues education in early years, schools, colleges and public services**. Specialist services and general services see a need for much more extensive and coordinated prevention work starting at an earlier age.
- **Better public and easily accessible information about existing services**. This issue was raised by general service providers and minority group organisations/agencies.
- **Accurate prevalence research**.

PROMISING DEVELOPMENTS

The developments identified are:

- the Traveller DSGBV Community Worker pilot scheme,
- an eight-week course for women in direct provision facilitated by the Sligo RCC,
- the Yellow Flag cultural diversity schools programme run by the Irish Traveller Movement,
- the LGBTI Chartermark programme in Scotland,
- the HSE Foundation Programme in Sexual Health Promotion in Donegal,
- DkIT's Level 8 Certificate in the Fundamentals of Understanding and Responding to Domestic Abuse,
- Joint outreach premises operated by the Sligo-based RCC and DV service,
- A weekly callback service for survivors on the waiting list for counselling at the RCC in Louth, and
- The opportunity for online victim/survivor feedback in SATUs.

IDENTIFIED GAPS

When compared with best practice research and the Council of Europe minimum standards, there are specific gaps in existing services pinpointed by survivors, specialist services providers and other stakeholders in the areas of:

1) **Existing services locations** – There is no sexual violence service in Cavan and only a limited outreach in Monaghan. There is only a domestic violence outreach in Cavan.
2) **Existing services capacities** –
    a) COE standards would require at least six services providing individual and group counselling and the same number of advice/advocacy services with capacity to serve women and men. Local helplines are also required in addition to a national 24 hour line. The three RCCs provide individual counselling. There is one specialist DV counselling service for women. All of the existing RCC and DV services provide advocacy/advice.
3) **Services for specific groups of people** -
    a) Culturally appropriate and in appropriate languages – Services are best provided in a language in which the survivor is comfortable using. Sexual violence experiences can be very difficult to discuss and the addition of an interpreter as a third person in the conversation is inappropriate. Failing access to counselling in a particular language an aspirational standard in the COE minimum standards requires DSGBV training for trusted interpreters. Best practice research states that services should monitor the demographics of their service users and collaborate with groups and service to develop culturally competent and appropriate services. COE standards require staff training in cultural competency, accessible services for socially excluded persons and outreach to minority communities. Some collaboration goes on in the border counties. Culturally appropriate services for Travellers and for Roma are identified as gaps. Services available in a variety of languages are also identified as a gap.
    b) LGBTI+ - COE standards require accessible services for socially excluded persons and outreach to minority communities. The lack of clearly accessible services and personnel training was identified as an issue.
    c) Age appropriate – service need to take account of the fact that younger people believe their online life is as real as their face-to-face life. Minimum standards require the adaption of services to meet the needs.
4) **Staff Training** – European best practice research requires that services have trained personnel. COE standards require all relevant state and non-state personnel to have appropriate training. For state agency training, specialist NGOs should be used as trainers and paid appropriately. Cultural competency training for specialist services personnel is also a minimum standard. Services personnel in the border counties noted the need for both of these types of training.
5) **Interagency Links & Interagency Working** – Collaborative interagency working is a requirement of European best practice research. This can include co-training. While local specialist services

engage in many links with other agencies, there is no formal framework within which that can occur.

6) **Prevention & Social Change** – A Scottish literature review, commissioned by Rape Crisis Scotland, about the pros and cons of specialist services, found that the literature indicates social change work and direct services work needs to go hand-in-hand for RCCs. Specialist services in the border counties have limited capacities to engage in this work.

7) **Data** – Two significant data gaps have been identified. The first is the lack of current Irish-specific sexual violence data which takes account of the different vulnerabilities of different groups of people. The CSO is beginning the process of new prevalence research. The second is the lack of available data on who is using the services to know who is not. This is required in order to plan for services and adapt services to better meet the needs of people who do not currently access them.

RECOMMENDATIONS

SERVICES LOCATIONS
1: Develop a Rape Crisis Service in Cavan.
2: Ensure a more visible and accessible RCC service in Cavan.
SERVICES CAPACITIES
3: Existing RCCs to increase capacity to provide face-to-face counselling services, individual, relationship and group.
4: Existing RCCs to improve accessibility to increasing the provision of online and telephone services.
5: Existing DV services to increase capacity to provide supports.
PREVENTION
6: Specialist NGOs to participate more fully in preventative work.
APPROPRIATE & ACCESSIBLE SERVICES
7: All specialist sexual violence services to engage regularly with survivors in order to ascertain the quality and appropriateness of services delivery and to plan future services developments.
8: Sexual violence services, including telephone, social media, internet and face-to-face services to be provided in as many languages as possible.
9: All specialist sexual violence services to write informational documents, website pages, social media pages and apps in Plain English.
10: Domestic, sexual and gender-based violence (DGBSV) training to be provided for trusted interpreters.
11: Set up chartermark programmes to ensure appropriate and accessible services for members of ethnic minorities and LGBTI+ individuals.
12: Utilise learning from the Traveller DSGBV Community Worker Pilot Project to develop services in the border counties.
13: Pending development of a cultural diversity chartermark process, cultural competency training to be regularly delivered by HSE, Traveller and Roma personnel. This training to be available and

accessible to specialist sexual violence services.
14: Any future commissioned DSGBV research to include Traveller and Roma representation on the advisory or steering groups.
INTERAGENCY WORK, REFERRAL PATHWAYS, TRAINING & AWARENESS
15: Create local structures akin to CYPSC (Children & Youth Protective Services Committee) for DSGBV services and all related stakeholders for the groups of people names in this needs analysis project: Traveller & Roma Support Groups, Immigrant Support Groups, Refugee/Asylum Seeker services, LGBTI+ groups and youth groups.
16: Exploit possibilities for co-training between specialist sexual violence services and agency/groups working with and for Travellers, Roma, other ethnic minorities, LGBTI+ person and youth 14+.
17: All relevant stakeholders to be made aware of current referral pathways to and from specialist sexual violence services, and, where pathways do not exist, to create them.
18: Ensure health frontline services personnel receive appropriate sexual violence training.
19: Each county to have an easily accessible web-based directory of specialist and general services for sexual violence survivors, regardless of age or family status.
DATA
20: CSO prevalence research and resultant data to address the rates of sexual violence among differently vulnerable and marginalised groups of people, including those named in this NAP.
21: All statutory and NGO sexual violence service providers to collect information about survivor ethnicity and nationality following the SICAP guidelines and gender identity and sexual orientation following the principle of self-identification.
22: When LGBTI+ Youth Strategy Action 15(d) is complete, the information about the best ways to enquire about gender identity and sexual orientation to be used by all statutory and NGO sexual violence service providers.
22: Utilise the information gleaned from the previous recommended actions about service user's ethnicity, nationality, gender identity and sexual orientation as an aid to plan future services.
FUNDING
24: Tusla funding to be provided on a multi-annual basis to all DSGBV NGO services.

TABLE OF CONTENTS

TERMS OF REFERENCE

The Terms of Reference for this project are as follows:

1. Document relevant existing internationally recommended, survivor-centred best services delivery practice for all sexual violence survivors.
2. Provide an overview of existing therapeutic, advocacy, interagency and preventative services available for and to people who have experienced sexual violence, their supporters and, in terms of preventative services, the general public within the border region (Donegal, Leitrim, Sligo, Cavan, Monaghan and Louth). This includes:
    a. Direct frontline services in this jurisdiction such as Rape Crisis Centres, SATUs, Domestic Violence Services and the National Counselling Service,
    b. General services which sexual violence survivors may utilise such as Counselling in Primary Care (CIPS) or the Child and Adolescent Mental Health Services (CAMHS).
    c. Other agencies and organisations which provide services to Travellers, Roma, refugees and asylum seekers, immigrants, LGBTI persons and young people, and
    d. NI services which survivors in the border region may utilise.
3. Document who currently is and is not using existing services (these categories are not discrete).
    a. LGBTI persons
    b. Young people aged 14+
    c. Travellers, Roma, other ethnic minorities
    d. Refugees and Asylum Seekers
    e. Immigrants
4. In comparison with internationally identified best practice, provide an answer to the questions of whether existing therapeutic, advocacy, interagency and preventative services are adequate for purpose. This will have a particular focus on the above-named communities / groups.
5. Detail recommendations for the future direction and development of services – including the improvement of access for survivors who do not currently utilise the existing services.

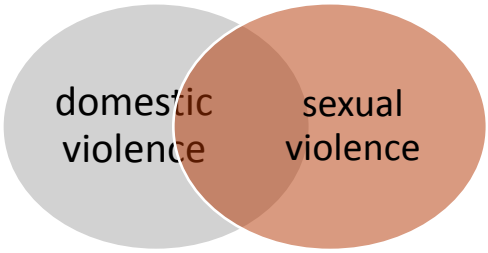
There are other specific marginalised groups of survivors who do not access many existing services in the same proportion as their percentage of the general population.[1] This includes people with dis/abilities and older people. This NAP specifically addresses the groups/communities of people named above.

[1] See, for example, https://www.rcni.ie/wp-content/uploads/RCNI-RCC-StatsAR-2015-1.pdf and https://www.rcni.ie/wp-content/uploads/Older-Women-and-Sexual-Violence-recognising-and-supporting-survivors-abstract.pdf

1.INTRODUCTION

This Needs Assessment Project is concerned with the availability of services for people who have experienced sexual violence in the border counties. The most obvious service providers are the Rape Crisis Centres (RCCs) and SATUs (Sexual Assault Treatment Units).

There is an overlap between sexual violence and domestic violence. Many people who experience domestic violence (DV) experience sexual violence as a part of that. In the course of this research DV service providers commented that an increasing number of women identify sexual violence as a component of the domestic violence they



experienced. Some men who have experienced domestic violence also disclose sexual violence to a specialist DV service provider.

As this NAP is not about domestic violence as a whole, it does not address specific domestic violence issues such as court availability for barring orders, refuge space, etc.

Some people who experience sexual violence report to the Gardai or PSNI. This NAP provides general information about the specialist Garda services in the border region and of the support services available to those who do report. It does not address specific court issues.

As this NAP is particularly concerned with the needs of youth age 14+, Travellers, Roma, Immigrants, Refugees and Asylum Seekers and LGBTI people, groups working with and for these individuals were a part of this project. Section 3 on methodology includes the specific information about how the research has been conducted.

2.DEFINITIONS & ABBREVIATIONS

In order to make the best use of this document, it is necessary to understand the abbreviations, terminology and definitions used. The term victim typically refers to someone who has recently experienced a sexual assault. It is often the term used when discussing a crime or talking about the court system. The term survivor often refers to an individual who is going or has gone through their own recovery process. This word is also used when discussing the impacts of sexual violence. Some people identify as a victim, while others identify as a survivor. Because of that the term

victim/survivor is sometimes used.[2] More recently the terminology of someone who has experienced sexual violence has become more common as it does not place the same emphasis on only one aspect of a person's life.

The terms survey and questionnaire are used interchangeably throughout.

2.1 ABBREVIATIONS

The most commonly used abbreviations include the following. Each is also fully named the first time it is used.

AGS - An Garda Síochána
CFI - Community Foundation of Ireland
CHO - Community Healthcare Organisation – HSE division
CIPC - HSE Counselling in Primary Care
COE - Council of Europe
CSFN - Tusla Child & Family Support Network
CSVC - Commission for the Support of Victims of Crime
DkIT - Dundalk Institute of Technology
DPSU - Garda Divisional Protective Services Unit
DSGBV - domestic, sexual and gender-based violence
DV - domestic violence
EIGE - European Institute on Gender Equality
ESHTE - Ending Sexual Harassment & Violence in Third Level Education Project
EUBPR - EU Parliament commissioned best practice research for women victims of rape
FGM - female genital mutilation
FRA - EU Fundamental Rights Agency
FRC - Family Resource Centre
GNBSP - Garda National Protective Services Bureau
IFPA - Irish Family Planning Association
IHS - Second HSE Intercultural Health Strategy 2018-2023
ISVA - Independent Sexual Violence Advisor
LCDC - Local Community Development Company
LECP - Local Economic and Community Plan
NAP - needs analysis project
NCS - HSE National Counselling Service
NTRIS - National Traveller & Roma Inclusion Strategy 2017-2021
PPN - Department of Rural & Community Development Public Participation Network
PSNAP - Peace & Security National Action Plan
RCC - Rape Crisis Centre
SACT - Sexual Assault Crisis Team
SAFE - Sexual Assault Forensic Examiner
SARC - Sexual Assault Referral Centre
SATU- Sexual Assault Treatment Unit
SICAP - Social Inclusion and Community Activation Programme
SAVI - Sexual Assault & Violence in Ireland – 2002 Prevalence Study
SNS - Second National Strategy on DSGBV 2016-2021
SV - sexual violence

[2] https://sakitta.org/toolkit/docs/Victim-or-Survivor-Terminology-from-Investigation-Through-Prosecution.pdf

UNODC - United Nations Office on Drugs & Crime
VAW - Violence against Women
WHO - World Health Organisation

2.2 SEXUAL VIOLENCE

There are many different definitions and understandings of the terms 'rape' and 'sexual violence'. These definitions and understandings have a profound impact on what individuals understand as sexual violence and on how prevalence is measured. The World Health Organisation (WHO) defines **sexual violence** as: "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work"[3] **Three types of sexual violence** are commonly distinguished: (1) sexual violence involving intercourse e.g. rape; (2) contact sexual violence e.g. unwanted touching excluding intercourse; and (3) non-contact sexual violence e.g. threatened sexual violence, exhibitionism and verbal sexual harassment.[4]

Rape is more specifically defined by the WHO as "physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object".[5] In some legal definitions, intercourse only applies to penetration of a person's vagina by a penis or of a female by a male. These legal definitions are relevant because they define reported crime rates, inform individual's reporting decision-making and frame some public discourse. The common definition of rape can often be more restricted than the legal definition. Survivors may be reluctant to use the term unless the circumstances are more extreme than those defined in law. This may well relate to the stigmatisation of rape victims in wider society and popular culture and obviously has consequences for the treatment of victims of rape and holding perpetrators accountable.[6]

In Ireland rape as defined in the Criminal Law (Rape) Act 1981 as "unlawful sexual intercourse with a woman who at the time of intercourse does not consent to it", where the man "knows that she does not consent to the intercourse… or he is reckless as to whether she does or does not consent to it." Sexual intercourse for the purposes of rape means vaginal intercourse. Marital rape only became a crime under Section 5 of the Criminal Law (Rape) (Amendment) Act 1990, which abolished "any

[3] Jewkes, R. et al. , in Krug EG et al., eds. (2002) *World report on violence and health,* Geneva, WHO.
[4] *Global Status Report on Violence Prevention 2014,* Geneva, WHO

[5] Jewkes, R. et al.

[6] Walby et al. (2013), *Overview of the worldwide best practices for rape prevention and assisting women victims of rape.* European Parliament Directorate General for Internal Policy, Department C, Gender Equality.

rule of law by virtue of which a husband cannot be guilty of the rape of his wife". Prior to that a husband could not be guilty of raping his wife because of what was considered to be mutual matrimonial consent. Since that time there have only been four convictions for marital rape.[7] This was and remains a gender-based definition. Rape under Section 4 is defined by the Criminal Law (Rape) (Amendment) Act 1990 as a sexual assault that includes "penetration (however slight) of the anus or mouth by the penis, or penetration (however slight) of the vagina by any objects held or manipulated by another person." This category of rape can be committed by someone of any gender identity against another person of any gender identity.

Female genital mutilation (FGM) is the practice of partial or total removal of female genitalia for non- medical reasons. The procedure has no known health benefits but can cause serious immediate and long-term obstetric, gynaecological and sexual health problems.[8] In Ireland the Criminal Justice (Female Genital Mutilation) Act 2012 makes it illegal to practice or attempt to practice FGM. It is a criminal offence for someone resident in Ireland to perform FGM or for someone resident in Ireland to take a girl to another country to undergo FGM.

Coercion covers a spectrum of degrees of force. In addition to physical force, it may involve psychological intimidation, blackmail or other threats. It may also occur when the person against whom the violence is perpetrated is not in a position to consent or refuse because, for example, they are drunk, drugged, asleep or mentally incapable of understanding the situation.[9]

The Criminal Law (Sexual Offences) Act 2017 Section 38 defines consent as meaning that "he or she freely and voluntarily agrees to engage in that act" . The definition of **consent** utilised by Irish SMART Consent third level research is more specific: "the freely given verbal or nonverbal communication of a feeling of willingness to engage in sexual activity".[10]

Sexual violence is perpetrated in a variety of contexts and by persons with a variety of relationships to the victim/survivor. These include:

[7] https://www.irishtimes.com/news/crime-and-law/courts/man-46-fails-in-appeal-against-conviction-for-marital-rape-1.3490611

[8] HSE Second National Intercultural Health Strategy 2018-2023

[9] Jewkes, R. et al.

[10] Hickman and Muehlenhard (1999, p. 259) cited in MacNeela P. et al. (2018) *Sustainable and Feasible in Third Level Institutions? Evidence from Implementing and Extending the SMART Consent Workshop.* Galway, School of Psychology, NUI Galway.

- Rape and other forms of contact sexual violence of an adult by an intimate partner, acquaintance, or stranger;
- Rape and other forms of contact sexual violence by someone in a position of power, e.g. priest, teacher, carer, medical professional;
- Rape and other forms of contact sexual violence against someone who is currently unable to consent, e.g. asleep, unable to understand what they are consenting to, drunk or otherwise incapacitated;
- Rape and other forms of contact sexual violence by a parent or other family member
- unwanted sexual advances or sexual harassment, including demanding sex in return for favours;
- Systemic sexual violence in armed conflict; [11]
- Forced marriage or cohabitation, including the marriage of children;
- Denial of the right to use contraception or to adopt other measures to protect against sexually transmitted diseases, e.g. stealthing or non-consensual condom removal;
- Forced abortion;
- Violent acts against the sexual integrity of women, including female genital mutilation and obligatory inspections for virginity;
- Forced prostitution and human trafficking for sexual exploitation; and
- Sexual bullying or instances in which sexuality or gender is used as a weapon to a person's face, behind their back or through the use of technology. This includes revenge porn. [12]

Domestic violence is a pattern of coercive/ threatening, controlling behaviour used by one person over another within a close or intimate relationship. It can include sexual abuse/ violence.[13]

2.3 SERVICES

The Istanbul Convention, which is discussed in the Section 5 on European and Irish conventions and strategies, explicitly recognises the difference between general and specialist services. **General support services** are universal services 'offered by public authorities such as social services, health services, employment services, which provide long-term help and are not exclusively designed for the benefit of victims only'. **Specialist support services** are designed and provided to meet the needs of victims of specific forms of violence and are not open to the general public. While these may be services run or funded by the government, in many countries the large majority of specialist services are provided by NGOs. The specialist sector is more likely to be 'holistic' in one of two ways, either by covering all or a range of forms of violence against women or another group of people and/or providing a range of supports. General services are more likely to focus on one area of

[11] Systematic and widespread sexual violence in armed conflict refers to the deliberate use of sexual violence as a military strategy to displace populations, instil fear, terrorise and control them, underscored by patriarchal attitudes, religious and cultural mores. For example, Wood E. (2006) *Variation in Sexual Violence during War.* Politics & Society. 34 (3): 307-341. and Rowley E. et al. (2012) *Post Conflict Settings: Developing a Research Agenda*. Geneva, UN Action, WHO and SVRI.

[12] Jewkes et al., Basile K.C. et al and The Rosey Project https://www.roseyproject.co.uk/content/sexual-bullying/ (accessed 15/03/19).

[13] https://www.safeireland.ie/get-help/understanding-domestic-violence/what-is-domestic-violence/

support – for example, health or employment. Some **specialist provisions** have developed **within general services**.[14] The example of the latter in this country is the hospital-based SATUs (Sexual Assault Treatment Unit).

3.METHODOLOGIES

Mixed methods were used for the data collection in order to draw upon the expertise and obtain input from as many individuals and groups/organisations as possible. The data collection methods included:

1. A literature and data review:
    a. Relevant literature on the prevalence of sexual violence
    b. Relevant literature on best practices and services standards
    c. Annual reports and statistical data from relevant organisations
    d. 2016 census population data, including obtaining specific 14+ figures from the CSO
    e. LECP (Local Economic & Community Plans) and CYPSC (Children & Young People Services Committee) plans from all six counties
    f. Data obtained from specialist services providers in the border counties
    g. Data obtained from services and the PSNI in Northern Ireland
    h. Relevant European conventions, EU directives, national strategies and reviews
2. Local services and stakeholder focus groups – (Letterkenny, Sligo, Cavan, Castleblayney):
    a. Specialist services – RCC (Rape Crisis Centre), SATU (Sexual Assault Treatment Unit) and DV (domestic violence) services
    b. Family Resource Centres (FRC)
    c. Tusla personnel
    d. HSE personnel
    e. Traveller support group staff
    f. Cultural Champions from a variety of countries
    g. Immigrant support group staff
    h. Youth workers
    i. LGBT organisation staff
    j. LGBT youth worker
    k. An Garda Síochána
3. Telephone consultations:
    a. national Traveller and Roma support organisations, immigrant support organisations, a transgender support organisation, a LGBT centre, youth LGBT organisations and the Garda National Protective Services Bureau
    b. local Traveller support groups
    c. SATU personnel
4. Individual and face-to-face consultations:
    a. Specialist services – RCC & DV services
    b. Traveller support personnel
    c. Refugee and asylum seeker support organisation personnel – “non-national” and Irish
    d. FRC manager
    e. Addiction worker
    f. Perpetrator programme counsellor

5. Online survey with stakeholder and service provider organisations.
   The surveys were disseminated through all of the CYPCS and to stakeholder organisations. Thirty responses were received. (opened online 11/03/19 and closed 05/05/19).
6. Survivor survey with option for online or hard copy completion.
   Surveys were disseminated through all of the RCCs, some of the DV services and some of the FRCs. Twenty responses were received. (opened online 13/3/19 and closed 05/05/19, information sheets and hard copies distributed to SV, DV and FRC services last two weeks in March). The survey was only available to survivors aged 18+ and sharing of demographic or potentially identifying information was optional.

The specific methodologies are named through the document and the table in Appendix 2 includes information about the methodologies used with each group. The online survey was designed, disseminated and collected using EUSurvey, an EU online survey tool which is GDPR compliant and stores the data within the EU.

4.GOOD AND BEST PRACTICES

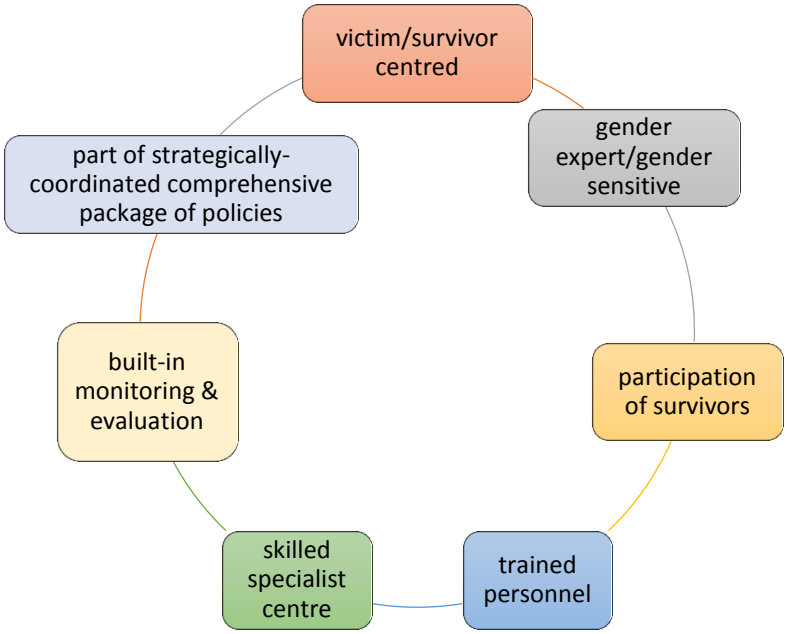
The UK Rape Victim Experience Review found that persons who had experienced rape wanted:

- **To be believed,**
- **To be treated with dignity,**
- **To be reassured that it was not their fault,**
- **To feel safe and comforted,**
- **Not to feel like a 'victim',**
- **Services that support them and their family,**
- **To feel in control, and**
- **To be able to make informed choices**.[15]

4.1 PRACTICE RESEARCH

Good practice or best practices[16] have been identified in 2013 European research[17] as practices that are innovative, proven to have made a difference, and models for development elsewhere. This research identifies criteria that encompass therapeutic, advocacy, interagency and preventative work. The general criteria for sexual violence services are:

[15] Payne, S. (2009) *Rape; The Victim Experience Review*. London, UK Home Office.
[16] Good practice is often the preferred term since best may be the best for now but that may change in a few years time.
[17] Walby, S. et al. This research utilises definitions of good or best practice developed by EIGE in *Good Practices in Gender Mainstreaming* 2011.



The good practice case study for a RCC named in the same research is a SACT (Sexual Assault Crisis Team) in the USA that stretches the boundaries for what is often perceived as a RCC. It has a sexual violence refuge as well. The residential based support is available to both women and men: victim-survivors of recent rape and sexual assault, those coming to terms with historic rape experiences, including as a child, and those who have returned to the area to testify at trial. It also provides a 24 hour helpline answered by trained advocates, a range of advocacy services for both residential and non-residential clients, including: hospital advocacy; legal advocacy; attorney consultation through a specialist law project; education, training and support programmes; information and training on date rape, stranger rape, surviving incest, inner child workshops, ritualised abuse, different types of harassment, support groups, cults and criminal activity; and school and community safety programmes. All of the services are available to non-offending family members and support networks as well. Collaborative arrangements with other organisations means residential services can be provided to victims of sex trafficking, male domestic violence victims, hate crime victims, transgender violence victims, child victims and older person victims.

In accordance with the EIGE (European Institute on Gender Equality) criteria, SACT is not only innovative but also transferable to other settings where there is an identified need for expert rape-specific refuge interventions and where coalitions can be developed which incorporate expertise on refuge-based interventions and working with victim-survivors of rape. It also meets all of the eight criteria named above.

The best practice example cited for coordinated and integrated services is Yarrow Place in Australia. It was created in 1993 by merging the community based and feminist RCC with the SARC (Sexual Assault Referral Centre) in order to ensure that both immediate forensic and health-care needs and longer term psychological support needs, including counselling and advocacy, can be me in the one location. This enables anyone to access gynaecological healthcare months or even years later from a doctor who is sensitive to and aware of the effects of sexual violence. The service is survivor-centred with a long-term service provision focus designed to integrate counselling and medical services. It has also been involved in trialling and implementing restorative and interrogative justice approaches and well as feminist approaches. The recommendations for future projects based on this example once again highlight the requirement for survivor-centred service which incorporate cultural and ethnic awareness, with adequate and predictable funding and informal sustainable networks between and across services and agencies.

The Rape Crisis Network Europe (RCNEurope)[18] offers a guide to best practice for services for rape survivors in Europe. Good practice includes education, empowerment and awareness raising in the wider society. RCNEurope believes that staff expertise should be used to influence the media as well as to engage in coalitions and co-operation with other organisations, not only shelters or refuges. To contribute to the development of effective social and political response to rape, service providers should have the resources to engage in education, awareness raising, advocacy work and lobbying. RCNEurope also suggests that best practice includes seeing the interaction between victim and service provider as one between equals who cooperate to remove the threat of violence.[19]

The development of specialist centres of expertise to provide services to victims/survivors of rape has been central within this policy field. Rape crisis centres have been at the forefront of challenging mistaken and often misogynist views about rape in the wider society. They are important institutions; sites through which women have been enabled to engage in transformative actions.[20] An Irish best practice model from 2010 identified what makes RCCs unique. The guiding principles include feminism, egalitarianism and human rights. The operating principles include a gender-based power analysis, a reduced-power analysis (taking account of ethnicity, social class, dis/ability and

[18] Rape Crisis Network Europe was a Daphne funded project led by Rape Crisis Network Ireland. In addition to developing links between European service providers, the project also included research on services practices and best practices.
[19] Cited in Walby et al.
[20] Walby et al. p. 45.

sexual orientation) , a survivor-centred approach, a trauma based approach and holding perpetrators accountable. [21]

Prevention work is not necessarily just specifically about rape. The EUBPR noted that best practices for the prevention of sexual violence against women includes a recognition of the relationship between the economic situation of women and their vulnerability to sexual violence. The research cites US work identifying economic advocacy as a core requirement for rape prevention practices.[22] Economic advocacy is defined as the provision of information, advocacy and support to expand economic resources and reduce or eliminate economic-related risk factor that contribute to sexual violence. In the UK ISVAs support individual women who have experienced sexual violence to, among other things, access education, volunteering and employment opportunities and skill-building workshops to help improve survivor's economic status over the long term.

4.2 PROS & CONS OF SPECIALIST SERVICES

There is a large body of knowledge about what works and what survivors want and a vast array of policies and strategies to organise and order services delivery. Specialist services, because of the inconsistency of funding and implementation are 'far from fulfilling their true potential'. Specialist services, such as those provided by RCCs are intrinsic to the necessary culture shift. Not only do they provide what survivors need and want, they also challenge norms.[23] As Martin notes "Neither rape nor its victims are top priorities in most mainstream organizations".[24]

A Scottish 2012 literature review regarding the pros and cons of specialist sexual violence service provision states that the following principles need to be noted in considering what type of agency/organisation should provide services:[25]

1. **Those affected by sexual violence have different needs, wants and experiences;**
2. **They overwhelmingly want women-only staff (male victims also prefer to speak to a female member of staff);**
3. **It is important to provide for diversity within the population of survivors and the range of their experiences of sexual violence;**
4. **Services should take account of those with specific needs e.g. black minority ethnic and disabled women;**

[21] Rape Crisis Network Ireland (2010) Best Practice Model and Direct Services Standard
[22] Greco, D. and Dawgert, S. (2007), *Poverty and Sexual Violence: Building Prevention and Intervention Responses.* Pennsylvania Coalition Against Rape.
[23] Martin, P. (2009) *Rape Crisis Centers: helping victims, changing society* in Hasenfeld Y (Ed) Human Services Organisations. 2nd Edition. Sage.
[24] Ibid
[25] Henderson, S. (May 2012), *The pros and cons of providing dedicated sexual violence services: A literature review.* Glasgow, Rape Crisis Scotland.

5. **Services should be flexible in responding to the broad range of sexual violence;**
6. **Agencies should work together to provide the best response to women;**
7. **Services should be accessible to women wherever they live; and**
8. **Training and raising awareness of sexual violence go hand in hand with service delivery**.

A study comparing SARCS with RCCs in the UK showed that each setting had a different emphasis and each had notable benefits for survivors. For example, rape crisis centres were able to work with survivors of historical sexual violence and were seen as being more independent. Survivors saw this as a particular benefit which meant they were more likely to approach the RCC. The study concluded that the two approaches are different yet complementary and that both are important for survivors.[26]

Having a diversity of services and different 'entry points' is important as it increases the likelihood of survivors finding the help they need. The UK Map of Gaps 2 research examined what and where the gaps in violence against women services were in the UK. It recommends that the government should aim for the diversity of services with multiple entry points in order to 'ensure multiple routes into support as well as providing targeted services to meet specific needs.'[27] In this instance targeted services are those, for example, for a particular group of people such as members of ethnic minorities.

The Scottish literature review concludes that research indicates RCCs offer a unique and vital response for survivors of any form of sexual violence. NGOs are better at providing a survivor-led response, better at responding to historical sexual violence and can improve uptake of and increase quality in mainstream services. Sexual violence survivors benefit from multi-agency responses. The specialist services are vital in ensuring the response is mediated, coordinated and relevant. While there are overlaps between voluntary sector specialist services (e.g. sexual violence and domestic violence), the evidence indicates that there are differences in goals, approach and experiences of survivors. This obviously requires a close collaboration between sexual and domestic violence services. Amalgamation between the two is contraindicated because evidence indicates this places sexual violence survivors at a disadvantage. Awareness-raising work is also diluted. When sexual violence services are taken into other settings or merged with other organisations, it is vital to ensure that the specialist focus, knowledge and ways of working are maintained. Dedicated specialist services may also represent a massive cost savings. Costs to the community could be

[26] Robinson, A., Hudson, K. (2011) "Different yet complementary: two approaches to supporting victims of sexual violence in the UK". *Criminology & Criminal Justice* 11(5): 515-533. London, Sage.
[27] Kelly, et al. (2009) Map of Gaps 2

reduced by having more effective specialist services; sexual violence is not simply a health issue and other interventions might not only reduce the health burden/costs but also a wide range of other public costs including loss of earnings, less productivity and homelessness. While the costs of not providing suitable responses have not been quantified they are likely to be enormous in the short and long term. Effective responses, including the prevention of longer-term negative impacts may stop people from requiring additional services in the future.

4.3 MINIMUM STANDARDS

The Council of Europe commissioned research in 2007 on what the minimum standards should be for violence against women services.[28] These standards were developed based on the Beijing Platform and using human rights standards. The areas covered are those for specific types of VAW services and areas such as staff, empowerment and general service provision.

- 24 hour helpline
- support & advocacy
- multi-agency coordination
- accessibility for socially excluded
- access to financial supports,residence rights, education & training
- perpetrator work rooted in women's safety & prevention
- safe shelter

The minimum standards go on to note: *"The majority of the support services explored in this study should be provided by specialist women's NGOs, which have proved the most responsive and effective in enabling women to realise their rights to live free from violence and overcome its debilitating effects. . . . .in order to fulfil their responsibilities NGOs need to have skilled and knowledgeable staff, sufficient resources and work within a set of philosophical principles. It is the responsibility of states to ensure that sufficient resources are made available to sustain NGOs in*

[28] Kelly, L. & Dubois L. (2007) *Combatting Violence Against Women: Minimum Standards for Support Services*. Council of Europe.

providing quality services to all women who seek support. Such resources should also enable NGOs to continue to innovate, including putting into practice recognised international good practices."

The report also notes that while there was a recognition amongst a minority of research respondents that domestic violence and sexual violence were often intertwined, it was sometimes erroneously presumed that domestic violence services providers were able to, and did, cover both.

While the standards clearly articulate the need for specialist services, the report also indicates that there are elements of any effective support system which are the direct responsibility of the state. The two most emphasised are law enforcement and health services in the immediate aftermath of sexual violence.

Rape crisis centres are defined as NGOs that provide some combination of helpline, counselling, advocacy and self-help in supporting women and girls who have been assaulted recently or in the past. A practice principle has always been that reporting to state agencies is woman's choice. At a minimum every RCC should be in a position to provide an anonymous helpline, one-to-one support and counselling, accompaniment to other services – i.e. police, court, medical, forensic, group work, advocacy. Every RCC should also be able to engage in awareness-raising and social change work. Overall services are delivered using a survivor-centred and trauma-based model. RCCs operate from the knowledge that survivors have the capacity to grow and change and that they are the experts in what they need. Survivor identified indicators of recovery and healing inform the way in which services are delivered and developed. A trauma-based model means services are offered with the understanding that a survivor's reactions are a normal response to trauma.

The following section (5) contains information about the standards required by the Istanbul Convention.

5.CONVENTIONS, DIRECTIVES, STRATEGIES, REVIEWS & REPORTS

The Irish government itself has responsibilities to and for victims/survivors. In addition to a Council of Europe (COE) convention and an EU Directive, there are Irish-specific strategies to address the violence and to address violence-related issues for different groups of people. These strategies name the responsibilities of the relevant government departments. There are also reviews detailing

plans for future services developments. The most relevant of the conventions, directives, strategies and reviews are identified below with links to the complete texts.

Domestic, Sexual and Gender Based Violence (DSGBV)

- The Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence - known as the Istanbul Convention (https://www.coe.int/en/web/conventions/full-list/-/conventions/rms/090000168008482e)
- The Second National Strategy on Domestic, Sexual and Gender Based Violence 2016-2021 and associated action plan (http://www.cosc.ie/en/COSC/Pages/WP16000018)
- HSE National SATU Review published in 2019 (https://health.gov.ie/wp-content/uploads/2019/04/SATU-Policy-Review-Report-March-2019.pdf)

Ethnic Minorities

- The National Traveller and Roma Integration Strategy (http://www.justice.ie/en/JELR/National%20Traveller%20and%20Roma%20Inclusion%20Strategy,%202017-2021.pdf/Files/National%20Traveller%20and%20Roma%20Inclusion%20Strategy,%202017-2021.pdf)
- The HSE Second National Intercultural Health Strategy (https://www.hse.ie/eng/about/who/primarycare/socialinclusion/intercultural-health/intercultural-health-strategy.pdf)
- Roma in Ireland – A National Needs Assessment (https://www.paveepoint.ie/wp-content/uploads/2015/04/RNA-PDF.pdf)

Youth

- Safe, Respectful, Supportive and Positive: Ending Sexual Violence and Harassment in Irish Higher Education Institutions 2019 (https://www.education.ie/en/Publications/Education-Reports/framework-for-consent-in-higher-education-institutions.pdf)
- LGBTI+ Youth Strategy 2018-2020 (https://www.dcya.gov.ie/documents/20180628NatLGBTIYouthStrategy.pdf)

Crime Victims

- EU Directive 2012/29/EU known as the Victims Right's Directive transposed into Irish law by the Criminal Justice (Victims of Crime) Act 2017 (https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2012:315:0057:0073:EN:PDF) for the directive itself and (http://www.justice.ie/en/JELR/Pages/Victims-Charter) for the resultant guides to the criminal justice system for crime victims.

It is not within the scope of this project to conduct a detailed analysis of all of the strategies, conventions, directives, reviews and the progress made to date. What follows are the highlights which require particular attention.

5.1 DOMESTIC, SEXUAL & GENDER-BASED VIOLENCE

The conventions, strategies and reviews in this section involve obligations under a Council of Europe convention and national strategies and reviews.

5.1.1 ISTANBUL

Ireland ratified the Istanbul Convention in March 2019. The Convention aims to ensure the design of a comprehensive framework, policies and measures for the protection of and assistance to all victims of such violence. The specifics of the Convention have been informed by the Council of Europe minimum standards for violence against women services. Ratifying the Convention opens Ireland up to International monitoring by GREVIO (Group of Experts on Action against Violence against Women and Domestic Violence). States are expected to develop 'effective cooperation' both between state agencies and with the NGO specialist sector, recognising the latter's unique contribution through funding and invitations to be part of assessing, adapting and extending existing supports.[29]

Some of the relevant key elements of the Convention are to:

- Regularly run awareness-raising campaigns;
- Ensure adequate police intervention and protection as well as specialised support services;
- Ensure general social services understand the realities and concerns of survivors of violence against women and support them accordingly in their quest to rebuild/resume their lives;
- Ensure survivors have adequate information;
- Make 24/7 telephone helplines free of charge;
- Set up easily accessible rape crisis or sexual violence referral centres;
- Implement comprehensive and co-ordinated policies involving government agencies, NGOs and national, regional and local parliaments and authorities.

5.1.2 NATIONAL STRATEGY & REVIEW

The Second National Strategy on Domestic, Sexual and Gender Based Violence 2016-2021 (SNS) is the national strategy of most relevance. Other strategies and reviews refer to specific goals and actions contained in it. Overall the strategy covers awareness raising, prevention, service provision and data collection. Specific actions include awareness and education programmes in primary, secondary and third-level and cultural competence in services delivery.

The Department of Health recently conducted a review of the Sexual Assault Treatment Units in the country. That review was launched in March 2019. Over the next year several changes are being

made. This include an extra €0.5 million in funding, an increase in the number of specially trained forensic nurse examiners from 6 to 15, the funding of 2 additional training programmes for forensic medical examiners, and the provision of "rapid-responder" forensic examiners to travel to the unit closest to the person who has experienced sexual violence if there are local staff shortages. Longer term plans include provision for patient liaison manager positions, loosely based on an ISVA (Independent Sexual Violence Advisor) role. This role would have responsibility for follow-up contact.

5.2 ETHNIC MINORITIES

The National Traveller and Roma Inclusion Strategy 2017-2021 (NTRIS) includes addressing the incidence of violence against Traveller and Roma women. This strategy references the SNS and, among other things, requires Tusla and the HSE to develop non-discriminatory policies and practices for sexual violence and domestic violence services. Tusla held a Traveller and Roma DSGBV conference in May 2019 on ethics and values. Under the area of Gender Equality, HSE Community Health (CHO) Area 1 (Donegal, Leitrim, Sligo, Cavan, Monaghan) Traveller Health Strategy adopted regional actions in line with NTRIS.

The aim of the National Roma Needs Assessment 2018 (NRNA) was to establish how best to improve state agencies' interaction with the Roma community in Ireland. It was commissioned by the Department of Justice and Equality in line with recommendation 4.2.3 of the Logan Report.[30] The Assessment was required to make recommendations for key priorities across Departments to improve access to services. It is intended to be a 'living document' which can be updated to complement the strategies of Government Departments. The recommendations in relation to health include ensuring that Roma women experiencing violence can access appropriate supports.

The HSE Second National Intercultural Health Strategy 2018-2023 was launched in January 2019. In addition to implementation of the relevant portions of the SNS, the strategic actions include (1) coordinating the implementation of Ireland's National Action Plan for Women, Peace and Security 2015–2018, with particular regard to provision of appropriate support and protection for migrant women experiencing sexual harassment, (2) review current service provision for migrant women who experience sexual and/or domestic violence, (3) train healthcare staff, (4) develop data

[30] Logan E, *Garda Síochána Act 2005 (Section 42) (Special Inquiries relating to Garda Síochána) Order 2014 – (The Logan Report)* (Ombudsman for Children 2014). This report was undertaken following the removal of 2 children from their Roma parents by An Garda Síochána.

collection in order to be able to analyse minority ethnic communities' use of SATUs, (5) continue education and public awareness campaigns in term of FGM, and (6) provide appropriate support to survivors of FGM.

5.3 YOUTH

The ESHTE (Ending Sexual Harassment and Violence in Third-Level Education) project aims to prevent and combat sexual violence and harassment (SVH) and build a culture of zero tolerance in third-level education throughout Europe. The framework aims for students from the ESHTE review are to:

- Develop understanding, confidence, and capacity for active consent, at a personal level and in supporting peers.
- Acquire skills and agency for confident reporting/support seeking for sexual harassment, sexual assault, and rape.
- Be aware of equality and diversity, the impact of gender role expectations, and contextual factors such as alcohol and drug use.
- Develop the knowledge and the capacity to challenge any perceived normalisation of unwanted sexual comments or behaviour.

ESHTE was included in the Second National Strategy in 2017.

The LGBTI+ Youth Strategy 2018-2020 Goal 2, Objective 12 is to strengthen health services and education to respond to the needs of LGBTI+ young people, including in the area of consent. Specifically, 12(d) is to ensure that the education and information made available relating to sexual health, sexual consent and coercion, and sexual violence includes LGBTI+ experiences and also provides LGBTI+ specific education and awareness. The HSE has lead responsibility for this objective, with the assistance of the Department of Education and Skills.

5.4 CRIME VICTIMS

The Criminal Justice (Victims of Crime) Act 2017 It provides for information to be given to survivors from their very first contact with criminal justice agencies, including An Garda Síochána. It also means that a survivor can request and receive additional information during the course of the investigation and court process. Specifically, survivors are entitled to access support services and to receive an individual assessment to identify their own specific protection needs. There are also regional strategies aimed at local implementation of the national strategies.

6.SEXUAL VIOLENCE PREVALENCE

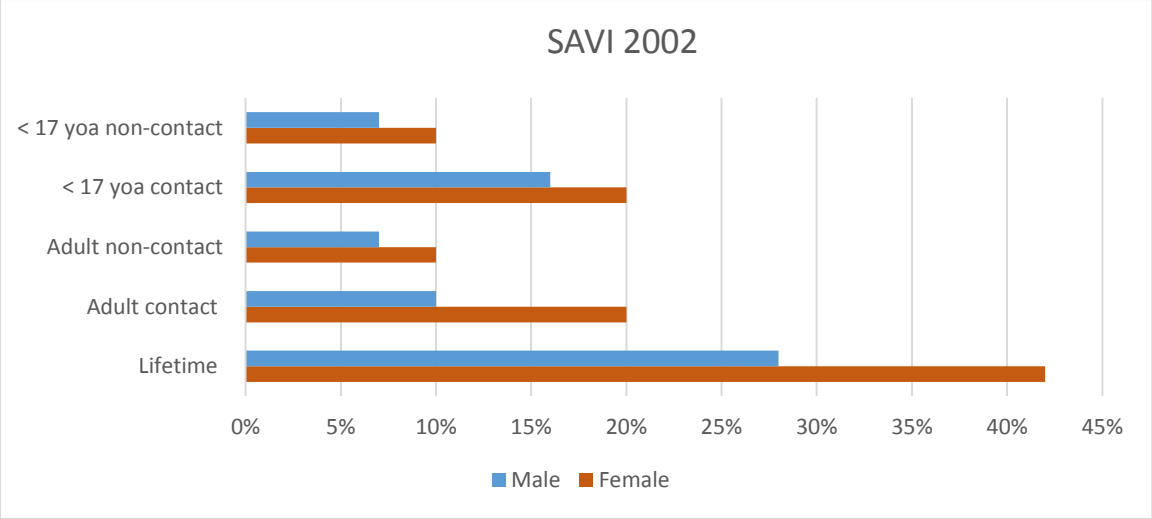
Different research utilises different definitions of sexual violence. Results are frequently based on health surveys or included in VAW (Violence Against Women) now often named GBV (Gender Based

Violence) research. In the latter, data is regularly divided into violence from an intimate partner or ex-partner and other. When an intimate partner or ex-partner data is included, it is often as physical and/or sexual violence. WHO statistics are an example of this.[31] Different groups of people are differently targeted in terms of sexual violence. Much of the existing research names women as a group and does not necessarily differentiate based on social class, ethnicity, sexual orientation, gender identity or dis/ability. Generally, population-based research reports lower prevalence rates than research in which participants opt-in.

6.1 OVERALL PREVALENCE

No Irish-specific population-based research measures sexual violence prevalence in a way that can be disaggregated by ethnicity, nationality, sexual orientation or gender identity. The Central Statistics Office (CSO) is to oversee the development of a new sexual violence survey and that process has just begun.[32]

In Ireland, there was detailed population-based research on sexual violence experienced by females and males in 2002 (SAVI-Sexual Abuse & Violence in Ireland).[33]



The researchers acknowledge that a number of marginalised groups were not included as their members were not contactable by telephone landline – the primary methodology. Travellers were

[31] WHO, London School of Hygiene and Tropical Medicine & South Africa Medical Research Council (2013), Global *and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence.* Geneva, WHO.
[32] CSO press release 10 January 2019 https://www.cso.ie/en/csolatestnews/pressreleases/2019pressreleases/csotooverseenewnationalsurveyontheprevalenceofsexualviolenceinireland/
[33] McGee, et al. (2002) *The SAVI Report: Sexual Abuse and Violence in Ireland*. Dublin, Dublin Rape Crisis Centre & The Liffey Press.

one of these groups and their experiences are not represented in these numbers. A SAVI focus group with ten Traveller women indicated that barriers to accessing services included the intersection of racism and violence, a lack of faith in the response of the Gardaí, and distrust of Social Services. The greatest barrier to disclosing sexual violence was seen to be the shame that disclosure would bring on the abused person themselves and their family, creating a situation whereby the abused person is held accountable, not the perpetrator. The women felt the cost of disclosure within the Traveller community at the time was simply too high.

As SAVI research participants were not asked about their ethnicity, sexual orientation, gender identity if it was not male or female or if it differed from the gender assigned to them at birth, it is not possible to ascertain whether and how prevalence rates vary for people depending on which of those identities are theirs. Findings identifying that the perpetrator was a spouse/partner, boyfriend/girlfriend or ex-partner do not name the gender of the perpetrator in relation to the gender of the victim, therefore it is not possible to ascertain how many experienced sexual violence from a same-gender partner or ex-partner. Those under the age of 18 were not included.

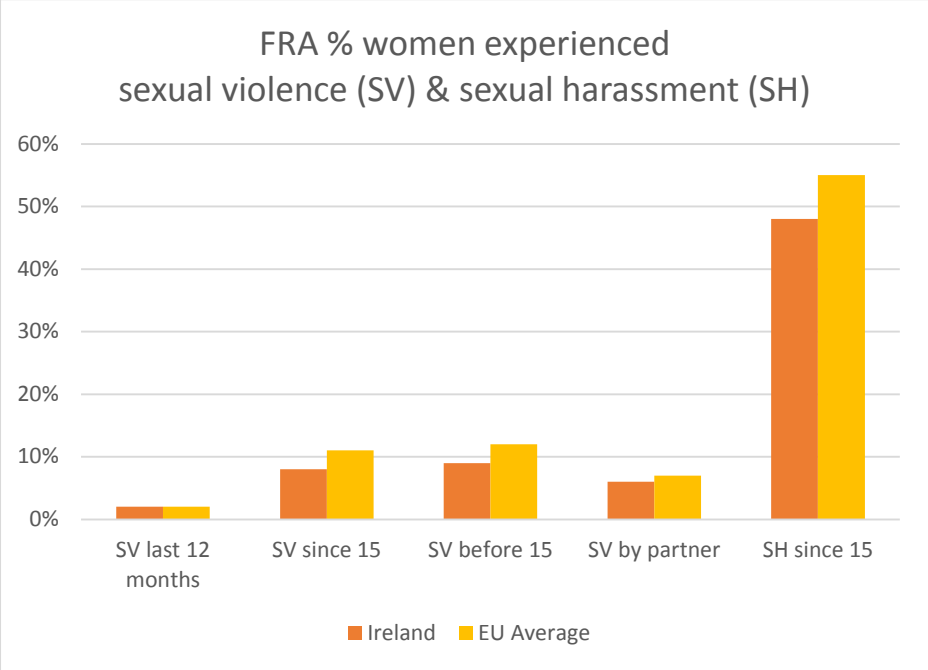
6.2 WOMEN

According to the WHO, 30% of women around the world have experienced physical and/or sexual violence from an intimate partner and 7% of women have been sexually assaulted by someone other than a partner.[34] These numbers were derived from a literature review of existing research.

In 2012 the EU Fundamental Rights Agency (FRA) researched sexual violence against women across EU member states by interviewing women aged 18-74.[35] The types of sexual violence included rape, attempted rape, contact sexual violence and consented because afraid of consequences if she did not. Sexual harassment was also included in the questions, with inquiries about physical, verbal and non-verbal harassment. It is possible to examine results based on the age, rural or urban living area, income and employment status of the women and whether the violence occurred in the past 12 months , since the age of 15 or as a child. It is not possible to disaggregate based on ethnicity, sexual orientation or gender identity. There is no way to tell whether Traveller women or Roma women experienced sexual violence at the same rates; this is also true for women from immigrant communities. Refugees and asylum seekers may not have been represented at all. Any disclosure of

[34] WHO, London School of Hygiene and Tropical Medicine & South Africa Medical Research Council (2013).
[35] Report available at: https://fra.europa.eu/sites/default/files/fra_uploads/fra-2014-vaw-survey-main-results-apr14_en.pdf

sexual violence under the age of 18 was retrospective. It is also not possible to ascertain if a partner perpetrator was male, female, gender non-binary, intersex or trans from the published results.



There may well be overlap between the categories, for example one woman may have experienced sexual violence since the age of 15 and the perpetrator was her partner. While most of the Irish numbers are lower than the EU average, the FRA posits several possible explanations for differences in observed prevalence rates across countries. If it is more culturally acceptable to talk to other people about experiences of violence, people may also be more willing to share information with researchers and thus the rate will be higher. Greater levels of gender equality could also lead to greater levels of disclosures of violence against women since the incidents are more likely to be openly addressed and challenged. Women's exposure to risk factors for violence can vary between countries. Overall levels of violent crime also need to be examined. From its own research the FRA names evidence of a relationship between perpetrator drinking habits and women's experiences of domestic violence which may help explain some aspects of violence against women.[36]

As a background, Irish statistics highlight dangerous and damaging culture and beliefs that continue to underpin the high level of sexual violence and harassment experienced by Irish women according to Eurobarometer research in 2016.[37]

21% of Irish people think that there are justifiable and understandable reasons for having

[36] FRA study
[37] Eurobarometer 2016 poll results https://ec.europa.eu/ireland/news/21-de-mhuintir-na-héireann-den-tuairim-go-bhfuil-caidreamh-colla%C3%AD-gan-toiliú-ceart-go-leor-i_en.

sexual intercourse without consent – i.e. rape.

11% believe it is acceptable if the woman is drunk or has used drugs.
9% believe it is acceptable if the woman voluntarily goes home with someone.
9% believe it is acceptable if the woman is wearing revealing, provocative or sexy clothing.
7% believe it is acceptable if the woman is out walking alone at night.

23% of Irish people believe women often make up or exaggerate claims of abuse or rape.
18% believe that violence against women is often provoked by the "victim".

Overall 74% think sexual harassment against women is common. This appears to be true from existing research.

6.3 MEN

Research into the rates of sexual violence experienced by men is more rare than that regarding women. A study in the USA explored the prevalence of male sexual assault using four years' worth of data from a national criminological database. The results suggest that **approximately 90% of the sexual assaults perpetrated against men occur before they reach the age of 19**. Forcible fondling and sodomy were the most prevalent forms of sexual assault reported.[38] According to research published in 2017, also based on the same U S national criminological database, **17% of men experienced some form of contact sexual violence in their lifetime and 1.5% of men were raped at some point in their life.** The contact sexual violence rates are not dissimilar to the Irish rates from SAVI.[39]

6.4 LGBTI+

Research into the sexual violence experiences of LGB people is also not very plentiful. It has been even less frequently conducted for trans, intersex or non-binary people.

In 2016 LGBT Ireland commissioned a national mental health and wellbeing study of LGBTI people in Ireland, with a special emphasis on young people.[40] Young people and those living in Dublin were over-represented in terms of the Irish population as a whole. Eighty-nine percent identified as Irish.

---

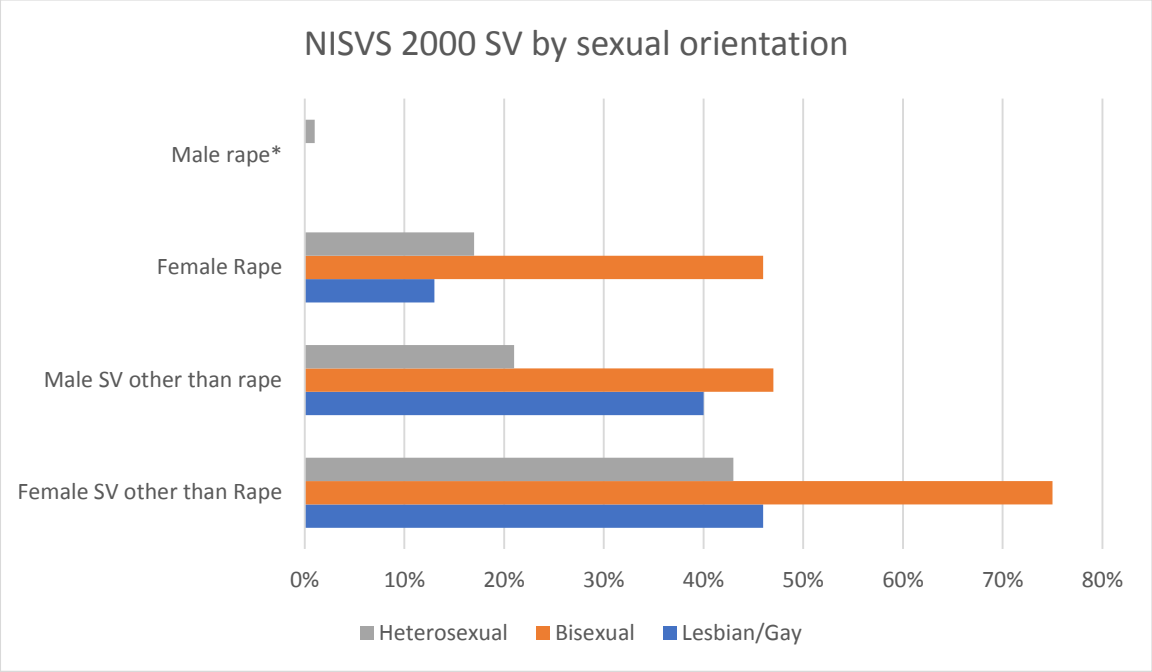
[38] Black, M.C., et al (2011), *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report*. Atlanta, GA, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

[39] Smith, S.G., et al.(2017) *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 State Report.* Atlanta, GA, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

[40] Higgins, A. (2016) *The LGBTIreland Report: national study of the mental health and wellbeing of lesbian, gay, bisexual, transgender and intersex people in Ireland.* Dublin, GLEN & BeLonG To.

Overall, **15% reported being "sexually attacked" because of their sexual orientation and/or gender identity during their lifetime**.

There is one US population-based study which specifically include LGB people. The NISVS (National Intimate Partner and Sexual Violence Survey) 2010 results were analysed by sexual orientation for sexual violence, stalking and intimate partner violence.[41] This study defines sexual violence other than rape as including being made to penetrate, sexual coercion (non-physical coercion), unwanted sexual contact and unwanted non-contact sexual experience.



*the figures for bisexual and gay male who reported rape were too small to be specifically detailed.

As can be seen from these figures, females and males who identify as bisexual experienced a significantly higher rate of sexual violence than their lesbian/gay or heterosexual counterparts.

Rothman and colleagues[42] reviewed 71 pieces of US research on the prevalence of sexual violence for LGB people. Overall, **lesbian or bisexual women were more likely to report child sexual abuse, adult sexual abuse, lifetime sexual abuse and intimate partner sexual abuse while gay and bisexual men were more likely to report hate crime sexual abuse** (author's terminology). Research

[41] Walters, M.L. et al. (2013) *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Findings on Victimization by Sexual Orientation.* Atlanta, GA, National Centre for Injury Prevention and Control, Centres for Disease Control and Prevention.

[42] Rothman et al. (2011) "The prevalence of sexual violence against people who identify as gay, lesbian or bisexual in the United States: As Systemic Review" *Trauma Violence Abuse*. 12(2) pp. 55–66.

based on population samples generally reported lower prevalence rates than non-probability samples. The rates of lifetime sexual abuse varied widely. For lesbian and bisexual women the range started at 15.6% and for gay and bisexual men the range started at 11.8%.

A UK Government online 'opt-in' LGBTI UK survey with 108,000 participants, the results of which were published in 2018, found **6% reported threats or actual physical or sexual harassment or violence in the previous year because they were LGBTI**. Two percent experienced sexual harassment in education during 2016-17. Just over four out of five (61%) of the participants identified as lesbian or gay, 26% as bisexual, 4% as pansexual, 2% as asexual and 1% as queer. Thirteen percent identified as trans and 6.9% as non-binary. Two percent identified as intersex. Two percent of all of the participants were from Northern Ireland.[43]

6.5 ETHNICITY

The Irish Women's Health Council published research about ethnic minority (indigenous and non-indigenous) women's experiences of GBV (gender-based violence) in 2009.[44] **Traveller women experienced discrimination against them by wider society and by mainstream services. For some, this presented as a risk factor for domestic violence,** as perpetrators felt that victims/survivors would face difficulty in accessing support from external services. Stigma surrounding domestic violence, which leads to victim/survivor ostracization for reporting abuse in some communities also made it easier for a perpetrator to carry out violence against them. In addition, Traveller women lacked trust in GPs and GBV services because of fears that if they reported the violence their children would be taken away from them.

Some women who had come here from another country experienced GBV (gender-based violence) in their country of origin. **Among those seeking asylum and those with refugee status, experiences of GBV included domestic violence, conflict-based rape, rape during their migration journey and sexual violence in prison.** Some interviewees experienced harmful traditional practices in their country of origin, namely forced marriage and FGM. Thirteen percent of the women accessing GBV services (refuges and SATUs) were non-indigenous minority ethnic women and 16% were Traveller women. The former made of 5% of the population at the time, and the latter made of 0.5% of the population. A prevalence study undertaken in 2015 by the European Institute on Gender Equality (EIGE), based on 2011 Irish Census data, estimated that **5,277 women and girls were living with**

[43] https://www.gov.uk/government/publications/national-lgbt-survey-summary-report/national-lgbt-survey-summary-report#the-national-lgbt-survey

[44] Women's Health Council. February 2009) *Translating Pain Into Action: A Study of Gender-based Violence & Ethnic Minority Women in Ireland*. Dublin. The Women's Health Council was subsumed into the Department of Health and Children in 2009.

FGM in Ireland.[45] Further research in 2015 estimated that between 1% and 11% of 14,577 girls from FGM practicing countries in Ireland were at risk of FGM in Ireland.[46]

The Irish Women's Health Council research[47] noted that the nature of migration, particularly forced migration, is often linked to isolation, which can heighten women's risk of intimate partner violence. It can also create barriers to seeking help. For example, women can be more vulnerable to manipulation if they are dependent on a partner for their visa, do not speak the language of the country to which they have migrated and/or have no financial independence. Isolation, language barriers, unfamiliarity with services and institutional racism all serve as barriers in the help-seeking process of such women and further increase their vulnerability to domestic violence, including sexual violence.[48]

As Jewkes et al.[49] noted in WHO reports, **rape and other forms of sexual violence have been used as strategies in many conflicts and wars.** In some armed conflicts rape has been used a deliberate strategy to subvert community bonds and as a tool for ethnic cleansing. The social and economic disruption caused in armed conflicts can force large numbers of people into prostitution. This equally applies to the situation of refugees fleeing natural disasters in addition to escaping war. Refugees can also be at risk of sexual violence in their new settings – such as refugee camps.

Ireland is also a destination country for the trafficking of humans. UNODC (United Nations Office on Drugs & Crime) figures indicate that 98 persons were trafficked into Ireland in 2014, 153 in 2015 and 179 in 2016. Two-thirds of the persons trafficked into the country in 2015 were trafficked for sexual exploitation.[50]

6.6YOUTH

The FRA 2012 survey notes that, as a group, **young women are particularly vulnerable to violence**. Say Something, a quantitative study on the prevalence of sexual violence and harassment in Irish

[45] Van Baelen, L. et al (2016) "Estimates of first generation women and girls with female genital mutilation in the European Union, Norway and Switzerland" *The European Journal of Contraception & Reproductive Health Care*, DOI: 10.1080/13625187.2016.1234597.

[46]

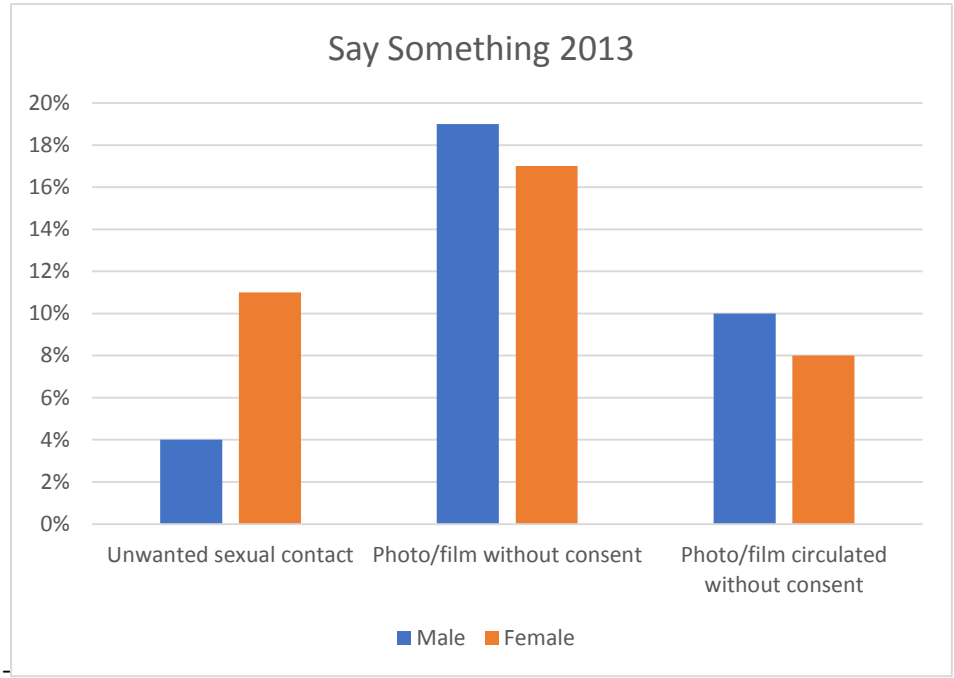
[47] Women's Health Council.

[48] HSE Second National Intercultural Health Strategy.

[49] Jewkes et al.

[50] UNODC (2018) *Monitoring Target 16.2 of the United Nations Sustainable Development Goals: multiple systems estimation of the numbers of presumed victims of trafficking in persons – Ireland.*

higher education institutes, was commissioned by the Union of Students of Ireland (USI) in 2013.[51] This was an online opt-in survey. Gender identity options were woman, man and other. A small number of students self-identified as other than female or male. Overall 16% of students reported some type of unwanted sexual experience at their current third level institution, with 9% of all respondents reporting unwanted sexual contact.

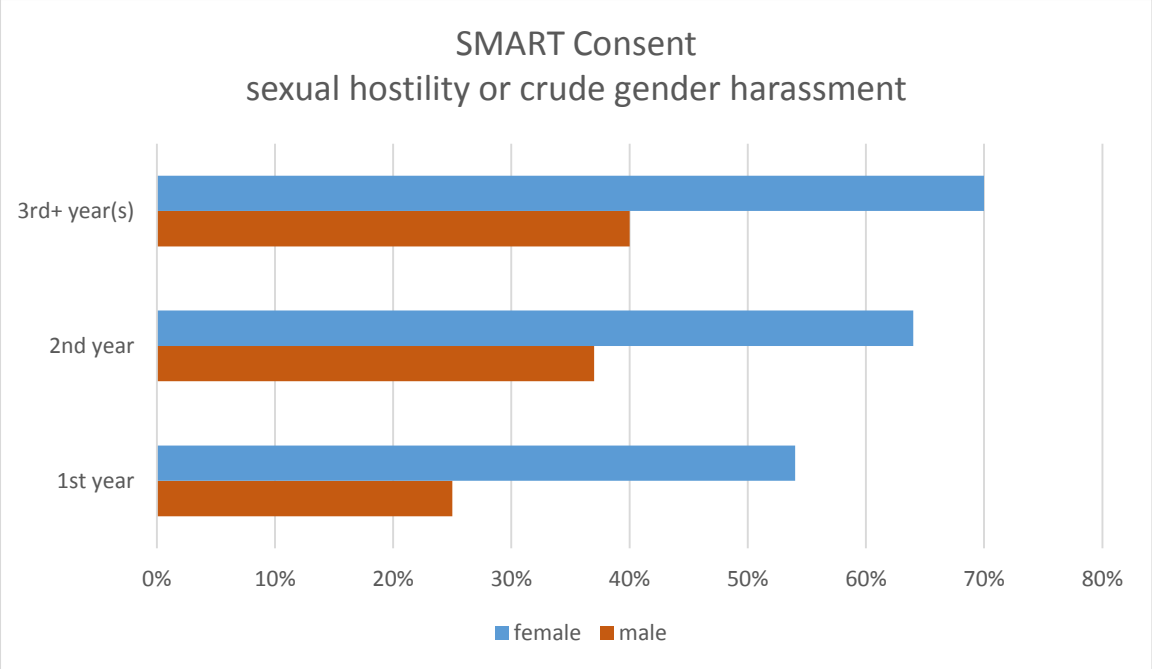


Although the numbers were smaller, results suggest that LGB and Trans students experienced higher rates of harassment, violence and unwanted sexual behaviour than their non-LGBT counterparts.

The research team involved in SMART Consent[52] conducted a survey with 634 students in 2018.

[51] USI (2013), *Say Something: A Study of Students' Experiences of Harassment, Stalking, Violence & Sexual Assault.* Dublin: USI, Cosc, DOJE.

[52] MacNeela et al



Clearly, the rates are high and the longer someone is in a third level institution the more likely they are to experience the hostility or harassment.

6.7 REPORTING TO AN GARDA SÍOCHÁNA

Another useful source of information is the number of crimes reported to the police, and more particularly in whether the rates rise or fall. The under-reporting of sexual violence to police authorities is recognised internationally and there are a variety of reasons for it.[53] Individuals may think they will not be believed, do not believe that what happened to them was a crime or may not want to deal with the inevitable loss of control which comes from reporting to law enforcement. Many people who have experienced sexual violence utilise support services without ever reporting the incident to a police authority. In terms of sexual crimes reported to An Garda Síochána there has been a **60% increase in reported sexual violence crimes between 2014 and 2018**.[54] In 2018 alone the reports of rape and sexual assault rose by 10.3% to 3,182.[55] This does not necessarily mean that sexual crime rates have gone up by the same amount; it may mean that more of the sexual crimes which are perpetrated are being reported.

[53] Allen, W. D. (2007) "The Reporting and Under-reporting of Rape" *Southern Economic Journal* 73(3): 623-641.

[54] https://www.irishexaminer.com/breakingnews/ireland/sexual-assault-cases-up-30-forensic-science-ireland-report-shows-as-upward-trend-continues-916574.html

[55] https://www.cso.ie/en/releasesandpublications/ep/p-rc/recordedcrimeq42018/

Of the 2,771 survivors of reported rape and sexual assault offences in 2018, 82% were female and 18% were male. Sixty-three percent reported a crime which had taken place less than one year ago and 25% reported a crime which had occurred more than 10 years previously. Eighty-three percent of the crimes occurring more than 10 years ago involved child sexual abuse. The median age for reporting sexual violence occurring more than one year ago was 34 years of age and the median time period between occurrence and reporting was 20 years.[56]

7.BORDER COUNTIES

The population of the border counties (Donegal, Leitrim, Sligo, Cavan, Monaghan and Louth) is 11% of the population as a whole, according to the 2016 Census. Donegal is the fourth largest county in geographic terms. It shares 93% of its land boundary with Northern Ireland, with much of the border area part of the hinterland of Derry. It is rurally dispersed with 33 persons/km sq compared to a state average of 70 persons/km sq. The northeast and east of the county are more highly populated and have a larger population of persons under 30. There is a large dependency on road-based transport and private cars.[57]

The population of Leitrim has risen dramatically since 2002. Out-migration persists as an issue. More than 90% of the population lives in a rural area – the highest percentage in the state. More young and more old people than the national average live in the county. The population density is 20 persons/km sq compared to the state average of 70 persons/km sq.[58]

Sligo is a largely rural county with 60% of the population living in such areas. It experienced the highest rate of increase in urbanisation in the state from 37% in 2011 to 40% in 2016. The population density is 31 persons/km sq. It is predicted that by 2025 26% of the population will be over the age of 65, higher than the national average.[59]

Seventy percent of the population of Cavan lives in a rural area with a population density of 39 km/sq. Between 2006 and 2011 the population grew at approximately twice the national average. There has been a significant population expansion in the south of the county which forms part of the commuter belt to Dublin, contrasting with very sparsely population rural areas of West Cavan.

[56] https://www.cso.ie/en/releasesandpublications/ep/p-rcv/recordedcrimevictims2018/
[57] Donegal LECP 2016-2022 Volume 1 and CSO Census 2016
[58] Leitrim LECP summary and CSO Census 2016
[59] Sligo LECP and CSO Census 2016

Transport options in rural areas are very limited, and some rural communities have no public transport options at all.

Monaghan is also 70% rural and has a population density of 48/km sq. Between 2011 and 2016 the population size increased at the same rate as the national average, however the increase was not uniform throughout the county. Significant population growth occurred in the rural areas surrounding the main towns and along the N2 while there was little population growth and some decline in rural areas removed from main towns. There are higher percentages of people aged 65+ in rural areas removed from the main towns, while higher percentages of children and young people live in the rural areas near main towns. [60]

Louth is the smallest county in geographic size. Drogheda and Dundalk residents comprise 62% of the population of the county. It is the most densely populated county outside of Dublin with a density of 156/km sq, over twice the national average.[61] The county is within commuting distance of Dublin. There is a larger than average population of young age dependents and a smaller than average population of older age dependents. By 2040 it is predicted that Louth will be part of an east coast urban corridor.

With the exception of Louth, the rest of the region is largely rural. Overall, by 2040 the population of the region is expected to increase by 0.5% and comprise 10.5% of the total state population. These projections do not take specific account of the potential negative impact of Brexit on the border region.[62]

7.1 DIVERSITY OF RESIDENTS

The following tables list the diversities of the population with particular relevance to this NAP from Census 2016 figures. All of the tables based on Census 2016 figures include those aged 14 and up as this NAP does not include anyone under the age of 14.[63] All of the percentages are rounded to one decimal point. As the Census did not include specific questions, there are no accurate figures regarding the number of lesbian, gay, bisexual, transgender, gender non-binary or intersex residents.

[60] Monaghan County Council Socio-Economic Profile 2015
[61] Louth County Council Socio-Economic Profile 2015
[62] Morgenroth, E. (January 2018), *Prospects for Irish Regions and Counties: Scenarios and Implications Research Series Number 70.* Dublin, ESRI.

[63] Census figures for those aged 14+ were specifically generated by the CSO for this NAP. The age range that the CSO utilises in the standard published results is from 15-19 and not 14-19. In addition, the CSO does not name specific numbers when they represent less than 6 people. In those instances, the figures in these tables were calculated using 3 whenever the CSO table indicated <6.

Table 1

Female & Male Population 2016					
	TOTAL	**Female 14+**	**%**	**Male 14+**	%
Donegal	**126,488**	64,341	**50.9**	62,147	**49.1**
Leitrim	**25,598**	12,786	**49.9**	12,812	**50.1**
Sligo	**53,101**	27,119	**51.1**	25,982	**48.9**
Cavan	**59,638**	29,755	**49.9**	29,883	**50.1**
Monaghan	**48,223**	24,147	**50.1**	24,076	**49.9**
Louth	**101,273**	51,668	**51.0**	49,605	**49.0**
Total	**419,321**	**212,816**	**50.8**	**206,505**	**49.2**

This table includes the number and percentage of youth aged 14-24 in each county. Again, this is from a total of residents age 14 and up.

Table 2

Youth Population 2016			
	14+	**Youth 14-24**	**%**
Donegal	126,488	20,745	**16.4**
Leitrim	25,598	3,651	**14.3**
Sligo	53,101	8,846	**16.7**
Cavan	59,638	9,824	**16.5**
Monaghan	48,223	7,814	**16.2**
Louth	101,273	17,680	**17.5**
TOTAL	**419,321**	**68,560**	**16.6**

The following table lists the number and percentage of Travellers resident in each county as indicated in Census results.

Table 3

Traveller Population CSO 2016 Census			
	14+	**Travellers 14+**	**%**
Donegal	126,488	375	**0.3**
Leitrim	25,598	118	**0.5**
Sligo	53,101	221	**0.4**

Cavan	59,638	275	**0.5**
Monaghan	48,223	173	**0.4**
Louth	101,273	530	**0.5**
TOTAL	**419,321**	**1,692**	**0.4**

The Census captures Traveller ethnicity by asking whether someone is Irish or Irish Traveller. Local counts of Travellers are higher than that featured in the Census count. This is due to Travellers not completing the census forms and also the potential reluctance to identify as a Traveller as a result of experiences of discrimination and racism.

Table 4

Traveller Population CHO 1 local reports	
Donegal	1,221
Leitrim	272
Sligo	556
Cavan	(estimate)900
Monaghan	276

In Donegal the difference between the number of Travellers recorded by the CSO and the number of Travellers recorded in the local count is due to incorrect guidance given to Travellers when completing the census form. The Travellers were told to tick both the Irish and Irish Traveller ethnicity boxes, and only the former would have been counted.[64] Literacy skills may also have been a factor. Please note that the figures in Table 4 are for the total population and not just those aged 14+.

There is no accurate information regarding the number and percentage of Roma in Ireland. The Census did not ask for information about Roma ethnicity. It asked about nationality and Roma have a variety of nationalities including Romanian, Italian and Hungarian.

The next table lists the nationalities of residents who identified as other than Irish. It does not include those who did not indicate nationality when completing the census form. Nationalities with less than 1,000 were combined within a continent or continents. Census figures list Africa as a single unity. All of the continent and region figures obviously include people from a variety of countries, speaking a number of different languages, and having a diversity of cultures.

Table 5

2016 Residents Age 14+ Nationality identified as other than Irish								
	Donegal	**Leitrim**	**Sligo**	**Cavan**	**Monaghan**	**Louth**	**TOTAL**	**%**
UK	5,508	1,416	1,806	1,882	939	1,872	**12,007**	**2.9**
Poland	1,625	667	1,270	1,823	990	1,743	**8,118**	**1.9**
Lithuania	279	122	180	1,194	2,132	1,641	**5,548**	**1.3**
Latvia	153	127	152	570	338	956	**2,296**	**0.5**
Romania	215	44	61	192	189	425	**1,126**	**0.3**
Rest of Europe	947	465	868	757	552	2,053	**5,642**	**1.3**

[64] CHO 1 Traveller Health Strategic Plan 2018 - 2022

Asia	617	130	383	200	263	1,133	**2,726**	**0.7**
Africa	247	44	250	252	154	831	**1,778**	**0.4**
America (N, C, S)	390	99	194	274	113	274	**1,344**	**2.9**
Other Nationalities	189	44	106	102	74	177	**692**	**0.2**
TOTAL	**10,170**	**1,742**	**5,270**	**7,246**	**5,744**	**11,105**	**41,277**	
% of total	**8**	**6.8**	**9.9**	**12.1**	**11.9**	**11**	**9.8**	

In addition, the Reception and Integration Agency (RIA) provides monthly reports with some information about asylum seekers living in direct provision centres. The below table is based on the October 2018 month report; the most recent available at the time of writing. The top five countries, in order, from which people arrived in Ireland during that month and claimed asylum are Georgia, Albania, Syria, Zimbabwe and Pakistan.[65] These five countries are the same as for the previous year, although in a different order.

Table 6

Direct Provision Centre Residents Population Oct 2018	
Donegal	**0**
Leitrim	**0**
Sligo	**215**
Cavan	**30** (all emergency accommodation)
Monaghan	**246** (75 in emergency accommodation)
Louth	58
Total	**549**

While the direct provision centre population figures include emergency accommodation, that accommodation is not in a direct provision centre. According to figures obtained by RTE News *"The number of asylum seekers being accommodated in emergency beds increased from 114 in October 2018 to 351 on 24 February, [2019] with a further increase of 30 people in just a week to 381 as of 3 March."*[66] This is in addition to asylum seekers currently resident in Direct Provision Centres.

7.2 RESIDENTS IMPACTED BY SEXUAL VIOLENCE

Utilising 2016 Census figures for males and females and SAVI calculations, the below table details the number of border counties residents age 14+ likely to have been impacted by some form of sexual violence during their lifetimes. It is an approximation that is bound by caveats. SAVI research was conducted a number of years ago. Those figures do not take account of the different vulnerabilities of different groups of people, other than female/male gender. FRA research indicates that younger women may be particularly vulnerable. The specific numbers are not as important as the indications about the level of the impact.

[65] RIA Monthly Report October 2018 – the most recent available at time of writing.
[66] https://www.rte.ie/news/2019/0312/1035804-direct_provision/

Table 7

2016 Female and Male Residents aged 14+ who have experienced sexual violence based on SAVI					
	Females Total	**Females Experienced SV**	**Males Total**	**Males Experienced SV**	**Total Experienced SV**
Donegal	64,341	**27,023**	62,147	**17,401**	**44,424**
Leitrim	12,786	**5,370**	12,812	**3,587**	**8,957**
Sligo	27,119	**11,390**	25,982	**7,275**	**18,665**
Cavan	29,755	**12,497**	29,883	**8,367**	**20,864**
Monaghan	24,147	**10,142**	24,076	**6,741**	**16,883**
Louth	51,668	**21,701**	49,605	**13,889**	**35,590**
TOTAL	212,816	**89,383**	206,505	**57,821**	**147,204**

FRA researchers contacted adult females and separated out asking about lifetime sexual violence experiences since the age of 15 and prior to the age of 15. FRA participants were also asked about experiences of sexual harassment and stalking since the age of 15. The published results refer to the number of women who have experienced each of the different categories of sexual violence and harassment/stalking separately and there may well be an overlap between the categories. Sexual harassment included a range of behaviours including forcing the viewing of pornography and unwanted touching, kissing or hugging. These figures are obviously lower than those from SAVI. The definitions of the sexually violent and abusive behaviours utilised are different. The reasons posited in the FRA research for differences in disclosure rates also need to be kept in mind. The table below utilises the population figures of those aged 14+ as a general guide, although the research inquired about experiences after turning 15, and details sexual violence experiences only. Again, an individual woman may have experienced sexual violence both prior to the age of 15 and after the age of 15.

Table 8

Sexual violence experiences for females resident in 2016 based on FRA figures			
	Sexual violence 15+		
	by anyone	**by non-partner**	**Sexual violence before 15**
Donegal	5,146	3,216	5,791
Leitrim	1,023	639	1,151
Sligo	2,170	1,356	2,441
Cavan	2,380	1,488	2,678
Monaghan	1,932	1,207	2,173
Louth	4,133	2,583	4,650
TOTAL	16,784	10,489	18,884

Without new Irish, well designed, context specific and demographic rich research, it is not possible to estimate more accurately.

7.3 REPORTED TO AN GÁRDA SÍOCHÁNA OR THE PSNI

As mentioned previously, another indicator of the levels of sexual violence is to look at the numbers of police reports. The following table lists the sexual crimes reported to An Garda Síochána in 2018. These figures are released by the CSO under reservation.[67] The number of reports to the Gardaí are only for one year, while the figures in Table 7 refers to a person's lifetime and Table 8 to experiences before the age and 15 and time since the age of 15. The numbers in Table 9 only represent reported crimes which have been recorded appropriately in PULSE (the Garda computer data collection system). They also represent the crimes reported in each county. There are persons who are resident in one county who experienced sexual violence in another county.

Table 9

Recorded Sexual Crime Offences by Garda Division and Quarter

		Q1	Q2	Q3	Q4	2018
Sexual offences	**Northern Region**	**112**	**100**	**90**	**99**	**401**
	Donegal	41	24	32	33	130
	Sligo/Leitrim	14	19	16	16	65
	Cavan/Monaghan	23	23	17	25	88
	Louth	34	34	25	25	118
Rape and sexual assault	**Northern Region**	**104**	**88**	**81**	**91**	**364**
	Donegal	37	20	29	31	117
	Sligo/Leitrim	14	18	14	14	60
	Cavan/Monaghan	23	21	14	23	81
	Louth	30	29	24	23	106
Other sexual offences	**Northern Region**	**8**	**12**	**9**	**8**	**37**
	Donegal	4	4	3	2	13
	Sligo/Leitrim	0	1	2	2	5
	Cavan/Monaghan	0	2	3	2	7
	Louth	4	5	1	2	12

[67] The classification Under Reservation has been applied to reflect the fact that there are data quality issues in the underlying sources used to compile these statistics. This approach of differentiating statistics based on quality concerns associated with the underlying data is consistent with other jurisdictions such as England and Wales. https://www.cso.ie/en/methods/crime/statisticsunderreservationfaqs/

Experiencing sexual violence in a county other than that in which a person normally lives obviously includes living within the Garda Northern Region and experiencing sexual violence in a county in Northern Ireland. In particular, Donegal shares 93% of its land boundary with Derry. Within the year to the end of February 2019 there were 3,537 reports of sexual violence in Northern Ireland, with 1,074 of those reports being of rape. Published information does not include the residence location of those reporting to the PSNI. Sexual offences reports increased by 2.8% since the previous year and rape reports increased by 10% in that time. Other offences include sexual assault, sexual activity, sexual grooming, exposure and voyeurism [68] In Northern Ireland the level of sexual offences 2017/18 is almost three times the level in 2000/01. The level of reported rapes has increased fourfold within that time frame. A portion of that increase is due to the fact that prior to 2003/04 the offence of rape could only be committed against a female.[69]

In order to facilitate criminal investigations on both sides of the border An Garda Síochána and the PSNI have agreed protocols for the sharing of evidence.[70] An example would be CCTV footage showing activities prior to the perpetration of sexual violence which corroborate a victim's statement within the PSNI jurisdiction when the crime itself was committed within An Garda Síochána jurisdiction – and vice versa.

7.4 LOCAL GOVERNMENT & TUSLA STRUCTURES

New local government structures were introduced throughout Ireland as part of the Local Government Reform Act 2014. The Local Community Development Committees (LCDCs) are responsible for developing, coordinating and implementing a coherent and integrated approach to local and community development, including the governance, planning and oversight of publicly funded local and community development interventions. LCDCs developed and launched Local Economic and Community Plans (LECP) between 2015/ 2016, which set out objectives and supporting actions to promote economic development and local and community development. The table below highlights if and how sexual violence or domestic violence feature in the LECPs.

Table 10

CURRENT LECP

[68] https://www.psni.police.uk/globalassets/inside-the-psni/our-statistics/police-recorded-crime-statistics/2019/february/crime-bulletin_-feb-19.pdf
[69] ibid
[70] An Garda Síochána sexual offences investigator

Donegal	2016-2022	No mention of SV or DV in plan
Sligo	2016-2021	No mention of SV 12. "No refuge for victims of domestic violence and insufficient interagency cooperation in relation to these issues."
Leitrim	2015-2021	No mention of SV or DV in plan
Cavan	2016-2021	No mention of SV or DV in plan
Monaghan	2015-2021	No mention of SV or DV in plan
Louth	2016-2022	Action 3.6 "Ensure that crime victims and victims of sexual offences, domestic violence are supported, and safeguard the welfare of individuals at risk." Lead Agency: An Garda Síochána. This is to be measured by recent victim-focused policy and legislation implemented at local level, numbers of interventions supporting victims of crime made and numbers of cases before the Courts.

The Children and Young People's Services Committee's (CYPSCs) are county wide committees that bring together the main public and NGO agencies and organisations providing services to children and young people (age 0-24) in the county. Their role is to enhance interagency co-operation and to realise the five National Outcomes for children and young people, as set out in Better Outcomes, Brighter Futures: National Policy Framework for Children and Young People 2014-2020.[71] The CYPSCs are relevant to this NAP because there are services for young people aged 14+ who have experienced sexual violence represented or potentially represented at the CYPSCs.

Table 11

CYPSC PLANS		
Donegal	2018-2020	Names RCC and DV services and includes briefing of staff in the legal system in regard to children and young people's need regarding domestic violence. Under Outcome 3 it also refers to internet and cyber safety with Donegal DV service being one of the lead agencies responsible for actions.
Sligo	2017-2019	Names the RCC and DV services and under the heading of safeguarding children and young people and domestic violence. The objective is to ensure all relevant organisations have a Children First policy.
Leitrim	2017-2019	In CYPSC with Sligo
Cavan	2018-2021	Currently being edited. Extrapolates from SAVI and FRA research the number of women impacted by domestic and /or sexual violence. One DV service based in area. CYPSC to push for additional resources.
Monaghan	2018-2021	Currently being edited. Extrapolates from SAVI and FRA research the number of women impacted by domestic and /or sexual violence. One DV service based in area. CYPSC to push for additional resources for DV.

[71] Entire plan available at https://www.dcya.gov.ie/documents/cypp_framework/BetterOutcomesBetterFutureReport.pdf

Louth		Currently being edited.

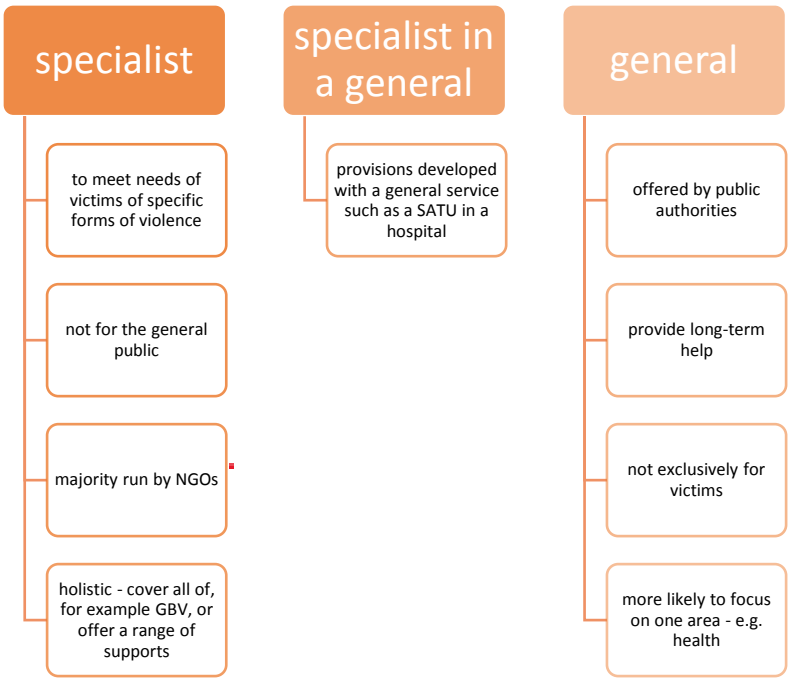
8.CURRENT SERVICES OVERVIEW

The services specifically available to an individual are based on:

1. Where they live,
2. Their age,
3. Their gender,
4. The relationship of the perpetrator to them,
5. How long ago the violence occurred,
6. In which language they are comfortable,
7. Whether or not they perceive the services as appropriate and available to them, and
8. Access to transport.

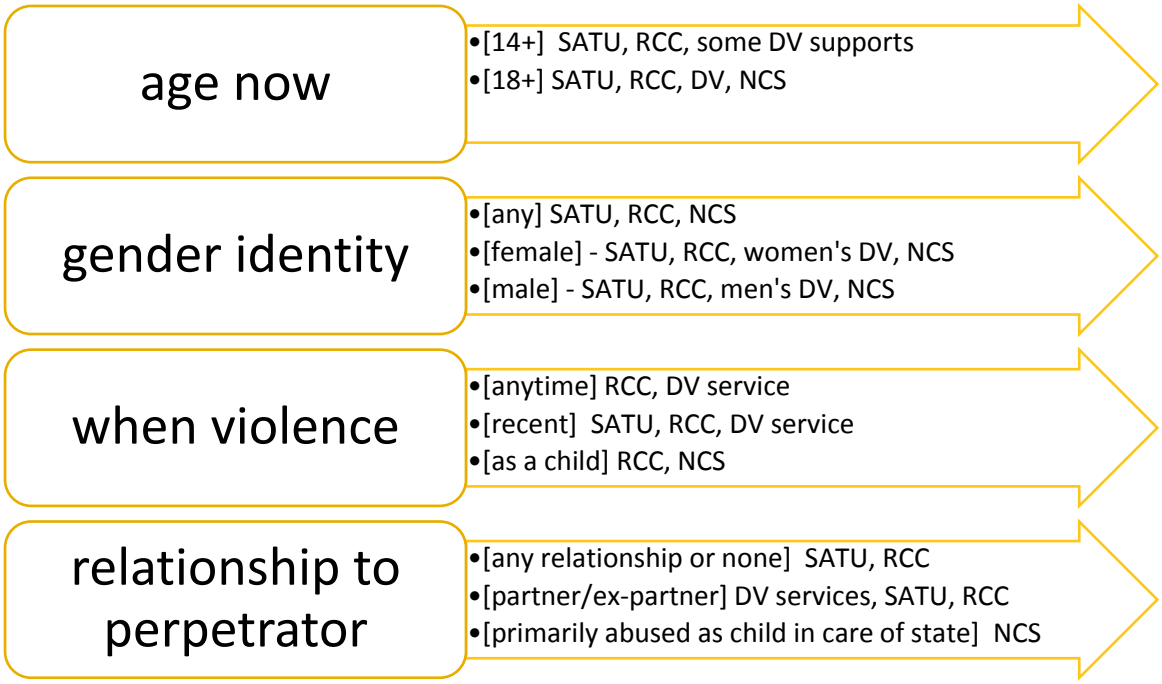
The latter is a particular issue for residents of counties in the region with areas of more rural population.

Services can be broken down into categories based on the definitions in the Istanbul Convention: specialist, specialist in a general service and general. Individuals may access services in several different categories as a result of being subjected to sexual violence.



This categorisation is relevant because of the different purposes served by specialist services. In some parts of the border counties, for example Cavan, it may be easier for someone to access a general service such as CIPC than to access a specialist service.

Different specialist services provide supports to different groups of people.

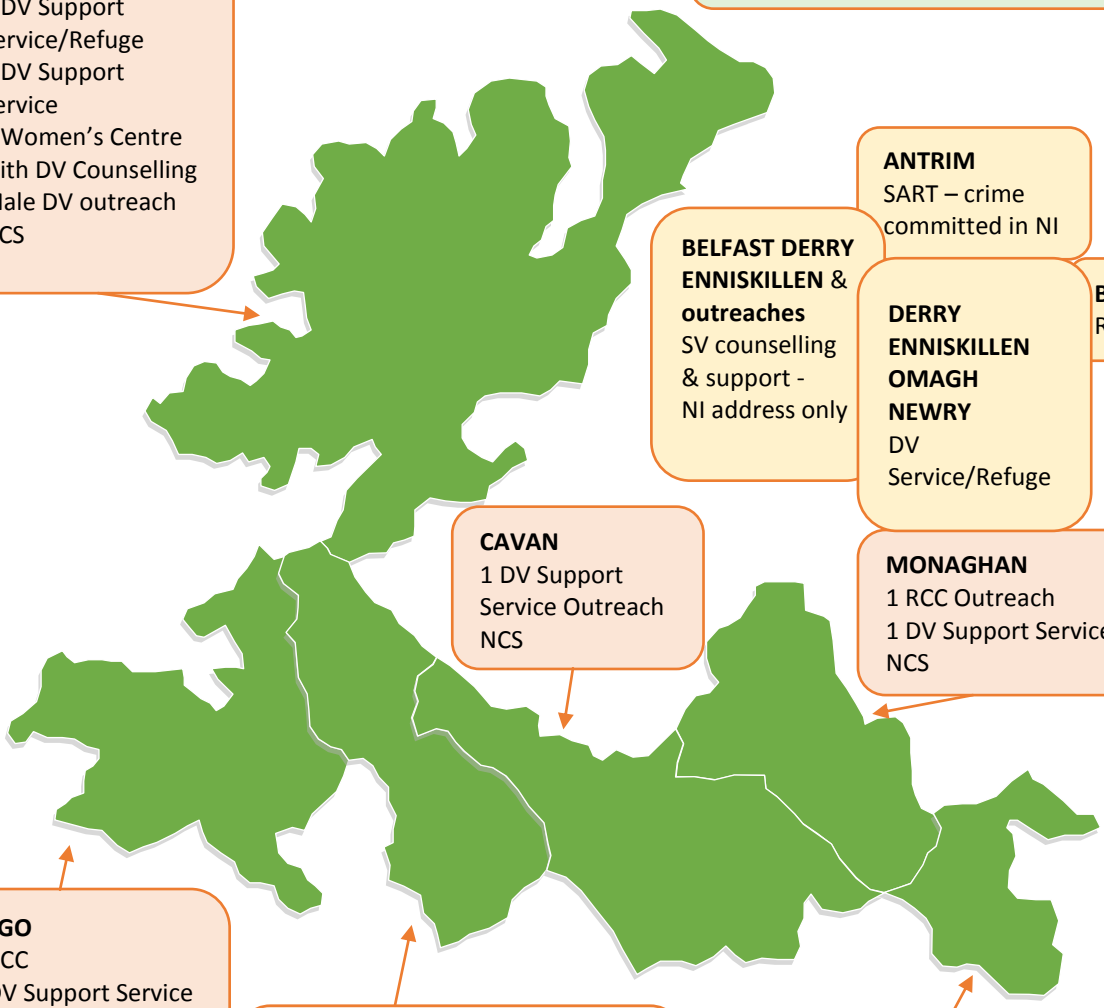


In order to use this diagram the appropriate bracket in each arrow needs to be chosen. For example, the appropriate specialist services for a 16 year old female who was raped last night by a stranger are a SATU and/or a RCC. These two are named in all of the arrows: 14+, female, recent violence and no relationship to the perpetrator. Some DV supports and DV services are indicated in the 'age now', 'gender identity' and 'when violence' arrows but not in the 'relationship to perpetrator' arrow. If the violence occurred in Northern Ireland or someone has a Northern Ireland address, services there might be more appropriate or accessible.

This section provides an overview of

1. **Local specialist and specialist based in a general setting services – both sexual violence and domestic violence because there is an overlap,**
2. **National relevant specialist services,**
3. **Appropriate NI services,**
4. **Commonly used general services,**
5. **Preventative services, and**
6. **Services specifically for Travellers, Roma, refugees, asylum seekers, immigrants and LGBTI persons.**

8.1 SPECIALIST SV SERVICES



DONEGAL
1 SATU
1 RCC
1 DV Support Service/Refuge
1 DV Support Service
1 Women's Centre with DV Counselling
Male DV outreach
NCS

ANTRIM
SART – crime committed in NI

BELFAST DERRY ENNISKILLEN & outreaches
SV counselling & support - NI address only

BELFAST
RCC

DERRY
ENNISKILLEN
OMAGH
NEWRY
DV Service/Refuge

CAVAN
1 DV Support Service Outreach
NCS

MONAGHAN
1 RCC Outreach
1 DV Support Service
NCS

SLIGO
1 RCC
1 DV Support Service
RCC Outreach
DV Outreaches
NCS

LEITRIM
1 shared RCC/DV Support Outreach
RCC outreach
DV outreaches
NCS

LOUTH
1 RCC
2 DV Support Service/Refuge - 1 with Meath
NCS

GALWAY
1 SATU

WESTMEATH
1 SATU

DUBLIN
1 SATU

24 HR NATIONAL RAPE CRISIS HELPLINE

24 HR NATIONAL WOMEN'S AID HELPLINE

MENS DV OFFICE HOURS HELPLINE
-Amen

CONNECT telephone counselling & support
Adult survivors of child abuse, trauma & neglect

36 HR/WK MENS DV HELPLINE
Men's Development Network – counsellors

8.1.1 SATU

SATUs (Sexual Assault Treatment Units) are the location in which multi-agency services to people aged 14+ who have recently experienced sexual violence. By its very nature, the system is an inter-agency collaboration between nursing and medical staff, An Garda Síochána, RCCs, the National Forensic Science Laboratory and the Office of the Director of Public Prosecutions. There is one SATU located in the region. It is in Letterkenny. For anyone in Louth, Monaghan or Cavan the unit in Mullingar, Co. Westmeath or the SATU situated in Dublin which may be closer or easier to access for some. SATUs serve anyone aged 14+ who has recently been subjected to rape or sexual assault or thinks they might have been. Services based on what an individual chooses; a medical examination – along with any appropriate prescriptions and follow-up, a forensic examination, refrigerated secure evidence storage to allow time to decide about reporting to the Gardaí, Gardaí reporting, psychological support, and links to ongoing supports are provided.

Nationally there was a 21% increase in the numbers of people attending SATUs between 2016 and 2017 according to the SATU annual report.[72] In 2017 92% of people attending a SATU were women, 92% of the sexual violence was perpetrated in Ireland, 77% identified as Irish, 68% were born in Ireland and 2% required interpreters. Sixty-eight percent of people reported the crime to An Garda Síochána at the same time as going to the SATU. A further 9% opted to have their forensic evidence collected and stored to give them time to decide whether they want to report the crime or not. Seventy-six percent reported an "incident" from less than seven days previously. Thirteen percent of the time the perpetrator was a partner, ex-partner or family member.

Table 12

SATUs		**2017**
Unit	**Number of people**	**% of national total**
Letterkenny	73	8%
Dublin	327	38%
Mullingar	174 (people from 19 counties attended)	20%

The Letterkenny SATU reports that 64% of the people attending were under the age of 25. SAFE (Sexual Assault Forensic Examiner) personnel in the units also engage in local education, training and preventative work. Staff in the Letterkenny Unit reached 400 14-24 year olds in the past year with sexual health, anti-bullying, violence and/or healthy relationships workshops. In addition, they provided trainings to 70 medical, mental health and education personnel.

[72] SATU Annual Report 2017.

A Sligo Liaison Group was established by the Letterkenny SATU after noticing that they were very few people were attending from Sligo. One of the nurse midwives can provide follow-up services in a local community hospital in South Donegal. The Unit is also working on more formal referral protocols with the Rowan Centre – the Sexual Assault Referral Centre (SARC) in Antrim.

8.1.2 RAPE CRISIS CENTRES

There are three rape crisis centres located in the Border Region. These are based in Letterkenny, Sligo and Dundalk. All provide therapeutic, advocacy, interagency and preventative services to youth age 14+ and adults regardless of gender identity who have experienced sexual violence, as well as family members and other supporters. Rape Crisis North East based in Louth provides therapeutic services to youth age 12+. All therapeutic and advocacy services are provided free of charge. Counsellors are accredited with IACP, IAHIP or BACP. Advocacy is provided in terms of accompaniment to legal and medical settings and with other organisations. Survivors are also supported before and after court, whether centre personnel accompany them or not. Each centre also maintains a local, limited hours, helpline. The figures below were provided by the RCCs.

Tusla is the major funder for all of the RCCs. RCNI provides training in Garda and court accompaniment and disperses funding from the Department of Justice and Equality for the expenses of RCC personnel providing the accompaniment. The other sources of funding for each individual centre are included in the tables below, along with information about the types and levels of support the RCCs are in a position to provide.

Table 13

DONEGAL SEXUAL ABUSE & RAPE CRISIS CENTRE		
SERVICES	**2017**	
Appointments	1677 offered - 1509 used	Letterkenny, Buncrana, Donegal Town, Lifford
Waiting times	After initial appointment within 2 weeks wait times between 1 and 8 months. Crisis and youth prioritised.	
Clients		91% female
SATU accompaniment	33	
Training	3rd level	LYIT students – 3rd year nursing and 3rd year law
LOCATIONS		
Main Centre		Letterkenny
Outreaches		Buncrana, Donegal Town, Lifford

STAFF/VOLUNTEER LEVELS	
This is in addition to board members in 2018.	1 manager full-time since July
	1 administrator 20 hrs/wk
	3 counsellors 1X33 hrs/wk, 1X 29 hrs/wk 1 X 15 hrs/wk
	1 SATU coordinator 17.5 hrs/wk – position filled for 3 months
	3 volunteers – SATU accompaniment hrs/wk vary

FUNDING other than Tusla	
These are funding sources for 2018	Fundraising and donations

Table 14

RAPE CRISIS & SEXUAL ABUSE COUNSELLING CENTRE – SLIGO, LEITRIM & WEST CAVAN		
SERVICES	**2017**	
Helpline	1410	32% counselling and support
Appointments	1683 offered, 1389 attended	Sligo 83%, Manorhamilton, Carrick-on-Shannon, Tubbercurry
Waiting times	Depending on level of crisis and location service required – up to one year.	
Clients	111	86% female
		85% survivors
		Sligo 61%, Leitrim 26%, Donegal 3%, Cavan 2%, Mayo, Roscommon & Fermanagh 1% each
		Irish citizen 77%, Other EU citizen 10%, Asylum seeker 4%
		Ireland 77%, Other EU country 11%, African country 3%
		Living in direct provision 4%
		<18 9%
		Heterosexual 90%, lesbian or gay 2%
		Adult sexual violence 39%, child sexual violence 40%, both 11%
Training		Training and support for professionals dealing with disclosures
Reporting		Gardaí 20%
		more than one authority including Tusla & education 11%
		Other national police 2%
		Asylum application 2%

LOCATIONS	
Main Centre	Sligo Town
Outreaches	Carrick-on-Shannon (new shared location with DVAS as of 2019), Manorhamilton, Tubbercurry

STAFF/VOLUNTEER LEVELS	
This is in addition to board members. These figures are for 2018.	1 CEO full time
	1 counsellor/administrator 17.5 hrs/wk
	2 counsellors 1X 22.5 hrs/wk, 1X20 hrs/wk
	1 counsellor with expenses paid 4 hrs/wk
	10 volunteer counsellors with between 1 and 5 clients per week

FUNDING other than Tusla	
These are funding sources for 2018.	IHREC
	Education & Training Board
	Fundraising & donations

Table 15

RAPE CRISIS NORTH EAST – DUNDALK		
SERVICES		**2018**
Helpline	2606 calls	87% female
		Irish settled 93% (in 2017 other countries 8%, Irish Traveller 0.04%
		(in 2017 59% Louth, 17% Monaghan, 11% Cavan)
Appointments	1407 offered	62% Dundalk
		25% Drogheda
		13% Castleblayney
Waiting times	Approximately 9 months depending on the level of crisis	
Clients	108 new	93% survivors
		67% Louth 13% Monaghan 13% Meath
		20% <18, 14% 14-16
		54% child sexual abuse
Accompaniment	0%	8% provided in previous year
Training		Sexual abuse module on level 8 qualification training 'The Fundamentals of Understanding and Responding to Domestic Abuse' at IT
Reporting		Gardaí /PSNI 48%

Counselling waiting list time	Approximately 9 months
LOCATIONS	
Main Centre	Dundalk
Outreaches	Drogheda
	Castleblayney
STAFF/VOLUNTEER LEVELS	
This is in addition to board members	1 Manager full time
	4 counsellors 1 x 26 hrs/wk, 2 x 20 hrs/wk, 1 x 7 hrs/wk
	6 CE staff 19.5 hrs/wk each – administration and cleaning
	5 helpline volunteers 4 hrs/wk each
FUNDING IN ADDITION TO TUSLA	
	Courts Poor Box
	Dundalk Credit Union
	National Lottery
	National Pen Company
	PayPal
	Rotary
	Donations & fundraising

8.1.3 NATIONAL SEXUAL VIOLENCE HELPLINE

There is one specific sexual violence national Irish helpline. It is a 24-hour service operated by the Dublin Rape Crisis Centre. In 2017 there were 10,818 contacts, 7,333 of which were for support/counselling. Of the callers, 78.7% were female, 20.8% male and 0.5% other. Most, 95%, of the people who shared their country of origin information were from Ireland. For those who disclosed their age, 5% were under the age of 18. Helpline personnel referred the caller to another RCC 29% of the time. About one-third (34%) of the contacts to the helpline (again from those who gave the information) were from people outside of Dublin. The statistics do not provide a further breakdown of the location of callers.[73]

8.1.4 NI SPECIALIST SEXUAL VIOLENCE SERVICES

The Rowan Centre (SARC) based in County Antrim provides medical, forensic and psychological support services to anyone, regardless of age, who has experienced sexual violence in Northern Ireland. That includes people living in one of the border counties who may have experienced sexual violence in the North. For the year ending 31 March 2018 the Centre offered support, advice or

[73] Dublin Rape Crisis Centre 2017 Statistics Supplement.

direct care to 903 individuals. Six hundred and forty six individuals were referred into the Rowan for support services, with a further 257 individuals seeking support, information and referral to other services only. Two-thirds (66%) were aged 18 or over and 86% were female. Almost 75% were reporting an assault which had been perpetrated within the past 7 days. For one-tenth the perpetrator was an intimate partner. For a small number of individuals and families who engaged with the service English was their second language and that number is in line with population size. Almost half had additional or complex needs including living with chronic and enduring mental ill-health, physical ill-health or learning disabilities. About 5% came back to the Rowan having experienced an additional, separate sexual violence incident. The available current e-briefing does not indicate the residency area of those using the service.

Nexus NI offer free counselling (up to 18 sessions) and post counselling support in terms of a reconnection to society programme called Connexion and a self-confidence improvement course called Steps. It is only available to those with a Northern Ireland address. The service operates from three main offices in Belfast, Derry and Enniskillen as well as a number of outreach locations.

Table 16

Nexus NI Counselling – 2017/18 (12 mos)	
Counselling sessions offered	17,776
Counselling Sessions delivered	14,964
Clients completing counselling	632
Referrals	1893 - 1463 female & 430 male
Referral Age Range 11-16	41
Referral Age Range 16-24	420
Referral Age Range 25-49	1087
Referral Age Range 50-75	345
Referral Age Range 75+	3

After a high profile rape case in 2018, the waiting list for counselling stood at 800+. It now (as of 2019) operates the NI domestic and sexual violence helpline and partnered with Women's Aid and the Men's Development Project to restart Belfast Rape Crisis Centre in 2018.

It is also engaged in a partnership with the PSNI to support "achieving best evidence"[74] in the court process. Additionally, the organisation participates in DIS.CO – a European Erasmus+ project which is to develop, pilot and disseminate skills and knowledge about counselling female survivors of violence at a distance. The project is aiming to promote innovative digital learning methods along with work-related digital tools.

[74] Achieving best evidence refers to UK interview procedures regarding victims and witnesses, including vulnerable witnesses.
https://www.cps.gov.uk/sites/default/files/documents/legal_guidance/best_evidence_in_criminal_proceedings.pdf

8.2 SPECIALIST DOMESTIC VIOLENCE SERVICES

There are seven domestic violence services in the region for women and one domestic violence service for men with an outreach in the area. Support services are located in Inishowen, Sligo, and Monaghan. The Sligo service has outreaches in Leitrim and the Monaghan services has an outreach in Cavan. There are refuges in Letterkenny, Dundalk and Drogheda which also provide support services. There is a specialist domestic violence counselling service for women in Letterkenny. The outreach for men experiencing domestic violence is in Donegal.

8.2.1 SPECIALIST DOMESTIC VIOLENCE SERVICES FOR WOMEN

All of the information contained in the tables in this section is provided by the DV services.

Table 17

LIFELINE INISHOWN	
SERVICES	**2018**
Information, support, accompaniment	45 women
Counselling	4 sessions/week
This centre also provides low-cost general counselling & psychotherapy.	
Education & training	Healthy relationships for secondary schools
STAFF/VOLUNTEER LEVELS	
	1 part time children's counsellor
	1 part time support worker
	8 volunteers covering a total of 4 hrs/day 5 days/wk
FUNDING – in addition to TUSLA	
	Community Foundation of Ireland
	Fundraising & Donations

Table 18

DONEGAL WOMEN'S CENTRE	
SERVICES	**2018**
Counselling – DV	109
This centre offers a variety of services for women. It is a member of SafeIreland. It also hosts a community counselling service.	
LOCATIONS	
Main Centre	Letterkenny
STAFF/VOLUNTEER LEVELS	
This is in addition to board members	Manager 10% of full time for this specific service
	2 counsellors 1 FT, 1 28 hrs/wk
FUNDING by Tusla	

Table 19

DONEGAL DOMESTIC VIOLENCE SERVICE	
SERVICES	**2018**
Helpline	1290 calls - 390 people
Support (individual & group)	950 sessions - 227 people
Accompaniment	155 sessions - 75 people
Refuge	1477 nights – 30 individuals
Education Programmes	2nd level - 12 students
	3rd level – 45 legal students
LOCATIONS	
Main Centre	Letterkenny
Outreaches	At mutually agreed locations
STAFF/VOLUNTEER LEVELS	
This is in addition to board members	Manager full time
	Administrator full time
	Support workers X 3 full time
	Team Leader full time
	Night workers X 2 full time
	Locum cover as required
FUNDING other than Tusla	
	Commission for the Support of Victims of Crime
	Education and Training Board
	Fundraising & Donations

Table 19

DOMESTIC VIOLENCE ADVOCACY SERVICE - SLIGO, LEITRIM, WEST CAVAN	
SERVICES	**2018**
Helpline/Phone based support	117 calls – 24 women
Support (individual & group)	31 sessions (10 X 2 groups) (11 X 1 group)
Information & Advice	35 sessions – 20 women
Accompaniment	31 times – 22 women
Advocacy	254 sessions – 111 women
Supported housing	5 women
Training of other professionals	1 hour – 7 midwives
	2 hours – 22 community-based family support workers
Education programme	4 X 2 hours - 3rd level 60 CMH students & marketing students
Social Change Work	SHINE project (Safe Homes, Information, Networking, Empowerment) – 6-month radio ad campaign, 5 social media videos.
LOCATIONS	
Main location	Sligo
Second location shared with RCC	Carrick-on-Shannon (from 2019)
Outreach & support sessions	Ballymote, Enniscrone, Tubbercurry – Co Sligo
	Mohill, Ballinmore, Drumshanbo, Manorhamilton – Co Leitrim
	In FRCs, Foróige youth centres, community spaces
STAFF/VOLUNTEER LEVELS	
This is in addition to board members	1 Manager full time
	1 Administrator 28 hrs/wk
	5 Support Workers – 1X35 hrs/wk, 1X30 hrs/wk2X24 hrs/wk, 1X21 hrs/wk
	(2 workers – 1X35 hrs/wk & 1X24 hrs/wk on long term sick leave for most of 2018)
	1 volunteer 1 day per week for helpline & court support
FUNDING other than Tusla	
	Commission for the Support of Victims of Crime
	Community Foundation of Ireland
	County Council

	LEADER
	Fundraising & donations

Table 20

TEARMANN DOMESTIC VIOLENCE SERVICE – CAVAN & MONAGHAN	
SERVICES	**2018**
Helpline	630 calls – 262 people
Support	602 sessions
Information & Advice	35 sessions – 20 women
Accompaniment	168
Advocacy	113
Awareness raising	22 sessions – 1461 2nd level students and community members
LOCATIONS	
Main location	Rooskey, Monaghan
Outreach	Cavan Town
STAFF/VOLUNTEER LEVELS	
This is in addition to board members	1 Manager full time
	2 Support Workers full time
FUNDING other than Tusla	
	Commission for the Support of Victims of Crime
	Fundraising & donations

Table 21

WOMEN'S AID DUNDALK	
SERVICES	**2018**
Helpline	1441
Support	144 women/2377 sessions
Court Clinic	88
Advocacy	600
Tenancy support	6

Refuge	41 – unable to accommodate 303
STAFF/VOLUNTEER LEVELS	
This is in addition to board members	Women support workers 15 -32 hrs/wk
	Court support worker 19 hrs/wk
	Tenancy support worker 24 hrs/wk
	Women's support coordinator
	Services manager
	CE Scheme 19 hrs/wk
	6 volunteers 8 hrs/wk

Table 22

DROGHEDA WOMEN'S & CHILDREN'S REFUGE	
SERVICES	**2018**
Helpline	No numbers provided
Support (individual & group)	
Accompaniment	
Refuge	
Education Programmes	
LOCATIONS	
Main Centre	Drogheda
Outreaches	
STAFF/VOLUNTEER LEVELS	
This is in addition to board members	Manager full time – no other info provided

8.2.2 DOMESTIC VIOLENCE SERVICE FOR MEN

Table 23

AMEN	**2016**
Helpline	2,563 crisis calls, 30 sv disclosures
Counselling	32 clients, 212 hours – Dublin & Navan
Support	301 clients – 456 sessions most in Navan
Accompaniment	176 men – some to court in Louth
	1 outreach in Donegal

In May 2019 the Men's Development Network in Waterford launched a 36 hour per week domestic violence helpline for men.

8.2.3 NATIONAL HELPLINE

Women's Aid in Dublin operates a 24-hour domestic violence helpline. In 2018 they received 15,835 calls of which 84% were support calls. 646 of the callers were migrant women, Traveller women or women with a dis/ability. In 202 of those calls their Language Line service was used to facilitate communication in a language other than English. 438 disclosures of "sexual abuse" were made.[75]

8.2.4 NI SPECIALIST DOMESTIC VIOLENCE SERVICES FOR WOMEN

Women's Aid Federation NI has six affiliated domestic violence services. The most relevant to women living in the border counties are those in Derry, Enniskillen, Omagh and Newry. These services all offer refuge in addition to support, advocacy and training for other agencies. As noted above, Nexus is now operating the NI sexual and domestic violence helpline.

8.2.5 NI SPECIALIST DOMESTIC VIOLENCE SERVICES FOR MEN

The Men's Advisory Project, with offices in Belfast and Foyle, offers counselling for men experiencing domestic violence. The helpline operated by Nexus is open to both men and women.

8.3 SERVICES FOR ADULTS WHO EXPERIENCED ABUSE AS A CHILD

The HSE operates the National Counselling Service (NCS). This service was set up provide free counselling and psychotherapy services to adults who experienced trauma and abuse in childhood. Priority is given to people who were abused in institutions. It is possible to self-refer. There are services in the HSE West region of Donegal, Leitrim and Sligo and the Dublin North East Region which includes Cavan, Monaghan and Louth. The service is accessible through freephone numbers for each region.

Connect is a free telephone counselling and support service for adults who experienced trauma, abuse or neglect in childhood. That can include sexual violence. It is an additional service to the National Counselling Service and operates from 6-10 pm Wednesday to Sunday. Phone counselling involves speaking to a qualified and experienced counsellor over the phone. The options are to call with no appointment or arrangement in advance or to call at a fixed time to speak with the same counsellor each time. The supportive counselling offered involves shorter phone calls over a

[75] Women's Aid Impact Report 2018.

number of weeks. The therapeutic counselling offered is more in-depth and involved scheduled times for a number of months.

In 2014, the most current available statistics, 6,052 calls were made to the service nationally and 986 calls went unanswered. Four hundred and seventy individuals received a service. Of those, 66% were female, 32% were male and 2% were trans. Forty percent of the callers were aged between 31 and 50. A small number of callers were from the border counties: 5% from Sligo, 2% from Cavan/Monaghan and 1-2% from a number of different counties including Donegal and Louth. As always, with a telephone line, this information is based on the number of callers who chose to give it.[76]

8.4 GENERAL LOCALLY AVAILABLE THERAPEUTIC SERVICES

There are two types of general services – those which are local and those which are national services and available locally. Any general service, in Istanbul Convention terms, may end up providing services to someone who has experienced sexual violence. This includes counselling services, GPs and addiction services. It is beyond the bounds of this NAP to map all of the myriad of services utilised by sexual violence survivors. This section highlights the most commonly available therapeutic services utilised by survivors, outside of addiction services.

The following table lists the Family Resource Centres by county which are specifically funded by Tusla to provide counselling. FRCs offer a variety of other supports, including groups. Some DV services have outreaches located within FRCs.

Table 24

DONEGAL	
Donegal FRC	Donegal Town
Downstrands FRC	Portnoo
Moville & District FRC	Moville
Raphoe FRC	Raphoe
St Johnston & Carrigans FRC	Lifford
The Forge FRC	Pettigo
LEITRIM	
Breffni FRC	Carrick-on-Shannon
Mohill Family Support Centre	Mohill
SLIGO	

[76] Connect Service Report 2015.

Tubbercurry FRC	Tubbercurry
CAVAN	
Teach Oscail FRC Project	Cavan
Focus FRC	Killishandra
MONAGHAN	
Teach Na Daoine FRC	Mullaghmatt
Clones Family Resource Centre	Clones
LOUTH	
Connect FRC	Drogheda

In addition, the following organisations also provide low-cost counselling and psychotherapy.

Table 24

Donegal	
Pastoral Centre Letterkenny	Letterkenny
Leitrim	
Carrick-On-Shannon Family Life Centre	Carrick-on-Shannon
North Leitrim Women's Centre	Manorhamilton
Sligo	
Sligo Social Service Council Ltd.	Sligo
St Michaels Family Life Centre	Sligo
Monaghan	
Blayney Blades	Castleblayney
Louth	
Drogheda Community Services	Drogheda
Dundalk Counselling Centre	Dundalk
Family Ministry Dundalk	Dundalk

CIPC (Counselling in Primary Care) short term counselling is available through primary care GP referral for adult medical card holders with mild to moderate "psychological difficulties". The referral contact offices for the HSE CHO 1 area are in Donegal and Sligo. The referral contact office for Louth, Monaghan and Cavan (CHO 8 and part of CHO 1) is in Meath. CIPC services are supervised by NCS personnel. Eighteen percent of persons availing of this service report trauma or abuse as one of the reasons they began participating in counselling.[77]

Adult mental health services can be accessed through community mental health teams. There are various locations throughout each county. It is also possible to access psychology and social work services through HSE primary care teams. The psychology service can provide assessment and interventions and in by referral from a GP or PCT member. Social Work provides early interventions

[77] Counselling in Primary Care Service: National Evaluation Study Report of Phase 1, April 2018

in the areas of children and family, older people and vulnerable adults living alone. Social work services can be accessed by self, GP or PCT member referral. Again, there are various locations throughout each county. According to the HSE quarterly performance report for July to September 2018, between 71% and 75% of adults accessing mental health services were seen within 12 weeks.[78]

Donegal Youth Service in Letterkeny provides low cost access to counselling and psychotherapy. There is one Jigsaw (youth mental health service for young people aged 15-25) in the region. It is operated as a partnership between the HSE and The Alcohol Forum and based in Letterkenny with five outreach locations. Nationally Jigsaw supported 4,387 young people in 2017.[79] Letterkenny IT, Sligo IT, Monaghan Institute and DkIT all provide a counselling service for enrolled students.

GPs, as well as consultants and Jigsaw, can refer a young person experiencing mental health difficulties to CAMHS (Child & Adolescent Mental Health Service). Sligo, Cavan, Monaghan and Louth all have one referral location. Donegal has two with one in the south of the county in Donegal town. In March 2018 HSE's Mental Health Services released information that of the 2,691 children and young adults awaiting CAMHS appointments nationally, 1,369 were waiting for up to three months, 470 for up to six months, 241 up to nine months, 225 up to 12 months, 178 for up to 15 months, 80 for up to 18 months, and 128 for over 18 months.[80] The HSE adopted a KPI (Key Performance Indicator) in terms of waiting list times for CAMHS. The KPI is that 100% of referrals receive a first appointment within a year. The services in the border counties achieved that at least 94.9% of the time according to the July – September 2018 HSE Performance Report (the most recent available at time of writing). The Donegal CAMHS has outsourced therapy services to an agency in Northern Ireland for some of the young people referred to it.

8.5 ADDITIONAL PREVENTATIVE SERVICES

Preventative services are vital in terms of working towards a society in which there is no more sexual violence. In addition, preventative work often involves awareness raising – both of available services and of the issue itself, training and education. That means many people who have been engaged with in the course of a preventative campaign, social conversation, education or training programme may well be in a better position to respond if and when someone discloses an experience of sexual violence.

[79] Jigsaw annual report 2017
[80] https://www.irishtimes.com/news/social-affairs/nearly-2-700-young-people-waiting-for-mental-health-appointments-1.3623250

In addition to the preventative services provided by the specialist services as indicated in the previous section, there are other providers of sexual health, sex education and consent education and training programmes across the border counties. One such programme is the Real U (Relationships Explored and Life Uncovered) personal development and sex education programme developed by Foróige in consultation with the RCNI and BeLong To. It is aimed at young people aged between 12-18 years in a group work setting and can be delivered in any part of the country in which facilitators have been trained. The last evaluation of the programme was in 2013. That evaluation, by the Child and Family Research Centre in NUIG was positive.[81]

The NUIG researchers who established and rolled out the national SMART Consent programme have just announced a major four-year programme of research and implementation on Active Consent. The programme targets young people from 16-23 years of age in order to promote a positive approach to the important issue of sexual consent and will partner with a range of schools and sporting organisations in the delivery of the Active Consent initiative.[82]

Dundalk Institute of Technology (DkIT) is one of the higher education institutes in Ireland participating in the development of It Stops Now, a Daphne III funded European project (ESHTE) on Ending Sexual Harassment and Violence Against Women in Third Level Education. The National Women's Council is the lead agency in Ireland. A toolkit was launched in early 2019 for third level institutions to utilise in understanding the issues, research data collection, supporting staff to change the culture, policies, disclosures, investigations and campaigning for change.

Another facet of prevention involves perpetrator treatment programmes. While that is not within the scope of the NAP, it is worth noting that there is a small service called COSC operating in Donegal. It provides assessment and treatment for adults who have sexually harmed children (convicted/non-convicted, contact/non-contact offences including accessing abuse images of children). Support for adult partners/family members is also available. There are currently about 60 men engaged in this programme. There is also the beginnings of a programme in Louth, currently only undertaking assessments. One in Four in Dublin also provide individual and group counselling

[81] https://www.foroige.ie/our-work/relationships-sexuality-programme
[82] http://www.nuigalway.ie/about-us/news-and-events/news-archive/2019/january/minister-launches-new-four-year-active-consent-programme-at-nui-galway.html

for sexual violence perpetrators. In 2017 they worked with 54, two-thirds of whom were from outside Dublin.[83]

8.6 GROUPS AND SERVICES FOR TRAVELLERS, ROMA, REFUGEES, ASYLUM SEEKERS, TRAFFICKED PERSONS, IMMIGRANTS AND LGBTI PERSONS

There are a myriad of support groups, projects and organisations providing services with and to these groups of marginalised people living in the border counties. This section only includes highlights. All of those listed are potential gateways to the more specialised sexual violence services.

8.6.1 TRAVELLERS & ROMA

There is a Traveller & Roma Support Group in Letterkenny. Sligo has a Traveller Support Group as does Cavan. Among other pieces of work, the Sligo staff work with young women prior to marriage. They use that opportunity to ensure the young women are aware of the sexual and domestic violence services in the area. There is one person providing Traveller Support in Louth. There are Traveller Primary Health Care Projects in Donegal, Leitrim, Sligo, Cavan and Louth. The Project in Cavan has minimal services in Monaghan. The remit includes providing health education and information to Travellers in the County.

There is a Traveller Counselling Centre providing services in various Dublin area locations. The service works from a perspective of culture centred counselling and psychotherapy.

8.6.2 IMMIGRANT COMMUNITIES

There are a number of groups providing services to a wide variety of immigrants. Those more specifically for refugees and asylum seekers and trafficked persons are included below.

Fáilte Isteach is a project of Third Age Ireland and welcomes migrants through conversational English and had branches in all of the border counties. The Monaghan branch participated in the Focus Group that was facilitated there.

The Donegal Intercultural Platform has produced Connecting for Life suicide prevention leaflets in eight languages about where people can access health services, emergency services and mental health supports, including rape crisis. It also explains access to translation services at emergency and primary care services. The group also participates in the iReport system for online reporting of racist incidents.

[83] One in Four Annual Report 2017

Monaghan Integrated Development is a local development company promoting social inclusion, equality and diversity. One of the projects it runs is a Cultural Champions programme. Cultural Champions are members of a variety of ethnic communities who act locally as ambassadors for their own cultures. There is a desire to turn this into a social enterprise offering advocacy training modules.

Since 2014 the IFPA (Irish Family Planning Association) has run a FGM clinic in Dublin. This service was developed with the support of the HSE National Social Inclusion Office and AkiDwA – the Migrant Women's Network.

8.6.3 REFUGEES & ASYLUM SEEKERS

Diversity Sligo works with and supports asylum seekers living in direct provision in Sligo, and has a close working relationship with the Sligo RCC. That county has the largest percentage of asylum seekers in the country. The organisation is currently training volunteers resident in Globe House in listening skills to be present in a specific place at specific times. These volunteers will be able to refer on to other organisations or groups when appropriate.

Dublin-based Spirasi is the only organisation in the country providing specialist services for survivors of torture who are asylum seekers, refugees, or other disadvantaged migrant groups. Referral is from a GP or primary health care worker. Assessments, medico-legal reports, family therapy, groups, complementary therapies, psychosocial and integration support, outreach support and education can be provided with access to a professional interpreter if required. At the beginning of 2018 the organisation had 684 open 'cases'. Four in ten (40%) were female, 60% between 31 and 50, and 89% were asylum seekers. The top ten countries came were Zimbabwe, Pakistan, DRC, Afghanistan, Nigeria, Iran, Malawi, and Iraq & Cameroon. During 2017 193 assessments were completed, as were 97 medico-legal reports and 3,722 therapy session.

8.6.4 HUMAN BEINGS WHO ARE TRAFFICKED

Individuals are trafficked into and through Ireland for sexual, labour and forced crime. The HSE Anti-Human Trafficking Unit are responsible for care planning for persons who have been trafficked. People are referred into the service from the Garda National Immigration Bureau (Human trafficking and Investigation Unit). The team is responsible for assessment and care planning with each individual. Staff also support persons through the investigation process with GNIB and liaise with all

the statutory and NGO services who can offer additional support to persons who have been trafficked.

Ruhama is a Dublin-based NGO which works on a national level with women affected by prostitution and other forms of commercial sexual exploitation. Services are provided to women who are victims of sex trafficking. In 2018 the organisation supported 122 persons trafficked into this country from 29 different countries.[84]

In 2018 the Immigrant Council provided legal advice and assistance to 23 human trafficking victims from several African, South American and Asian countries. All were female and 20 were trafficked for the purpose of sexual exploitation. [85]

8.6.5 LGBTI

There is one adult and youth LGBT centre called Outcomers in the region. It is based in Dundalk and offers a drop-in centre, befriending, groups for youth (14-17), young adults, women and men, health information and education, outreach, training within the LGBT community and training for statutory and NGO services. It is one of the members of LGBT Ireland. For border county residents LGBT Ireland offers a LGBT helpline, online chat and instant messaging. It also offers a gender identity family support line.

BreakOut is a Donegal youth project focused on LGBT young people aged between 12 and 30 years. The project operates a weekly drop-in provision in Letterkenny and Ballybofey as well as training, information and one to one support.

SMILY is a youth group in Sligo and Leitrim for young people aged between 14-23 years who identify as LGBT or who are questioning their identity. It is facilited by a LGBT youth worker based in North Connaught YouthReach. That youth worker also engages in a variety of interagency, preventative and support work and wants better linkages to sexual and domestic violence services.

8.7 AN GARDA SIÓCHÁNA

The Garda National Protective Services Bureau (GNPSB) is responsible for sexual crime , domestic abuse, child abuse, online child exploitation and human trafficking. It includes the Sex Offender Management and Intelligence Unit (SOMIU), Sex Offender Risk Assessment and Management (SORAM) and the Garda Victim Liaison Office (GLVO).

[84] Ruhama Annual Report 2018
[85] Immigrant Council Impact Report 2018

The border counties are contained in the Garda Northern Region. Within this region there are four divisions: Donegal, Sligo/Leitrim, Cavan/Monaghan and Louth. Within each division there are districts and sub-districts. There is a Divisional Protective Services Unit (DPSU) in Castlebellingham, Co Louth and it is planned that by the end of 2019 there will be one unit in each division. That requires each division to have developed a business service plan for the unit and to have obtained premises. There is also competition within An Garda Síochána for the staff positions in each of the units. Budgets need to be allocated for each unit – including for cars. In the long term the DPSUs are to be responsible for the investigation of the same types of crime as the GNPSB including sexual crime, human trafficking, child abuse and domestic violence. DPSUs will also focus on the provision of support for vulnerable victims of crime, including enhanced collaboration with the Child and Family Agency to safeguard children. The units are commencing by working on serious sexual violence crime. DPSU personnel engage in on-going modular training, some at Templemore and some online.

Each division also has a Victim Services Office. The Victim Service Offices , open 9-5 Monday to Friday, are to be the central point of contact for victims of crime in each Division. In the Northern Region the Victim Services Offices are in Glenties for Co Donegal, Carrick-on-Shannon for Leitrim and Sligo, Ballyconnell for Cavan and Monaghan and Dunleer for Co Louth. The staff in each of the units are responsible for administrative work. They are also able to provide contact details for relevant support/counselling services. Victims of domestic violence, sexual crime or other crimes where there is trauma are to continue to be given advice and support in person from investigating or specialist Gardaí.

There is currently a sexual assault investigation unit located in Letterkenny with four full time Gardaí. In the three years it has been in operation there has been a turnover of staff. However, the staff have received training so that helps improve services in the areas to which they move. They have bi-monthly meetings with the PSNI.

There is a forthcoming new Garda strategy which is to include a diversity strategy. This is to address the future of what had been ethnic liaison officers and LGBT liaison officers.

8.8 OTHER SERVICES FOR VICTIMS OF CRIMES

In addition to the advocacy and accompaniment services offered by RCCs and DV services, there are organisations which provide telephone support and referral and accompaniment services specifically for crime victims.

8.8.1 CRIME VICTIMS SERVICES

In 2018 the Crime Victims Helpline responded to a number of contacts from people living in the border region. A small percentage of those calls related to sexual violence. During the year 124 contacts were from people in Leitrim, Sligo, Cavan and Monaghan and none of those calls related to sexual violence. Six of the 75 contacts from Donegal related to sexual violence and one of the 77 contacts from Louth did. To put this into some context, during the previous year nationally 6% of the contacts related to sexual violence, and 10% of the contacts were from residents of the border counties. The Helpline referred people to the National Sexual Violence Helpline and the National Women's Aid Helpline as well as to legal services.

V-SAC (Victims Support at Court) offers pre-trial court visits and court accompaniment to "victims" of crime. Their definition of victims includes family members, friends and witnesses. Based in Dublin at the Criminal Courts of Justice, the organisation will provide services in the border counties if requested. In 2017 they provided support to 613 survivors, family members and witnesses in rape and sexual assault court appearances.[86]

8.8.2 CRIME VICTIMS SERVICES IN NORTHERN IRELAND

Victim Support NI receives referrals directly from the PSNI and works with victims of all types of crimes in terms of reporting, attending court and pursuing claims through the criminal injuries compensation tribunal. They host two ISVA (Independent Sexual Violence Advisor) positions who worked with 443 people in 2017/18 (12 months). The role of the ISVA is to "provide an informative, non-judgemental support service to victims who have already engaged with the police or criminal justice system, or who are thinking of reporting their crime." Again this service is available to any resident of the border counties who experienced sexual violence in Northern Ireland.

[86] V-SAC 2017 Annual Report

9.RESEARCH FINDINGS: SURVIVOR EXPERTISE & OPINIONS

"NOT MY FAULT" A survivor's description of how a service was helpful to them.

Due to the time constraints of the NAP it was not possible for the researcher to access sexual violence survivors to ascertain their opinions and draw upon their expertise in an ethical, safe and respectful way outside of requesting information from survivors currently utilising existing services. These survivors had immediate access to support if the survey raised uncomfortable or challenging issues for them. Surveys were made available in English at RCCs, DV services and FRCs. The survey form itself, along with the introduction, is included in Appendix 3.

The survey was designed to capture:

- Demographic information relevant to this NAP;
- How they got to/found out about the RCC/DV/FRC;
- What specific services they used and for what time period;
- Waiting list times, if relevant;
- What would make it easier for them to use the services;
- Any referrals to other services;
- What they found particularly helpful;
- What additional services would be helpful; and
- What would be helpful for someone else needing services.

All of the people who completed the surveys are themselves survivors of sexual violence. The survivors' experiences and opinions captured are useful and helpful and are not necessarily representative of all survivors or even all survivors currently using specialist services. Survivors of sexual violence are not a homogenous group, nor are their experiences, responses or needs the same. These vary according to the intensity, level and frequency of the violence and abuse, the support they currently have, their circumstances and their personal resilience.[87]

Twenty sexual violence survivors using existing specialist sexual violence (16) and domestic violence (3) services and family resource centre (3) counselling services completed a questionnaire. Two are currently using more than one of the services. The gender identity of eighteen respondents is female, one is female non-binary and one is male. Nineteen identify as heterosexual and one as lesbian. One identifies as Black African/Black Irish and the remainder as White/settled/Irish or White/other. Most were born in Ireland (14), one in Africa and the rest in Great Britain. Everyone who completed a questionnaire was able to access services in a preferred language. This is not

[87] Henderson (May 2012).

surprising given that the form was only available in English. The participants are primarily aged between 41 and 60 (13) with the youngest in the 18-24 year old age bracket and the oldest in the 61-80 year old bracket. With the exception of Cavan, residents of all of the border counties and three neighbouring counties are represented. Cavan is the county without a sexual violence service or outreach.

People found out about services in a variety of ways. Some indicated more than one way. In terms of RCCs, the two most common ways were counsellors/mental health services and the internet/social media, followed by addiction services and GPs. Other information sources were suicide NGOs, Garda, Family Resource Centres, SATU and friends and family members. Women found out about DV services from the Gardaí and FRCs. People found out about the FRC from CAMHS and Social Workers. The time people spent getting to services varied from less than 15 minutes to between one and two hours. For five of the participants public transport was not available at all. For an additional five it was available but would take too long and for two it was unavailable at the times they required it. For three, the financial cost of getting to the service was a problem.

What survivors found helpful about the services very much mirrors what was found in the report of what rape survivors want from the UK Victim's Champion. What they said was:

The most common service used at RCCs was counselling, the most common in DV services were support and accompaniment. Counselling and information was accessed through FRCs. At RCCs, people also utilised the helpline, accompaniment, other advocacy, and legal information. In DV services women also used refuges and counselling. For RCCs the current service usage time ranged from one month to more than two years, with the latter being the most common. Two people used RCC services previously – one six or seven months prior to this time and the other one year before. In order to access counselling half had been on a waiting list varying from three weeks to six months. For DV services the current usage time varied from one to four months and for an FRC from one month to more than two years. No one reported a waiting list for DV or FRC services.

The most helpful service named at RCCs was counselling and, as above, this is the most commonly utilised service. Counselling was also named as helpful by those using DV and FRC services. Information, legal information, support and advice, advocacy and accompaniment were all found to be helpful in all of the services. One person using RCC services found legal accompaniment particularly helpful. Support groups in DV services were specifically named. Another said that accompaniment increased their safety.

Half of the participants were referred to other organisations/agencies. For RCCs referrals included SATU, another specific issue NGO, Tusla – Meitheal, addiction services and a social worker. For DV services this included a RCC and for FRCs this included a counsellor, GP and a social worker.

Participants were asked about what services are needed to improve accessibility – both for themselves and for anyone else who might need the service. The area named by more than half of the survivors using RCC services and about one third of survivors using DV services or FRCs was for additional access to supports/counsellor by telephone, skype or other internet facilities or text. One survivor commented that sometimes talking was just too much and texting would allow communication. Snapchat was suggested by one, as conversations are immediately erased. This poses questions for service providers about adapting to meet the needs of survivors. Connect, the telephone service connected with the NCS, currently offers telephone appointments for counselling. The Glasgow & Clyde Rape Crisis Centre offers services in a variety of ways by telephone and electronically. Some of these services are specifically aimed at younger people.

For RCCs specifically, additional counselling times such as evenings and weekends and more outreach locations were also commonly named. Two said additional counsellors are needed to create more available times for appointments and cut waiting list times. About one quarter think family counselling or group counselling should be available. One suggested the option of a variety of

counselling approaches and information about what might be the most helpful should be available. One noted a need for counselling to be available in additional languages. Another participant thinks that walk-in counselling services should be available. Another commonly mentioned need from RCC service users was for support groups. Support groups for families, perhaps a childcare issue, was mentioned in terms of DV services and FRCs. Another wanted extra supports to be available in the lead up to a court hearing and afterwards. One participant suggested classes on expressing feelings in an active, safe way such as dance, physical movement, drama, boxing would be helpful.

About one quarter of survivors using all three types of services believe that education prevention programmes should be available/more available, with a few mentioning that it should be for all age ranges. Several expressed a need for more awareness of the issues and services in terms of other people who might need services. One suggested that talks and reading materials naming "common feelings" be provided for people supporting survivors. Another named better social workers/family support as needed in terms of improving services accessibility for others. One survivor who is using RCC services believes mandatory training for GPs would improve accessibility and a survivor using DV services believes legal change is needed.

One participant said that they would have found it helpful for the service to contact them, as making that first phone call was extremely difficult. This was in the context of having been told about the RCC by a general service provider and feeling that it would have been helpful if the referrer could have, with their permission, passed on their contact information and requested a call.

Some participants also shared negative experiences. One felt the referral to the RCC was too soon and was overwhelmed. One got the message that services were very restricted and felt they were taking someone else's spot. They were further told about the option of donating money and felt bad because they were not in a position to do so. Another described feeling too raw and exposed after sessions opened up pain and felt they were given no assistance with coping mechanisms.

Survivor's contributions are combined with those gleaned from direct services, general services and stakeholder personnel in the Gaps section.

10.RESEARCH FINDINGS: ORGANISATIONAL EXPERTISE & OPINIONS

Information was obtained from specialist services, general services and stakeholder services through online surveys, focus groups, individual interviews, telephone interviews, electronic communication and a data review. The online survey form is in Appendix 4.

Thirty individuals completed the online questionnaire. They work in a variety of roles within statutory and NGO services including Tusla – various sections/services, the HSE – various services, Foróige, YouthReach, YouthWork Ireland, a youth centre, a childhood network trainer, two third level institutions, a LGBT centre, an addiction service, a youth addictions service and a county council. Twenty-two of them work in an organisation or in a role within an organisation which does not provide direct services to sexual violence survivors. In the online surveys, respondents were asked about the following areas:

- Organisation, role and county
- Therapeutic, advocacy & preventative services delivered, targets & levels
- Referrals to and from
- Who used services in past year
- Interagency work with whom & purpose
- Specific group training needs
- Perception of gaps (if any)
- Priorities to address gaps
- Examples of good practice

Personnel in organisations or groups working with Travellers, Roma, refugees, asylum seekers and immigrants are not represented within the group of questionnaire respondents. Their views were sought through individual interviews, telephone interviews and focus groups. Focus groups were given best practices information and the prompts were 'what was working well, what, if any, gaps existed and what ideas for improvement'. Interviews requested information on what the stakeholder service issues are, what services the stakeholder provides in the border counties, what gaps exist, services the stakeholder thinks need to be provided and any ideas for future developments.

Focus groups were held in Donegal, Sligo, Cavan and Monaghan. Two attempts were made to schedule a group in Louth. However an insufficient number of participants were available on both of these occasions This may reflect the workload and priorities of the relevant organisations and personnel. In total there were twenty-six participants from RCCs, SATU, DV services, FRCs, a Traveller Support Group, youth groups, LGBT services, immigrant support, and An Garda Síochána. Individual interviews were conducted with DV services, RCC personnel, FRC personnel, refugee and asylum seeker support organisation personnel, Traveller Support group personnel, a RCC group facilitator with experience of direct provision, a youth mental health worker and a perpetrator programme counsellor. Information was obtained by telephone from national organisation personnel and local group personnel with Traveller and Roma organisations, LGBTI+ adult and youth organisations, immigrant organisations and An Garda Síochána National Protective Services Bureau.

10.1 SERVICES FOR SPECIFIC GROUPS OF PEOPLE

All of the survey respondents providing therapeutic, advocacy and preventative services thought they needed to be in a better position to provide services to gender non-binary people, immigrants, intersex people, Travellers, Roma and refugees and asylum seekers. Most thought they needed to be in a better position to provide services to LGBT people and youth. What would help them to improve services for these groups of people is information about other existing agencies and groups, training, additional staff, links with other people doing similar work, and interagency working. This desire to be in a better position to provide services to anyone who needs them was echoed in individual interviews and in focus groups.

One focus group discussed the need for a training, development and certification programme for both specialist and general services across all of the grounds covered in Equal Status legislation similar to that of the LGBTI Charter Mark in Scotland or the schools Yellow Flag cultural diversity programme run by the Irish Traveller Movement here. The Yellow Flag programme again came up in discussions with a Traveller Support person in Louth. The programme provide a series of 8 practical steps that raise issues of interculturalism, equality and diversity. It works with students, staff, management, parents and community groups so that these issues are not merely seen as 'school subjects. There is an award given to schools which successfully complete all of the steps. There are currently five primary schools in Louth and one in Cavan which have Yellow Flag status. A secondary school in Louth is undertaking the process now.

10.1.2 CULTURE & LANGUAGE

Traveller and Roma groups identified a need for cultural training for specialist services, as did specialist service providers. A distrust of statutory services is an issue. Lack of literacy skills may also play a role in being able to access information about services or the issues themselves.

Sexual violence specialist services as well as immigrant, refugee and asylum seekers organisations in all of the border counties are concerned about the lack of, and often lack of qualification of, available interpreters. A HSE social worker sees a need for all healthcare professionals, including occupational therapists, physiotherapists, etc., to have easy access to interpreter services. Signs of DSGBV can be picked up or suspected during other health checks and appointments. When family members act as interpreters the opportunities for the healthcare professional to speak freely are limited. GP survey participants in Louth and Monaghan expressed concern about interpreters and what agency pays the cost. There are no set qualifications for interpreters in this country and the quality of translation can vary enormously. No local training was named as an issue in the focus

group in Monaghan. CrossCare indicates that there is a lack of awareness about HSE funding for interpreters in GP and social work settings. Services in a language other than English, particularly in the border counties, are almost non-existent.

Beyond simply interpretation, a social worker in Monaghan believes that there should be ethnic minority appropriate DSGBV services in all large towns. Diversity Sligo thinks that there is a need for cultural interpreters in addition to language interpreters. The Cultural Champions programme in Monaghan has been set up to address some of this gap. Some of the Cultural Champions pointed out that while interpretation may be appropriate for an initial assessment, it is not for psychotherapy or counselling. This means services need to be available in a variety of languages from people with cultural competencies.

Diversity Sligo noted that in addition to language there are issues of which service providers need to be aware in order to work with refugees and asylum seekers.

- Individuals may well not want to talk about the violence – they may just want to put it behind them.
- A multiplicity of traumas and experiences in home country can cloud issues. Which to deal with first, which agency?
- Loss of community, family, elders, grandmothers that might they have talked to about their experiences. Do not know that we deal with by talking about it e.g. counselling. We need to explain the process.
- For those in direct provision all days are the same and it can be a challenge to keep track of days and times – may need contact to remind them about appointments.

10.1.3 LGBTI+

LGBTI issues that were raised focused on lack of visibility, specific service provision and lack of access to schools. The only LGBTI youth and adult organisation in the border counties is concerned about the lack of visibility of LGBTI people in existing sexual violence services, no specific staff and volunteer training for those services, and minimal or no signposting to services aimed at the LGBTI community. A third level institution thinks there should be services focusing on LGBTI people. The youth LGBT officer in Leitrim/Sligo is concerned about the lack of access to schools to discuss all of the issues. This is because she would be there to talk about LGBT issues. It is notable that intersex people are even less frequently mentioned than LGBT people.

In 2013 the RCNI recommended:

1. Enhanced interagency cooperation, supported and resourced, between specialist sexual violence and LGBT organisations to enhance learning, skills and LGBT responsive needs-led services;
2. Partnership initiatives to ensure the visibility of those services to LGBT people alongside measures to build trust in these confidential services; and
3. The development of an online resource for people and practitioners who are first responders or are providing information and guidance on LGBT sexual violence.[88]

10.1.4 YOUTH

A youth addiction worker pointed out that younger people are digital 'natives' in that they interact with the world in a digital manner and format. For people under the age of 30 the internet and social media are not an 'add-on' but as important as what older people consider 'real life'. Services need to reflect this change much more than they do at the moment. One youth worker indicated a need for training on how to support and help young people reporting sexual violence in a confidential, caring and supportive way.

In terms of youth mental health services, concern was expressed in focus groups and in telephone interviews that the referral threshold for CAMHS is too high.

10.1.5 OTHER SPECIFIC GROUPS OF PEOPLE

Another specific group of people are those who have reported to the Gardai or PSNI. While the rates of reporting sexual crimes have increased, RCCs across the country do not have the capacity to provide additional accompaniment services. It is difficult to find people to commit the often open-ended time to go to court in Dublin and stay there until the case is over. There is a lot of cooperation between Centres in terms of providing accompaniment if the court hearing is in a different area to that in which the person lives.[89] In terms of future services provision, the Monaghan/Cavan DV service noted that the new DV legislation was already leading to an increase in demand for supports in obtaining barring orders.

[88] RCNI (2013) *Finding a Safe Place: LGBT Survivors.*
[89] Caroline Counihan, Legal Policy Director, RCNI.

10.2 TRAINING

The need for training on a variety of issues for sexual violence services personnel and sexual violence training for other agency personnel was identified by a number of stakeholder, specialist services and general services personnel. One HSE counsellor in Cavan/Monaghan indicated that a majority of survivors were now presenting in the local emergency department and that training for ED personnel was essential. The training for sexual violence services personnel includes cultural competencies. Many expressed a need for easily accessible information on services types, locations and specific supports provided.

10.3 CROSS-REFERRAL

"Sexual violence needs to seen as bigger than one agency or one visit or one option, we need to pick up the phone and use other resources to provide holistic care to victims of sexual violence and not be so protective of our own service." SATU Sexual Assault Forensic Examiner

Staff, both from organisations which provide specialist services and organisations which provide more general services which survivors of sexual violence access, engage in a lot of cross-referral. This is indicative of the broad range of needs someone who has experienced sexual violence may have and could reflect the required multiple entry points named in the UK Map of Gaps 2 research. Within the past year specialist NGO services have gotten referrals from other specialist NGO services, FRCs, addiction services, CAMHS, CIPC, GPs, LGBTI group, other mental health services, a Traveller and Roma group and youth groups. Those same specialist NGO services have referred people to other specialist NGO services, CAMHS, CIPC, another counselling or mental health service, An Garda Síochána and GPs. GPs mention referring people to RCCs, DV services, CIPC, CAMHS and addiction services. HSE social workers name referrals to DV services, addiction services, CIPC, other mental health services, GPs, refugee and asylum seekers groups.

All of the RCCs identified a lack of ongoing positive relationships with Tusla social workers as an issue. Staff movement and lack of knowledge can inhibit relationship building. The RCCs are clear that the social workers have very high workloads. Two commented that they do not always get information about what happened with the Children First referrals they have made, other than an electronic acknowledgement.

10.4 INTERAGENCY WORK

Interagency work increases service provider information and knowledge about other services and issues for specific groups of people and includes training opportunities as well as the possibilities for

appropriate cross-referrals. Questionnaire respondents, specialist services providers and other focus group participants reported engaging in a variety of interagency work in order to establish referral pathways, improve referral pathways, change or update protocols or policies, work jointly on providing services and training. Focus group participants and interviewees also named working with a variety of other organisations. In addition to the specialist services agencies which reported engaging in interagency work or were named by another organisation in their interagency work include:

- Criminal justice - Gardaí/PSNI/Court Services
- Ethnic minority– Traveller & Roma Support, Diversity Sligo
- Youth – Foróige, YouthWork Ireland, National Youth Council, ISPCC,
- Education - schools, 3rd Level Students Union, Education Training Board
- Medical – GPs, GUM Clinic, College Medical Department
- Addiction/Alcohol/Drugs – Regional drugs force, addiction services
- Mental Health – CAMHS, Psychology Service
- Government – Dept of Social Protection, Local Authority, Tusla

The RCC in Sligo and Diversity Sligo have close links and have worked together on culturally appropriate services provision.

Collective groups that specialist services participate in include a LCDC equality sub-group, Public Participation Networks (PPNs) and Homeless Action Teams. One focus group participant thought that the discussion on the LCDCs and PPNs are not broad enough and needs to include all forms of VAW.

Several NGO staff expressed concern that as Tusla's remit is for children and families the focus is skewed away from survivors who are over the age of 25, or do not have a child who has experienced violence are not within any priorities of the organisation. For adults the focus is on parenting. There are fora for staff from organisations providing services to children and young people to get together including CYPSC sub-committees. CYPSCs are about implementing the national plan and therefore have a limited remit in relation to sexual violence perpetrated against adults. As examples, the current Sligo Leitrim CYPSC plan names RCC and DV services and then lists safeguarding children and young people with an objective to make sure that all organisations have Children First policies. The current Donegal CYPSC plan names RCC and DV services. An objective is the briefing of staff in the legal system in regard to children and young people's need regarding domestic violence. The latter CYPSC is seen as being quite proactive in terms of interagency linkages. However for effective sexual

violence interagency working, there are a variety of other organisations which are not involved with the CYPSC remit.

There are no Tusla-facilitated regional or county fora with all relevant agencies to address sexual violence, regardless of the age of the survivor or the perpetrator. The Monaghan Focus Group wanted to continue meeting so that they could continue networking and sharing information.

GPs and a CAMHS staff member want a central information source for agency information: location, opening times, referral process, range of services, etc. Sligo/Leitrim and Cavan/Monaghan both have online directories (sligoleitrimdirectory.ie and cavanmonaghanservices.ie) which allow searching for a variety of services by location; including counselling for sexual violence. The opening screen of the websites for both directories states that they include services for children, families and young people. If an adult who is seeking services for themselves, and not as part of a family, there is nothing on this screen to indicate there is relevant information for them.

10.5 SERVICE LOCATIONS

The issue of no sexual violence service in Cavan was frequently raised in individual interview, focus groups and organisational questionnaires. It is worth noting that none of the survivors who participated in the questionnaire reside in Cavan. Both the Sligo-based sexual violence service and domestic violence service have catchment areas which include West Cavan. Neither are currently in a position to provide services within Cavan. The domestic violence service based in Monaghan has an outreach in Cavan town. That is the only specialist service location in the county and obviously does not include services for people who are subjected to sexual violence by a perpetrator who is not a current or former partner. A Monaghan stakeholder organisation staff member expressed concern about a lack of services in some parts of the county. FRCs cover some of these areas but "victims may not go there." There is one outreach in Castleblayney from the Louth-based RCC. Letterkenny SATU staff are concerned about the lack of easily accessible SATU services for residents of Cavan and Monaghan.

The only domestic violence refuges for women in the region are in Donegal and Louth. A Tusla PPFS staff member is concerned that the SATU in Galway is two hours away from Sligo. This may be due to a lack of knowledge regarding the Letterkenny SATU services or a concern in relation to services for those under the age of 14.

10.6 PREVENTATIVE WORK

Specialist services indicate a need for additional resources to engage in more preventative and social change work. Prevention work can be quite narrowly defined and only address topics such as if you commit sexual violence you may be criminally charged or much more broadly defined and include an equality analysis. Several services noted that it can be difficult to account for the prevention work in which they engage and to measure its effectiveness.

Participants in three of the focus groups brought up that sexual violence prevention and education programmes need to start at a much younger age in the school system. Several examples were given of what young teens believe is expected of them in terms of sexual behaviour. One statutory services person believes the Department of Education & Skills should standardise and require sexual violence and consent education. Several believe schools should not be able to opt out of SPHE modules. While many think it is appropriate that someone other than a teacher delivers the education or training, that means other organisations need to be resourced to do so. The Women's Centre in Donegal noted a lack of examples of best practice in education, prevention and support services and therefore a lack of information about programme design and delivery.

One specialist services provider, using a broader prevention framework, articulated the need for creating more informed communities. This would mean that survivors would be living in communities that believe the prevalence of the violence and also believe that change is possible. This would be in line with European best practice research and would require significant and coordinated investment in societal attitudinal change.

10.7 DATA

One HSE counsellor identified the need for prevalence research. Several others also noted the lack of prevalence and services usage data. It is striking to note that data from statutory agencies which provide services to sexual violence survivors in the form of annual statistical reports has been difficult, if not impossible, to obtain for this NAP. The issue of the lack of available data and the lack of reliable data is a broader issue than just the data relating to sexual violence in this country.

10.8 FUNDING

Specialist service providers indicated a need for multi-annual funding. This would not mean that services would report less frequently. It would mean that services would be able to plan more effectively, strategically and efficiently and that the time currently spent completing an annual application could be used in other ways.

While there is at least one more recent funding source (Irish Human Rights & Equality Commission) one DV service noted that there have been no good funding possibilities to replace Atlantic Philanthropies now that source no longer exists . The Manuela Riedo Foundation has now also ceased . A number of sexual violence services and domestic violence services had been able to provide additional supports and education programmes and engage in research because of funding from both of these sources.

10.9 ADDITIONAL ISSUES

Cavan services noted that southern women in border counties are not represented in terms of the Irish Peace and Security National Action Plan in the same way the northern women are. This means their voices are not heard and there are very limited options for drawing upon their expertise. The National Action Plan does mention violence against women issues.

10.10 PRIORITIES

Questionnaire respondents were asked about their first priority to improve services locally. Priorities were also identified in focus groups and through interviews. When a single service/stakeholder named a priority that is identified, otherwise the priority was named by a variety of services/stakeholders.

Specific **services capacities and location** priorities include:

- Sexual violence services in Cavan,
- Increased level of services in Monaghan (as there is only an outreach),
- Increased capacities across the board, both for direct services provision and for preventative/social change work,
- Increased services capacity in Donegal (in terms of qualified staff and locations), and
- Improved resources for advocacy (CAMHS).

Awareness, training and education priorities include:

- Ongoing awareness raising with and for young people,
- Equality and specific violence issues embedded in early years, schools, colleges and public services,
- Better public and easily accessible information about existing services , who they serve and how to access them,
- Ongoing training and the resources to access it (statutory general service),
- LGBTI visibility and clear message that service are accessible,
- LGBTI training for services and for law enforcement (LGBTI service), and
- Campaigns for at-risk groups such as asylum seekers (GP).

Other specific priorities raised include:

- Accurate prevalence research (HSE counsellor)
- ensuring all services are aware of and understand how to use referral pathways (youth addiction and DV services)
- more support around disclosures and how to handle them
- working with parents and guardians to inform them of patterns of behaviours or changes in behaviours of young people (women's centre).

11.PROMISING IRISH DEVELOPMENTS & PRACTICES

There are some promising developments and practices worth noting, some from Ireland and some from Scotland.

11.1 TRAVELLER AND ROMA

Pavee Point Traveller and Roma Centre, Cork Traveller Visibility Group and Wicklow Travellers Group recently teamed up to deliver a Tusla-funded new national pilot project to employ four Traveller DSGBV Community Workers. The project is to promote a model of Traveller participation in DSGBV prevention, create dialogue between Travellers and DSGBV local service providers, create and carry out awareness raising and capacity building and inform DSGBV policy and practice at local and regional levels. The aims of this project are to:

- Support Traveller knowledge and understanding of, and response to, issues of domestic, sexual and gender-based violence
- Improve responses to domestic, sexual and gender-based violence against Travellers through service and policy development
- Work to ensure equality of access to, and outcomes from, DSGBV services, to identify barriers, and to engage with Traveller women in accessing and using their services.

11.2 ASYLUM SEEKERS

Diversity Sligo recently obtained funding to train Globe House (direct provision centre) resident volunteers in listening skills. They will be sitting in the same place at the same times each week so that all of the residents will know where and how to access them. The volunteers will be able to signpost appropriate and available services for anyone who needs/wants them.

The Sligo RCC has run an eight-week course for women in the local direct provision centre. The programme was experiential and covered sexual violence and domestic violence. The recent course was co-facilitated by a RCC counsellor and someone with experience of direct provision. The women in direct provision formed their own WhatsApp group to continue the support. Some of the women chose to then participate in counselling at the RCC.

11.3 CULTURAL DIVERSITY

The Yellow Flag Programme run by the Irish Traveller Movement provides practical steps towards equality and interculturalism for primary and secondary schools. There is an award for successful completion of those steps

11.4 LGBTI+

LGBT Youth Scotland operates a chartermark system for agencies and organisations to indicate they are available and accessible to LGBTI people. There are different chartermarks for frontline services, national organisations and schools. RCCs and DV services in Scotland, as well as some government entities, either have a chartermark or are in the process of getting a chartermark. For many of the NGOs it has been a funding requirement. BeLonG To – the Irish LGBTI young people's organisation has been linking with LGBT Youth Scotland and the Proud Trust in Manchester in order to examine the possibility of an accreditation scheme for youth groups. Their concern is that the sticker from the LGBTI youth strategy does not have anything behind it. The Dublin Youth Services Board has an online youth worker toolkit about identity experiences and challenging bias. It is accessible to anyone.

11.5 SEXUAL HEALTH

Two commented on the HSE's Foundation Programme in Sexual Health Promotion currently being offered in Donegal. It is seen as an excellent programme for developing professional knowledge on sexuality, sexual health and sexual violence. It further educates staff on local services availability. It is co-facilitated by a HSE staff member and a NGO staff member.

11.6 TRAINING & EDUCATION

DkIT now offers a Level 8 Certificate in the Fundamentals of Understanding and Responding to Domestic Abuse. It was developed in conjunction with frontline service providers.

11.7 WAITING LISTS

For survivors on the waiting list for counselling in Louth, the RCC offers a weekly call-back service. If a survivor chooses and continues to choose, one of the helpline volunteer contacts them each week for the period of time they are on the list to check in and see how they are doing. This allows identification of any specific needs or of a crisis for the survivor. It also maintains skill levels of the volunteers.

11.8 SERVICE OUTREACH

The Sligo-based RCC and women's DV services now share premises for a joint outreach in Carrick-on-Shannon, Leitrim. This will allow for greater service provision in the area. It does require ongoing negotiation in several areas, for example when and how men can use the RCC service so that women using the DV service are not uncomfortable.

11.9 SURVIVOR INPUT

There is an online feedback form that anyone who attends one of the SATUS can complete.

12. IDENTIFIED GAPS

"Like many other issues, until we put services in place, we will never truly know the full extent of the issue of sexual violence. However I see the adverse effects it has on the human spirit and body for so many people. We need this to change." HSE Counsellor

The Terms of Reference for this NAP require the examination of current services provision in comparison with best practice standards. This section distils information from the mapping section, the survivor expertise section and the organisational expertise section. EUBPR and the COE Minimum Standards are the two pieces of research with the most specific practice standards information. Both of these refer to services for women. Both require services to be victim/survivor centred and gender expert/gender sensitive. The minimum standards state that the majority of the services required are best provided by specialist NGOs. EUBPR criteria for sexual violence services include that skilled specialised centres are to act at beacons of good practice to mainstream services. The same criteria include services as a be part of a comprehensive package of policies to combat DSGBV that are strategically coordinated. Since RCCs provide services to males who have been subjected to sexual violence, an additional analysis of why and how the violence is perpetrated is required. This fits in with the principles of the minimum standards requirement that services be adapted to the needs of the group to which the survivor belongs.

Overall the minimum standards calls for survivor involvement and regular monitoring and evaluation. The development of services should be based on survivor needs, actively seeking out survivor views and taking them into account as part of regular monitoring. This NAP report does include the views and expertise of some survivors using services in the border region. SATUs seek survivor feedback and some RCCs collect service users views.

When compared with best practice research and COE minimum standards, the specific gaps in existing services as pinpointed by survivors, specialist service providers, general service providers and other stakeholders occur in the areas of: (1) existing services locations, (2) services capacities, (3) services for specific groups of people, (4) interagency links (5) staff training (6)inter-agency working (7) prevention, (8) data, and (8) funding .

12.1 EXISTING SERVICES LOCATIONS

There are no sexual violence services in Cavan at all and only a limited outreach in Monaghan. There are no refuges in the region for anyone who has experienced sexual violence outside of an intimate partnership or ex-intimate partnership, as indicated in the EUBPR best practice example. Refuges for women experiencing sexual violence from a partner or ex-partner exist only in Donegal and Louth. The other counties only have limited safe-homes or emergency accommodation. There is limited outreach in Donegal provided by the one domestic violence service for men. SATU personnel in Letterkenny are concerned about the practical accessibility of SATU services for Cavan and Monaghan residents and there are no additional SATU locations planned by the HSE. Again according to the EUBPR, health care for rape survivors requires both specialised services and access to mainstream services. There is clearly a lack of specialised services.

12.2 SERVICES CAPACITIES

While not everyone who experiences sexual violence will want, need or choose to access one of the specialist or mainstream services in the course of any given year; all of the available prevalence information make it obvious that there is not sufficient existing services capacity. As highlighted in previous sections, the lack of local specialist services provision was a common concern of survivors, specialist NGO service providers, other NGOs and statutory services in every county. Many survivors are on waiting lists for counselling, many for a long number of months. The recent Department of Heath SATU Policy Review does not provide for any additional SATU locations, making the provision of other local support services even more vital.

In terms of local DSGBV services the minimum standards require:

- 1 SATU per 400,000 women and by extension according to SAVI 1 per 344,000 men or an increased capacity in the existing units
- 1 RCC per 200,000 women and by extension according to SAVI 1 per 172,000 men or an increased capacity in existing services
- 1 advice/advocacy service per 50,000 women and by extension 1 per 43,000 men or an increased capacity in existing services
- 1 counselling service per 50,000 women and also 1 per 43,000 men or an increased capacity in existing services

- Outreach to largest minority groups

There is not enough reliable prevalence information to ascertain the level of service provision required for non-binary, trans or intersex survivors.

For a population the size of the border counties, that means at least six counselling services, providing both individual and group work, for women and four to five for men (or six counselling services with increased capacity). The minimum standards state that the counselling services can include specialist DSGBV services such as shelters, RCCs and women's counselling centres **if** they offer long term counselling/group work. All of the RCCs do provide individual counselling. Most of the DV services do not. Some DV services do offer support groups. The NSC is only available to adults who experienced abuse, trauma or neglect in childhood. There are not as many specialist counselling services in the region as would be required and not all of those that exist have the capacity to provide group counselling. The same number of advice/advocacy services (6 for women and 4-5 for men) are also required. Also, the ability to get to the service needs to be taken into account. That is an issue in largely rural areas, as five of the six border counties are. Further, due to the limited capacity, it is difficult for services to engage in social change work including preventative work. This is an important facet of RCC work and goes hand in hand with services delivery, as indicated in the Scottish literature review. It is no different for DV services.

The minimum standards also specify the services that a RCC should provide. These include:

- Anonymous telephone helpline (in addition to the national 24 hour helpline)
- Individual support and counselling
- Group work
- Accompaniment
- Advocacy
- Information and referral
- Legal advice/advocacy
- Practical support
- Assistance with compensation

The Services Overview (Section 6) demonstrates that not all of the supports are provided by every service in the region. Survivors indicated a need for additional availability of counselling appointment times as well as couples, family and group counselling. Increased reporting of crimes to the Gardai and the PSNI and legal changes in terms of coercive control leading to additional barring orders being sought are not being met by a corresponding increase in the ability to provide accompaniment. Such accompaniment is funded by the Department of Justice and Equality.

12.3 SERVICES FOR SPECIFIC GROUPS OF PEOPLE

This area is obviously linked with services capacity. It is another frequently identified area of gaps by specialist services and other stakeholders. This area can be broken down into (1) services in additional languages, (2) culturally appropriate services, (3) services for LGBTI people, and (4) age appropriate services. There is clearly an overlap between the first two. All of these gaps were identified by agencies and organisations in all of the border counties, as well as national stakeholder NGOs. According to the Scottish literature review and Map of Gaps2, services should take account of those with specific needs, such as members of minority ethnic communities. This would also apply to any other group with specifics needs including LGBTI+ people.

12.3.1 APPROPRIATE LANGUAGES

Translation and interpretation services are completely unregulated in Ireland. Sexual violence specialist services as well as immigrant, refugee and asylum seekers organisations across the border counties are concerned about the lack of, and often lack of qualification of, available interpreters. In addition, there are issues with using interpreters. Sexual violence experiences can be very difficult to identify, name and say out loud to another human being. The involvement of an additional person in the conversation only increases those difficulties and may make it difficult for a survivor to accurately express themselves. This means services are best provided in a language the survivor is comfortable using. Failing that an aspirational standard listed in the minimum standards calls for the training of translators/interpreters in DSGBV issues.

12.3.2 CULTURALLY APPROPRIATE SERVICES

Culturally appropriate services are a broad area encompassing services for many diverse indigenous and non-indigenous cultures. Such services also need to be mindful of and take account of the racism experienced by members of ethnic minorities. EUBPR states that rape and sexual violence services should monitor the demographic of survivors using services and collaborate with groups and services to develop culturally competent and accessible services. Monitoring the demographics of survivor using services is discussed in the data gap section below. Specialist services do some collaboration with groups and agencies for minority ethnic groups, however they need to be resourced to engage more fully.

Culturally appropriate services for Travellers and Roma are seen as gaps across all of the counties. This need has also been identified on a national basis and has led to the recent commencement of Traveller DSGBV Community Worker Pilot Project. Immigrants, refugees and asylum seekers come from a broad range of cultures, some of which have significant oral traditions. The COE minimum

standards require staff training in cultural competence, accessible services for socially excluded women and outreach to minority communities. Training needs for specialist services were identified by several Traveller groups as well as Cultural Champions.

As mentioned by Diversity Sligo, some people come from cultures where counselling, as understood here, is not a familiar concept. This means providing people with information about the counselling process, providing avenues through which someone can become more comfortable with the idea and/or providing supports in other ways.

12.3.3 LGBTI+ SERVICES

One of the specific minimum standards requires outreach to marginalised groups and adaption of services to meet the survivors needs. Lesbian women are specifically named, as are a number of other groups of women. Both the lack of clearly accessible services and lack of staff training on the issues was identified in the issues section.

12.3.4 AGE APPROPRIATE SERVICES

As noted by the youth addiction worker, services need to take account of the fact that younger people believe their online life to be as real as their face-to-face life and services need to take account of that. Again the minimum standards require the adaptation of services to meet the needs of this group of people.

12.4 STAFF TRAINING

The EUBPR requires trained personnel. According to the COE standards all relevant professionals in state and non-state agencies require training. For state agency training specialist NGOs should be used as trainers and paid appropriately. Training of appropriate other professional staff, such as those working in A & Es where someone may present after experiencing sexual violence, was mentioned as an issue. While counsellors in RCCs either have or are in the process of obtaining accreditation (usually the volunteers) with one of the recognised accreditation bodies, other training is required as well. Cultural competency training for staff is also a minimum standard.

12.5 INTERAGENCY LINKS & INTERAGENCY WORKING

EUBPR states that collaborative inter-agency working is required. This can include co-training. While local specialist services engage in many links with other agencies, there is no formal framework within which that can occur. Many local services do have bilateral agreements with

other services and stakeholders. Already stretched services do not need additional meetings to attend or forms to complete. However, it is the responsibility of the major funder of the sector to ensure that there are readily available fora for exchanging information and promoting collaboration based on sexual violence or on all of the facets of DSGBV. This could be based on local implementation of the SNS. The currently existing Tusla fora are focused on children, youth or adults parenting roles and not on everyone who experiences DSGBV.

The relevant minimum standards are that services should develop guidelines for multi-agency cooperation and that referral to other therapeutic services only be made to appropriately qualified professionals who have specialist experience or training. While cross-referrals may well be for other than therapeutic services, interagency links make it easier to have a full knowledge of other services and service provider qualifications.

12.6 PREVENTION & SOCIAL CHANGE

Specialist services in the border region have minimal capacity to engage in social change or prevention work. They do not currently access primary schools. According to the principles named in the Scottish literature review on the pros and cons of specialist services, social change work and direct services work needs to go hand in hand for RCCs. In addition to prevention and social change work delivered by specialist services, there are currently a number of initiatives in third level institutions here such as ESHTE and a variety of programmes delivered by youth groups such as Foróige. Focus group participants indicate that third level or even second level is far too late to begin this work.

12.7 DATA

There are two categories of data in which there are relevant gaps. The first, and very substantial gap, is about the prevalence of sexual violence within Ireland generally and within differently vulnerable groups. There is a significant lack of data about the levels of sexual violence experienced both in this country and around the world. That is obviously a much broader issue than this NAP can address. The CSO is beginning to plan new Irish prevalence research.

The second is that without knowing who is using services, it is not possible to know who is not. Ethnically obtained and accurate service user data on ethnicity, nationality, sexual orientation and gender identity are necessary to ascertain who is not using services. This is required in order to plan for services that can be and are used by anyone who needs them. The process of conducting this

NAP has been frustrated by the lack of available services data, particularly on the part of state agencies. Minimum standards , and the Istanbul Convention Articles 11 and 65, specify that data should be collected and maintained in a systematic way on survivor demographics and the nature of the violence in ways that do not violate survivor confidentiality rights (now encompassed in GDPR).

12.8 FUNDING

The minimum standards require services provided by NGOs to be sustainable and capable of providing long term support. The current lack of multi-annual funding was mentioned as an issue by specialist services providers. This acts as a hindrance to sustainable services capable of providing long-term support.

13. CONCLUSION

This is simply a brief summary about what is working well in the border counties and what needs improvement.

13.1 WHAT IS WORKING WELL

Most of the survivors who completed the questionnaires reported very positive and helpful experiences with the services they accessed. Their experiences mirrored what the research commissioned by the UK Victim's Champion found. Service providers and other stakeholders were, for the most part, enthusiastic participants in this project research and eager to learn about related issues. They have developed expertise in delivering a variety of types of services and are keen to increase their knowledge and develop additional skills.

13.2 WHAT REQUIRES IMPROVEMENT

RCCs are only in a position to provide limited outreach in what is a largely rural area with limited or non-existent transport. DV services also have limited capacities. This is particularly so for both service types in the Cavan/Monaghan area. Local specialist sexual violence and domestic violence services have limited resources and are not in a position to meet all of the needs of the survivors who contact them. There are long waiting lists. Some of the general services such as counselling that survivors may utilise have waiting lists and/or high referral thresholds. Service providers are keenly aware of gaps in location of services, level of services. These services providers, particularly the ones operating in smaller communities, have good relationships with many other services in the area simply because they all know each other. However, at the focus groups many services met other services or other personnel, particularly those involved in groups with LBGTI+, Traveller, Roma, or immigrants for the first time.

A consequence of the lack of similar data regarding ethnicity, nationality, primary language, gender identity and sexual orientation from across the services means it is not possible to accurately ascertain who is using services, and therefore who is not. That makes service planning difficult.

14. RECOMMENDATIONS

For ease of reference, these recommendations are divided into sections based on the identified gaps:

1. services locations,
2. services capacities,
3. appropriate and accessible services,
4. interagency working and training,
5. awareness, prevention and social change
6. data, and
7. funding.

These are interlinked and overlapping – for instance delivery of appropriate services can be assisted by training.

14.1 SERVICES LOCATIONS

Context: Article 22 of the Istanbul Convention requires governments to take the necessary action to provide, or arrange for the provision of, adequate geographical distribution of immediate, short and long-term specialist support services for any victim/survivor. Further Article 25 requires the provision of appropriate, easily accessible rape crisis centres or sexual violence referral centres for victims in sufficient number. There is no sexual violence service currently operational in Cavan. The RCC based in Sligo does not have the resources to cover west Cavan and the RCC based in Louth does not have the resources to cover east Cavan. When additional 2019 funding was allocated to RCCs and DV services in April 2019 Cavan/Monaghan was not prioritised. In addition to providing direct services, RCCs serve as a visible indicator in a community that sexual violence does exist and that there is support available. Historically RCCs have developed as the result of local community efforts. That has not happened in Cavan or in Monaghan. Monaghan only has a minimal outreach service one day per week.

Recommendation 1: Develop a Rape Crisis Service in Cavan.

Recommendation 2: Ensure a more visible and accessible RCC service in Monaghan.

Responsibility: While this is primarily the financial responsibility of Tusla as the major funder for the sector, these developments need to be undertaken in conjunction with neighbouring RCCs and local community groups. For Monaghan this can be accomplished through funding Rape Crisis North East to work with community groups in Monaghan to determine the best possible way to provide additional services, and to provide the services. As Cavan currently has no specific SV service, this development requires working with neighbouring RCCs and local community groups. The COE Minimum Standards indicate that these services are best provided by specialist NGO agencies.

14.2 SERVICES CAPACITIES

Context: Article 20.2 of the Istanbul Convention requires states to implement measures to ensure that that services are adequately resourced. Services which have long waiting lists are not adequately resourced to provide current support types at a sufficient level. All RCCs in the region currently have long waiting lists with, depending on the level of urgency and location which is accessible for an individual, waiting times of between one month and nine months. Online services may well be a preferred option for younger people. Provision of online and telephone services may also address difficulties presented by the lack of public transport. More demand for services, particularly accompaniment services, as a result of recent legal change is one example of the need for extra supports to be available.

Recommendation 3: Existing RCCs to increase their capacity to provide face-to-face counselling services, individual, relationship and group.

Recommendation 4: Existing RCCs to improve accessibility by increasing the provision of online/telephone services.

Recommendation 5: Existing DV services increase capacity to provide supports.

Responsibility: Exploring the provision of online services could be done with youth workers or existing youth supports such as SpunOut. Accompaniment to the Gardaí and the courts is the funding responsibility of the CSVC and/or the Department of Justice and Equality. Recommendations 8-13 address the provision of accessible and appropriate services and, as such, relate to these recommendations. Other supports funding is the responsibility of Tusla.

14.3 PREVENTION

Context: The importance of engaging in preventative work with children and young people was highlighted by survivors and service providers. It was a priority for a significant number of survivors

and service providers. Many of the specialist services currently provide a small amount of training and education. While prevention is clearly not the sole responsibility of frontline services, they do have a lot of expertise in the area. There are currently a variety of initiatives on the issues of consent such as Active Consent and ESHTE.

6: Specialist NGOs to participate more fully in preventative work.

Responsibility: Frontline services need to be resourced to engage in this work. Funding responsibility primarily lies with Tusla, the Department of Health and the Department of Education and Skills.

14.4 APPROPRIATE AND ACCESSIBLE SERVICES

Context: Survivors currently using services are uniquely placed to provide feedback on the services and the need for different or additional services. This can be done using a variety of methods such as online options, anonymous questionnaires or open days. Minimum and best practice standards require that services are survivor-centred and have survivor involvement.

Recommendation 7: All NGO specialist sexual violence services to engage regularly with survivors in order to ascertain the quality and appropriateness of services delivery and to plan future services.

Responsibility: This is the responsibility of individual services.

Context: Article 20.2 of the Istanbul Convention requires states to implement measures to ensure that victims have access to health care and social services. In order to access services it is necessary to understand what the services are and how to reach them. English literacy can be an issue for people whose primary language is not English and for people who do not have much formal education.

Immigrant Council research indicates that major barriers to accessing health services include a lack of accessible information along with the unavailability of interpreters. Sexual violence may be quite difficult to discuss in a language other than someone's primary language. The best possible way is for services personnel to be fluent in the language with which the survivor is most comfortable. As that is not always possible, there are several other measures to take to ease access. The software utilised by the National Women's Aid helpline allows for communication in a variety of different languages. Online information such as websites need to be available in as many languages as possible. For anyone with English literacy difficulties, written Plain English is easier to understand.

COE minimum standards include, as an aspiration, that interpreters be trained in DSGBV issues. There are no standards for who can call themselves an interpreter in this country. For interpreters with whom services are already confident, training would be useful and helpful.

Recommendation 8: Sexual violence services, including telephone, social media, internet and face-to-face services to be provided in as many languages as possible.

Recommendation 9: All specialist sexual violence services to write informational documents, website pages, social media pages and apps in Plain English.

Recommendation 10: DSGBV training to be provided for trusted interpreters.

Responsibility: As measures to ensure access are a state responsibility under the Istanbul Convention, the funding to do this to be provided by Tusla or the HSE. Responsibility for implementing the recommendations, following on from the funding, lies with sexual violence service providers.

Context: In addition to language, services need to be provided in a culturally appropriate manner. In terms of services for Travellers and Roma, NTRIS action 102 requires that the HSE and Tusla develop joint approaches to implementing community-based outreach and referral programmes to achieve best outcomes for gender-based violence survivors in the Traveller and Roma communities. The HSE CHO 1 Traveller Health Strategy adopted regional actions in line with NTRIS. A need for cultural interpretation as well as language interpretation has been noted in this research. Goal 2 of the National LGBTI+ Youth Strategy 2018-2020 is to improve the physical, mental and sexual health of LGBTI+ young people. This requires sexual violence services that are aware of and accessible to LGBTI+ people.

Recommendation 11: Set up chartermark programmes to ensure appropriate and accessible services for members of ethnic minorities and LGBTI+ individuals.

Responsibility: The completion of this recommendation will require an organisation or organisations to be resourced to develop and operate chartermarks. This can build on the work of BeLonG To and the Irish Traveller Movement's Yellow Flag cultural diversity programme. Funding responsibility belongs to several different government departments and agencies including the Department of

Children and Youth Affairs, the Department of Health, the HSE and the Department of Education and Skills.

Context: Pavee Point has partnered with two local Traveller Projects and Tusla to pilot the employment of a Traveller DSGBV Community Worker.

Recommendation 12: Utilise learning from the Traveller DSGBV Community Worker Pilot Project to develop services in the border counties.

Responsibility: The involvement of groups and organisations and the sources of the funding will depend on the learnings from this pilot project.

Context: Action 104 of the HSE Intercultural Health Strategy is to continue to deliver training to service providers on violence against Traveller and Roma women to remove barriers to services. While training from HSE personnel is useful, it is also necessary to have training from Traveller and Roma groups themselves.

Recommendation 13: Pending development of a cultural diversity chartermark process, cultural competency training to be regularly delivered by HSE and Traveller & Roma personnel. This training to be available and accessible to specialist sexual violence services.

Responsibility: This is the responsibility of the HSE.

Context: NTRIS Action 103 requires Tusla engagement with Traveller and Roma communities as part of its commissioning process in order to identify and implement evidence-informed responses to GBV in these communities.

Recommendation 14: Any future commissioned DSGBV research to includes Traveller and Roma representatives on the advisory or steering groups.

Responsibility: This is the responsibility of Tusla and any other government agency or department commissioning research and will not cost any additional money.

14.5 INTERAGENCY WORK, REFERRAL PATHWAYS, AWARENESS, TRAINING

Context: There is a significant lack of formal opportunities for local sexual violence services to engage with other stakeholders, particularly stakeholders working with and for minority ethnic groups and nationalities and LGBTI+ groups. The existing Tusla interagency fora structure has not allowed for this.

Recommendation 15: Create local structures akin to CYPSC for DSGBV services and all related stakeholders for the groups of people named in this NAP: Traveller & Roma Support Groups, Immigrant Support Groups, Refugee/Asylum Seeker services, LGBTI+ groups and youth groups.

Responsibility: As the major funder, Tusla has the primary responsibility for ensuring that this type of interagency forum is developed and maintained. This interagency forum would significantly ease the implementation of the following two recommendations.

Context: Article 20.2 of the Istanbul Convention requires states to implement measures to ensure that professionals are trained to assist victims and refer them to the appropriate services. All of the services survey respondents whose organisation provided direct services think they need to be in a better position to provide services to Travellers, Roma, immigrants and refugee and asylum seekers. Most think they need to be in a better position to provide services to LGBTI+ persons and youth.

Recommendation 16: Exploit possibilities for co-training or cross-training between specialist sexual violence services and agencies/groups working with and for Travellers, Roma, other ethnic minorities, LGBTI+ persons and youth.

Recommendation 17: All relevant stakeholders to be made aware of current referral pathways to and from specialist sexual violence services, and, where pathways do not exist, to create them.

Responsibility: The interagency forum would significantly improve the opportunities for services to inform each other and to develop interagency working, including co-training or cross-training.

Context: Another training issue is the training of other professionals regarding sexual violence issues. This would include healthcare professionals. This area as specifically named as a gap by several stakeholders. Specialist services do provide some training to professionals but have a limited capacity to provide that training. The expertise to develop and deliver this training already exists in the sexual violence sector. Existing services do not currently have the resources to undertake this work on any significant scale. Even co-training or cross-training requires extra personnel time.

Article 20.2 of the Istanbul Convention also requires states to implement measures to ensure that professionals are trained to assist victims.

Recommendation 18: Ensure health frontline services personnel receive appropriate sexual violence training.

Responsibility:. The HSE has an obligation to provide DSGBV training to all staff. Tusla offers training via Work Force Learning and Development. With the provision of funding from the HSE and Tusla the existing sector expertise could be utilised to ensure all frontline services personnel receive the training.

Context: People increasingly look online to get information. The existing online services directories for Sligo/Leitrim and Cavan/Monaghan do not indicate on the first web page that they include services appropriate for adults who are looking for supports for themselves. These directories can be easily accessed by victim/survivors themselves as well as anyone trying to determine what service might be appropriate for a friend, family member, patient or client. This also relates to Recommendation 8 about information in Plain English.

Recommendation 19: Each county to have an easily assessible web-based directory of specialist and general services for sexual violence survivors, regardless of age or family status.

Responsibility: This is the responsibility of Tusla. Work is currently being undertaken on this and it is to be operational before the end of 2019.

14.6 DATA

Context: There is no current Irish sexual violence prevalence data from research designed to capture the potentially different levels and types of sexual violence experienced by the groups of people with whom this NAP is particularly concerned; youth 14+, Travellers, Roma, immigrants, refugees, asylum seekers and LGBTI people. That makes it difficult to plan for future services needs. The CSO is to conduct Irish sexual violence prevalence research. The design of this work is in its early stages.

Recommendation 20: CSO prevalence research and resultant data to address the rates of sexual violence among differently vulnerable and marginalised groups of people, including those specifically named in this NAP.

Responsibility: This is ultimately a joint responsibility of the research steering group including government department and DSGBV sector representatives.

Context: Sexual violence survivors access a variety of services in their recovery processes. In order to determine who is not using existing services, it is necessary to know who is. Different services collect different groups of data using different methods. Specifically Goal 4 of the HSE Intercultural Health Strategy requires SATUs from 2020 to develop data collection and analysis of minority ethnic communities' use of the Units to inform policy and services delivery.

Recommendation 21: All statutory and NGO sexual violence service providers to collect information about survivor ethnicity and nationality following the SICAP guidelines and gender identity and sexual orientation data following the principle of self-identification.

Recommendation 22: When LGBTI+ Youth Strategy Action 15(d) is complete, the information about the best ways to enquire about gender identity and sexual orientation to be used by all statutory and NGO sexual violence service providers.

Responsibility: This may be an in-house staff training need for sexual violence services.

Context: One of the major reasons for the data collection is to be able to provide for future services delivery.

Recommendation 23: Utilise the information gleaned from the previous recommended actions about service users' ethnicity, gender identity and sexual orientation as an aid to plan future services.

Responsibility: While this is primarily a responsibility of Tusla as the major funder, other government agencies involved in implementing the Second National Strategy on Domestic Sexual and Gender-Based Violence also bear a financial responsibility.

14.7 FUNDING

Context: Article 22.1 of the Istanbul Convention requires the provision of immediate, short- and long-term specialist support. All of the RCCs and most of the DV services in the region receive the majority of their funding from Tusla. These frontline services also have sourced money from a variety of government entities, foundations and fundraising. Multi-annual funding from the primary funder would allow for more strategic planning of services provision and reduce the time spent completing annual funding applications from the major funder.

Recommendation 24: Tusla funding to be provided on a multi-annual basis to all DSGBV services.

Responsibility: This is the responsibility of Tusla.

REFERENCES

RESEARCH

Allen, W. D. (2007), 'The Reporting and Under-reporting of Rape' *Southern Economic Journal*, 73(3): 623-641.

Black, M.C., et al. (2011) *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report.* Atlanta, Georgia, USA, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Available at: www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf

Coy, M. et al (2009), *Map of Gaps 2: Postcode lottery of VAW support services in Britain.* End Violence Against Women and UK Equality & Human Rights Commission.
European Commission (2016), Eurobarometer poll results. Available at: https://ec.europa.eu/ireland/news/21-de-mhuintir-na-héireann-den-tuairim-go-bhfuil-caidreamh-colla%C3%AD-gan-toiliú-ceart-go-leor-i_en

European Institute of Gender Equality (2016), *Estimation of girls at risk of female genital mutilation in the European Union: Report*. Available at: https://eige.europa.eu/publications/estimation-girls-risk-female-genital-mutilation-european-union-report.

European Union Fundamental Rights Agency (2014), *Violence Against Women: An EU Wide Survey*. Available at: https://fra.europa.eu/sites/default/files/fra_uploads/fra-2014-vaw-survey-main-results-apr14_en.pdf.

Greco, D. and Dawgert, S. (2007), *Poverty and Sexual Violence: Building Prevention and Intervention Responses.* Pennsylvania Coalition Against Rape. Available at: https://www.pcar.org/sites/default/files/pages-pdf/poverty_and_sexual_violence.pdf.

Henderson, S. (May 2012), *The pros and cons of providing dedicated sexual violence services: A literature review.* Glasgow, Rape Crisis Scotland. Available at: https://www.rapecrisisscotland.org.uk/publications/SVservices-lit-review-1.pdf.

Higgins, A. (2016), *The LGBTIreland Report: national study of the mental health and wellbeing of lesbian, gay, bisexual, transgender and intersex people in Ireland.* Dublin, GLEN and BeLonG To. Available at: https://www.hse.ie/eng.services/list/4/mental-health-services/connecting-for-life/publications/lgbt-ireland-pdf.

Hinson L., et al. (2018), *Technology-facilitated gender-based violence: What is it, and how do we measure it?.* Washington DC, International Center for Research on Women. Available at: http://www.svri.org/sites/default/files/attachments/2018-07-24/ICRW_TFGBVMarketing_Brief_v8-Web.pdf.
Immigrant Council of Ireland, NUIG and Irish Research Council (2017), *Language and Migration in Ireland*.

HSE (April 2018), *Counselling in Primary Care Service: National Evaluation Study Report of Phase 1.*

James, S. E. et al.(2016), *The Report of the 2015 U.S. Transgender Survey*. Washington DC, National Center for Transgender Equality. Available at: https://www.transequality.org/sites/default/files/docs/USTS-Full-Report-FINAL.PDF.

Jewkes et al. (2002), *World Report on Violence and Health, Chapter 6 Sexual Violence.* Geneva, WHO. Available at: https://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap6.pdf.

Kelly L. and Dubois, L. (2007), *combating violence against women: minimum standards for support services.* Council of Europe. Available at: https://www.coe.int/t/dg2/equality/domesticviolencecampaign/Source/EG-VAW-CONF(2007)Study%20rev.en.pdf.

McGee, et al. (2002), *The SAVI Report: Sexual Abuse and Violence in Ireland*. Dublin, Royal College of Surgeons & Dublin Rape Crisis Centre.

MacNeela P. et al. (2018), *Are Consent Workshops Sustainable and Feasible in Third Level Institutions? Evidence from Implementing and Extending the SMART Consent Workshop.* Galway, NUIG School of Psychology.

Martin, P. (2009), *Rape Crisis Centers: helping victims, changing society* in Hasenfeld Y (Ed) Human Services Organisations. 2nd Edition. New York, Sage.

Morgenroth, E. (January 2018), 'Prospects for Irish Regions and Counties: Scenarios and Implications' *ESRI Ireland Research Series Number 70*.

Payne, S. (2009) *Rape: The Victim Experience Review.* London, UK Home Office.

RCNI (2014), *The Older Child & Sexual Violence: Questions and Challenges for a National Response*.

RCNI (2013) *Finding a Safe Place: LGBT Survivors.*

Robinson, A., Hudson, K. (2011) 'Different yet complementary: two approaches to supporting victims of sexual violence in the UK' *Criminology & Criminal Justice* 11(5): 515-533. London, Sage.

Rothman et al. (2011) 'The prevalence of sexual violence against people who identify as gay, lesbian or bisexual in the United States: A Systemic Review' *Trauma Violence Abuse*, 12(2) 2011 pp. 55–66.

Rowley E. et al. (2012), *Research Themes and Questions to Guide a Research Agenda on Sexual Violence on Conflict and Post-Conflict Settings*. World Health Organisation, UN Stop Rape Now, South Africa Medical Research Council and Sexual Violence Research Institute. Available at: https://www.svri.org/sites/default/files/attachments/2016-01-14/Research%20themes%20and%20questions%20to%20guide%20research%20on%20sexual%20violence%20in%20conflict%20and%20post%20conflict%20settings.pdf

Sexual Assault Toolkit Initiative (2018), *Victim or Survivor Terminology from Investigation Through Prosecution.* Available at

Smith, S.G., et al. (2017), *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 State Report.* Atlanta, Georgia, USA, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Available at: https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf.

UK Government Equalities Office (July 2018) *National LGBT Survey: Summary Report.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722314/GEO-LGBT-Survey-Report.pdf.

Union of Students in Ireland (2013), *Say Something: A Study of Students' Experiences of Harassment, Stalking, Violence & Sexual Assault.* Dublin, USI, Cosc, Department of Justice & Equality.

United Nations Office on Drugs and Crime & Department of Justice & Equality (2018), *Monitoring Target 16.2 of the United Nations Sustainable Development Goals: multiple systems estimation of the numbers of presumed victims of trafficking in persons – Ireland.*

Van Baelen, L. et al (2016) 'Estimates of first generation women and girls with female genital mutilation in the European Union, Norway and Switzerland' *The European Journal of Contraception & Reproductive Health Care*, DOI: 10.1080/13625187.2016.1234597.

Walby et al. (2013), *Overview of the worldwide best practices for rape prevention and assisting women victims of rape.* European Parliament Directorate General for Internal Policy, Department C, Gender Equality. Available at: http://www.europarl.europa.eu/RegData/etudes/etudes/join/2013/493025/IPOL-FEMM_ET(2013)493025_EN.pdf.

Walters, et al. (2013), *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Findings on Victimization by Sexual Orientation.* Atlanta, Georgia, USA, National Centre for Injury Prevention and Control, Centers for Disease Control. Available at: https://www.cdc.gov/violenceprevention/pdf/nisvs_sofindings.pdf.

Watson, D. et al. (2017), *A Social Portrait of Travellers in Ireland*. Dublin, ESRI.

Women's Health Council (February 2009), *Translating Pain Into Action: A Study of Gender-based Violence & Ethnic Minority Women in Ireland.* The Women's Health Council was subsumed into the Department of Health and Children in 2009.

WHO (January 2018) *FGM Fact Sheet.* Available at: https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation#.XG6-nJ1G3rQ.email.

WHO (2014) *Global Status Report on Violence Prevention 2014.* Available at: https://www.who.int/violence_injury_prevention/violence/status_report/2014/en/.

WHO, London School of Hygiene & Tropical Medicine and South African Medical Research Council (2013) *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence.* Available at: https://apps.who.int/iris/bitstream/handle/10665/85239/9789241564625_eng.pdf?sequence=1

Wood E. (2006), 'Variation in Sexual Violence during War' *Politics & Society*, 34 (3): 307-341.

STRATEGIES, REVIEWS, GUIDELINES & CONVENTION

Council of Europe (2011), *Convention on preventing and combating violence against women and domestic violence (Istanbul Convention).* Ratified by Ireland 8 March 2019.

CYPSC (2018), *Current plans Donegal, Sligo/Leitrim, Cavan, Monaghan.*

Department of Children & Youth Affairs (2018), *LGBTI+ National Youth Strategy 2018-2020.*

Department of Education & Skills (2019), *Safe, Respectful, Supportive and Positive: Ending Sexual Violence and Harassment in Irish Higher Education Institutes.*

Department of Foreign Affairs (2015), *Second National Action Plan on Women, Peace and Security 2015-2018.*

Department of Health (March 2019), *Department of Health Policy Review: Sexual Assault Treatment Units (SATUs).*

Department of Health (2015). *National Sexual Health Strategy 2015-2020.*

Department of Justice & Equality and Pavee Point (2018), *Roma in Ireland: A National Needs Assessment.*

Department of Justice & Equality (2017), *National Traveller and Roma Inclusion Strategy 2017-2021.*

Department of Justice & Equality (2016), *Second National Strategy on Domestic, Sexual and Gender-Based Violence 2016-2021*.

An Garda Síochána (2018), *Annual Policing Plan 2018.*

HSE (2018), *Second National Intercultural Health Strategy 2018-2023*.

HSE CHO 1 (2018), *Traveller Health Strategic Plan 2018 – 2022.*

HSE (2018), *Midlands Louth Meath Operational Plan 2018.*

HSE (2015), *Health Profiles Donegal, Leitrim, Sligo, Cavan, Monaghan, Louth.*

LECP (2015-16), *Current plans Donegal, Leitrim, Sligo, Cavan, Monaghan, Louth.*

Pavee Point (2017), *Strategic Plan 2017-2021.*

Social Inclusion & Community Activation Programme (2017), *Ethnic Data Collection: Good Practice Guidelines for SICAP Programme Implementers (PI).* Department of Housing, Planning, Community and Local Government, Pobal, Pavee Point.

SPIRASI (2018), *Strategic Plan 2018-2020.*

ANNUAL REPORTS & STATISTICAL REPORTS

Amen, *Annual Report 2016.*

Connect, *Service Report 2015.*

Cosc, *Second National Strategy on DSGBV Annual Report 2017.*

CSO, *Census 2016.*

CSO, *Recorded Crime (Quarterly) 2018.*

CSO, *Recorded Crime Victims 2018.*

Dublin Rape Crisis Centre, *Statistics Supplement 2017.*

EndFGM European Network, *Annual Report 2018.*

Foróige, *Annual Report 2017.*

Immigrant Council of Ireland, *2018 Impact Report.*

Irish Refugee Council, *Impact Report 2017.*

HSE, *SATU Annual Key Service Activity Report 2017.*

Jigsaw, *Annual Report 2017.*

National Traveller Counselling Service, *Annual Report 2017.*

Nexus NI, *Social Return on Investment Report 2017-2018.*

Northern Ireland Statistical & Research Agency *Police Recorded Crime in Northern Ireland Update to 31 March 2019.*

One in Four, *Annual Report 2017.*

Pavee Point, *Annual Report 2017.*

Reception & Integration Agency, *Monthly Report October 2018.*

The Rowan Sexual Assault Referral Centre, *Year 5 (2017-2018) e-brief.*

Ruhama, *Annual Report 2018.*

Victim Support at Court, *Annual Report 2017.*

Victim Support NI, *Annual Report 2017-2018.*

Women's Aid Dublin, *Impact Report 2018.*

APPENDIX 1

BORDER COUNTIES SEXUAL VIOLENCE SERVICES NEEDS ANALYSIS PROJECT

ADVISORY GROUP MEMBERS

Anita	**Byrne**	DkIT
Collette	**Deeney**	Tusla CYPSC Coordinator – Cavan & Monaghan
Trish	**Flynn**	Rape Crisis & Sexual Abuse Counselling Centre – Sligo, Leitrim & West Cavan
Cathal	**Grant**	Tusla PPFS – Monaghan
Grace	**McArdle**	RCNE
Connie	**McGilloway**	Letterkenny SATU
Majella	**McGovern**	Mohill FRC
Carmel	**McNamee**	DVAS Sligo, Leitrim, West Cavan
Marina	**Porter**	Donegal Sexual Abuse & Rape Crisis Centre
Mary	**Roche**	Tusla DSGBV
Mary	**Rourke**	Monaghan Integrated Development
Ann	**Ryan**	Tusla DSGBV

ADVISORY GROUP MEETINGS

29 January 2019	Tusla, St Davitts, Rooskey, Monaghan
28 February 2019	Teleconference
28 March 2019	Mohill FRC, Mohill, Co Leitrim
18 April 2019	Teleconference
4 June 2019	Tusla Wellbeing Centre, Castleblayney, Monaghan

APPENDIX 2

STAKEHOLDER INVOLVEMENT							
	Stakeholder	**email**	**Data**	**Survey**	**Telephone Interview**	**In-person Interview**	**Focus Group**
YOUTH	**Jigsaw Donegal**	☒	☐	☐	☒	☐	☐
	Donegal Youth Centre	☐	☐	☒	☐	☐	☒
	YouthReach Donegal	☐	☐	☒	☐	☐	☐
	YouthReach Sligo	☐	☐	☒	☐	☐	☐
	Foróige Sligo	☒	☐	☒	☐	☐	☐
	Sligo IT	☐	☐	☒	☐	☐	☐
	Monaghan Institute	☐	☐	☒	☐	☐	☐
	DkIT	☒	☐	☐	☒	☐	☐
LGBTI	**BeLonG To**	☐	☐	☐	☒	☐	☐
	TENI	☐	☐	☐	☒	☐	☐
	SMILY	☐	☐	☐	☐	☐	☒
	Outcomers	☐	☐	☒	☒	☐	☒
Travellers	**Pavee Point – Traveller & Roma**	☒	☐	☐	☒	☐	☐
	Sligo Traveller Support Group	☒	☐	☐	☐	☐	☒
	Louth Traveller Movement	☐	☐	☐	☐	☒	☐
Roma	**Roma Cultural Champion**	☐	☐	☐	☐	☐	☒
RASS & Immigrants	**Crosscare**	☒	☐	☐	☐	☒	☐
	Diversity Sligo	☒	☐	☐	☐	☒	☐
	Monaghan Integrated Development	☒	☐	☐	☐	☐	☒
	Failte Isteach Monaghan	☒	☐	☐	☐	☐	☒
	Cultural Champions – Monaghan	☐	☐	☐	☐	☐	☒
An Garda Síochána	**GNPSB, Louth PSB, Letterkenny sexual violence investigation**	☒	☐	☐	☒	☐	☒

	Stakeholder	**email**	**Data**	**Survey**	**Telephone Interview**	**In-person Interview**	**Focus Group**
Specialist Services	**Lifeline Inishowen**	☒	☐	☐	☒	☐	☐
	Donegal Women's	☒	☐	☐	☐	☐	☐

	Centre						
	Donegal Domestic Violence	☐	☐	☐	☐	☐	☐
	SATU Donegal	☒	☒	☒	☒	☐	☒
	Donegal RCC	☒	☒	☐	☒	☒	☒
	Sligo, Leitrim & West Cavan RCC	☒	☒	☐	☒	☒	☒
	DVAS Sligo, Leitrim, West Cavan	☒	☒	☐	☒	☒	☒
	Tearmann Monaghan, Cavan	☒	☒	☐	☒	☒	☒
	RCNE Louth Monaghan	☒	☒	☐	☒	☒	☒
	Dundalk Women's Aid	☒	☐	☐	☒	☐	☐
	Drogheda Women & Children's Refuge	☒	☐	☐	☐	☐	☐
FRCs	**Breffni FRC Leitrim**	☐	☐	☐	☐	☒	☐
	Mohill FRC Leitrim	☒	☐	☐	☐	☐	☐
	Focus FRC Cavan	☒	☐	☐	☐	☐	☒
Tusla	**DGBSV**	☒	☒	☐	☐	☐	☐
	Data Collection	☒	☐	☐	☒	☐	☐
	EWS Donegal	☐	☐	☒	☐	☐	☐
	PPFS CFSN Donegal	☐	☐	☒	☐	☐	☐
	PSW Donegal	☐	☐	☒	☐	☐	☐
	PPFS	☒	☐	☐	☐	☐	☐
	CYPSC Chair Cavan, Monaghan	☐	☐	☐	☒	☐	☒
	EWS Cavan, Monaghan, Louth	☐	☐	☒	☐	☐	☐

	Stakeholder	**email**	**Data**	**Survey**	**Telephone Interview**	**In-person Interview**	**Focus Group**
HSE	**SW Intellectual Disabilities Donegal**	☐	☐	☒	☐	☐	☐
	School Leaver Support Donegal	☐	☐	☒	☐	☐	☐

	Autism Support Cavan, Leitrim, Sligo	☐	☐	☒	☐	☐	☐
	CIPC Cavan, Monaghan	☐	☐	☒	☐	☐	☐
	CAMHS x 2 Monaghan	☐	☐	☒	☐	☐	☐
NI	**Victim Support NI**	☒	☐	☐	☐	☐	☐
	Nexus	☒	☐	☐	☐	☒	☐
	Rowan SARC	☒	☐	☐	☐	☒	☐
	Donegal Addiction Community Project	☐	☐	☒	☐	☐	☐
	COSC Perpetrator Treatment Donegal	☒	☐	☐	☐	☒	☐
	Sligo Childcare Committee	☐	☐	☒	☐	☐	☐
	Cavan/Monaghan Drug & Alcohol	☐	☐	☒	☐	☐	☐
	Monaghan CoCo Community Section	☐	☐	☒	☐	☐	☐
	GP Monaghan	☐	☐	☒	☐	☐	☐
	GP Louth x 2	☐	☐	☒	☐	☐	☐
	National Childhood Network Training – office in Monaghan	☐	☐	☒	☐	☐	☐
	Rape Crisis Scotland	☐	☐	☐	☐	☒	☐

This table does not list the facilitation of survivor input. All RCCs, some DV services and some FRCs handed out questionnaires for survivors to complete.

APPENDIX 3

The first page in this appendix is the information sheet that was made available to survivors using services in all RCCs, some DV services and a few FRCs. The questionnaire itself is in the separate questionnaire document.

HAVE YOU EXPERIENCED SEXUAL VIOLENCE?

Tusla, the Child and Family Agency, is looking at services in your area for anyone who has experienced sexual violence or abuse. My name is Susan Miner. I am the person who has been hired to do this work. I used to work for the rape crisis network and have worked in a women's refuge.

I am gathering information about what works well with services you are using, what gaps there are in services and what extra or different services you think would be helpful.

If you have experienced sexual violence and are at least 18 years of age now I would really like to get your opinion. I would appreciate it if you would fill out a survey. It will take about 10 minutes to finish. You can do the survey on paper or online. If you complete the survey on paper, please use the stamped, self-addressed envelope attached to the survey to post it back to me.

If you would rather complete the survey online please go to
https://ec.europa.eu/eusurvey/runner/BorderRegionSexualViolenceServiceNeeds
The password for the survey is SVBR If you want to answer some of the questions and go back later to answer the rest just click the button on the right hand side of the page that says "Save as Draft". This will save the answers you have finished and give you a link to use for when you go back and finish the survey.

The introduction to the survey has more detailed information.

APPENDIX 4