TUSLA

An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Sexual Violence Needs Analysis Project

The Midlands, Meath and Roscommon

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Executive Summary

Introduction and Methodology

This sexual violence needs analysis in the Midlands, Co. Roscommon and Co. Meath was conducted through documentary review, focus groups and interviews as well as a survey of service users (with 111 individual contributors). The work was supported and overseen by an Advisory Group which involved a mixture of representatives from the statutory and non-statutory organisations sectors as well as from the community and voluntary sector locally. This needs assessment is set in the context of European and Irish policies in relation to the provision of sexual violence services; and in the particular circumstances of the Midlands, Co. Roscommon and Co. Meath the majority of which (with the exception of East Meath and the larger towns) is rural in nature.

Incidence data

Nationally data on the incidence of sexual violence is almost twenty years out of date. The findings of a new sexual violence prevalence study are expected in 2024. What data exists suggests that in Ireland 42% of women and 28% per cent of men experienced some form of sexual abuse or assault in their lifetime, (while 20% of girls and 16% of boys in Ireland experience contact sexual abuse in childhood). Using projected incidence data, the report concludes that similar to the national level, there is in all probability significant levels of underreporting occurring in the study area.

Local services

There are two (Tusla funded) specialist sexual violence support services based in the study area: The Regional Sexual Abuse & Rape Crisis Centre Tullamore and Athlone Midlands Rape Crisis Centre. Individuals based in Co. Meath are thought to attend the Dublin Rape Crisis Centre and to a lesser extent Rape Crisis North East (who are based in Dundalk), while individuals in Co Roscommon are thought to attend outreach services provided by Galway Rape Crisis Centre or Sligo Rape Crisis Centre depending on their location. The Regional Sexual Abuse & Rape Crisis Centre Tullamore also provide psychological accompaniment support for individuals attending the HSE funded Mullingar based Sexual Assault Treatment Unit (SATU). The needs analysis also identified a range of services, whose principal focus is not sexual violence, but who nevertheless have important functions in relation to sexual violence. These include: Tusla (specifically related to reports of retrospective child sexual abuse); A&E; Primary Care Teams (especially GP's), Mental Health Services; An Garda Síochána; Counselling services; Addiction Services as well as the Office of the Director of Public Prosecutions (DPP) and the Courts.

What is working well?

Local specialist sexual violence services where they exist provide some key supports. Service users place significant value on the services they receive locally, and the quality of the staff in the specialist services. Some local domestic violence services host outreach for the Rape Crisis Centres and this is helpful in terms of facilitating domestic violence client's access to Rape Crisis Centre supports. The specialist sexual violence service providers have developed useful connections with some key local service providers including the local Gardai. The local Rape Crisis Centres largely through the goodwill of their staff manage to see all referrals in about two weeks. This compares favourably with waiting times for other Rape Crisis Centres outside the study area.

What is working less well?

There is no specialist sexual violence service in either Co Meath or Co. Roscommon. The mandatory reporting of disclosures of retrospective child sexual abuse is having a negative impact on the relationship between the service provider and the individual. The reported cessation of mental health services until a disclosure is dealt with is also challenging. A DPP decision not to pursue a case is always going to be difficult for the individual involved to process and as such needs to be delivered in person to the individual. The time delay between the decision to proceed with a case and the court hearing is very difficult for the individuals involved.

Referrals to Rape Crisis Centres (e.g. domestic violence services, GP's, etc.) are lower than might be expected. The rural nature of the study area and the lack of a comprehensive public transport system, means that those who do not have access to private transport are at a disadvantage. Certain groups (e.g. Travellers, Men, Non-Irish Nationals, etc. are less likely to present for Rape Crisis services than others.

For individuals whose first language is not English, interpretation services are only available within SATU and often only during working hours. Interpretation services are not currently available in the Rape Crisis Centre. There are resourcing implications to interpretation services. There is a concern that many service providers do not ask directly whether sexual violence is an issue, because of their lack of awareness of the signs and symptoms of sexual violence, as well as a lack of awareness of what supports are available locally.

Key needs

The report identifies a series of needs arising from the various consultations. For individuals who had experienced sexual violence important needs included having a safe and ideally local place to go, which they could access quickly and where they could talk about what had happened to them and

access information and therapeutic supports they needed to process this experience. Where individuals required health screening, medical attention and /or forensic examination it was important that they were referred to their local SATU as soon as possible, with psychological support accompaniment services provided by the relevant Rape Crisis Centre. Individuals also identified a range of mental and physical health needs arising from their experiences of sexual violence.

Consultees identified a need for ongoing training and upskilling of existing and new Gardaí. There was a need identified in relation to the establishment of referral pathways to enable individuals disclosing retrospective child sexual abuse to access the supports they need, to assist them process what happened to them. The adversarial nature of the court system was recognised by many consultees, as was the need for more support for individuals who have experience sexual violence attending court, in order to avoid any secondary re-traumatisation. It was also noted that there is a need to reduce the time delay between the decision to proceed with a case and the actual court date.

The initial disclosure of an experience of sexual violence was identified as traumatic. Disclosures of sexual violence are not uncommon in either domestic violence services or third level institutions. The report found that where a disclosure of sexual violence is made it is important that individuals are referred to the specialised support services they need as soon as possible, with closer collaboration needed between domestic violence services and the specialised sexual violence services. Men were found to present to services in lower numbers than would be expected. Some groups including non-Irish nationals, Travellers, individuals with disabilities, individuals from the LGBT+ community were also found to present in lower numbers, while the issue of elder sexual abuse was not raised by any consultees.

The study identified a lack of clarity across wide sections of the community in relation to what constitutes sexual violence and the breath and nature of services offered by the specialist sexual violence service providers. The study also found an absence of understanding among some groups of what constitutes a normal healthy sexual relationship and what constitutes consent, with awareness raising work needing to be done in all of these areas. The specialist sexual violence services in the area were found to be stretched, which in turn meant that some services were reliant on the goodwill of staff/volunteers to meet current levels of demand. Additional resources were needed to meet the growing numbers presenting for services, to provide appropriate and sufficient levels of administrative support and for support and supervision for some counselling staff and volunteers. Resources were also needed to enable the services recommence their awareness

raising and prevention work. The commitment to implement the 10 National SATU Review Actions was recognised as a key potential support for the Mullingar SATU.

Recommendations

I.	**Specialised services for victims/survivors of sexual violence**
1.	Provide outreach Rape Crisis Centre services in Co Meath and Co. Roscommon as a matter of priority
2.	Increase the number of outreach provision locations where demand arises.
3.	Provide sufficient resources to enable the Rape Crisis Centre's to see people in crisis as early as possible but with a maximum of a one-month period (without having to rely only on the goodwill of Centre staff).
4.	Where there are no sexual violence specialists services recognise that individuals will attend non-specialist services that are local and that are quickly accessible. Provide these non-specialist services with inputs in relation to how they can best support individuals who have experienced sexual violence.
5.	Support the implementation of the 10 Actions arising from the national review of the SATU's. Together with the relocation of the Mullingar SATU to a quieter location where individuals and Gardaí can attend without being observed.
6.	Raise awareness of the sexual health screening role of SATU among local service providers, leading to increased referrals to SATU
II.	**Health needs**
7.	Raise awareness of the various negative effect of sexual violence on an individual's mental health.
8.	Raise awareness of the consequences of a decision to cease mental health services following a disclosure of retrospective child sexual abuse, until after the disclosure is dealt with.
9.	Ensure that young people who have experienced sexual violence and who are engaged with Child and Adolescent Mental Health Service (CAMHS) are referred as needed to a relevant counselling service to continue with their therapeutic support.
10.	GP's and other health professionals should be trained to probe whether sexual violence is an issue and what the associated referral pathway is for individuals who have experienced sexual violence.
11.	Staff working in A&E's without a SATU need to be aware of where their nearest SATU is and what services they offer, and be proactive in terms of bringing it to the attention of anyone disclosing sexual violence.
III.	**Policing, reporting and the legal system (the DPP and Courts)**
12.	Continue training and upskilling of existing and new Gardaí as part of their continuing professional development.
13.	Tusla, Child and Family Agency to establish referral pathways to ensure and enable individuals who disclose retrospective child sexual abuse are (with the individual's consent), referred to the services they need, to assist them process what has happened to them. (Currently there are no automatic referrals).
14.	Put more supports in place to support individuals attending court in order to avoid secondary re-traumatisation.
15.	Prioritise sexual violence cases and reduce the time delay between the decision to proceed

	with a case and the actual court date.
IV.	**Disclosures**
16.	Domestic Violence services and Rape Crisis Centre's to develop clear collaborative referral pathways when supporting individuals who have experienced sexual violence in intimate relationships.
17.	More collaboration/shared training between domestic violence services and Rape Crisis Centre's.
18.	More input and support from the specialised sexual violence services for school chaplains, guidance counsellors etc. and the staff in third level institutions who primarily deal with individuals who have experienced sexual violence.
V.	**Inclusion**
19.	Provide clarity about the nature of the connections between Child Protection Services and Tusla, Child and Family Agency funded Rape Crisis Centre's.
20.	Raise awareness of issue of consent and linked to this awareness of rape within marriage/and committed relationships as a form of sexual violence.
21.	Existing services to be seen and promoted as non-gender specific and open to all.
22.	Elder sexual abuse needs further research as well as engagement with the Safeguarding Vulnerable Adults Team/s locally.
VI.	**Awareness, prevention and training**
23.	Undertake ongoing awareness raising of what services the specialist sexual violence services provide with a) key referrers and b) service providers locally (e.g. Duty Social Work Team, schools, sporting organisations, etc.).
24.	Train and support wider service providers (GP's Dentists, etc.) to ask directly whether sexual violence is an issue for the individual presenting
25.	Deliver awareness raising programmes/interventions for individuals and groups in relation to what constitutes a) healthy relationships and b) consent.
VII.	**Resources, coordination and planning**
26.	Review Rape Crisis Centre staff's salaries etc. with a view to bench mark salaries against other similar services.
27.	Ensure there is adequate resourcing to: ○ Provide support and supervision for all Rape Crisis Centre staff and volunteers ○ Provide adequate administrative support ○ Enable the Rape Crisis Centre's recommence active programmes of awareness raising and prevention work ○ Establish/maintain an ongoing and active web presence. ○ Ensure the specialist sexual violence services can meet the expected increase in disclosure levels and the complexity of presenting issues. ○ Enable services (that involves one to one counselling, group work, peer support, on-line content and support materials) meet the different and complex needs of individuals, providing a clear pathway for moving forward. ○ Enable services access modern communication technologies including (video conferencing), reducing resources spent on travel. ○ Enable the specialist sexual violence services build linkages with minority groups ○ Provide interpretation services for those who need them.
28.	Revisit the membership of the existing SATU Multidisciplinary Group to ensure it functions as a useful local liaison group supporting communication between the specialist service providers and key referrers (e.g. Tusla, Child and Family Agency, local domestic violence service providers, CYPSC's and Athlone Institute of Technology).
29.	Locate additional resources to enable the specialist sexual violence services use the media to raise awareness of the services they offer.

30.	Review the existing led model used to provide SATU accompaniment support locally, to ensure it can meet the needs of service users

List of Tables and Figures

Terms of reference

Working from the Tusla, Child and Family Agency Guidance Document on Needs Analysis Projects (NAP), the following were the terms of reference for the SV NAP in the Midlands, Meath & Roscommon area:

- To present an overview of sexual violence services in the study area, statutory and voluntary, funded by Tusla, Child and Family Agency and not, and where gaps exist to enable equitable access to services.
- To present an analysis of who uses the existing sexual violence services.
- To present a picture of who, where and how data and statistics on sexual violence are gathered or could be gathered but are not currently. To identify areas of overlap in data gathering.
- To gather a clear picture as to whether the current level of service provision in sexual violence is suited to service needs/demands in the study area.
- To give detailed Information and analysis on the gap between service delivery and service needs/demands giving clear recommendations based on evidence for future direction & integrated development of sexual violence services to women, children, families and the wider community in the study area.
- To gain clear information on what can be done to improve the outcomes for service users and or those who need services but don't use them.
- To establish if there are specific groups e.g. ethnic minorities who have/do not have access to services that are provided in a culturally appropriate way.

The NAP was to develop a constructive analysis of the information gathered, inform the practice of the organisations working in this area by presenting recommendations on how identified needs (if any) can be met and inform future planning within the DSGBV Programme of Tusla, Child and Family Agency. In responding to sexual violence, the needs of the following groups were to require particular attention:

- Services for/to women and men (aged 18 and over)
- Services for those who experience sexual violence in the context of other intimate partner violence
- Services for/ to Travellers, and RASS (Refugee, asylum seekers, immigrants, Roma and other ethnic minority groups)
- Services for/to Sexual Assault Treatment Unit Service Users

In responding to service provision gaps or needs, the following areas will need particular attention: Public Awareness; Legal system, Interagency work (including referrals and training) Preventative work and early intervention; Mental health and Substance misuse.

The outputs from the Needs Analysis Projects, (NAPs) should result in an evidence base from which needs can be matched with services either existing or new. Future Commissioning of sexual violence services in the study area will be informed by this NAP. Following a competitive tendering process KW Research and Associates Ltd. were appointed to undertaken the project and work commenced in Sept 2018.

Methodology

This project was undertaken using a mixed method approach, which involved a number of different elements including ongoing engagement with members of the Advisory Group[1]. Group members provided valuable input into the project in terms of commenting on the various research instruments, helping to set up the consultations, and commenting on the draft report. Methodologies used were as follows:

1. Literature and secondary documentation review including
   - Review of the 2016 census population data and the data available in relation to uptake levels of different sexual violence services.
   - A review of the relevant local (LECP's and CYPSC) strategies
2. Focus groups (6 groups in total with 49 individual participating)Focus group with staff from the two Rape Crisis Centres, the specialist sexual violence service providers based in the study area
   - Focus group with staff from specialist domestic violence services
   - Focus group with members of An Garda Síochána
   - Focus group with Traveller Health Workers based in Offaly
   - Focus group with staff and students in Athlone Institute of Technology
   - Focus group with the four-county wide Tusla, Child and Family Agency Child Protection Duty Social Work team at their monthly meeting in Tullamore
3. A mixture of 36 in person and telephone interviews with individuals working in service provider orientated organisations:
   - 14 were conducted with national level stakeholders
   - 7 were conducted with regional level stakeholders
   - 15 were conducted with stakeholders based in the study area
4. A mixture of eight in person and telephone interviews with individuals who have experienced sexual violence

[1] See Appendix 1 for details of the Advisory Group membership and meetings

5 An online survey of individuals who have experienced sexual violence (opened on 25/02/2019 and closed on 10/5/2019 received 18 valid responses). The invitation to participate in the survey was shared by specialist services providers and others. AIT promoted participation in the survey through their Facebook pages and shared the link to the survey on a number of occasions

See Appendix 2 for details of the consultations undertaken and Appendix 3 for a profile of the survey respondents

Acknowledgements

Special acknowledgement and thanks go to the members of the Advisory Group who specifically assisted in promoting the survey and organising the focus group and individual interviews. Group members gave their time, energy, enthusiasm and commitment and this was a crucial part of the success of the project.

Particular thanks go to Anita Clancy Clarke and Mary Roche at Tusla who supported and oversaw the development of report.

Thanks are also due to the local service providers who attended the focus groups and/or who participated in interviews.

Very particular thanks are due to the individuals who told us of their particular needs related to their experience of sexual violence.

1 Introduction

1.1 What is sexual violence/abuse?

Section 48 of the Criminal Law (Sexual Offences) Act 2017 highlights the centrality of consent to all sexual offences. It includes a positive definition of consent to a sexual act, and an open list of situations in which there is no consent. Further, it has been clarified that consent may be withdrawn at any time before the sexual act begins, or once it has begun. As before, failure to resist the act does not amount to consent. This positive definition of consent is similar to that in England & Wales and says that a person "consents to a sexual act if he or she freely and voluntarily agrees to engage in that act". The open list of situations in which there is no consent includes where force is being used or threatened (whether against the other person or against someone else), where the complainant is asleep, unconscious, incapable of consent because of alcohol or other drug, unable to communicate whether s/he consents because of a physical disability, is mistaken about the "nature or purpose" of the act or about the identity of the would-be perpetrator, or is being unlawfully held against his/her will, or if the only indication of consent comes from a third person. Sexual violence can occur between family members, between same sex couples and be perpetrated by women against men. However, because women are disproportionally affected sexual violence is generally regarded as a form of gender-based violence which includes physical, sexual and psychological violence; in addition to verbal, economic and social abuse.

1.2 Responding to the needs of individuals who have experienced sexual violence

The needs of those who have experienced sexual violence differ depending on their particular circumstances, as well as their resilience and capacity. Different responses may also be needed for someone in the immediate aftermath of sexual violence compared with someone who experienced sexual violence some time ago and who is dealing with long term post-traumatic stress or other issues as a result of this experience. Among the needs of those who have experienced sexual violence include: practical, financial, medical, legal and moral support; information from and help reporting to police (should they decide this is something they want to do); protection from re-victimisation[2]; and the need for someone to talk to.

[2] Re-victimisation is where previously traumatised individuals are exposed to additional trauma or abuse that may or may not relate to the original trauma.

A 2013 study[1] which identified a range of practices to prevent rape and assist individuals who experience rape grouped the supports into a number of categories including: prevention, protection, prosecution, provision and partnership, with a need for a gender equality perspective and gender sensitive programming throughout these practices. This study (p16) also identified the main policy fields in this context as:

- Planning and coordination,
- Specialised services for victims/survivors,
- Health
- Law and justice,
- Economy and social inclusion and
- Culture, education and media

See Table 1.1 for further details

Table 1.1 The main policy fields to prevent rape and to assist survivors of rape

Planning and coordination	This involves strategic planning at both local and particularly at national level. It works best when it is integrated into a wider framework of combating gender-based violence. Local coordination is required to ensure services are effectively coordinated and focus on the needs of survivors.
Specialized services for victims/survivors	Within the Istanbul Convention the Council of Europe list of minimum services for preventing violence against women and assisting victims includes: free 24 hour helplines, support and advocacy services; accessible services for socially excluded women, especially recent migrants, refugees, women from ethnic minority groups and those with disabilities; access to financial support, housing, residence rights, education and training, networking between specialist NGOs, multi-agency co-ordination; training curricula for professionals addressing the continuum of violence against women within a human rights framework, work with perpetrators rooted in women's safety and prevention and safe shelters. Ireland ratified the Istanbul convention on the 8th March 2019.
Health	The health consequences of sexual violence and rape can include: sexual and reproductive health problems including unwanted pregnancy, HIV and sexually transmitted diseases, mental health problems and health risk coping strategies; physical injuries; and social ostracization (linked to social inclusion below). The current overarching definition of best practice for health services for victim-survivors of rape is a health led, multi-sectoral 'one-stop shop' unit, housed in a hospital or primary health care facility with a separate entrance and providing

[1] Watts, S et al. (2013) *Overview of the Worldwide Best Practices for Rape Prevention and for Assisting Women Victims of Rape.* DIRECTORATE GENERAL FOR INTERNAL POLICIES POLICY DEPARTMENT C: CITIZENS' RIGHTS AND CONSTITUTIONAL AFFAIRS GENDER EQUALITY. European Parliament, Brussels

	health interventions, forensic evidence collection (if required), advocacy and counseling. Practice standards for this type of health-led intervention can be differentiated into six domains: Capable and Care Conducive Environment; Health and Medical Care; Forensic Examination and Evidence Collection; Community and Social Support; Specialist Referral and Follow-up Care; Quality and Monitoring
Law and justice	The UN Handbook for Legislation on Violence against Women and the Council of Europe Istanbul Convention presents internationally respected standards for legislation in this area. The best practices in the Criminal Justice System (CJS) to prevent rape and assist women victim-survivors of rape are those that deliver increasing conviction rates for perpetrators of rape whilst preventing secondary trauma for victim-survivors. This includes: provision of support and advocates for victims throughout the CJS process; development of expert knowledge and skills among police, prosecutors, judiciary and other CJS personnel through training; specialist courts; embedding inter-agency working practices, and adequately funded and evidence-based practises that feed back into further improvement.
Economy and social inclusion	Robust access to the means for livelihood is necessary for effective recuperation from rape (in both domestic and other contexts), so the package of support to women victim-survivors of rape needs to address such economic issues by providing economic advocacy addressing issues of immediate income support followed by access to education, training and employment.
Culture, education and media	Intervention in this area include programmes to raise awareness and to change individual behaviour, as well as to regulate the media. Media regulations have been put in place (as part of the legislation) requiring anonymity for victim and perpetrator prior to conviction. Social media in contrast has been used as a site for the discussion of the meaning of sexual violence/rape in both positive and negative ways. Individual programmes are used to encourage positive attitudes and behaviour in children and young people and to change the behaviour of individuals who have already become violent. Relationship approaches are used to influence interactions inside families and negative influences from peers. Awareness raising campaigns have provided information to inform people as to the rights of women and the wrongs of sexual violence. Targets include the school curriculum and educational institutions, with some promising practices in this field.

Source: Walby, S et al. (2013) Overview of the Worldwide Best Practices for Rape Prevention and for Assisting Women Victims of Rape. DIRECTORATE GENERAL FOR INTERNAL POLICIES POLICY DEPARTMENT C: CITIZENS' RIGHTS AND CONSTITUTIONAL AFFAIRS. GENDER EQUALITY. European Parliament, Bruxelles

1.3 Sexual violence globally

Global estimates published by WHO indicate that about one in three (35%) women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime. It is not surprising therefore to find that one of the UN Sustainable Development Goals (SDGs) 2016-2030 (which represent[4] a set of targets for countries across the world, designed to end poverty, protect the planet and ensure prosperity for all) makes specific reference to sexual violence. SDG 5, 'Achieve gender equality and empower all women and girls', underlines the importance of sexual and reproductive health, while also including commitments to 'eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation' and 'eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation'. Unlike its predecessor (Millennium Development Goal (MDG3)), the goal calls on governments to achieve, rather than just promote, gender equality and the empowerment of all girls. At national level the third National Action Plan on Plan on Women Peace and Security published in July 2019 contains a related high level goal (3.2) as follows *'Institutional mechanisms and services are effectively coordinated and strengthened to ensure the protection, relief, recovery and rehabilitation of women in Ireland affected by conflict.'* which will include women who have been raped and or sexually assaulted.

Most of the violence experienced by women globally is intimate partner violence. Worldwide, almost one third (30%) of women who have been in a relationship report that they have experienced some form of physical and/or sexual violence by their intimate partner in their lifetime. The prevalence estimates of intimate partner violence range from 23.2% in high-income countries and 24.6% in the WHO Western Pacific region to 37% in the WHO Eastern Mediterranean region, and 37.7% in the WHO South-East Asia region. Globally, as many as 38% of murders of women are committed by a male intimate partner.[5] In addition to intimate partner violence, globally 7% of women report having been sexually assaulted by someone other than a partner, although data for non-partner sexual violence are more limited. Intimate partner and sexual violence are mostly perpetrated by men against women.

The WHO report that women are more likely to experience intimate partner violence if they have low education, exposure to mothers being abused by a partner, experience of abuse during childhood, and have developed attitudes accepting violence, male privilege, and women's subordinate status. While men are more likely to perpetrate violence if they have low education, a history of child maltreatment, exposure to domestic violence against their mothers, harmful use of alcohol, unequal gender norms including attitudes accepting of violence, and a sense of entitlement over women. It

[4] http://www.un.org/sustainabledevelopment/sustainable-development-goals/
[5] https://www.who.int/news-room/fact-sheets/detail/violence-against-women (accessed 7th Jan 2019)

also notes that situations of conflict, post conflict and displacement may exacerbate existing violence, such as by intimate partners, as well as and non-partner sexual violence, and may also lead to new forms of violence against women.

At a European level the FRA survey which focused on violence against women [6] found that an estimated 13 million women in the EU had experiences physical violence in the course of the previous 12 months. This represents approx. 7% of women aged 18-74, while 3.7 million women (2%) had experience sexual violence. The consequences of sexual violence can according to the WHO[7] include serious short- and long-term physical, mental, sexual and reproductive health problems for the individual and for their children, as follows:

- Fatal outcomes like homicide (According to Women's Aid[8] annually an average of 10 women die violently in Ireland (with one in every two femicide victims killed by a current or former male intimate partner) or suicide.
- Injuries, 42% of women who experience intimate partner violence reporting an injury as a consequence of this violence.
- Unintended pregnancies, induced abortions, gynecological problems, and sexually transmitted infections, including HIV. The 2013 analysis found that women who had been physically or sexually abused were 1.5 times more likely to have a sexually transmitted infection and, in some regions, HIV, compared to women who had not experienced partner violence. They are also twice as likely to have an abortion.
- Intimate partner violence in pregnancy also increases the likelihood of miscarriage, stillbirth, pre-term delivery and low birth weight babies. The same 2013 study showed that women who experienced intimate partner violence were 16% more likely to suffer a miscarriage and 41% more likely to have a pre-term birth.
- Psychological issues including depression, post-traumatic stress (with a sub category defined as Rape Trauma Syndrome (RTS) and other anxiety disorders, sleep difficulties, eating disorders, and suicide attempts. The 2013 analysis found that women who have experienced intimate partner violence were almost twice as likely to experience depression and problem drinking.
- Headaches, back pain, abdominal pain, gastrointestinal disorders, limited mobility and poor overall health.
- Increased smoking, drug and alcohol misuse, and risky sexual behaviours in later life.

[6] FRA (2014) Violence against women and EU-wide survey – Main results. Luxembourg: Publications Office of the European Union.
[7] https://www.who.int/en/news-room/fact-sheets/detail/violence-against-women (accessed 7th January 2019)
[8] Women's Aid (2018) Femicide Watch 2017 Republic of Ireland.

The social and economic costs of sexual violence can include isolation of the individual, an inability to work, loss of wages, lack of participation in regular activities and limited ability to care for themselves and their children.

At international levels the WHO in 2016 launched its Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children.[9] It also launched guidelines on the health sector responses for partner and sexual violence again women, emphasising the urgent need to integrate these issues into clinical training for health care providers[10]. See Table 1.2 for a summary of the key WHO recommendations.

Table 1.2 Key WHO Health Recommendations for Responding to Partner and Sexual Violence[11]	
Women-centered care	Health care provides should offer first line support when women disclose violence (empathetic listening, non-judgmental attitude, privacy, confidentiality, links to other services)
Identification and care	Health-care providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence in order to improve diagnosis/identification and subsequent care.
Clinical care	Offer comprehensive care including first line support (e.g. emergency contraception, STI and HIV prophylaxis and take a complete history recording events to determine what interventions are necessary.
Training of health care providers	Training at pre-qualification level in the first-time line of support should be given to health care providers
Integration of care	Care should be integrated into existing services rather than a stand-alone service.
No mandatory reporting of intimate partner violence	Health care providers should offer to report the incident if the individual chooses

At European level, the Council of Europe's Convention on preventing and combating violence against women and domestic violence (also known as the Istanbul Convention and referenced in Table 1.3) aims to prevent violence, protect victims and end the impunity of perpetrators. Ireland ratified the Convention in 2019 making it a legal obligation on the State which will be subject to monitoring by the Council of Europe. The Council of Europe Minimum Standards for the Provision of Services identifies the types of services which in general such victims require and gives guidance on appropriate levels of provision. The EU Victims Directive transposed into Irish law by the Victims of

[9] http://apps.who.int/iris/bitstream/handle/10665/251664/WHO-RHR-16.13-eng.pdf;jsessionid=80D8C748F40ACA3E53F051672ACEF078?sequence=1 (accessed 7th January 2019)
[10] WHO (2013) Responding to intimate partner violence and sexual violence against women. WHO clinical and policy guidelines. Geneva
[11] WHO (2013) Responding to intimate partner violence and sexual violence against women. WHO clinical and policy guidelines. Geneva

Crime Act 2017 places obligations on member states to protect victims of crime and to recognise victims with specific protection needs, which may include victims of DSGBV. The WHO also have three publications[12] focused on responding to intimate partner violence and sexual violence against women. to essential services package which aims to provide all women and girls who have experienced gender-based violence with greater access to a set of essential quality and coordinated multi-sectoral services. The UN have indeed developed a framework for the various essential services that are needed. See Table 1.3 for details.

Table 1.3 WHO Framework for essential services needed by women subjected to intimate partner violence

Principles	A rights-based approach	Advancing gender equality and women's empowerment	Culturally and age appropriate and sensitive
	Victim/survivor centered approach	Safety is paramount	Perpetrator accountability

Common characteristics	Availability	Accessibility
	Adaptability	Appropriateness
	Prioritize safety	Effective communication
	Data collection & information management	Informed consent and confidentiality
	Linking with other sectors and agencies through referral and coordination	

Essential services and Actions	**Health**	**Justice and Policing**	**Social services**
	1. Identification of survivors of intimate partner violence 2. First line support 3. Care of injuries and urgent medical treatment 4. Sexual assault examination and care 5. Mental health assessment and care 6. Documentation (medico-legal)	1. Prevention 2. Initial contact 3.Assessment/investigation 4. Pre-trial processes 5. Trial processes 6. Perpetrator accountability and reparations 7. Post-trial processes 8. Safety and protection 9. Assistance and support 10. Communication and information 11. Justice sector coordination	1. Crisis information 2. Crisis counselling 3. Help lines 4. Safe accommodations 5. Material and financial aid 6. Creation, recovery, replacement of identity documents 7. Legal and rights information, advice and representation, including in plural legal systems 8. Psycho-social support and counselling 9. Women-centered support 10. Children's services for any child affected by violence 11. Community information, education & community outreach 12. Assistance towards economic

[12] 1) World Health Organization (2013) Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva, Switzerland: World Health Organization. 2) WHO, UNW, UNFPA. (2014) Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook. Geneva: WHO.. (WHO/RHR/14.26) and 3) UN (undated) Module 2 Health Essential Services Package for Women and Girls Subject to Violence. Core Elements and Quality Guidelines (accessed at http://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2015/essential-services-package-module-2-en.pdf?la=en&vs=3835)

			independence,

Coordination and governance of coordination	
National level: Essential actions	**Local level: Essential actions**
1. Law and policy making 2. Appropriation and allocation of resources 3. Standard setting for establishment of local level coordinated responses 4. Inclusive approaches to coordinated responses 5. Facilitate capacity development of policy makers and other decision-makers on coordinated responses to VAWG 6. Monitoring and evaluation of coordination at national and local levels	1. Creation of formal structures for local coordination and governance of coordination 2. Implementation of coordination and governance of coordination.

Foundational elements	Comprehensive legislation and legal framework	Governance oversight and accountability	Resources and financing
	Training and workforce development	Gender sensitive policies and practices	Monitoring and evaluation

Source: UN (undated) Module 2 Health Essential Services Package for Women and Girls Subject to Violence. Core Elements & Quality Guidelines

The UN has also issued specific guidelines in relation to essential health services for women subjected to intimate partner violence. See Table 1.4 for details.

Table 1.4 UN Guidelines for essential health services needed by women subjected to intimate partner violence

ESSENTIAL SERVICES 1. IDENTIFICATION OF SURVIVORS OF INTIMATE PARTNER VIOLENCE	
Information	– Written information on intimate partner violence and non-partner sexual assault should be available in healthcare settings in the form of posters, and pamphlets or leaflets made available in private areas such as women's washrooms (with appropriate warnings about taking them home if an abusive partner is there).
Identification of women suffering intimate partner violence	– Health service providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence in order to improve diagnosis/identification and subsequent care. – Asking women about violence needs to be linked to an effective response, which would include a first-line supportive response, appropriate medical treatment and care as needed and referral either within the health system itself or externally. – "Universal screening" or "routine enquiry" (i.e. asking women in all health-care encounters) should not be implemented. While it can increase the identification of women suffering violence it has not been shown to improve health outcomes or even referrals. It is challenging to implement in high-prevalence settings with limited resources or referral options. – Before asking about partner violence, the health system should put in place the following minimum requirements: – Private setting – Health care providers who have been trained to ask appropriately (for example, in an – empathic, non-judgmental manner) and how to respond appropriately – System for referral in place – Protocol / standard operating procedure in place. – Where health service providers suspect violence but women do not disclose it:

	– Do not pressure her, give her time – Provide information (regarding available services/effects of violence on women's health and their children's health – Offer a follow-up visit.
ESSENTIAL SERVICE: 2. FIRST LINE SUPPORT addressing: (1) immediate emotional / psychological health needs; (2) immediate physical health needs; (3) ongoing safety needs; (4) ongoing support and mental health needs.	
Women- centered care	– Women who disclose any form of violence by an intimate partner (or other family member) or sexual assault by any perpetrator should be offered immediate support. – Health service providers should, as a minimum, offer first-line support when women disclose violence. First line support includes: – Being non-judgmental and supportive and validating what the women is saying – Providing practical care and support that responds to her concerns but does not intrude on her autonomy – Asking about her history of violence, listening carefully, but not pressuring her to talk (care should be taken when discussing sensitive topics when interpreters are involved) – Listening without pressuring her to respond or disclose information – Offering information; helping her access information about resources, including legal and other services that she might think helpful, and helping her to connect to services – and social supports – Provide written information on coping strategies for dealing with severe stress (with – appropriate warnings about taking printed material home if an abusive partner is there) – Assisting her to increase safety for herself and her children, where needed – Offering comfort and help to alleviate or reduce her anxiety – Providing or mobilizing social support (including referrals). – Health service providers should ensure: – That the consultation is conducted in private – Confidentiality, while informing women of the limits of confidentiality (i.e. when there is mandatory reporting). – If health service providers are unable to provide first line support, they should ensure that someone else (within their healthcare setting or another that is easily accessible) is immediately available to do so.
Mandatory Reporting	– Mandatory reporting of violence against women to the police by health service providers is not recommended. – Health service providers should offer to report the incident to the appropriate authorities, including the police, if the woman wants this and is aware of her rights. – Child maltreatment and life-threatening incidents must be reported to the relevant authorities by the health service provider, where there is a legal requirement to do so.
ESSENTIAL SERVICE: 3. CARE OF INJURIES AND URGENT MEDICAL ISSUES	
History and examination	– History taking should follow the standard medical procedures, but keeping in mind that women who have experienced intimate partner or sexual violence are likely to be traumatized, so review any papers she may have and avoid asking questions she has already answered. – Explain and obtain informed consent for each aspect: – medical examination – treatment – forensic evidence collection – for the release of information to third parties, i.e. police and courts. – If women want evidence collected, call in or refer to a specifically trained provider who can do this. – Conduct a thorough physical examination. Record findings and observations clearly. – At each step of the exam, ensure communication and ask for permission first.
Emergency treatment	– Where a woman has suffered life threatening or severe conditions, immediately refer the woman to emergency treatment.
ESSENTIAL SERVICE: 4. SEXUAL ASSAULT EXAM AND CARE	
Complete history	– Take a complete history, recording events to determine what interventions are appropriate and conduct a complete physical examination (head-to-toe including genitalia).
Emergency	– Offer emergency contraception to survivors of sexual assault presenting within 5 days of

contraception	sexual assault, ideally as soon as possible after the assault, to maximize effectiveness. – If a woman presents after the time required for emergency contraception (5 days), emergency contraception fails, or the woman is pregnant as a result of rape, she should be offered safe abortion, in accordance with national law.
HIV post-exposure prophylaxis	– Consider offering HIV post-exposure prophylaxis (PEP) for women presenting within 72 hours of a sexual assault. Use shared decision-making with the survivor, to determine whether HIV PEP is appropriate and follow national guidelines for prophylaxis.
Post-exposure prophylaxis for STI's	– Women survivors of sexual assault should be offered prophylaxis for the most common sexually transmitted infections and hepatitis B vaccine following national guidance
ESSENTIAL SERVICE: 5. MENTAL HEALTH ASSESSMENT AND CARE	
Mental health care for survivors of intimate partner violence	– Women experiencing violence should be assessed for mental health problems (symptoms of acute stress/post-traumatic Stress Disorder (PTSD), depression, alcohol and drug use problems, suicidality or self-harm) and be treated accordingly, using the WHO evidence-based clinical protocols for mental health problems. – Mental health care should be delivered by health service providers with a good understanding of violence against women.
Basic psychosocial support	– After an assault, basic psychosocial support may be sufficient for the first 1-3 months, at the same time monitoring for more severe mental health problems. This includes: – Helping strengthen her positive coping methods – Exploring the availability of social support – Teaching and demonstrating stress reduction exercises – • Providing regular follow-up
More severe mental health problems	– Conduct an assessment of mental status (at same time as physical examination) assessing, for immediate risk or self-harm or suicide and for moderate-severe depressive disorder and PTSD. – Women with depression and PTSD will still benefit from first- line support, helping them strengthen social support, learning stress management and empathetic and support follow up. Referral to trained therapists if available. – Refer as necessary for brief psychological treatments or cognitive behaviour therapy.
ESSENTIAL SERVICE: 6. DOCUMENTATION (MEDICO-LEGAL)	
Comprehensive and accurate documentation	– Document in the medical record any health complaints, symptoms and signs, including a description of her injuries. – It may be helpful to note the cause or suspected cause of these injuries or other conditions, including who injured her – Get her permission to write this information in her record – Follow her wishes.
Collection and documentation of forensic specimens	– Where a woman has consented to forensic evidence collection, it is critical that the chain of custody evidence is maintained and that everything is clearly labeled.
Providing written evidence and court attendance	– Health service providers need to be familiar with the legal system; know how to write a good statement; as a minimum, document injuries in a complete and accurate way; make sound clinical observations; and reliably collect samples from victims for when they choose to follow a legal recourse

1.4 National context - sexual violence in Ireland

1.4.1 National statistics

Research (SAVI, 2002) found that in Ireland 42% of women and 28% per cent of men experienced some form of sexual abuse or assault in their lifetime, (while 20% of girls and 16% boys in Ireland experience contact sexual abuse in childhood). While much of the discourse and data on domestic,

sexual and gender-based violence has been framed with respect to violence against women, it is now widely accepted that both men and women can be victims and perpetrators (COSC, 2016).

24% of perpetrators of sexual violence against adult women are partners or former partners. There is strong evidence that sexual violence is underreported in Ireland. The 2002 SAVI study found that just one in five Irish victims of physical or sexual abuse have been found to report this abuse to the Gardai and or legal and medical services, while just the one in 10 women avail of services such as victims support or refuges suggesting that there are a lot of individuals who have been subject to violence who have unmet needs for assistance. The Hanley (2009) study on Rape and Justice in Ireland found that '34% of study participants had not made a report to the Gardai' (p6). Among the many reasons why individuals may not report experiences of sexual violence, including 'fear of retaliation, feeling their experiences is not serious enough, an ongoing relationship with the perpetrator, not recognizing their experience as abusive, misplaced fear of embarrassment, while the most common reason cited generally related to not wanting others to know.'

Of the sixty-six per cent of individuals who had contacted the Gardai in the Hanley study, only 58% went on to make a statement, with 9% subsequently withdrawing their complaints. the most common reason for this was 'not wanting others to know what had happened'. It should also be noted in this context that the impact of sexual violence can reach far beyond the victim themselves, affecting children, wider family, friends and others. Another key concern in the Irish context is that the levels of unmet needs among Irish women are consistently higher than the European average across all types of needs.

Table 1.5 details the numbers and nature of sexual violence offences reported to the Gardai (excluding offences relation to young people aged less than 17 years). Given that the number of offences does not relate to the number of perpetrators (e.g. one perpetrator may for example be responsible for many offences) and ongoing changes in Garda collection methods only very limited comparative analysis of this data is possible. Nationally there is clearly an upward trend in terms of the levels of reporting of sexual violence and rape crimes. Whether this upward trend is because of increased prevalence and/or increased reporting is a matter of some speculation. The decision by government in November 2018 to commission the CSO to undertaken a comprehensive national report on levels of sexual violence may go some way to answering this question. This will be the first report in almost two decades on sexual violence in Ireland and will take five years to complete with information on prevalence due in 2024 [13]

[13] Holland, K (2018) Concerns raised that report on sexual violence in Ireland will take five years, Irish Times Wed 21st Nov 2018.

			2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
021 Rape and sexual assault	0211	Rape of a male or female	324	409	420	388	355	331	363	468	448	457	392	460	518	516	644
	0213	Sexual offence involving mentally impaired person	23	14	12	15	12	7	8	15	14	24	12	12	23	18	29
	0214	Aggravated sexual assault	11	14	7	18	17	12	10	7	9	7	9	5	9	9	8
	0215	Sexual assault (not aggravated)	1,002	867	960	914	809	771	956	1,486	1,184	1,218	1,281	1,241	1,395	1,528	1,705
021 Rape and sexual assault			1,360	1304	1388	1311	1193	1121	1337	1,976	1,663	1,706	1,694	1,738	1,945	2,071	2,384
022 Other sexual offences			101	64	58	59	92	68	99	170	151	141	127	105	211	294	346
		Overall total	1,461	1368	1447	1370	1285	1189	1436	2,146	1,814	1,847	1,821	1,843	2,156	2,365	2,730

Source: https://www.cso.ie/px/pxeirestat/Database/eirestat/Recorded%20Crime/Recordec%20Crime_statbank.asp?sp=Recorded%20Crime&Planguage=0&ProductID=DB_CJ...

1.4.2 National policy

The first national strategy on domestic, sexual and gender-based violence (2010 - 2014) was developed by COSC, the National Office for the Prevention of Domestic, Sexual and Gender-based Violence which was located with the Dept of Justice and Equality[14]. COSC and the Dept of Justice and Equality were also responsible for the preparation and development of the 'Second National Strategy on Domestic, Sexual and Gender-based Violence 2016 – 2021'. This second strategy has three key aims as follows:

1. Change societal attitudes to support a reduction in domestic and sexual violence
2. Improve supports available to victims and survivors and
3. Hold perpetrators to account

This strategy details what state agencies need to do in order to meet the requirements of the Istanbul convention, while the Child and Family Agency Act 2013, identifies Tusla, Child and Family Agency as the primary state agency with responsibility to meet the needs of victims/survivors of these forms of violence.

Direct specialized services provided for victims/survivors include:

- Immediate medical treatment (which can include emergency contraception, medication for the prevention of sexually transmitted infections, minor wound care management, Hepatitis B vaccination etc.).
- Where an individual wishes to report/many wish to consider reporting the assault they can avail of a forensic examination (within seven days of the assault)
- Helpline and online services
- Information provision (face to face)
- Face to face supports (including support and counselling)
- Accompaniment services (e.g. to SATU, to court, etc.)

Indirect supports include

- Domestic violence accommodation crises accommodation (These services are pertinent to individuals who have experienced sexual violence because sexual violence can occur in association with domestic violence).
- Education and training for other service providers and professionals and in schools

[14] Following a Transformation Programme (Jan-Sept 2019) with the Dept of Justice and Equality the COSC office no longer exists. The functions of this office will now be undertaken using a functional model which will see this work being delivered under the Civil Justice and Equality policy function

While dominant users of sexual violence services in Ireland are white Irish women, other groups that use these services include

1) Men (who make up 17% of sexual violence service users (p22)[15]),
2) Young people (aged 14-17 years)
3) Transgender men and women (with more of this group availing of sexual violence services than domestic violence services), and
4) Travellers and other ethnic minority groups including Roma as well as asylum seekers and refugees.

1.4.3 Legal issues

A person who has been the victim of a sexual offence in Ireland can engage with either or both the criminal law and/or the civil law processes. They can also choose not to engage with either process.

The criminal justice process begins once a crime is reported to the Gardaí. According to Rape Crisis Network Ireland Guide[16] there are four main stages in the criminal process:

1. Reporting to the Gardaí, Garda investigation and evidence gathering
2. Decision of the DPP, including charging the accused person and issues of bail
3. Going to Court
4. Sentencing

The criminal law relating to sexual violence is contained in a variety of pieces of legislation each of which provides a maximum sentence for the offence created by that legislation. See Table 1.6 for a list of the most commonly prosecuted sexual offences including the court that will hear the case and the maximum sentence provided by law for that offence.

Table 1.6 Most commonly prosecuted sexual offence, court that will hear the case and the maximum sentence provided by law for the offence.

Rape	Central Criminal Court	Life imprisonment
Rape under section 4	Central Criminal Court	Life imprisonment
Sexual assault	Circuit Court (District Court can hear case in certain circumstances)	10 years imprisonment. If victim under 17 years of age, maximum sentence is 14 years
Aggravated sexual assault Life imprisonment	Central Criminal Court	Life imprisonment
Sexual act with a child under	Circuit Court	Life imprisonment

[15] Tusla (2016) Domestic, Sexual & Gender Based Violence Services Working Report on 2015 services, activities and use: Towards evidence informed services.
[16] Rape Crisis Network Ireland (2018) Guide to the Legal Process for Survivors of Sexual Violence 2nd Edition

15 years (aka "defilement")		
Sexual act with a child under 17 years (aka "defilement")	Circuit Court (District Court can hear case in certain circumstances)	7 years or 15 years if 'a person in authority'
Sexual act with a protected or relevant person	Circuit Court	14 years (protected person) or 5 or 10 years (relevant person), depending on the offence
Source: Rape Crisis Network Ireland (2018) Guide to the Legal Process for Survivors of Sexual Violence 2nd Edition pp 40-41		

The civil process involves the person who has been the victim of a sexual offence suing the accused person for the harm that they have caused by perpetrating that sexual abuse. During the civil process, the perpetrator is referred to as 'the defendant' and the survivor is known as 'the plaintiff'. The outcome may be that the judge decides in in the plaintiff's favour and awards them compensation which the perpetrator must pay. There are consequences (that may or may not include the payment of some/all costs) for the plaintiff if they lose their civil action against the perpetrator

Some of the key difference between the criminal law and the civil law include the following:

1) Within the criminal process the person who has been the victim of a sexual offence, appears as a witness for the State. This is because the law views crimes committed against persons as crimes against all the people of the State The Director of Public Prosecutions represents the State in criminal proceedings and the person who has been the victim of a sexual offence is usually the main witness in the prosecutor's case In contrast during the civil process, the person who has been the victim of a sexual offence has more control over proceedings since the case is being taken by them personally, rather than by the State on behalf of the public interest.
2) With the civil process the person who has been the victim of a sexual offence has to prove it with 51% the balance of probabilities that the alleged perpetrator did the things that they are accused off standard of proof is much higher during the criminal process and the prosecution must prove that the accused person carried out the offence with which he is charged beyond all reasonable doubt.

Sexual offences can be tried in the District Court, Circuit Criminal Court and the Central Criminal Court. The Circuit Criminal Court tries sexual offences before a judge and jury and the only sentencing limit that applies in this court is that provided by law for the offence with which the person is charged. The most serious sexual offences, namely rape and aggravated sexual assault

must be tried in the Central Criminal Court before a judge and jury. See Tables 1.7 for details of sexual offences dealt with in the various different courts.

Table 1.7 Sexual offences dealt with in the various different courts (2017-2015)

	Year	*Incoming*		*Resolved offences*		
		Offences	*Defendants*	*Summary*	*Indictable dealt with summarily*	*No of Cases sent forward to trial*
District Court	2017	2828	498	34	289	2645
	2016	2730	461	42	229	2260
	2015	1862	637	61	109	1515
	2014	1748	221	80	176	1264

	Year	Incoming		Resolved: offences						
		Offences	Defendants	Guilty	Trials		N/P[17]	TIC[18]	Quash[19]	Dec[20]
					Convicted	Acquitted				
Circuit Court	2017	1440	245	377	131	111	268	111	0	2
	2016	971	205	489	231	98	228	29	0	1
	2015	632	131	348	212	129	180	23	0	66
	2014	717	131	398	172	103	283	59	19	5

	Year	Trials	Defendants (in trials)	Incoming		Resolved: offences					
				Offences	Defendants	Guilty plea	Trials	N/P[21]	TIC[22]	Quash[23]	Dec[24]
Central Criminal Court[25]	2017	4	4	875	54	170	443	234	137	0	53
	2016	7	7	1090	58	144	353	112	229	0	0
	2015	-	-	803	53	40	144	62	47	0	80
	2014	-	-	-	-	116	421	203	24	0	50

[17] N/P = nolle prosequi
[18] TIC=taken into consideration
[19] Quash return for trial
[20] Dec. Accused deceased
[21] N/P – nolle prosequi
[22] TIC=taken into consideration
[23] Quash return for trial
[24] Dec. Accused deceased
[25] Statistics related to indecent/sexual assault and other offences

1.5 Local context -The Midlands, Meath and Roscommon

The Midlands are located in the heart of Ireland, and encompasses the counties of Laois, Longford, Offaly and Westmeath. Co. Roscommon is adjacent to Counties Longford, Westmeath and Offaly and Co Meath is adjacent to Westmeath and Offaly. The area had a combined population of **551,787** individuals in Census 2016. (11.6% of state total). The major urban centres are Navan (pop. 30,173), Athlone (pop. 21,349), Mullingar (pop. 20,928), Portlaoise (pop. 22,050), Tullamore (pop. 14,607), and Longford (pop. 10,008). (The population of Roscommon town is just 5,876). Outside of these larger urban centres the majority of these counties are generally rural in nature (CSO, 2016) with the exception of Co, Meath, where the north of the county is rural in nature, while the south and east of the county are more urban in nature. Using projected national incidence data See Table 1.8 for the projected number of adults (female and male) likely a) experience b) report and c) avail of specialist SV support services.

Table 1.8 Projected numbers of adults[28] likely to likely a) experience b) report and c) avail of specialist SV support services

County	*Total Adult Pop aged 18-74*	*Women*				*Men*			
		Females aged 18-74	*42% Women experience sexual abuse or assault*	*20% of these report*	*10% avail of services*	*Males aged 18-74*	*28% Men experience sexual abuse or assault*	*20% report*	*10% avail of services*
Laois	56,601	27,972	11,748	2350	1,175	28,629	8016	1603	160
Longford	28,306	14,045	5899	1180	590	14,261	3993	799	80
Meath	130.059	65,894	27,675	5535	2768	64,165	17,966	3593	353
Offaly	54,405	26,388	11,083	2217	1108	26,017	7285	1457	146
Roscommo	45,399	22,470	9437	1887	944	22,929	6420	1284	128
Westmeath	60,463	30,347	12,746	2549	1275	30,116	8432	1686	169
Totals	**245,304.05**	**187,116**	**78,588**	**15,718**	**7,860**	**186,117**	**52,112**	**10,422**	**1,036**

Locally the populations of the five counties have become increasingly ethnically and culturally diverse over the last two decades and this is something that needs to be factored into service provider plans going forward See Table 1.9 and Table 1.10 for details. The fall in non-Irish nationals can in part be explained by the rise in the number of those with dual Irish nationality, who are

[28] Individuals who are transgender can currently self-identify as either male or female or both male or female or may chose not to identify their gender at all. The CSO are currently actively reviewing the choice of choice of possible gender answers that will be included in the Census 2021 form.

classified as Irish in the census. Persons with dual-Irish nationality increased by 87.4 per cent to 104,784 persons in 2016.

Table 1.9 Percentage of 'Non-Irish' nationals in 2002, 2011 & 2016						
Year	2002[27]		2011		2016	
County	Total Pop	% non-Irish nationals	Total Pop	% non-Irish nationals	Total Pop	% non-Irish nationals
Laois	57,926	4 6	80,559	10.5	84.732	10.1
Longford	30,919	6 3	39,000	14.1	40.810	14 7
Meath	133.300	5.9	182,825	10.8	195,044	10.1
Offaly	63,404	4 9	76,687	9 2	78,003	8.5
Roscommon	53,123	6 4	64,065	10.8	64.436	10 3
Westmeath	71,013	6 6	86,164	11.9	88.396	11 3

At national level 12 countries (Brazil, France, Germany, India Italy, Latvia. Lithuania. Poland, Romania Spain and the United Kingdom) accounted for 73.6 per cent of all non-Irish nationals in 2016 Three towns within the study area where more than 26% of the population were non-Irish in 2016 were Longford, Edgeworthstown and Ballymahon. both in County Longford. The largest non-Irish group in all of these locations were Polish citizens.

The percentage of Irish Travellers in the area is stable in most counties in the study area. Longford is the county that has seen the greatest increase in the Traveller population.

Table 1.10 Percentage of Irish Travellers in the five counties in 2002, 2011 & 2016									
Year	2002[28]			2011			2016		
County	Total Pop	No of Travellers	% Traveller	Total Pop	No of Travellers	% Travellers	Total Pop	No of Travellers	% Travellers
Laois	57,926	457	0.8%	80,559	668	0.8%	84,732	761	0.9%
Longford	30,919	545	1 8%	39,000	744	1.9%	40.810	1049	2 6%
Meath	133,300	710	0 5%	182 825	967	0.5%	195,044	977	0.5%
Offaly	63,404	664	1%	76,687	1026	1.3%	78,003	910	1 2%
Roscommon	53,123	366	0 7%	64,065	397	0 6%	64,436	514	0 8%

[27] CSO Census 2002 Volume 4 Usual Residence Migration, Birthplaces and Nationalities. (Table 36A)
[28] CSO Census 2002 Volume 4 Usual Residence Migration, Birthplaces and Nationalities. (Table 36A)

Westmeath	71,013	599	0.8%	86,164	853	1%	88,396	1008	1.1%
Nationally	3,917,203	23,681	0.6%	4,581,259	29,495	0.6%	4,761,865	30,987	0.7%

Unfortunately, comprehensive data on the actual incidence of sexual violence is not available from either An Garda Síochána or the courts at local level. An Garda Síochána only currently record incidents where an individual's make a statement, rather than the total number of incidents attended.

2 Overview of services

2.1 Specialist sexual violence and sexual support services nationally

Nationally there are two dedicated types of specialist sexual violence services; Sexual Assault Treatment Units (SATUs); and Rape Crisis Centres.

2.1.1 SATUs

There are six SATUs located in Cork, Dublin, Galway Mullingar, Letterkenny and Waterford. Each provides clinical, forensic and supportive care *'for adults and adolescents (*aged fourteen years and over) *who are the victims of rape or sexual assault'*[29]. The specialist staff provide services which address the immediate medical, psychological and emotional needs. This includes provision of treatment such as emergency contraception and medication to reduce the possibility of developing sexually transmitted infection. The SATU services may also collect forensic evidence to aid the legal process. There is no charge for any of the SATU services, related medication or follow up appointments. SATU can also often act as a conduit to other services including counselling, mental health, domestic violence services and Rape Crisis Centres. The SATU is also mobile and can see clients outside of the Unit. See Table 2.1 for details of the total numbers presenting to the various units.

Table 2.1 SATU attendance figures

SATU	2017	2018
Dublin (Rotunda Hospital)	327 (38%)	319 34%)
Mullingar (Midlands Regional Hospital, Mullingar)	174 (20%)	203 (22%)

[29] Dept of Health (2019) Policy Review: Sexual Assault Treatment Units Summary.

Cork (South Infirmary Victoria University Hospital)	140 (16%)	165 (18%)
Galway (Hazelwood House, Parkmore Rd)	85 (10%) (not inclusive of those who attended CASATS)	97 (10%) (Not inclusive of thise who attended CASATs)
Letterkenny (NoWDOC Premises, Oldtown)	73 (8%)	84 (9%)
Waterford (Waterford Regional Hospital)	6 (8%)	73 (8%)
Total	865[30]	941[31]
No. of individuals attending SATU who also met with a psychological support worker at the time of their SATU attendance	665 (78%)	762 (81%)

Individuals who attend a SATU can do so with or without Garda accompaniment (ideally within 7 days of the assault) and may or may not to have forensic samples taken depending on their preference. Individuals may also have forensic samples take and retained by the SATU (for a period of up to one[32] year), while they consider whether or not they want to report the crime to An Garda Síochána. The SATU's were the subject of a Dept of Health Policy Review published in 2019. This Review identified a series of recommendations for the future development of the SATU's with accompanying additional financial resources. An implementation group has been put in place to oversee the implementation findings and a national Director appointed. Key recommendations include both increasing financial and human resources as well as resourcing to introduce a more holistic, whole-person care for patients over the longer term, and enhance patient experience and service setting.

2.1.2 Rape Crisis Centres

There are 16 Tusla, Child and Family Agency funded Rape Crisis Centres around the country (See Appendix 4 for details of their location and resource allocations). These Rape Crisis Centres offer individuals (male and female) who have experienced rape, sexual abuse, or any other form of sexual violence access to professional counselling and support, in a safe and secure environment. Counselling is provided by professionally accredited and experienced therapists in line with best practice requirements. The Rape Crisis Centres also provide information and support with the legal and medical processes involved with the aftermath of rape and sexual abuse as well as having a role in relation to increasing public awareness on to the nature and extent of sexual abuse.The Rape Crisis Centres may also (should resources allow) provide support for family members of

[30] An additional 24 people were cared for in the out-of-hours service at University Hospital Limerick, which has a slightly different structure and is funded through a different stream.
[31] Egan, M (2019) National Sexual Assault Treatment Unit (Satu) Executive Summary of Annual Key Service Activity Year Ending: December 2018.
[32] Samples can be retained for longer by the SATU following a request in writing that they be retained for a further period.

people whose lives have been affected by sexual abuse and rape. Some Rape Crisis Centres also provide accompaniment support to SATU and to the Garda.

2.1.3 Other supports at national level

Other supports at national level include the National 24-Hour Helpline (operated by Dublin Rape Crisis Centre) and the website RapeCrisisHelp.ie (managed by the Rape Crisis Ireland Network) and the former COSC[33] website. Both the Helpline and the website provide users with referral information. The Dublin Rape Crisis Centre also note that some callers to the National Helpline use it as a support after they have finished counselling, or indeed while they are waiting to attend their first appointment.

The Rape Crisis Helpline (operated by Dublin Rape Crisis Centre)

This 24-hour helpline is for women and men who have been raped, sexually assaulted, sexually harassed or sexually abused at any time in their lives. The helpline is also used by family and friends and by professionals and front-line workers dealing with victims of sexual violence. See Table 2.2 for details of the helpline contacts in 2018.

Table 2.2 Dublin Rape Crisis Centre Helpline Statistics[34] in 2018	
Total no. of calls	11,240 (estimate that 1,000 relate to DRRC appointments and 400 are hoax/abusive calls)
Total no. of texts	1,000
Total no. of emails	800
Contacts through social media	284
Total no. of first-time contacts in 2018	7,400
Percentage Callers/contactors who chose to disclose location (callers/contacts are not asked to disclose this)	Of the 58% who disclosed location 65.7% of were from the wider Dublin area
Gender (callers/contacts are not asked to disclose this)	Of the 90% who disclosed their gender the breakdown was as follows: Female 77.3%, Male 21.6% and Other 1.1%
Age (callers/contacts are not asked to disclose this)	Of the 60% who disclosed their age the breakdown

[33] Following a Transformation Programme (Jan-Sept 2019) with the Dept of Justice and Equality the COSC office no longer exists. The functions of this office will now be delivered under the Departmental Civil Justice and Equality policy function
[34] Blackwell, N (2019) In person interview, 20th March 2019

	was as follows: 2.1% < 16 years 2% -16-17 years 15% 18-23 years 14.6%- 24-29 years 19.6% 30-29 years 22.3% 40-49 years 24.4% >50years
Purpose of calls/contacts	Referrals (40% are referred to other Rape Crisis Centre, 9% referred to the Garda, 8% referred to medical supports and 7% to SATUs) Follow up support (after therapy) Support while waiting for appointments

RapeCrisisHelp.ie

This website (developed and maintained by Rape Crisis Network Ireland) contains information in relation to the professional supports available to survivors of sexual violence.

www.cosc.ie

This website (which was developed and maintained by COSC the National Office for the Prevention of Domestic, Sexual and Gender-based Violence) provides links to the contact details for national and local services. Following a recent Transformation Programme (Jan-Sept 2019) with the Dept of Justice and Equality the COSC office no longer exists. The functions of this office will now be delivered under the Civil Justice and Equality policy function.

Female Genital Mutilation (FGM) [35] Treatment Service

The practice of FGM is internationally recognized as a human rights violation of women and girls. It is also recognised by the WHO and many others as a form of sexual and other gender-based

[35] Female genital mutilation (FGM) is a practice carried out on girls in some countries. It is the 'cutting' or 'closing' of the female genitals for no medical reason.

violence[36]. The Criminal Justice (Female Genital Mutilation) Act 2012 makes it a criminal offence to remove a girl from the Irish state to mutilate her genitals. Since 2011 It is estimated that there have been about 3,780 women living in Ireland who have undergone the mutilation. A 2015 EIGE report suggested that the number of girls at risk of FGM in Ireland was between 158 (a low-risk scenario) and 1,632 (a high-risk scenario)[37].

The Irish Family Planning Association (IFPA) provide free specialised medical care and counselling in their Dublin City Centre Clinic to women and girls in Ireland who have experienced FGM[38]. Translation services can be arranged where requested. Raising awareness of FGM nationally is a core objective of AkiDwa a national network of migrant women living in Ireland. They have a network of volunteer Community Health Ambassadors that work on raising awareness of FGM within their local communities and in direct provision centres. AkiDwa have also produced 'Towards a National Plan to Combat Female Genital Mutilation 2016-2019' where they estimate that a total of 3,780 women between the ages of 15 and 44 residing in Ireland have undergone FGM.

2.2 Specialist sexual violence and sexual support services in the study area

2.2.1 An overview

Within the study area there are two Tusla, Child and Family Agency funded Rape Crisis Centres as well as a HSE funded SATU based in Mullingar. The Rape Crisis Centres are located in Athlone (The Athlone Midlands Rape Crisis Centre) and in Tullamore (Regional Sexual Abuse & Rape Crisis Centre Tullamore). These services also provide outreach by appointment in the domestic violence services offices in Longford, Mullingar and Portlaoise respectively). There are currently no dedicated or outreach services in Co. Meath or Co Roscommon, with individuals from Meath understood to be presenting to either the Dublin Rape Crisis Centre and or its outreach, or Rape Crisis North East (in Dundalk or Drogheda) depending on where an individual lives within the county. Rape Crisis Centres in locations outside the study area report that individuals from Roscommon present in small numbers at the Galway's Rape Crisis outreach in Ballinasloe in particular, the Mayo Rape Crisis Centre and the Sligo Rape Crisis Centre (at their outreach in Carrick on Shannon). Some also present to the more general National Counselling Services located locally. It was not possible to get details of the exact numbers from the study areas presenting at services outside the study. See Table 2.3 provides details of the numbers presenting at the two Rape Crisis Centres in the study area.

[36] https://www.who.int/hac/techguidance/pht/SGBV/en/ (accessed 4th June 2019)
[37] EIGE (2015) Estimation of girls at risk of female genital mutilation in the European Union. (https://eige.europa.eu/node/419)
[38] There is also a Clinical Nurse Specialist in Holles Street who specialises in urodynamics.

Table 2.3 Rape Crisis Centres numbers in the study area				
Statistics			*Regional Sexual Abuse & Rape Crisis Centre Tullamore*	*Athlone Midlands Rape Crisis Centre*
Total no of clients in	2018		161	81
	2017		170	73
	2016		142	94
New clients in 2018			36	47
Repeat clients in 2018			37	34
Total number of counselling sessions provided by your service in 2018?			925	686
No. of counselling sessions provided by counsellors working in a voluntary capacity?			313	5
Does you provide SATU accompaniment support?			Yes	No
No. of individuals supported at SATU in 2018			162	-
Wait-time for an appointment		Average waiting time for an appointment	10 days	2-3 weeks. (Can be a little longer for outreach).
		Wait time for individuals in the immediate aftermath of sexual violence/rape	Immediately	Usually within the week (as soon as therapist is available).
		Wait time for individuals who experience SV/Rape as an adult	10 days	2-3 weeks
		Wait time for individuals who experienced SV/Rape as a child (historic):	10 days	2-5 weeks (as soon as therapist is available.)
Total number of counselling sessions provided by service in 2018			**925**	**686**

2.2.2 Athlone Midland Rape Crisis Centre and Tullamore Rape Crisis Centres (and Dublin RCC)

See Table 2.4 for a profile of the two services operating in the study area as well as the Dublin Rape Crisis Centre which is the Centre where it is thought[39] that the majority of individuals from Meath attend.

Table 2.4 Profile of the Rape Crisis Centres that primarily serve the study area			
Description of service	*Regional Sexual Abuse & Rape Crisis Centre Tullamore (Co Offaly)*	*Athlone Midlands Rape Crisis Centre (Co Westmeath)*	*Dublin Rape Crisis Centre*
Opening Hours	Monday- Friday: 9.30 am – 5pm. Some appointments take place outside of these times. Saturday: By	Monday-Friday 9am- 7.30 (as required)	Mon to Fri – 8.00am to 5.30pm and Sat 9.00am – 3.30pm. Some appointments take place outside of these times.

[39] Source: A variety of local consultations including with local Gardai who indicated that they refer individuals to the Dublin Rape Crisis Centre.

		appointment		
Clients	Female	Yes (majority)	Yes (majority)	Yes (majority)
	Male	Yes	Yes	Yes
	Individuals from the LGBT + community	Yes	Yes	Yes
	Travellers	Yes	Yes	Yes
	Ethnic Minority Communities	Yes (assumes they speak English)	Yes (assumes they speak English)	Yes
Do you have access to interpreters for individuals who do not have English as a first language		No	No	Yes
Do you have access to sign interpreters for individuals who are deaf/hard of hearing		No	No	Yes
Where do your referrals come from:		Self-referral, SATU, Family members Gardai, Medical professionals (including local GP's), Social workers, Domestic violence services locally, Other counsellors/counselling services, Other Rape Crisis Centres, National helpline, Social workers Solicitors Homeless services, Parents/ Guardians, CAMHS, Adult mental health services, Pieta House, etc.		
Cost of appointment		Free	Free	Clients are asked to pay what they can afford. Many will not be able to afford to contribute
How many counselling slots do you have available per week?		Approx 20 per week (over 48 weeks)	29	120
Counselling staff	Full-time	0	0	1 (Clinical Director)
	Part-time	0	3 (One works 17 hours; one works 8 hours and one works 6 hours/week)	12 counsellors[40] on the payroll to end July, 1@ 2 day and 11 @ 3 day 2 new counsellors will commence in August 2019
	Sessional staff	3 (hours vary weekly)	1 (8 hours per week)	None
	Counsellors who work on a voluntary basis	4	1	None
Do you provide support and supervision for your counsellors? If yes please describe the nature of this support/supervision		No- Self-employed counsellors are responsible for their own supervision	One to one supervision once a month. Usually 1 – 1.5 hours Group session every 3 months. Usually 3 hours. Extra sessions if needed by arrangement Supervision provided by accredited supervisors	Internal and external support and supervision is provided to staff
Does your service use volunteers		Yes	Yes One professional	Yes Out of office hours

[40] This does not include paid Counsellors who work on the national helpline.

		20 are involved in SATU accompaniment 4 volunteers who are professional counsellors provide counselling	counselor who works on the phone and who provides one to one counselling	only trained volunteers help operate the National 24-hour helpline Volunteers provide accompaniment services to people attending the Rotunda SATU, Garda stations or court Volunteers give talks to schools and community groups.
SATL Support	Do you provide SATU support	Yes	No	Yes
	Who provides this support?	Volunteers and paid staff	N/A	Volunteers[41] and paid staff
	Is this service 24-hour?	Yes	N/A	Yes
Do you provide outreach?		Yes Portlaoise (Co Laois) By request in – Portarlington, (Co. Laois) – Mountmellick (Co. Laois – Edenderry (Co Offaly) Birr (Co Offaly)	Yes Longford (weekly by appointment; 0.5 days/week) (Co Longford) Mullingar (weekly by appointment, 1 day per week) (Co Westmeath) Teach Failte[42] in Mullingar, 0.3 day per week by appointment	Yes Coolock Civic Centre ((two therapists 1-3 days a week) Tallaght University Hospital (two therapists one half day a week, meeting clients from Wicklow and South Dublin) Dóchas Centre, Mountjoy Women's Prison (one therapist for 0.5-1 day a week) Balbriggan (two therapists three days a week) This commenced in August 2019
Do you provide court accompaniment		Yes	Yes	Yes
Do you provide accompaniment to An Garda Síochána		Yes	Yes	Yes
Website		No	Yes	Yes

For a three month trial period (Q4 2009-Jan 2019) Rape Crisis North East CLG provided outreach rape crisis counselling service every Saturday in a room in the Family Resourcing Centre, Commons Rd, Navan. Despite no adverting or awareness raising Tusla reported[43] a steady uptake

[41] Volunteers are rostered and supervised by paid staff

[42] Teach Failte is a hostel for homeless women and their children

[43] Email communication Tusla's Anita Clancy Clarke as part of this NAP study 20th Sept 2019.

of services. Statistics on the exact numbers attending were not located as part of this study. This outreach ceased, due to funding & resources issues. Since then Peadar Tóbín TD has made ongoing representation to get it re-instated.

The Dublin Rape Crisis Centre offers similar direct supports to those offered by the two Rape Crisis Centres within the study area. The biggest difference between Dublin Rape Crisis Centre and the local Rape Crisis Centres is that the wait time for appointments can be considerably longer in Dublin (because of the high levels of demand). For example, the wait time for individuals who experienced sexual violence in the last six months is generally two to three weeks, while it can be up to nine months for individuals who experienced sexual violence more than six months ago. While individuals are waiting, they can access support from the national helpline, it may also be that they look to other services for supports. Clients attending the Dublin Rape Crisis Service are generally seen once a fortnight for an average of two years. Clients attending the Athlone service are generally seen on a weekly basis for an average of 12-15 months, while clients attending the Tullamore service are initially seen weekly for six sessions, and thereafter fortnightly as required by the client, with some clients finishing their support after 10 sessions, others after 20 sessions. In some cases Tullamore reports that some clients attend the service for two years, attending monthly or bimonthly as required.

Rape Crisis Centre Local SATU Accompaniment.

The Regional Sexual Abuse & Rape Crisis Centre Tullamore have provided SATU accompaniment support for individuals attending the Mullingar SATU since 2009. This service is provided 24/7 365 days a year. This service is provided by Tullamore RCC volunteers (with staff filling in the gaps as necessary) attending the SATU as requested. Key statistics for this service are as follows:

- A total of 1026 survivors and their families and friends have been supported by this service since its establishment.
- A total of 66 volunteers and two staff (acting in a voluntary capacity) have been involved in the provision of this support
- A total of 836 individuals (81%) have been provided with accompaniment support by volunteers.
- A total of 190 individuals (195) have been provided with accompaniment support by Centre staff with one staff member attending 182 callouts on a voluntary basis since 2009.

Up until recently the service has been dependent on volunteers. Volunteers are not paid for the services they provided but receive travel expenses. In 2012 when the HSE funding for SATU accompaniment support was cut from €41,000 to €30,000 travel expenses for volunteers were also cut. Over the last three years as employment levels have risen the Centre has found it increasingly difficult to retain and attract volunteers (This is a national phenomenon), as a result the service is increasingly reliant on staff members to fill in the growing gaps in the 24-hour roster. This practice is unlikely to be sustainable.

2.2.3 Mullingar SATU

The Mullingar SATU is located in the Midland Regional Hospital, with Regional Sexual Abuse & Rape Crisis Centre Tullamore psychological support workers available to all who attend. Specific referral pathways exist of individuals with mental health difficulties. The Mullingar SATU can also request that a Psychiatric Nurse attend SATU to determine whether the individual is well enough to be dealt with by SATU. Where required the individual will receive the medical attention they require first. Where interpretation services are required, they can be provided by the HSE or An Garda Síochána.

In 2017 174 individuals attended this SATU (this represents 20% of total attendees at SATU's). The Mullingar SATU received patient referrals from 19 counties with 30 (18%) cases from Dublin and 26 (16%) cases from Westmeath. The high level of patient referrals from Dublin represented the ongoing support provided by the Mullingar SATU to the Rotunda because of staff shortages at that time and this issue has subsequently been addressed. Limited breakdown is available on the profile of the individuals attending Mullingar SATU in their absence some national statistics[44] of relevant include the following

- 1 in 10 SATU patients are men
- 1 in 2 SATU patients are under 25 (38% are students)
- 1 in 10 SATU patients are between the ages of 14 and 18
- 6 in 10 attend SATU with the Gardaí
- There has been an average 11% increase in presentations to SATU since 2014

Mullingar SATU referrals come from a variety of sources include An Garda Síochána, the local Rape Crisis Centres and Domestic Violence Services as well as local schools and colleges (including AIT). The Mullingar SATU have on occasion also attended the AIT Health Centre to undertake forensic examinations there.

[44] Dept of Health (2019) Policy Review: Sexual Assault Treatment Units Summary.

The issue of staff shortages with SATUs was raised in the 2019 Dept of Health Policy Review of SATUs. It concluded that while *'there is huge pride in the SATU services delivered to patients in Ireland, the services are... seriously under pressure with demand for the services increasing'*[45]. As a result of this review 10 practical actions are due to be undertaken to enhance the services. These actions include: increased levels of investment in the service; an increase in the number of forensic nurse examiners (from 6 to 15) and the number of forensic medical examiners; the introduction of 'rapid responder' forensic examiners able to travel of patients in their local units if there are staff shortages; as well as expansion of the service to enable patients have the option of liaison initially and ultimately medium term support after their visit to SATU; and the establishment of a SATU network linking all units together and ensuring a consistent national service. Fully implemented these actions have the capacity to enhance the services available to individuals attending the units.

2.3 Other relevant services and supports

2.3.1 Overview

Individuals who experience sexual violence can also access a range of other services depending on what is happening. See Figure 2.5 for details.

Table 2.5 Other services accessed by individuals who have experienced sexual violence		
Retrospective child sexual violence/abuse	*Sexual violence that took place over six months ago*	*Sexual violence that took place within the last six months*
Tusla, Child and Family Agency		A & E
Primary care services (especially GP's)	Primary care services (especially GP's)	Primary care services (especially GP's)
Counselling services	Counselling services	Counselling services
Mental health services (including community-based services and through presentations to A&E (self-harm, overdose, suicidal ideation, etc)	Mental health services (including community-based services and through presentations to A&E (self-harm, overdose, suicidal ideation, etc)	Mental health services (including community-based services and through presentations to A&E (self-harm, overdose, suicidal ideation, etc)
An Garda Síochána	An Garda Síochána	An Garda Síochána
The Office of the Director of Public Prosecutions and the Courts (where a decision is	The Office of the Director of Public Prosecutions and the Courts (where a decision is made to prosecute a	The Office of the Director of Public Prosecutions and the Courts (where a decision is made to prosecute a

[45] Dept of Health (2019) Policy Review: Sexual Assault Treatment Units Summary.

made to prosecute a case in the Circuit or Central Criminal Courts)	case in the Circuit or Central Criminal Courts)	case in the Circuit or Central Criminal Courts)
Addiction services	Addiction services	Addiction services

2.3.2 Counselling services

There are a variety of counselling services available locally and nationally including a myriad of private counselling services and a number of publicly funded services. This section focuses on publicly funded services available in the study area.

The HSE National Counselling Service primarily provides a counselling service to adult survivors of child sexual abuse. Since its establishment, its primary clients have been adults who experienced abuse whilst in the care of the state as children. Individuals can self-refer (the majority) or can also be refereed by their GP and other health professionals. The service is locally based (e.g. RIAN Counselling in Navan) and available free of charge. The HSE areas relevant to this study are:

- HSE Dublin North East (North Dublin & Meath)
- HSE Dublin North East (Navan, Cavan, Louth & Monaghan)
- HSE Dublin Mid-Leinster (Laois, Offaly, Longford & Westmeath)
- HSE West (Galway, Mayo & Roscommon)

There is a waiting list for this service, with all potential clients assessed and ranked based on the screening interview. Service users report a wait time for an appointment of between six and nine months and up to a year in Dublin. Supplementary services provided by the NCS include Counselling in Primary Care (CIPC)) This CIPC service is provided by professionally qualified and accredited counsellors or therapists who work under the supervision of the HSE National Counselling Service. This service is accessed via GP referrals. Clients are generally referred for a specific reason and given eight sessions of counselling this can be extended to 12 sessions if needed. The initial session is focused on identifying the individual's needs. Where CIPC is found not to be the right services referral is made to other services (e.g. mental health/addiction services). Information is currently not collected in relation to whether sexual and/or domestic violence present as issues. This service is open to medical card holders aged 18 years and over. It is planned to open this service to GP card holder in 2019.[45] The service reports that adults who have experienced recent rape or sexual assault do not present to this service. Where it later transpires

[45] Interview Mary Kilcommins (NCS Director Galway Roscommon Mayo, 1st May 2019 (conducted by Anita Clancy Clarke)

that individuals disclose that they have also experienced sexual violence as an adult the therapist in recognition of the therapeutic relationship that has been established will continue to work with these clients. The CIPC operating model since 2013 is as follows:

- Counselling is subcontracted to contract counselling agency workers at an hourly rate
- There is no payment if the counselling agency worker receives 24 hours' notice of an appointment cancellation
- A set amount of external supervision is provided depending on client load (in workers own time)
- Contract counselling agency workers provide their own insurance
- No travel costs are paid

The NCS are currently undertaking/considering undertaking the following pilot schemes:

- Pilot online counselling scheme (via SKYPE)- this is in progress with a waiting list
- Pilot blogs for peer support groups (to participate an individual would have to have engaged online with a counsellor (under consideration)
- Pilot text counselling (under consideration)

Connect is a free telephone counselling and support service for adults who have experienced abuse, trauma or neglect in childhood. The service is also available to partners or relatives of people with these experiences. It is an additional service to the HSE's National Counselling Service, available Wednesday to Sunday, 6pm – 10pm.

Tusla, Child and Family Agency funded domestic violence services that serve the area

There are seven Tusla, Child and Family Agency funded domestic violence services located across the study area. See Table 2.5 for details. All of these services can provide access/referral to counselling services, much of the cost of which is covered through fundraising (e.g. Meath Refuge fundraise about €8,000 which enables them to provide 100 hours of counselling, with clients also making a contribution of €10/hour). Many of these services[47] believe that sexual abuse is happening as a part of domestic abuse but because of the stigma associated with sexual abuse it is the last thing that individuals are likely to disclose. Some services also believe that some individuals (because they are married/in long term relationships do not recognise what they are experiencing as sexual violence. Most services ask clients as part of their assessment process

[47] Source: A focus group with various domestic violence service providers (11th Feb 2019) and various interviews with domestic violence service managers.

whether there is sexual violence but clients do not generally indicate that this is an issue at this point in time.

Table 2.6 Tusla, Child and Family Agency funded domestic violence services in the study area.			
County	*Name of the Service*	*For Females*	*For Males*
Laois	Laois Domestic Abuse Services[48]	√	
Longford	Longford Women's Link Domestic Violence Service	√	
Meath	Meath Women's Refuge and Support Services	√	
Offaly	Offaly Domestic Violence Support Service	√	√
Roscommon	Roscommon Safe Link Ltd	√	√
Westmeath	Westmeath Support Services	√	
	Esker House Women's Refuge[49]	√	

AnyMan (formerly known as AMEN) provide support and practical assistance to male victims of domestic abuse. It also works to promote increased awareness and understanding among the wider public of the issues surrounding domestic abuse; and to collaborate with statutory and non-statutory bodies to advance the aims and the needs of male victims of domestic abuse. AnyMan is based in Navan Co. Meath and provides a Confidential Support Line which is open Monday to Friday, 9.00 am to 5.00 pm. This Support Line offers a point of contact for men, their concerned family members or friends. AnyMan also offers one-to-one support sessions to men and their family members who require further information or support.

Tusla, Child and Family Agency funded Family Resource Centres (FRCs) as part of their provision of a range of universal and targeted services that address the needs of families, provide counselling and support to individuals and groups. See Table 2.7 for details of the FRCs in the study area. Some centres have a protocol where the issue of domestic violence is raised, it is unclear what if anything is in place in relation to a sexual violence disclosure.

Table 2.7 FRC's in the Study Area	
Laois	Portlaoise Family Resource Centre, Portlaoise, Co Laois
Longford (2)	Bridgeways Family Resource Centre, Ballymahon, Co Longford

[48] Laois Domestic Abuse Services also provide counselling services.
[49] Esker House Women's Refuge also provide support and outreach.

	Lus Na Greine Family Resource Centre, Granard, Co Longford
Offaly	Clara Family Resource Centre, Clara, Co Offaly Tullamore Family Resource Centre, Tullamore, Co Offaly
Meath	Kells Family Resource Centre Laytown Family Resource Centre Trim Family Resource Centre
Roscommon	Ballaghdereen Family Resource Centre Boyle Family Resource Centre, Boyle Co Rosommon Castlerea Family Resource Centre
Westmeath	Cara Phort Family Resource Centre, Mullingar Co Westmeath Athlone Family Resource Centre, Co Westmeath

Other services that provide therapeutic support/counselling include:

Nationally/outside the study area

- One in Four provided support and resources to women and men who have experienced sexual violence/abuse during childhood. Services provided include psychotherapy, advocacy and prevention services.
- SPIRASI (a Dublin based organisation) provide counselling and support for survivors of torture, with rape recognised as a form or torture. The organisation when contacted was not aware of any of the specialised services in the study area.
- The Men's Development Network (a Waterford based organisation) have a counselling programme designed to support men affected by, but not restricted to marginalisation and relationship issues which are generally focused around conflict and loss. These circumstances can be linked to mental health issues such as depression and anxiety amongst other issues which include anger, violence, trauma, and health issues. The numbers attending this service from the study area are understood to be very, very small, given the logistics involved. The Men's Development Network (with the support of Tusla) also implement a specialist domestic violence support as part of their services, which will include an advice line for men; initial assessment; counselling and outreach support. The specialist domestic violence supports being developed by the Men's Development Network will use the RESPECT Model of service delivery. The Men's Development Network launched its Male Advice Line on the 20th May 2019.

- HSE Refugee Psychology Services (Dublin based), asylum seekers may with their consent be referred for this service for support for various issues

Within the study area

- Vita House Family Centre in Roscommon Town
- Meath Springboard Family Support Services based in Navan generally focus what limited counselling support they have at children and young people attending their service. Where a young person/child declines counselling the services can provide affordable counselling for their parent. This is partly funded by Tusla, Child and Family Agency, with the remainder funded by the parent and by local fundraising. In 2018 42 individuals were provided with access to counselling (30 children and young people and 12 adults)
- The 4,500 students attending Athlone Institute of Technology (AIT) can access general counselling services though the Institute's Health Centre. This Centre is independently funded by AIT and has two full time and two part time counsellors.

2.3.3 Mental health services

Experiences of sexual violence/assault can have a very negative impact on the individual's mental health. Most people with mental health issues are treated by their GP, where therapy services are required individuals are referred to mental health services (either day or hospital services). Individuals may also present to A&E. See Table 2.7 for details of mental health services accessible from the study area. Referrals are generally prioritised and subsequently assessed by a Psychiatrist who will determine what support an individual needs. Community mental health teams are generally multidisciplinary. For example, the team in Longford includes a consultant Psychiatrist, Community Nurses, a Cognitative Behavioural Therapist, and Occupational Therapist, a Social Worker and a Psychologist. Services report that while sexual violence is generally not a/the referral issue, neither is the question explored directly, it can be disclosed. Where a disclosure of historic sexual abuse is made mental health services are required to report this to Tusla, Child and Family Agency. Where the individual is not prepared to name the alleged perpetrator, the incomplete form is submitted.

Where a disclosure is made some mental health services suggest to individuals that they could attend specific services to help them process this experience but it is up to the individual to self-refer. Some services will also attend mental health services offices to have an informal conversation with the individual and this can work well in terms of allaying the individuals fears of presenting to new services. Services report that men in particular struggle to disclose an experience of sexual violence, they also report that women often appear to feel more comfortable making a disclosure to another women. Mental

health services note that there appear to be more referral options for supports for women than there are for men.

Table 2.8 Adult mental health services accessible from the study area[50]	
Laois and Offaly	Community Mental Health Birr Community Mental Health Portlaoise Community Mental Health Tullamore St. Fintan's Hospital, Portlaoise St. Loman's, Mullingar Psychiatry for Later Life Suicide Resource Office
Longford and Westmeath	Community Mental Health Centre Mullingar Community Mental Health Centre Ré Nua Athlone Community Mental Health Centre Longford Day Centre Grace Road Athlone St. Loman's Hospital Mullingar Psychiatry for Later Life Suicide Resource Office
Meath[51]	Navan Mental Health Service Out-Patient Clinic HSE Mental Health Services, 93 Troytown Heights, Navan, Ashbourne Health Centre An Re Orga, Kennedy Road, Navan, Department of Psychiatry, Our Lady's Hospital, Navan, Kells Mental Health Centre Mental Health Day Services, Oldcastle, Kells, Rath na Riogh Hostel, Navan, Tain Mental Health Centre, Navan
Roscommon	Psychiatric Unit, Roscommon County Hospital Day Hospital Primary Care Centre, Roscommon
	Also noted as servicing County Roscommon – Day Hospital Athenry – Day Hospital Ballinasloe – Day Hospital Loughrea – Day Hospital Portumna – Day Hospital Tuam – Psychiatric Unit, University College Hospital, Galway – St. Brigid's Hospital, Ballinasloe – St. Mary's Hospital, Castlebar,

2.3.4 Primary Care/Health Centre's

See Table 2.9 for details of the Primary Care Centres operational in the study area in 2019. It is envisaged that these teams will be further strengthened in the future so that they will be the main unit both for the delivery of health and social care services and the development of health and wellbeing initiatives in primary care areas.

[50] https://www.hse.ie/eng/services/list/4/mental-health-services/ (accessed 28th May 2019)
[51] To access inpatient psychiatric services Meath residents must attend Our Lady of Lourdes Hospital in Drogheda, Co. Louth

Table 2.9 Primary care/health centres operational in the study area[52]

County	*Centres*	
Laois	Abbeyleix Health Centre	Mountmellick Primary Care Centre
	Ballylynan Health Centre,	Mountrath Health Centre,
	Borris-in-Ossory Health Centre,	Portarlington Primary Care Centre
	Clonaslee Health Centre,	Portlaoise Health Centre,
	Durrow Health Centre,	Rathdowney Health Centre,
	Emo Health Centre,	Stradbally Health Centre,
Meath	Ashbourne Primary Care Centre,	Kells Primary Care Centre
	Athboy Health Centre	Laytown Health Centre,
	Ballivor Health Centre,	Nobber Health Centre,
	Drumconrath Health Centre,	Oldcastle Health Centre,
	Dunshaughlin Health Centre,	Slane Health Centre,
	Enfield Health Centre	Summerhill Primary Care Centre
	Johnstown Health Centre, Johnstown	Trim Primary Care Centre,
	Navan	Wilkinstown Health Centre
Offaly	Banagher	Daingean
	Birr	Edenderry
	Blueball	Ferbane
	Borris-in-Ossory	Kilcormac
	Clara	Kinnity
	Cloghan	Moneygall
	Clonbullogue	Rhode
	Cloneygowan	Shinrone
	Cloughjordan	Tullamore Primary Care Centre
Roscommon	Aughrim	Boyle
	Athleague	Castlerea Primary Care Centre
	Ballaghaderreen (with clinics at Frenchpark and Ballinameen)	Elphin
	Ballinlough	Monksland
	Ballydangan	Roscommon Primary Care Centre
	Ballyforan	Strokestown
Longford and Westmeath	Athlone	Edgeworthstown
	Ballinalee	Granard
	Ballymahon	Killashee
	Ballymahon Primary Care Centre	Killucan
	Ballymore	Kinnegad Primary Care

[52] Source: https://www.hse.ie/eng/services/list/

	Ballynacargy	Lanesboro
	Castlepollard	Longford
	Castletown Geoghegan	Legga Health Centre Aughnacliffe
	Colehill	Moate
	Delvin	Mullingar Primary Care Centre
	Drumlish	Newtowncashel

2.3.5 An Garda Síochána[53]

The Gardaí are generally the primary conduit between the individual who experienced the sexual violence and the justice and legal system providing the key source of information and connection for the individual. An Garda Síochána define their role following receipt of a formal report/statement related to a sexual crime as follows:

- To investigate the report fully without exception. This investigation will be undertaken in a compassionate, sensitive and professional manner. With very effort made to have a Garda of the gender of the complainant's choice allocated to the investigation.
- To vindicate the rights of all parties involved in the investigation. Victims will be dealt with in accordance with EY Directive 29/2012 for Victims of Crime, Irish legislation and the Garda Síochána Victims Charter.
- To record all complaints of sexual crime and child abuse on the Garda Síochána PULSE computer system with access restricted to personnel involved in the investigation and supervisors.
- To provide the complainant with the contact details of the investigating Garda and to keep them updated on the progress of the Garda investigation on a regular basis. The complainant will also be provided with the PULSE Incident Number relating to their complaint.
- The complainant will be provided with details of available support services relevant to the crime that they report.
- The complainant will be accompanied by a solicitor and/or another person of their choice when engaging with An Garda Síochána. They may also be provided with other special protective measures such as specially trained interviewers and/or an interpreter, depending on their circumstances.
- An Garda Síochána will communicate and work with Tusla, Child and Family Agency Child where any child protection concerns arise.

[53] Counties Westmeath, Meath, Laois and Offaly are part of the eastern region Laois/Offaly Division Meath division and Westmeath division respectively, while Longford and Roscommon are part of the western region, Roscommon/Longford division.

- When the investigation in serious crimes is complete, the Gardaí send an investigation file/book of evidence to the Director of Public Prosecutions (DPP) who will make the determination in relation to whether there is sufficient evidence to pursue the case and at what level. In less serious crimes, the Gardaí make the decision, although they still prosecute in the name of the DPP, who has the right to tell the Gardaí how to deal with the case[54]. In some cases, the DPP can request that further investigations be carried out by the Gardaí or further statements be obtained. In practice, it often takes several months for the DPP to make a decision in a case involving sexual violence[55].

A recent positive development with An Garda Síochána has been the establishment of Divisional Protective Services Units (DPSUs). More than ten units are now in place (including one in Portlaoise with the remainder due to go live in the remaining Garda divisions throughout 2019[56]. The role of these Units is to investigate specialised crime types, including sexual crime, human trafficking, child abuse and sexual abuse. DPSUs also focus on the provision of support for vulnerable victims of crime, including enhanced collaboration with Tusla, Child and Family Agency to safeguard children. Up to 15 personnel will be attached to each unit. These include an Inspector, two Detective Sergeants, 10 Detective Gardaí and two administrative staff, with a small number being allocated on a phased basis. These Units bring a welcome degree of specialisation in the wider force. Training for personnel attached to each of the existing units commenced in January 2019. The first module, on sexual crime investigation included an input from a victim of sexual abuse.

In addition to the PDSUs the Garda National Protective Services Bureau (GNPSB) provides advice, guidance and assistance to Gardaí investigating the following: Sexual Crime Investigation; Online Child Exploitation Investigation; Child Protection, Domestic Abuse Intervention and Investigation; Human Trafficking Investigation; Organised Prostitution Investigation; Specialist Interview; Sex Offender Management; Missing Persons; Missing Persons in Care; and, Support for Victims of Crime. This bureau also leads the investigation in more complex cases. At national level positive formal working relationships are in place between the Gardaí, Tusla, Child and Family Agency and SATU, with the Gardaí a key member of the SATU working group.

2.3.6 The Office of the Director of Public Prosecutions and the Courts

The Gardaí when their investigation is complete forward their investigation file to the Office of the Director of Public Prosecutions (DPP) who make the decision in relation to whether there is

[54] Office of the Director of Public Prosecutions (2016) Going to court as a witness
[55] Rape Crisis Network Ireland (2012) Guide to the legal process for survivors of sexual violence
[56] https://www.garda.ie/en/about-us/our-departments/office-of-corporate-communications/press-releases/2019/january/six-new-divisional-protective-services-go-live-on-the-9-1-19.html (accessed 24th May 2019)

sufficient evidence to prosecute, is it in the public interest to bring the case to court, what the charges should be and once the prosecution begins, the Office of is responsible for the prosecution case. The DPP have Memorandums of Understandings with various counselling agencies (including the various Rape Crisis Centres nationally) that enables them to request an individual's counselling records where they are relevant to the case. Where the individual in question does not consent to the release of these records, the trial judge must make the decision as to whether the records or part of the records, should be released without consent.

Where the records are released (with or without consent) they can be seen by both the prosecution lawyers and the defence solicitors. The accused person is also allowed to see the information in the records that is relevant to the trial, but only if their solicitor or barrister is with them[57].

A judge and jury will hear the more serious cases in the Circuit Court or the Central Criminal Court. Serious cases can also be brought before three judges without a jury, in the Special Criminal Court. Less serious cases are heard by a judge without a jury in the district court. Under the Victims of Crime Act 2017, the office has 28 days to respond to requests for non-prosecutorial decisions. If a decision is made to prosecute, the individual who experienced the sexual violence appears as a witness within the case. With the introduction of the Victims Directive (EU Directive 29/2012) and the implementation of a suite of protective measures the Garda must do an assessment of vulnerable adults needs (in the situation that the case goes to trial). Options to support vulnerable adults include being able to give evidence by video link, the used of screens, exclusion of the public, the use of interpreters and intermediaries, the restriction of cross examination[58].

Where a decision is made not to prosecute, the victim is entitled to seek details of why this decision was made. The review request should generally be submitted within 28 days of receipt of the letter detailing the reasons for not prosecuting. The most common reason for the decision not to prosecute is 'insufficient evidence'[59]. Following receipt of the reasons for a particular decision the victim may also seek a review of the decision. Reviews of decisions are undertaken by solicitors (not involved in the original decision) within the Victims Liaison Unit of the Office. Only about 2% of cases reviewed result in referrals[60].

Where the DPP decides to make an application for trial the Victims Directive also allows for procedural rights for victims, such as being kept informed of the progress. (It is the responsibility of the investigating Garda to keep the victim up-to-date on how the case is developing and to tell the victim about the DPP's decision when it is made. If the DPP decides to prosecute a case, the Garda

[57] DPP (2019) Releasing my counselling records.
http://www.cpprelaid.ie/files/www/documents/information_booklets_new_and_revised_2018/Releasing_my_counselling_records_ENG_revised_Feb_2019.pdf
[58] The video link option is not in place in certain counties
[59] Office of the Director of Public Prosecutions (2018) The Role of the DPP
[60] This statistic is broadly similar to that for the UK

should also tell the victim the time, date and place of the court hearing). In the case of sexual offences, the Office of the DPP will offer the victim, a pre-trial meeting. The purpose of this meeting is to explain to the victim what will happen in court. The meeting takes place with the investigating Garda, the prosecution solicitor and the barrister dealing with the case [61].

Waiting times for a hearing date differ, the current wait time for a date in the Central Criminal Court is one year exactly. Where the accused is found guilty or pleads guilty the victim can make a Victim Impact Statement describing how the crime has affected them.

2.3.7 Engagement with Tusla, Child and Family Agency in relation to retrospective[62] sexual abuse

Where an adult discloses childhood sexual abuse, where there may be a current or potential risk to children from the person against whom the allegation is made, a report must be made to Tusla, Child and Family Agency, Adult Retrospective Team (ART). . The report can be made by the individual themselves or by a mandated[63]/non-mandated person under Schedule 2 of the Children First Action 2015. In some instances where the adult is attending services (e.g. mental health services), this service may be paused until the allegation is assessed by ART.

Following receipt of a retrospective report a social worker from ART will[64]:

- Acknowledge receipt of the report to the complainant;
- Notify An Garda Síochána; and
- Make contact (by letter) with the complainant

In making contact with the complainant the social worker will

- Explain that they need to be interviewed so a full account of their story can be taken.
- Inform them that this is the first stage of the assessment which will be used as the reference point for the further assessment to be undertaken with the alleged abuser to determine if any children are currently at risk or whether there is a future risk to children yet to be identified.
- Be clear with the complainant that the social worker's task is to assess the allegations and should explain that no further action can be taken until such time as a professional determination on the reliability of the allegations has been made.

[61] Office of the Director of Public Prosecutions (2019) Releasing my counselling records.
[62] The term retrospective abuse refers to abuse that an adult experienced during their childhood. Retrospective abuse is also known as historic(al) abuse.
[63] See https://www.tusla.ie/children-first/mandated-persons/am-i-a-mandated-person/ie for details of mandated persons.
[64] Tusla (2014) Policy & Procedures for Responding to Allegations of Child Abuse & Neglect

Inform the complainant that as per the requirements of Children First, An Garda Síochána has been notified of the report and that they can, if they have not already done so, make a statement to An Garda Síochána at any point.

The complainant is requested to reply to this contact within a defined timeframe. Where a complainant does not reply the case is closed (although it can be re-opened at a later date). Tusla, Child and Family Agency estimate[65] that < 50% complainants respond to their initial contact, while approximately 70% of individuals ultimately do not progress a complaint. Where a complainant agrees to be interviewed this is undertaken in person (the complainant may bring a support person with them to this interview) by Tusla, Child and Family Agency staff. Tusla, Child and Family Agency staff while they do not have direct contact with local services often suggest that complainants make contact with local services and supports who may be able to help them process their experiences. Following this the social worker will determine whether they need to interview anyone else who may be of relevance (e.g. family member/friend who the complainant may have told about the abuse, or a therapist/counsellor that the complainant is/has attended). Following an assessment of the information collected (which can take some time) and discussion with colleagues (which may include An Garda Síochána if they are involved in the case) the social worker decides whether to continue the investigation or to take no further action. The complainant receives confirmation of this decision in writing at which point their contact with Tusla, Child and Family Agency ceases in relation to this complaint.

The second key stage of the assessment (which does not involve the complainant) is engagement with the alleged abuser. Initial engagement with the abuser is by letter. This initial letter must among other things provide the alleged abuser with full detail of the allegations (including the identity of the complainant unless that person wishes to remain anonymous) together with detail of the procedural process which will be followed. The alleged abuser has 14 days to respond and if no response is received, a second letter is sent allowing a further 14 days for response. Where the alleged abuser does not engage and a decision is taken to inform a relevant third party, the alleged abuser must be informed of this decision and be provided with the date on which the relevant third party will be informed. Where the alleged abuser engages with Tusla, Child and Family Agency they can respond in writing or they can agree to a meeting. Further information may also be provided by the alleged abuser that requires further assessment. Having provided an opportunity for the alleged abuser to make representation and having undertaken any follow up assessment enquiries, a Tusla, Child and Family Agency staff must make a provisional conclusion about the likelihood of future potential risk posed towards children by the alleged abuser. The two options for

[65] Interview Johnny Maguire 6th March 2019

the provisional conclusions are founded or unfounded. The potential abuser again has the opportunity to put forward new information. If there is no new information, the provisional conclusions will be deemed to be the final conclusion by a certain specified date.

2.3.8 HSE Sexually Transmitted Infection Services in Ireland

Individuals who have been sexually assaulted who do not attend SATU may attend an STI clinic to be checked for infections. Clinics are both public and private. There are two HSE STI clinics in the study area (See Table 2.10 for details)

Table 2.10 HSE STI services in the study area[66]	
Laois	STI Clinic, Out patients Dept. Midland Regional Hospital, Portlaoise
Westmeath	STI Clinic, Midland Regional Hospital, Mullingar

In September 2019 Athlone Institute of Technology was one of six projects in the Midlands awarded a Slaintecare grant to establish a sexual health service in the college67.

2.4 The policy framework locally

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 their six year Local Economic and Community Plans (LECP) in 2016, which set out objectives and supporting actions to promote economic development and local and community development in the two counties.

The Children and Young People's Services Committee's (CYPSC) are county wide committees that brings together the main public and not-for-profit agencies and organisations providing services to children and young people in the county to support the local implementation of Better Outcomes Brighter Futures the national policy framework for children and young people. Their three-year plan aims to ensure that children and young people are active and healthy, achieving their full potential, safe and protected from harm, have economic security and are connected, respected and

[66] https://www.sexualwellbeing.ie/sexual-health/hse-sti-services-in-ireland.html (accessed 4th June 2019)
[67] https://www.midlands103.com/news/midlands-news/midlands-gets-e2m-in-latest-slaintecare-grants/ (accessed 18th Sept 2019)

contributing to their world. A review of these plans where they are in place, has found that few of them make specific reference to sexual violence. See Table 2.11 for details.

Table 2.11 Review of the Local Economic and Social Plans (LECP's) and CYPSC in the study area from a sexual violence perspective.

County	*LECP*	*Reference to sexual violence*	*CYPSC*
Laois	Laois Local Economic and Community Plan (2016-2012)	None	Work is currently ongoing to develop the Laois Offaly three-year Children and Young People's Plan.
Offaly	Offaly Local Economic and Community Plan 2016-2021- Working together to shape the future	None	
Longford	Longford Local Economic & Community Plan 2016 - 2022 UNITY	Within this plan domestic violence (and homelessness) are identified as 'key issues in the county' (p38).	Work is ongoing to develop the Longford Westmeath three-year Children and Young People's Plan with an action expected to be included on domestic, sexual and gender-based violence[68].
Westmeath	Westmeath Local Economic and Community Plan (2016-2021	Makes reference to a submission made by Athlone Community Services Council on the 21 July 2014 in relation to the need for a realistic evaluation of the extent of domestic violence and its impact on the victims and their community (p3).	
Meath	Meath Local Economic & Community Plan 2016 - 2021	None	Work is currently ongoing to develop the Meath Children and Young People's Plan.
Roscommon	Roscommon Local Economic and Community Plan (2016-2021)	None	Work is currently ongoing to develop the Roscommon Children and Young People's Plan with an action on the Impact of Domestic Violence of Children to be included.

3. Findings arising from the consultations

3.1 How needs were identified

Individuals aged 18 and over whom experienced sexual violence contributed their views through in person and telephone interviews and via an online survey, with a total of 26 individuals contributing their views to this study. Service providers contributed their views through interviews and focus groups. Service providers were also involved in the Project Advisory Group. See Appendix 2 for

[68] This can be linked to the fact that the local CYPSC Co-ordinator was a member of the Advisory Group for this study.

details of the organisations involved and represented in the service provider consultations. In many instances service providers and individuals who experienced sexual violence identified common needs, in other instances they identified different needs or emphasised them differently. Where these differences occur, they are highlighted in the text. This chapter is structured using an adapted version of the policy fields identified in a 2013 European Parliament report[89].

3.2 Specialised services for victims/survivors of sexual violence

3.2.1 Overview

The needs of survivors of sexual violence consulted differed depending on their circumstances, as well as their character and capacity. These needs also differed in relation to when the sexual violence occurred (e.g. in the last few days or some time ago or indeed when they were a child) and the context (e.g. whether it was intimate partner violence or non-partner (date rape/stranger) sexual violence). Notwithstanding all of these differences it is also clear from all of the survey respondents and individuals interviewed that survivors have a number of shared needs that include:

- Being heard -

'What I needed was someone to sit there and listen, accept, believe and not judge' (Survivor of sexual violence)

- Information and support-

'I didn't know what to do and where to go, I was going mad.' (Survivor of sexual violence)

'I needed to talk about what happened to me. I could do that to a certain extent with family and friends but it was upsetting for them and not enough for me.' (Survivor of sexual violence)

[89] *Walby, S et al. (2013) Overview of the Worldwide Best Practices for Rape Prevention and for Assisting Women Victims of Rape. Directorate General for Internal Policies Policy Department C: Citizens' Rights and Constitutional Affairs. Gender Equality. European Parliament, Bruxelles*

Key needs:

- To be listened to and heard
- Information and support
-

3.2.2 Rape Crisis Centres

'64% of survey respondents and interviewees who had experience of sexual violence had direct contact with a Rape Crisis Centre'. In places where there was no Rape Crisis Centre some individuals accessed support from the National Counselling Service and/or a local Domestic Violence Service'. (Survey findings)

Rape Crisis Centres and friends were the two most frequently mentioned places individuals who experienced sexual violence reported they sought help from, followed by GP's and the internet. Rape Crisis Centres were rated the most useful of all of these services, friends were the next most useful source of help. There were more mixed responses in relation to the usefulness of other services with a lot seeming to depend on the particular individual the survey respondents and interviewees had immediate contact with. Making the first contact with the Rape Crisis Centre was identified as particularly challenging as *'opened up talk about what happened'* (Survivor of sexual violence)

'Contacting the Rape Crisis Centre was really difficult, as I did not know who I would get. At that point I did not trust anyone. I hung up at least three times and only on the fourth time did I speak and even then, I didn't talk, the girl on the phone was great, she said I didn't need to talk and she give me an appointment for the end of that week. I could not believe it was that easy'. (Survivor of sexual violence)

'For my first few sessions I did not really talk and they said that was ok there was no rush. In the beginning I came every week. I don't think I would be here without it. I was in a bubble and the Counsellor was giving me oxygen'. (Survivor of sexual violence)

All of the individuals involved in the study who had used a Rape Crisis Centre were very complimentary about the service they received.

'The RCC was very welcoming and made me feel at ease and comfortable. I would not have survived without it. I had previously attempted suicide and I cannot thank them enough for all of the support I received.' (Survivor of sexual violence)

The only negative comments about Rape Crisis Centres related to the absence of a local Centre, the waiting time to be seen at some Rape Crisis Centres and problems related to getting to accessing public transport to get to the services.

'I live in a rural area could not get to the Centre by public transport and I do not have a car. It was tricky to make my appointments. I would have liked to have been able to make more of them.' (Survivor of sexual violence)

The two Rape Crisis Centres in the study area try to see everyone who contacted them with a week or two depending on the availability and in some cases the goodwill of counsellors. While individuals who had attended the Dublin Rape Crisis Centre in particular reported a wait time of six to eight months.

'The trouble is that generally everyone that rings us (the Rape Crisis Centre) is in a crisis for whatever reason and they want immediate support. We do know this and we try and get people in here to meet us as quickly as we can.' (Rape Crisis Centre staff)

The Rape Crisis Centres are also keenly aware that they need to try to get people independent of them as soon as possible while also recognising that some individuals will need more extensive support or repeat support depending on their particular circumstances (e.g. winning or losing a case).

'We really do try not to hold onto clients, we want people to become independent of us. For some people that just takes longer, it may also be that something comes up for a person and they need to come back to us.' (Rape Crisis Centre staff)

Face to face counselling was identified as both the most common and the most useful type of support accessed from the Rape Crisis Centres.

'I would not have survived without it (the counselling).' (Survivor of sexual violence)

'The counselling has been great, at first it was once a week, then once a fortnight, then every three weeks, then every three to four months, if I would have had to pay, I could not have got this ' (Survivor of sexual violence)

'I was doing great till I heard he was getting out of prison, then it all went wrong I started self-harming, so I decided to come back for a second time to the . . . Centre ' (Survivor of sexual violence)

The services provided by the Rape Crisis Centres clearly went beyond one to one counselling, with individual counsellors making themselves available to provide extra support when needed.

'After my statement to the Guards I began to doubt myself luckily I was able to phone my Counsellor for support ' (Survivor of sexual violence)

It was interesting that individuals who had accessed counselling from various organisations noted that *'counselling someone dealing with sexual violence is specialised'* not least because these *'counselling notes could be required by the courts'*. (Survivors of sexual violence)

'The counselling notes from the service I attended before the Rape Crisis Centre were barely legible and not professional. This did not help my case.' (Survivor of sexual violence)

Interestingly Rape Crisis Centres were definitely not first point of call for individuals dealing with either historic sexual abuse, or sexual violence that happened some time ago.

I didn't think the Rape Crisis Centre was for me, given my sexual abuse had happened a long time ago. I only rang the Centre to ask them who I should speak to. I was pleased when they said they could help and took me seriously. That was so important.' (Survivor of sexual violence)

Key needs:

- Individuals who have experienced sexual violence and who contact a Rape Crisis Centre for help, need to be seen as soon as possible and as close as to home as possible.
- Rape Crisis services need to be made available in Co. Meath and Co. Roscommon respectively.
- In places where there is an absence of Rape Crisis Centres individuals are attending non-specialist services that are local and that are quickly accessible. These services may need support to address the specific needs of individuals who have experienced sexual violence.
- Accessing services in a rural area can be challenging – need more outreach services and need to consider the provision of online services and supports.

3.2.3 SATU's

'17% of survey respondents had contact with a SATU'.

Individuals and service providers working with individuals who have experienced sexual violence both recognised that in the immediate aftermath of this experience individuals need to be able to access health services that will be sensitive to what happened. Key needs in the immediate aftermath of sexual violence were identified as including and keeping the individual as physically comfortable as possible. The individual also needs to know that they are safe and are with people they can trust. Of the individuals who attended SATU's all were very positive about their experience and linked this to the sensitivity of the SATU staff and the support person from the local Rape Crisis Centre.

'The Guards took me to SATU. The nice woman there (at SATU) helped me calm down.'

(Survivor of sexual violence)

'They explained everything to me, I think I was in shock. I was just not able to process it all that was why the support person (from the local RCC), was great, they kept me on track. .. they were all so kind.' (Survivor of sexual violence)

Anyone can refer to SATU the Mullingar SATU reports getting the majority of its referrals from Gardai, Schools, Colleges, GPs, sporting organisations, etc For individuals in the immediate aftermath of a sexual violence incident the quicker they attend a SATU the better the opportunity there is for the collection of forensic evidence. From the consultations it was clear that many service providers only considered a referral to SATU in the immediate aftermath of a sexual violence experience and linked to a forensic examination.

The reality is that SATU offer sexual health screening for individuals who have had experience of sexual violence at any point in their lives. noting that while they have a lot of young women accessing this service. they would have expected to see more referrals for individuals who experienced historic and indeed more recent sexual violence

'Even though it was a long time after, the (Rape Crisis) Centre suggested that I would go to SATU and get checked out They staff there were great, warm and welcoming They checked me out and did lots of test. It was a relief when the results came through and they were all clear'. (Survivor of sexual violence)

It was noted as part of the consultations that the current location of the Mullingar SATU on an Administration corridor in the general hospital is not ideal. It was also noted that staff numbers have fallen in the SATU in Mullingar and currently the service is depending on the goodwill of stretched staff. The consultations found good relationships between the Gardai and SATU.

Key needs:

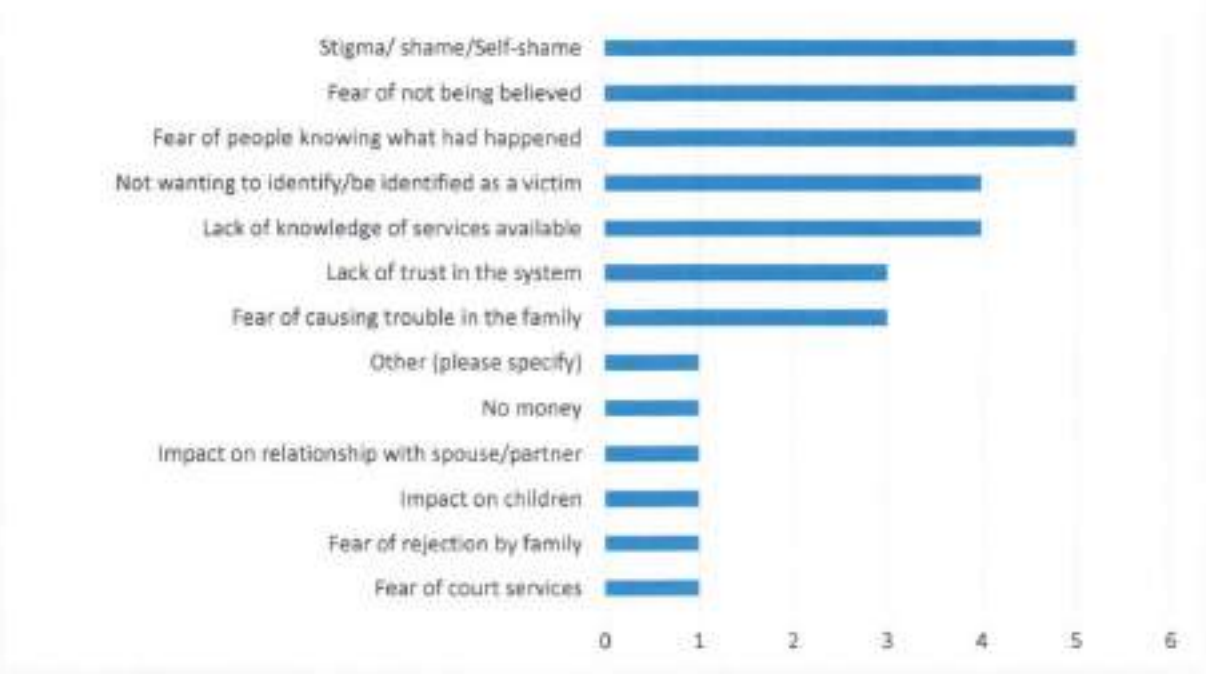
- Greater recognition and understanding of the sexual health screening role of SATU among local service providers. leading to increased referrals to SATU

- Continue the provision of SATU psychological support accompaniment services by the Rape Crisis Centres
- Relocation of SATU to a quieter location where clients and Gardaí can attend without being observed.
- Restoration and increase in staff numbers at Mullingar SATU to ensure there is adequate cover that is not dependent on the goodwill of staff. (This is included as an Action in the 2019 National Review)
-

3.2.4 Barriers to accessing specialist support

Key barriers to individuals accessing services were identified as both individuals blaming themselves for what happened and individuals being fearful that others would blame and shame them. It should be noted that 55% (10 individuals) of survey respondents (did not seek help. See Table 3.1 for details of the reasons survey respondents provided for not seeking help.

Table 3.1 Reasons survey respondents provided for not seeking help



Other reasons provided for not seeking help included the impact on the relationship with a spouse; the impact on children; fear of rejection by family; fear of court service; and having no money. The cost and availability of transport can also be an issue for individuals who do not live near a SATU or Rape Crisis Centres or outreach service. The prospect of mandatory reporting by the specialist services to Tusla, Child and Family Agency and or getting the Gardaí involved were also identified

as barriers to individuals attending the specialist services. Attending the Mullingar SATU without being observed was another barrier for some individuals/

For men there were particular barriers associated with not wanting to be identified as a victim, feelings of isolation, fear of people knowing what happened and fear of the court services. The other significant barrier identified through this study was a lack of awareness of the breath of services provided by the specialist providers to a cross section of the community. For example, SATU provides a lot more services that forensic examination and Rape Crisis Centres will support individuals of any gender who are dealing with experiences of sexual violence (both recent and historic).

3.3 Health needs

3.3.1 Mental health needs

All of the individuals consulted were clear that their experience of sexual violence had a particularly negative effect on their mental health leading to symptoms that included: suicidal thoughts, self-harm and depression. Particular points identified as triggers were:

- At the time and in the aftermath of the incident (Interestingly in this context the SATU in Mullingar has the capacity to access mental health services for an individual where they have concerns about an individual's mental health at the time of their presentation to SATU)
- Where the individual had not dealt with the incident and something happens to resurface it
- When a decision is made not to pursue a case

> *'When the DPP had decided not to pursue the case. That sent me into a black hole of despair. My GP, my husband and the counsellor were the only people who know and they rallied around me to try and support me. That was six years ago now and it is still difficult.'*
>
> (Survivor of sexual violence)

- When a case is settled (especially where verdict is not what the individual would have considered fair)
- When the perpetrator is released from prison.

Some individuals and services providers alike had concerns in relation to the particular consequences of an accidental historical sexual abuse disclosure when attending mental health services. Mandatory reporting requires health staff to report the disclosure to Tusla, Child and

Family Agency which in some instances can have a negative impact on the relationship between that staff member and the individual. More critical for service providers and individuals was the ceasing of the provision of services until the disclosure was dealt with.

While the study focuses on the needs of adult survivors of sexual violence/abuse various services and individuals had concerns in relation to what happens to young survivors of sexual abuse when the turn 18 years. Currently young people who have experienced sexual violence can attend the Health Service Executive Child and Adolescent Mental Health Services (CAMS) for counselling, however when they turn 18 this service ceases and they must attend an adult service. There was a clear view that as young people turn 18, they should be automatically referred to a relevant adult service.

3.3.2 Primary care health needs

GP's were the third most frequently mentioned place individuals who experienced sexual violence reported they sought help from (behind Rape Crisis Centres and friends). Some individuals had a positive experience, while others experiences were less positive.

'My GP was great, she listened, she took me seriously and she helped me plan what I wanted to do.' (Survivor of sexual violence)

'After a few visits my GP said there had to be more going on that what I was saying. I found I could not say it, so she got me to write it down. She was the first person I told, she was great, she believed me and that made such a difference'. (Survivor of sexual violence)

In many instances individuals and service providers reported that GP's were either too busy/did not want to know/or did not what to do.

'I went to my GP with various symptoms, but they never probed so I changed my GP.' (Survivor of sexual violence)

'GP's can be dismissive; they can also be too busy or too nervous about probing what is going on'. (Survivor of sexual violence)

3.3.3 Accident and Emergency (A&E) Services

A&E can be a place where people disclose sexual violence. Where this happens in Mullingar, staff in A&E will encourage the individual to go to SATU upstairs and will request a SATU staff to come and have an informal conversation with the individuals talking them through what attending the SATU would involve. The final decision to attend SATU or not is of course the individuals.

Key needs:

- Wider recognition of the negative effects of sexual violence on an individual's mental health.
- Reconsider the decision to cease mental services following a disclosure of historical sexual abuse, until after the disclosure is dealt with.
- CAMS to proactively connect young people who have experienced sexual violence, to a relevant adult counselling services when they turn 18 years of age.
- GP's and other key health professionals need to be trained to probe whether sexual violence is an issue and what the associated referral pathway is for individuals who have experienced sexual violence.
- Staff working in A&E's without a SATU must be aware of where their nearest SATU is and bring it to the attention of any one disclosing sexual violence.

3.4 Policing, reporting and the legal system (the DPP and the Courts)

3.4.1 An Garda Síochána

Individual's experiences in relation to An Garda Síochána appeared to depend on the particular Gardaí they had contact with. In particular, the first Guard an individual meets is very important and it can be very helpful, if this is a positive experience. Most of the experiences described were positive.

> *'I was lucky I was dealing with the same Garda most of the way through. Although at the very end, another Garda was assigned which was hard.'* (Survivor of sexual violence)

> *'I had to go to the station.....to make my statement. I was so nervous. It took six hours and the statement was 26 pages. They were good to me they gave me lots of cups of tea and biscuits. I liked that they were not in uniform and I didn't feel not believed.'* (Survivor of sexual violence)

Some of the less positive reported experiences related to being left waiting in the public office for some time, while awaiting to make their formal statement, as well as late notifications of court dates and/or prisoner releases.

> *'The Garda lets me know very late, about everything that is happening, I feel I should know a lot earlier.'* (Survivor of sexual violence)

Interestingly across a range of service providers who work with the Gardaí there was a clear view that the Guards are increasingly *'better trained and less judgemental'* and *'more victim centered'*. It was also reported that individual Garda are also *'more willing to have an informal chat with an individual, in order to support that individual, make the best decision for them in relation to whether they want to make a formal statement.'*

> *'When I was deciding to make a formal statement, the Centre contacted them (An Garda Síochána) and a Garda came here to meet with me to talk to me about it. That was so hard. But it really helped that she was a female Garda and was very understanding.'* (Survivor of sexual violence)

The Gardaí regarded their role as investigators followed by communicators and connectors in terms of keeping the individual informed and up to date in relation to what is happening. Notwithstanding the Gardaí believed that they were increasingly aware of the needs of individuals who have experienced sexual violence, noting that the embedding in of the various Protective Services Units locally should enhance services and expertise further. Key things the Gardaí recognised they can do for individuals who have experienced sexual violence included:

- *'Make sure the person is safe'*
- *'Recognise that for someone to walk into a Garda station they have to be courageous, and the Gardaí they meet at the desk needs to know this'*
- *'Give the individual information about their options (in terms of the decisions they need to make while also balancing what information a person needs with how ready they are to hear that information.'*
- *'Clearly explain the process of making a statement.'*

- *'Be honest about the court timeframes (Central Criminal Court process can take 2-5 years and Circuit Country can take 3-5 years)'*
- *'Manage expectations from the start (things can go quickly in the beginning then grind to a halt, also the DPP can take 9 months to make a decision)'*
- *'Keep the individual updated on progress (in serious cases the individual can be appointed a Family Liaison Officer)'*

3.4.2 Reporting historical sexual abuse

Accidental and planned disclosures of historical sexual abuse trigger the submission of a report to the local Tusla, Child and Family Agency, Retrospective Child Sexual Abuse Team who must then instigate an investigation to ensure that the alleged perpetrator does not pose a current child protection risk. Where an accidental disclosure triggers a report to be sent it can lead to the client feeling betrayed and ultimately disconnecting from the service provider, often a time when they would benefit most from their support.

Most individuals who disclose abuse do not proceed to make a formal complaint. Where an individual does make a formal complaint their contact with Tusla, Child and Family Agency largely ceases until after they have made a formal statement. Individuals who have been through this process described it as *'traumatic'*. They also reported feeling *'unsupported'*.

'Reporting what happened me as a child was so difficult. I had to go through everything again.' (Survivor of sexual violence)

'When I went to Tusla to make my report. I thought I was meeting with a social worker, but actually it was two social workers. That was difficult, as there was two of them and one of me, also one of them was a man I did not know and was not expecting' (Survivor of sexual violence).

'I met with the social workers, made my statement and that was it, I was done, I think they gave me a few leaflets, this was clearly something they were used to. They told me to leave it behind me, that was easy for them to say. I eventually got a letter saying what their decision was, but the whole thing was really unsatisfactory and difficult. I would not do it again and I would not advise anyone else to do it.' (Survivor of sexual violence)

'I got no feedback from Tusla and when I phoned them, they told me they could not discuss it with me.' (Survivor of sexual violence)

'I understand that the Tusla priority is the protection of children, but they need also to focus on the individuals who have experienced the violence. With the Tusla system, once you give your statement that is it. I was lucky I had some family support but what about people who do not have support'. (Survivor of sexual violence)

Tusla, Child and Family Agency staff report that they have few avenues of referral and most individuals (particularly men) they meet do not regard the Rape Crisis Centres as relevant to retrospective sexual abuse. They can however send a letter to the National Counselling service, to support the individual being prioritised for counselling.

3.4.3 The DPP and the Courts

The individuals who have experience of sexual violence involved in this study, reported little direct engagement with either the DPP or the Courts. Communication from the DPP appeared to be largely mediated by An Garda Síochána.

'I met the DPP once and it was very brief. I don't remember much about it'. (Survivor of sexual violence)

Most were aware however that it was the DPP who make the decision in relation to whether or not a court case would happen. There was a strong view among those who cases did not proceed because of a decision of the DPP that this decision needs to be communicated in person to the individual.

'The Guard phoned me to tell me that the decision had been made not to proceed with the case. This decision was distressing and should not have been communicated by phone.' (Survivor of sexual violence)

For the small number of individuals and service providers involved in a case that got to court both groups noted that the significant time gap between the decision to proceed and the court date.

'We need speedier progressing of cases through the legal and courts system, we cannot begin to move on till the case is ended, whatever the verdict'. (Survivor of sexual violence)

'I feel very sorry for our clients, for many of them their life is on hold till after the case.' (Rape Crisis Centre staff)

For some individuals the fact that the perpetrator was able to see what they had said about them but they could not see what the perpetrator had said about them as part of the investigation was particularly disempowering and in some cases re-traumatising. Individuals also noted that 'when you get to court you are a just a witness with no representation, you are on you own, you do not have a solicitor'. In this context the support provided to one individual by Victim Support was clearly very welcome.

'Victim Support in the High Court were great, they went everywhere with me, they never left me, I had two days being cross examined it was very stressful' (Survivor of sexual violence)

None of the individuals involved in the study had availed of the special measures introduced as part of the Victim Directive

Key needs:

- Continue training and upskilling of existing and new Gardai as part of their continuing professional development
- Establish referral pathways to enable individuals who disclose retrospective sexual abuse to access the supports they need to assist them process and deal with what has happened to them.
- The court system is adversarial and can be a traumatising experience for individuals who have experienced sexual violence. Need to put in place more support for these individuals, thus avoiding the individuals being re-traumatised by this experience (e.g secondary re-traumatisation).
- Reduce the time delay between the decision to proceed with a case and the actual court date.

3.5 Disclosures

3.5.1 The initial disclosure of sexual violence

Many individuals involved in this study described disclosing the experience of sexual violence as '*traumatic*'. Most appear to have disclosed to friends or individuals they trust (rather than family members) in the first instance. The three adults interviewed who experienced sexual violence as children, all reported struggling to tell their parents what had happened and ultimately each told a friend who in turn told their parents.'

'After it happened, I told a family friend, I could not tell my mother. She told my mother, who took me to the GP, who in turn got social workers involved. I was 14, and I was sent to counselling. I went for a year, but I did not tell them much about anything, I was terrified to, so the case was closed. Now I am an adult and as a result of me going to counselling, I have reported it to the Guards the case has been re-opened and they are getting my files from the HSE and the social workers.' (Survivor of sexual violence)

It was also noted within the consultations that sometimes individuals (young people and/or their parents) can disclose in a school or college environment. Where this occurs, in a school environment it is often the job of the school chaplain[70] to report the disclosure and support the individual to access to the services they need. At third level the disclosures are most common to health and related staff. Triggers for disclosure appear to be many and varied.

> *'My experience of sexual violence came back to haunt me after the birth of my child, everyone thought it was a bit of post-natal depression. I knew it was more than that.'*
> (Survivor of sexual violence)

There were also some suggestions by consultees that gender may be an issue in relation to disclosure, with both men and women preferring to disclose to women Among the reasons given for not disclosing were: *'a fear of not being believed', 'not being able to prove it happened' and 'not wanting their children to ever find out'.*

[70] There were 749 secondary schools nationally (Feb 2019) of which 450 have full time chaplains, many of whom have a background in counselling

3.5.2 Disclosures in a domestic violence service setting

The domestic violence service providers consulted reported that while sexual violence is one of the last things to be disclosed to them (if indeed it is disclosed) more women are indeed starting to disclose sexual violence in intimate relationships. The domestic violence service providers also noted that when sexual violence is disclosed is it very rarely referred to as rape.

'Sexual violence gets covered up by domestic violence because domestic violence is more visible.' (Domestic violence service provider)

'Our clients who tell us about experiences of sexual violence don't describe it as rape, it seems that they cannot bring themselves to describe it in those words.' (Domestic violence service provider)

Quite a number of service providers were of the view that sexual violence is often overshadowed and hidden by domestic violence. Responses to sexual violence disclosures in a domestic violence service differed between services.

'Where we get a disclosure, we do not ignore it, we try to get them to help, but we have to fight for services.' (Domestic violence service provider)

In some situations, locally, domestic violence service providers host their local Rape Crisis Centre's to provide outreach from their Centre. Where this is the case the referral process appeared very smooth.

'Rape Crisis Centre counsellors use our offices and can meet people here which is great. It makes it all very easy for the person.' (Domestic violence service provider)

In other situations, a sexual violence disclosure could result in a referral to the inhouse Domestic Violence counsellor, or it if were related to historical child sexual abuse a referral to the National Counselling Service or indeed to CARI. Some services also refer people to their GP. Where an individual was open to making a statement, domestic violence services may also get the Gardai involved. Among the reasons domestic violence services cited for not referring clients to specialist sexual violence services were:

'We only refer the clients that recognise what happened them as rape.' (Domestic violence service provider)

'We don't refer more because, they (the Rape Crisis Centre) does not have capacity to see more people'

'The services SATU provides are not really relevant to our clients.' (Domestic violence service provider)

Interestingly some domestic violence service providers made the case for the need for specialist counselling for women who have had to deal with sustained sexual violence over many years within an intimate partner relationship.

3.5.3 Local authorities as housing providers

Sexual violence is often cited as a contributory factor in individuals becoming homeless, domestic violence (which may or may not include sexual violence) in contrast is commonly identified as the cause of homelessness. Where an individual or family is homeless as a result of domestic violence (which may or may not include sexual violence) local authorities can provide very immediate short-term emergency accommodation but to go on the local authority housing list you have to be below the required income threshold. Where a joint house owner has left the private family home in order for them to be eligible for social housing a legal determination has to be made on the property. A joint house owner is not eligible for Housing Assistance Payment (HAP) unless they commit to pursuing this legal process which can take up to four-years. Local authorities do not fund refuges but refer women to refuges and often end up accommodating the women who cannot be accommodated in refuges. There may be additional barriers for migrants experiencing sexual violence whose legal status is dependent on the legal status on their partner. The Regional Homeless Fora was identified as a very useful structure for local authorities and domestic violence support organisations and refuges to meet.

3.5.4 Disclosure within third level colleges

Increasingly according to the NWCI third level institution have to deal with individuals who have experienced both recent and historic sexual violence. Local third level college staff report ongoing and positive contact with SATU as well as two-way referral with local Rape Crisis Centre's. Some

disclosures happen as part of the work of the healthcare and counselling staff working in the on-campus health centre. The on-campus health centres within the study area is funded and run by the Institute itself.

Among the reasons cited by students for the growing number of disclosures included: Course work (*'that gives a frame for identifying and naming what happened as sexual violence'*); Regular and occasional on campus campaigns run by the Students Union (e.g. SHAG week) as well as high-profile cases in the media. Where students locally present to the on-campus Health Centre they complete an initial assessment form which asks if there is any history of previous sexual assault. Usually a healthcare staff member then reviews the form with the individual and can sometimes spot there is an issue through an individual's body language or indeed hesitation in relation to answering the sexual violence question. In some instance students report a lack of clarity in relation to whether what happened was a sexual assault or not. Noting that legal definitions of sexual violence do not cover all issues e.g. condom removal without consent, uncomfortable sexual relationships, etc. Interesting students and staff alike believed that having an embedded-on campus health service (where individuals could access support) protects the confidentiality of individuals. They also noted that students are more likely to access on-campus counselling that off-site counselling, given that they can easily access the centre when on campus and can schedule appointments to fit around their lecture schedule.

3.5.5 Key needs in relation to disclosures

Key needs include:

- Domestic violence services need to act as a gateway and support for women who have experienced sexual violence to access specialist sexual violence services. This is particularly important where women do not recognise what has happened to them as rape or other sexual assault, as they are very unlikely to attend Rape Crisis Centres without this support. Domestic violence support workers need to be able to refer to and draw from the expertise of Rape Crisis Centres and SATU staff.
- There is a need for connection/linkages between domestic violence services, Rape Crisis Centres and the local SATU within the study area.
- There is a need for more collaboration/shared training between domestic violence services and Rape Crisis Centres.
- There is a need for specialised input from Rape Crisis Centres and from SATU for school chaplains and the staff in third level institutions who primarily deal with individuals who have experienced sexual violence.

3.6 Social inclusion

There are some groups which present to services in consistently lower numbers that would be expected. This section explores the particular needs of these different groups.

3.6.1 Non-Irish nationals

The specialist sexual violence services report that they see greater numbers of EU nationals attending their services, than individuals from other parts of the world, or individuals living in direct provision. Individuals living in direct provision are generally referred to the specialist services by their solicitor or by FLAC. There is also evidence from a study done by the Young Women's Christian Association of Ireland (YWCA 2018) that many Christian women (69% which represented 414 individual women, many of whom were non-Irish nationals) are likely if they experience /witness domestic/sexual violence to speak about it to their church leaders. Notwithstanding, this assertion, currently few if any referrals come from church leaders.

Interestingly Sligo Rape Crisis Centre when delivering a sexual violence education awareness programme in their local direct provision centre reported that a high level of unmet need emerged.

Concerns were raised by a number of service providers that often non-Irish nationals who have been abused/raped by Irish nationals can be reluctant to make report in case it impacts on their residency/claim for asylum. Services also note that FGM is an issue for women and girls from certain countries/communities where FGM is practiced.

Different cultural norms can also mean that in some culture's males are dominant and it can be acceptable for them to have multiple sexual partners and not to use contraception. For females brought up with these norms, while they may seek to look after their sexual health (attend for STI screening) they will not do anything further, given that this behaviour is considered normal where they come from. Service providers also noted that they have found that young non-Irish nationals can be reticent about divulging that they are sexually active as in a lot of cultures sex outside marriage is frowned upon and in some cases forbidden. The implication being that this reticence in turn could prevent disclosure.

SATU, some health services and An Garda Siochána by arrangement are able to provide interpreters but the Rape Crisis Centres do not have the necessary resources to do this. Service providers reported lots of challenges in relation to accessing quality interpreters.

'We are not going to risk a poor interpreter; we will wait till we have the right interpreter before we start.' (Service provider)

3.6.2 Travellers

Since responsibility for Rape Crisis Centres (and Domestic Violence Services) transferred to Tusla, Child and Family Agency there were some anecdotal suggestions that there may be an associated drop in numbers of Travellers attending these services, linked to child protection fears among the Traveller community.

Travellers who present to the specialised sexual violence services generally self-refer or are referred by the Gardaí, while presentations to the Gardaí generally, come through a third party. Historical sexual abuse disclosures have become more common among the Traveller community. In some cases, historical sexual abuse disclosures are made in the context of accessing mental health services and supports. In the past this information would have been kept within the family. It was noted that Individual Travellers are very unlikely to disclose sexual violence to Traveller Health Workers, because of the embarrassment and shame. Rape Crises Centres, Domestic Violence services and participants attending Traveller focus group also report that Travellers can tend to view sexual violence as rape or incest, but not consider rape within marriage as rape. It was noted that having a Traveller Social worker can be a support in terms of generating trust and getting individuals to open up.

3.6.3 Individuals with disabilities

The European Disability Strategy (EDS) 2010 – 2020 recognises that females with disabilities are more likely to be victims of physical and sexual violence, and neglect, than those without disabilities. They are also more likely to be less well protected. Contributing factors to the vulnerability of women with disabilities have been identified[71] as:

- Discrimination, social prejudice and the non-recognition or non-acceptance of the same rights for a
- disabled person as for the rest of the population
- Male values, attitudes and behaviours
- 'Devaluing' of disabled women

[71] NWCI (2009) Disability and Women in Ireland 'Building Solidarity and Inclusion' (https://www.nwci.ie/download/pdf/disability.pdf accessed 7th June 2019)

- Portrayal of disabled people as vulnerable beings easily under control

The specialist sexual violence service providers report that people with disabilities present to their services in very low numbers and are generally either self-referrals or referred by a social worker.

3.6.4 Individuals from LGBT+ communities

The specialist sexual violence services report receiving very limited referrals from this group. Most individuals they see are self-referrals or referrals from direct provision through a solicitor. Individuals from this community also occasionally present to the Gardaí. When individuals do present, they generally say very little about what has happened to them. Service providers believe that the reluctance to say anything about what has happened can be linked to *'high levels of shame'* and even higher *'levels of self-blame'*. Some service providers went further believing that the lack of disclosure was in some way linked to a *'fear of letting down the wider LGBT community'*.

3.6.5 Men

Sexual violence can be perpetrated against men, by women and by men. All service providers report that men struggle to disclose sexual violence linked to gender conditioning that 'speaking about feelings (particularly hurt and pain) makes them vulnerable' and 'is a sign of weakness' and they 'should be able to deal with what has happened by themselves'.

Service providers are off the view that most male disclosures of sexual violence are accidental, and generally emerge in the context of a one to one engagement often with a health professional. Where there is a disclosure, service providers will encourage the man to access support but often meet strong resistance to attending any form of support.

'The men I meet will not attend groups and they do not see Rape Crisis Centres as someplace for men to go.' (Service provider)

'As I see it there are a lot less services for men and few if any dedicated services.' (Service provider)

Service providers note the particular complexities that exist for men who are *'both perpetrators and victims'* remarking that there are very little supports for this group of men.

3.6.6 Elder (sexual) abuse

The issue of elder sexual abuse was not raised by any of the consultees.

3.6.7 Key social inclusion needs

Key social inclusion needs include:

- Increasing referrals from minority groups requires the specialist sexual violence services to build linkages with existing and potential referrers (e.g. church leaders). This will need additional resources.
- Resources need to be located to access interpretations services for those who need them.
- Greater clarity of where there are connections (under the Children First Act) between Child Protection Services and Tusla, Child and Family Agency and funded Rape Crisis Centres/Domestic Violence Services and also where there are not connections.
- Work with Traveller community to raised awareness that rape within marriage is sexual violence.
- Need to ensure existing services are seen to be open to men.
- Elder sexual abuse is an area that needs further research as part of that process need to engage with the Safeguarding Vulnerable Adults Team/s locally.
- Need to breakdown the data to provide details on update of services by minority groups.

3.7 Awareness and Prevention Education

3.7.1 Awareness education

It is clear from the consultations that there is a lack of clarity across wide sections of the community in relation to what constitutes sexual violence.

> *'Did not recognise what happened to me as rape at the time.'* (Survivor of sexual violence)

> *'Didn't realise that there was such a thing as rape within marriage.'* (Survivor of sexual violence)

It is also clear that there is a lack of understanding among both services providers and service users of the breath of services offered by the specialist sexual violence service providers.

'I thought the SATU was just for people who had been recently raped and who needed to have forensic evidence collected. I had not realised you could attend for sexual health screening months after the event'. (Domestic violence service provider)

'I didn't know the Rape Crisis Centre would provide support to someone like me, I thought it was about recent rape, I didn't know they would also help with dealing with child abuse.' (Survivor of sexual violence)

3.7.2 Prevention education

The consultations also highlighted the absence of understanding among some groups of what constitutes a normal healthy sexual relationship and what constitutes consent. They also highlighted the absence of boundaries (including the issue of sex without protection) often linked to limited/no sex education, peer pressure and increasingly readily assessable pornography.

3.7.3 Key Awareness and Prevention Education Needs

Key needs include:

- Need ongoing awareness raising of what services the specialist services provide with a) key referrers and b) service providers locally (e.g. Duty Social Work Team, schools, sporting organisations, etc.)
- Need to raise awareness of sexual violence across services providers. Need to encourage service providers to ask where relevant, whether sexual violence is an issue for the individual presenting
- Individuals and particular groups (e, g students) need to be better informed about what constitutes a) healthy relationships and b) consent.

3.8 Sexual Violence Services Resources, Coordination and Planning

3.8.1 Specialist services resources

It is clear from various consultations that specialist sexual violence services locally are stretched, and depend a lot on the goodwill of their staff to meet current demand for services. For example, in the study area in order to meet the demand and keep waiting times to a minimum some Rape Crisis

counsellors see more than five clients a day (while good practice suggests that counsellors see a max of 4-5 clients a day)

The recent national SATU review[72], has identified ten practical actions to enhance SATU services nationally. These actions include increased levels of investment in the service; an increase in the number staff across the Units. The implementation of these actions is expected to ease pressure at the Mullingar SATU. Meantime the pressure continues in the Rape Crisis Centres.

The majority of staff working in the two Rape Crisis Centre's are part-time because of resource issues. In addition, there is an expectation that the services will undertake fundraising to cover the cost of provision of some services. In Tullamore the counsellors are all self-employed and are responsible for looking after their own support and supervision, while the staff in Athlone receive support and supervision as part of their contract. There is no allocation of resources for the provision of supervision for volunteer support workers who provide the SATU accompaniment services. These workers have also had their travel expenses cut as a result of a shortage of resources. Permanent and sessional staff also had a number of pay cuts, which have never been restored since the recession, with staff burn out a real fear.

The focus of both of the Rape Crisis Centres is on using existing resources to provide the direct therapeutic support required by the individuals that contact them. This means that there are no resources available for prevention or awareness raising work and with no proactive advertising of the services, as the services struggle to meet existing demand

Key needs:

- Implementation of the 10 National SATU Review Actions
- Review of Rape Crisis Centre staff's salaries, terms and conditions, with a view to reinstating pay cuts and bench marking salaries against other similar services
- Resource support and supervision for all Rape Crisis Centre staff and volunteers
- Resource the provision of admin support, freeing other staff up to do prevention and awareness raising work
- Provide sufficient additional resources to enable the Centre's recommence their Awareness Raising and Prevention works (including talks, regular leaflet drops across health service providers and others, engagement with marginalised groups, etc).
- Ensure both services to establish/maintain a web presence.

[72] Dept of Health (2020) Policy Review: Sexual Assault Treatment Units Summary.

3.8.2 Connections and coordination

Relationships between the three specialist services are generally good. However, the opportunities for the three services to meet are limited and generally ad hoc.

The connections between some domestic violence services and SATU would appear somewhat limited as indeed they are between these services and some of the Rape Crisis Centres.

Key needs:

- There is a need for more formal and regular connection/linkages between domestic violence services, Rape Crisis Centres and the local SATU within the study area.
- Establish a local liaison group to support communication between services. This group could meet 2-3 times a year and ideally would involve Tusla, Child and Family Agency, SATU, local Rape Crisis Centres, local Domestic Violence Services and Athlone Institute of Technology Health Centre.

3.8.3 Planning for the future

The National Planning Framework[73] envisages an additional 1 million extra people in the country by 2040, putting increasing pressure on all services. All the evidence nationally and locally suggests that the numbers of people who have experienced sexual violence and who need support is much higher that the numbers presenting to services for a whole range of well documented reasons, even as the numbers of people reporting grows. As one service provider described it:

'We are only hitting the tip of the iceberg with our current services.' (Rape Crisis Centre staff)

The focus of the current specialist provision offer is sexual health and one to one therapeutic and in some cases accompaniment support. Best practice suggests that a more complex service is needed that meets the different and wider support needs of survivors and that provides more pathways to facilitate survivors moving on. This more complex service could include phone support, one to one counselling, group therapeutic support, as well as online support and one-off education and awareness programmes.

Key needs:

- Need to resource existing services sufficiently to enable them meet the growing numbers and complexity of presenting issues
- Need to develop a more complex service (that involves more than one to one counselling (e.g. peer support/group work, online courses and materials) that meets the different and

[73] http://npf.ie/project-ireland-2040-national-planning-framework/

varied needs of individuals and that offers these individuals a pathway (e.g. there are different phases of support) for moving forward.

4. Conclusions and recommendations

4.1 Conclusions

4.1.1 What is working well?

Local specialist sexual violence services where they exist provide those who attend with some key supports including therapeutic and, in some cases, accompaniment supports and clinical, forensic and supportive care. Service users place significant value on the services they locally receive and the quality of the staff in the specialist services. Some local domestic violence services host outreach for the Rape Crisis Centres and this is helpful in terms of facilitating domestic violence client's access to Rape Crisis Centre supports. The specialist sexual violence service providers have developed useful connections with some key local service providers including the local Gardaí. The local Rape Crisis Centres largely through the goodwill of their staff manage to see all referrals in about two weeks. This compares favourably with waiting times for other Rape Crisis Centres outside the study area.

4.1.2 What is working less well?

There is no specialist sexual violence service provision in Co Meath or Co. Roscommon respectively. The mandatory reporting of disclosures of historical sexual abuse often has a negative impact on the relationship between the service provider and the individual. The cessation of mental health services until a disclosure is dealt with is also challenging for the individual in question. A DPP decision not to pursue a case is always going to be difficult for the individual involved to process and as such needs to be delivered in person to the individual. The time delay between the decision to proceed with a case and court hearing is very difficult for the individuals involved.

Referrals to Rape Crisis Centres services (e.g. domestic violence services, GP's, etc.) to the specialist services are lower than might be expected, given the statistics on the incidences of sexual violence. The rural nature of the study area and the lack of a comprehensive public transport system, means that those who do not have access to private transport are at a disadvantage in terms of accessing what services that do exist. Certain groups (e.g. Travellers, Men, Non-Irish Nationals, etc.) are less likely to present for services than others.

For individuals whose first language is not English, interpretation services are only available within SATU and often only during working hours. Interpretation services are not available in the Rape Crisis Centre because of resourcing issues (e.g. cost, availability and accessibility of skilled and specialised interpreters etc.). There is a concern that many service providers do not ask directly whether sexual violence is an issue because of their lack of awareness of the signs and symptoms of sexual violence as well as a lack of awareness of what supports are available locally.

4.2 Gaps/need and recommendations to address gaps

I. Specialised services for victims/survivors of sexual violence

Individuals, who have attended the Rape Crisis Centres and/or SATU locally, clearly valued the support they received and the staff they met there. The key needs in relation to specialist sexual violence services related to the need to be connected to therapeutic supports (ideally specialist sexual violence) services and clinical/sexual health supports as soon as possible and as close to home as possible.

- **Recommendation 1:** Provide outreach Rape Crisis Centre services in Co Meath and Co. Roscommon as a matter of priority
- **Recommendation 2:** Increase the number of outreach provision locations in Co Laois and Co Longford respectively where demand arises.
- **Recommendation 3:** Provide sufficient resources to enable the Rape Crisis Centres to see people in crisis as early as possible but with a maximum of a one-month period (without having to rely on the goodwill of Centre staff).
- **Recommendation 4:** Where there are no sexual violence specialist services recognise that individuals will attend non-specialist services that are local and that are quickly accessible. Provide these non-specialist services with inputs in relation to how they can best support individuals who have experienced sexual violence.
- **Recommendation 5:** Support the implementation of the 10 Actions arising from the national review of the SATU's. Together with the relocation of the Mullingar SATU to a quieter location where individuals and Gardaí can attend without being observed.
- **Recommendation 6:** Raise awareness of the sexual health screening role of SATU among local service providers, leading to increased referrals to SATU

II. Health needs

Individuals who have experienced sexual violence can present to a variety of health services with a variety of health needs. Disclosures (planned and accidental) of sexual violence are not uncommon for GP's and at A&E and are more frequent for individuals attending mental health services.

- **Recommendation 7:** Raise awareness of the various negative effect of sexual violence on an individual's mental health.
- **Recommendation 8:** Raise awareness of the consequences of the decision to cease mental health services following a disclosure of historical sexual abuse, until after the disclosure is dealt with.
- **Recommendation 9:** Ensure that young people who have experienced sexual violence and who are engaged with Child and Adolescent Mental Health Service (CAMHS) are referred as needed to a relevant adult counselling service to continue with their therapeutic support.
- **Recommendation 10:** GP's and other health professionals should be trained to probe whether sexual violence is an issue and what the associated referral pathway is for individuals who have experienced sexual violence.
- **Recommendation 11:** Staff working in A&E's without a SATU need to be aware of where their nearest SATU is and what services they offer, and be proactive in terms of bringing it to the attention of anyone disclosing sexual violence.

III. Policing, reporting and the legal system (the DPP and the Courts)

Individual's experiences in relation to An Garda Síochána appeared to depend on the particular Gardaí they had contact with. The Gardaí appear to be increasingly 'better trained' and 'more victim centered'. Most individuals who disclose historical abuse do not make a formal complaint. Those that do find this process difficult, with limited/no support or referrals pathways to support. Individuals who experienced sexual violence report having little contact with either the DPP or the Courts but note that the decisions of the DPP and the judiciary can have a profound effect on them, in terms of the decision to/not to prosecute and the time it takes for the case to come to court. The adversarial nature of the court system was also challenging for the individuals who reported appearing as witnesses for the prosecution.

- **Recommendation 12:** Continue training and upskilling of existing and new Gardaí as part of their continuing professional development.
- **Recommendations 13:** Tusla, Child and Family Agency to establish referral pathways to ensure and enable individuals who disclose retrospective sexual abuse are (with the individuals consent), referred to the services they need, to assist them process what has happened to them. (Currently there are no automatic referrals).
- **Recommendation 14:** Put more supports in place to support individuals attending court in order to avoid secondary re-traumatisation.

- **Recommendation 15:** Prioritise sexual violence cases and reduce the time delay between the decision to proceed with a case and the actual court date.

IV. Disclosures

Disclosing (accidentally or planned) an experience of sexual violence is traumatic. Triggers for disclosure are many and varied. Many individuals report being more comfortable disclosing to a person of the same gender. A fear of not being believed and a fear of not being able to prove what happened are among the most common reasons for people not/being slow to disclose. Sexual violence disclosures are not uncommon in domestic violence services and in schools and colleges.

- **Recommendation 16:** Domestic Violence services and Rape Crisis Centres need to develop clear collaborative referral pathways when supporting victims of sexual violence in intimate relationships.
- **Recommendation 17:** More collaboration/shared training between domestic violence services and Rape Crisis Centres.
- **Recommendation 18:** More input and support from the specialised sexual violence services for school chaplains, guidance counsellors etc. and the staff in third level institutions who primarily deal with individuals who have experienced sexual violence.

V. Inclusion

Some groups consistently present to specialist sexual violence services in lower numbers that would be expected.

- **Recommendation 19:** Provide clarity about the nature of the connections between Child Protection Services and Tusla, Child and Family Agency funded Rape Crisis Centres.
- **Recommendation 20:** Raise awareness of issue of consent and linked to this awareness of rape within marriage/and committed relationships as a form of sexual violence.
- **Recommendation 21:** Existing services to be seen as non-gender specific and open to all.
- **Recommendation 22:** Elder sexual abuse needs further research as well as engagement with the Safeguarding Vulnerable Adults Team/s locally.

VI. Awareness, prevention and training

There is a lack of clarity across wide sections of the community in relation to what exactly constitutes sexual violence and what constitutes a healthy relationship.

- **Recommendation 23:** Undertake ongoing awareness raising of what services the specialist services provide with a) key referrers and b) service providers locally (e.g. Duty Social Work Team, schools, sporting organisations, etc.)
- **Recommendation 24:** Train and support wider service providers (GP's Dentists, etc.) to ask directly whether sexual violence is an issue for the individual presenting
- **Recommendation 25:** Deliver awareness raising programmes/interventions for individuals and groups in relation to what constitutes a) healthy relationships and b) consent.

VII. Resources, coordination and planning

Specialist sexual violence services locally are stretched and over dependent on the goodwill of their staff to meet current levels of demand for services. Relationships between the three specialist services locally are good but opportunities to meet collectively are limited. The focus of the current specialist provision offer is sexual health and one to one therapeutic support. Best practice suggests that a more complex service is needed that meets the different and wider support needs of survivors and that provides more pathways to facilitate move on as well as access to services or individuals living at a distance from the specialist services.

- **Recommendation 26:** Review Rape Crisis Centre staff's salaries etc. with a view to bench mark salaries against other similar services.
- **Recommendation 27:** Ensure there is adequate resourcing to:
    - Provide support and supervision for all Rape Crisis Centre staff and volunteers
    - Provide adequate admin support
    - Enable the Rape Crisis Centre's recommence an active programme of awareness raising and prevention work
    - Establish/maintain an ongoing and active web presence.
    - Ensure the specialist sexual violence services can meet the expected increase in disclosure levels and the complexity of presenting issues.
    - Enable services (that involves one to one counselling, group work, peer support, on-line content and support materials) meets the different and complex needs of individuals, providing a clear pathway for moving forward.
    - Enable services access modern communication technologies including (video conferencing), reducing resources spent on travel.
    - Enable the specialist sexual violence services build linkages with minority groups
    - Provide interpretation services for those who need them.
- **Recommendation 28:** Revisit the membership of the existing SATU Multidisciplinary Group to ensure it functions as a useful local liaison group supporting communication

between the specialist service providers and key referrers (e.g. Tusla, Child and Family Agency, local domestic violence service providers, CYPSC's and Athlone Institute of Technology).

- **Recommendation 29:** Locate additional resources to enable the specialist sexual violence services use the media to raise awareness of the services they offer.
- **Recommendation 30:** Review the existing led model used to provide SATU accompaniment support locally, to ensure it can meet the needs of service users.

Appendix 1 Membership and meetings of the Advisory Group

Organisation	*Name*
An Garda Síochána	Justine Reilly Sergeant
Athlone Midlands RCC	Ina Stanley Director
Athlone IT	Lisa Hanlon Healthy Campus Co-ordinator
Dublin RCC	Noeline Blackwell Director
CYPSC	Gráinne Reid Coordinator Longford/Westmeath
Longford Women's Link	Angela Keaveney Domestic Violence Coordinator
Mullingar SATU	Nessa Gill, Sexual Assault Forensic Examiner
Tullamore RCC	Catherine Dooley Manager
Tusla, Child and Family Agency	Mary Roche Senior Sexual Violence Co-ordinator
	Anita Clancy Clarke, Sexual Violence Co-ordinator

Meeting date	*Meeting purpose*
26th September 2018	Initial meeting of the Group with the consultant, identification of the consultee groups
21st November 2018	Discussion of the research instruments, organisation of the various consultations
9th January 2019	Discussion of the literature review
13th February 2019	Update on progress in relation to the various consultations and sign off on the on-line questionnaire
18th September 2019	Discussion of the draft report

Appendix 2 Consultations undertaken for the NAP

Consultations with Individuals who have experience sexual violence	
In person interviews	Three individuals who accessed services from the Athlone Midlands RCC
	Two individuals who accessed services from the Tullamore Rape Crisis Centre
Telephone Interviews	One telephone interview with an individual who accessed services from the Tullamore Rape Crisis Centre
	Two telephone interviews with individual who accessed services from a local Family Resource Centre
Online survey	19 responses in total, 18 valid responses

Consultations with Service Providers		
Type of Consultation	*Organisation*	*Representative*
National Level Interviews (14)	National Sexual Assault Treatment Unit Services	Dr Maeve Eogan, Medical Director
	COSC	Pat Carey
	Office of the Director of Public Prosecutions	Gareth Henry, Head of Victims Liaison Unit
	An Garda Síochána	Kate Mulkerrins , Executive Director Legal
	The Men Development Network	Sean Cooke
	Akidwa	Salome Mbugua
	SPIRASI	Aisling Hearns
	LGBT Ireland	Paula Fagan, CEO
	YWCA	Audrey Wilson, Director General
		Ally McGeever, Development Officer
	Balseskin HSE Medical Unit Balseskin Refugee Reception Centre	PJ Boyle, Clinical Nurse Specialist
	Jesuit Refugee Service	Áine Lambe, Intercultural Project Worker
	Dublin Rape Crisis Centre	Noeline Blackwell, Director
		Freda Somers, Therapist
Regional level interviews (7)	Galway Rape Crisis Centre	Cathy Connolly, Executive Director
	Sligo Rape Crisis Centre	Trish Flynn, Director
	Mayo Rape Crisis Centre	Loretta Brosnan McDonagh, Director of Services
	Crisis Centre North East (Dundalk)	Grace McArdle, Manager
	Dundalk Outcomers	Bernadine Quinn, Manager
	SATU Donegal	Connie McGilloway, Forensic Nurse Examiner
NAP area specific interviews (15)	SATU Mullingar	Nessa Gill, Forensic Nurse Examiner
	HSE Psychiatric Services	Colette Moriarty, Psychiatric Liaison Nurse (Mullingar)
	Tusla, Child and Family Agency Adult Retrospective Disclosures of Sexual Abuse (Tullamore)	John McGuire, Social Worker
	HSE Community Mental health Services	Aine Regan Carroll, Senior Social Worker, Longford
	Roscommon Safelink (Domestic Violence Service)	Ann Carey, Manager
	Meath Women's Refugee and Support	Sinead Smith, Manager

	Services	Deirdre Murphy, Worker
	Westmeath County Council	Kieran Sutlar Housing Welfare Officer
	Peadar Tobin TD	Peadar Tobin TD
	School Chaplin	Evelyn Breen
	Lus na Greine Family Resource Centre (Granard)	Eileen Finan, Manager
	Westmeath Communlly Development	Maria Duffy, Synan Refugee Re-settlement Officer
	Meath Springboard Family Support Services Navan	Sé Fulham Manager
	Kells Family Resource Centre	Angela Murphy, Manager
	National Counselling Service (Galway, Roscommon and Mayo)	Mary Kilcommins, Director
	National Counselling Service Rian Counselling (Navan)	Anne Matenson Business Manager
NAP Area Specific Focus Groups (6 groups with 49 individuals in attendance)	An Garda Siochána (Mullingar Station)	10 Gardai from across the study area in attendance
	Athlone Institute of Technology	5 attendees (including staff and student representatives
	Athlone Midland Rape Crisis Centre and Tullamore Rape Crisis Centre	7 attendees
	Tusla, Child and Family Agency Child Protection Duty Social Work Team	15 attendees
	Local Domestic Violence Services	8 attendees representing Longford Women Link, Laois Domestic Abuse Services and Offaly Domestic Violence Support Service
	Offaly Traveller Movement	6 Traveller Health Workers attended

Appendix 3 Profile of survey respondents and individual interviewees.

Survey Respondents

The survey was promoted by Rape Crisis Centres inside and outside the study area. it was also promoted by some of the local domestic violence services.

All 19 respondents who took part in this on-line survey were individuals who had experienced sexual violence. One respondent was under 18 years of age and as such was removed from the sample.

Of the 18 valid responses 16 (89%) were from females and 2 (11%) were from males.

53% of respondents were aged between 30 and 50 years old. Four (21%) were aged between 18 and 30 years and five (26%) were aged over 50.

Laois and Offaly had the largest proportion of survey respondents with six and five, respectively. Westmeath had two respondents (as did Kildare which is outside the study area) Longford and Roscommon both had a single respondent as did Galway and Carlow which are also outside the study area)

Individual Interviewees

All eight interviewees had experienced sexual violence and were female. Five interviews were conducted in person, three in the Rape Crisis centre in Athlone and two in the centre in Tullamore. Three interviews were conducted over the phone, with phone interviewees identified by Tullamore Rape Crisis Centre and Lus na Greine Family Resource Centre in Co. Longford.

Four (50%) interviewees were aged between 20 and 30 years, three were aged between 41 and 45, while one was aged 64.

Seven of the eight respondents lived in the study area and one respondent had recently moved out of the study area to a neighbouring county.

At least two interviewees reported having more than one experience of sexual violence

Three interviewees had experienced sexual violence when they were under 18 years of age.

Two interviewees were non-Irish nationals

One interviewee was gay.

Six interviewees had children aged under 18.

Two interviewees presented at a local domestic violence service first and only later disclosed that they had experienced sexual violence.

Appendix 4 Tusla, Child and Family Agency funding of Rape Crisis Centres[74]

Allocation of funds to Rape Crisis Centres (for years 2015 – 2018).					
Location	**Organisation**	**2015**	**2016**	**2017**	**2018**
RCCs in the study area	Athlone Midland Rape Crisis Centre	€107,081	€106,300	€113,100	€110,500
	Tullamore Rape Crisis Centre	€81,300[75]	€84,954	€116,900[76]	€120,300[77]
	Totals	191,050	192,616	232,017	226,818
RCC's adjacent to the study area	Galway Rape Crisis Centre	€333,000	€363,000	€400,805	€373,000
	Dublin Rape Crisis Centre	€1,043,257	€1,087,892	€1,141,627	€1,157,362
	Rape Crisis North East	€138,110	€159,110	€169,110	€179,110
	Rape Crisis and Sexual Abuse Counselling Centre - Sligo, Leitrim and West Cavan	€168,300	€168,300	€184,300	€200,300
	Mayo Rape Crisis Centre	€168,400	€168,400	€188,400	€188,400
	Totals	2,042,117	2,139,318	2,316,259	2,324,990
Other locations	Donegal Sexual Abuse and Rape Crisis Centre	€142,051	€142,000	€168,500	€177,000
	Rape Crisis Midwest	€346,400	€346,400	€361,400	€376,400
	Kerry Rape and Sexual Abuse Centre	€208,000	€208,000	€214,000	€220,000
	Wexford Rape Crisis and Sexual Abuse Crisis Service	€210,800	€210,800	€216,900	€214,300
	Carlow and South Leinster Rape Crisis Centre	€164,299	€163,500	€165,500	€163,500
	Waterford Rape Crisis Centre	€240,200	€240,200	€240,200	€240,200
	Tipperary Rape Crisis and Counselling Centre	€166,100	€166,100	€170,100	€166,100
	Sexual Violence Centre Cork	€290,500	€290,500	€290,500	€290,500
	Kilkenny Rape Crisis Centre	€175,397	€174,900	€179,500	€174,900
	Totals	3,985,864	4,081,718	4,322,859	4,347,890

[74] Zappone, K (2018) Written Answer (13th June 2018) to question from Mattie McGrath on funding to RCC in each of the past four years. (25745/18) (https://www.kildarestreet.com/wrans/?id=2018-06-13a.434)
[75] This does not include the €30,000 provided by the HSE for SATU accompaniment services.
[76] This includes the €30,000 previously provided by the HSE for SATU accompaniment services. Responsibility for the funding of SATU accompaniment services passed from the HSE to Tusla in 2017
[77] This includes €30,000 provided by Tusla for SATU accompaniment services.