COMPARING SEXUAL ASSAULT INTERVENTIONS

# *Comparing Sexual Assault Interventions*

# Summary report

## Recommendations to assess sexual assault interventions and country case studies

This project is supported by the European Union Directorate-General Justice DAPHNE III Programme 2007-2013: *Combating violence towards children, adolescents and women* (Just/2010/DAP3/AG/1395)

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# 1 Executive Summary

- The work of the *Comparing Sexual Assault Project* (COSAI) aims to aimed to improve the effectiveness, appropriateness and humanity of sexual assault interventions for women aged 16 and over across Europe. For this, it has looked at sexual violence research, policy and practice at international, national and local levels across Europe in order to identify existing models of interventions and make recommendations on evidence informed service provision.

- The Benchmarking & Evaluation Tool was designed according to the responsibilities and activities of the medical, legal and socio-political sectors involved in sexual assault response, including how they coordinate their efforts. It is an **instrument of self-reflection** which seeks to assist services, or those commissioning them, to assess what is in place in terms of service planning and provision, and make any changes according to the standards recommended.

- The COSAI project partners pilot tested the Tool with one or multiple services in their countries, including getting input from victims who had used the services. The assessment in each country case examined the effectiveness, appropriateness and humanity of sexual assault interventions in terms of
  - meeting the standards of good practice proposed in the Benchmark & Evaluation Tool;
  - responding to women's needs, both within the service and also according to the multi-sectoral approach, and
  - the extent to which service users are treated with respect, compassion and sensitivity and in a way to minimise any potential discomfort.

- The following general principles regarding the organisation of effective and accessible services can be summarised and form the essence of the COSAI project:
  1. Multi-sectoral services are available and have protocols of action to meet to the short-, medium and long-term needs of sexual assault victims.

  2. All sectors involved in sexual assault service provision acknowledge all dimensions of care and support required by survivors, which are guaranteed through coordination and referral efforts in a way which makes victims feel in control and knowledgeable of the process.

  3. Specialisation on sexual assault interventions is provided, either in the form of a dedicated service or professionals with services, to deal with the sensitive nature of sexual assault and counter prevailing myths and stigmas around sexual violence.

  4. Service users' perceptions on the effectiveness and suitability of services and the pathway to care are included in service design and evaluation.

# 2 Introduction

## 2.1 Context

Sexual assault does not exist in isolation, but within a larger societal problem of violence against women. Sexual assault, rape and other forms of sexual violence against women are prevalent in European societies. The levels across and within countries depends on the type of methodology used to report them. However, these rates likely underestimate the real numbers as this is one of the most unreported crimes and some forms of sexual violence, especially those that include non-physical force or verbal sexual degradation, have higher incidence rates, but may be perceived by victims or perpetrators as normal.

Moreover, it is well documented and accepted that sexual assaults are more prevalent among women than men, and that women appear to be equally at risk of being sexually assaulted as children and as adults. International literature has shown that certain population groups are more vulnerable to being victims of sexual assaults, namely, adolescents, young women, people with disabilities, poor and homeless, sex workers and those living in institutions, prisons or areas of conflict.

Contrary to rape myths involving a stranger, the reality found in studies and surveys is that the perpetrators are generally known to the victim and are likely to be a partner or ex-partner.

Sexual assault interventions from the medical, legal and socio-political perspectives are unequal and some countries have committed more time and resources to appropriately deal with the issue. The scope of the *Comparing Sexual Assault Interventions* (COSAI) work responds to the pressing need to reduce this gap by providing a series of recommended actions and standards which will improve the quality, effectiveness and humanity of services in Europe.

**Definition of Sexual Violence**

COSAI uses the WHO's definition of sexual violence as: any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object.

The expressions sexual assault, rape, sexual abuse and sexual violence are often used interchangeably. This document uses the term sexual assault to describe all forms of sexual violence including rape.

Source:
http://www.who.int/mediacentre/factsheets/fs239/en/

## 2.2 About the Comparing Sexual Assault Interventions project

The goal of the *Comparing Sexual Assault Interventions* (COSAI) project is to improve the effectiveness, appropriateness and humanity of sexual assault services by reviewing current practice and taking on board user attitudes to interventions following sexual assault, and therefore decrease the social, mental and health harm caused to the victims of sexual assault. The project's scope is limited to interventions for women aged over 16. The project objectives are to:

- Define the evidence base of policies and programmes for dealing with sexual assault by reviewing the international literature.
- Explore what models of intervention for victims of sexual assault exist in EU Member States and EFTA/EEA countries.
- Examine the positive and negative impacts of these models of intervention on the health, social and criminal justice outcomes of victims of sexual assault, from the point of view of the victims.
- Compare the acceptability, transferability, effectiveness and efficacy in achieving their outcomes, including by seeking women's views of services provided.
- Develop recommendations on good practice, and tools and training materials to build capacity and promote excellence.

The project developed between April 2011 and April 2013, under the coordination of the National Heart Forum / Health Action Partnership International (HAPI) and support of a steering group of project partners including Liverpool John Moores University (UK), Victim Support (Malta), the Latvian Association of Gynaecologists and Obstetricians (Latvia), the East European Institute for Reproductive Health (Romania) and the Educational Institute for Child Protection (Czech Republic). The Department of Health (England) and the World Health Organization Regional Office for Europe are associate project partners.

## 2.3 Background and purpose of the report

This report summarises the work done in the second phase of the COSAI project within the context of contributing to sexual assault service evaluation. While the first stage of the project used primary and secondary research to map sexual assault interventions policy and practice in Europe and indicators of effectiveness, the second stage assessed how the findings from that work translate into practice in the project's partner countries.

# 3 Evaluating service provision

## 3.1 Benchmark & Evaluation Tool

The work mapping interventions from the COSAI project found that commonly agreed indicators to measure effectiveness and accessibility to services have not been agreed in the research evidence. Sexual assault entails a multifaceted response to medical, psycho-social and legal needs of victims, which requires that each be assessed against multiple domains. It was thus possible to summarise some of the main features of good/appropriate practice in terms of delivering services which ensure comprehensive care and support, and more positive experiences for sexual assault survivors.

One of the key recommendations identified from the research was the need to develop more tools to evaluate sexual assault interventions. To contribute towards these efforts, the COSAI project

developed a Benchmark & Evaluation Tool based on the results from the mapping exercise. The recommended features identified in the research of COSAI were built into the tool as benchmarks or standards against which to assess what is in place in terms of service planning and provision.

The Benchmarking & Evaluation Tool was designed according to the responsibilities and activities outlined in the research from the medical, legal and socio-political perspectives. These are not exhaustive and will vary in different settings depending on the needs and resources available. Therefore, within the context of the setting using the tool, the assessment and recommendations analyse any gaps or distinctive service delivery features in terms of the context, priorities and capacity.

The Tool is not intended to be an international comparator, **it is an instrument of self-reflection** which seeks to assist services, or those commissioning them, to assess the way the work and make any changes according to the standards recommended. Consequently, the general topic areas provide a guide with standards for identifying existing protocols, activities, programming, and their gaps.

The Tool is divided into overall features regarding coordination and response in each local area where the services operate and then by the primary service needs involved in addressing sexual assault: forensic and medical services, psycho-social and practical assistance and legal support. Within each sector, responsibilities are categorised according to the service's administrative and response provisions. Administrative provisions are those that are more organisational than activity-specific. In addition to structural delivery of services, there are also some questions on staff perceptions of how services are delivered and what should be improved.

The Tool can be implemented for assessments at various levels: an individual service, all the services provided locally or the national situation in terms of sexual assault service provision and their standards and practices. Therefore, it can be used both by individual service providers and by national or local policy makers and commissioners who wish to review or design sexual assault service provision in their area.

## 3.2 Country case studies

In order to analyse how the research findings translate into practice, as well as to appraise the use of the tool as an instrument to assess sexual assault service provision and planning, the COSAI project partners pilot tested the tool with one or multiple services in their countries.

The assessment in each country case examined the effectiveness, appropriateness and humanity of sexual assault interventions in terms of:

- meeting the standards of good practice proposed in the Benchmark & Evaluation Tool;
- responding to women's needs, both within the service and also according to the multi-sectoral approach, and
- the extent to which service users are treated with respect, compassion and sensitivity and in a way to minimise any potential discomfort.

Each case study concludes with a series of recommendations based on the assessment.

One key addition of the case studies to the overall COSAI project was the incorporation of user perspectives. Through interviews, the case studies reflect the user's appraisal on the quality of the service and the impact it had on their experience, including identifying strengths, weaknesses and improvements.

The case reports were further explored during the project's peer learning missions to partner countries. The objective of these was to review key findings from the case studies and agree key actions to improve services between partners. It was also a way to encourage mentoring between different service providers across European countries so as to build skills and knowledge.

The learning during the visits was around ways to review and improve sexual assault interventions both in terms of how services are delivered and work with each other, as well as changes and recommendations at the policy level. The objective was not only about presenting what others are doing and comparing findings from the each case, but instead the visits focused on transferability of learning in order to have a positive impact on practice. In this sense, the assessment of learning transferability built on a better understanding of the cultural context of what works and why.

The review and feedback from the case studies and peer leaning missions were used to edit the Benchmarking & Evaluation Tool to ensure the context and standards proposed are appropriate to evaluate sexual assault services.

**Overview of the Case Studies**

The work by COSAI partners revealed the different stages in the development of effective and appropriate sexual assault interventions in each country. The UK case, through the example of a Sexual Assault Referral Centre (SARC), demonstrates a high level of commitment, collaboration and sensitisation to sexual violence by service commissioners and providers. The other partner countries suggest several action areas focussing not only on individual service delivery, but especially on increasing inter-agency coordination and awareness-raising efforts to place sexual violence high on the agenda of policy makers and practitioners, and also address existing myths and public perceptions.

### i. Czech Republic

The case study is based on interviews and assessments of services with the Ministry of Health, the Intervention Centre for Domestic Violence in Prague and service users. In the Czech Republic, rape is recognised as a crime and there are action plans and strategies to address the problem by different sectors. However, there is no unified model for sexual assaults and rape interventions. The report found that victims are generally unaware of the services available and are sent to different institutions and authorities, which work independently from each other. Furthermore, these services lack specialisation and training in sexual violence.

The report suggests greater government action to facilitate practical implementation of sexual violence action plans and protocols, as well as fostering inter-agency collaboration, widespread training of professionals dealing with victims and more awareness to victims of their rights and process in the case of an assault.

### ii. Latvia

The Latvian case study presents an overview of the different sectors involved in dealing with sexual violence in Riga. Interviews were conducted with police, legal representatives, social workers, forensic and medical staff, and government officials.

The study found that services are available to deal with all the aspects of sexual assault; however, there is no organisation or system in place which coordinates their efforts. Instead, each works independently from each other and referral systems are inadequate. Protocols and standards for sexual assault or specific training in this area are not common practice and professionals from each sector responds to cases at their own discretion.

The report concludes with recommendations by sector and also at the European Union level to develop multisectoral Sexual Violence Directives for Member States, which should be compulsory in the same way as those for Domestic violence and Child abuse are.

### iii. Malta

The case study focuses on the Three Cities Foundation in the Cottonera Region of Malta. The Foundation works with marginalised groups and individuals, and sees cases of sexual violence victims who receive psycho-social and practical support services. The report is based on an assessment of the results from the Benchmark & Evaluation Tool and how they compare with the experiences of victims with the services of the Foundation and other services available for them.

The findings from this case study suggest that strategies and protocols in agencies exist, but they are infrequently observed and are largely dependent on decisions of individuals. The service user feedback reflected the negative effect from such a fragmented system, especially in terms of knowing what services are available to assists them, and what the process and their rights are. Further, lack of training on sexual assault outside of third sector organisations, meant women who encountered forensic, medical or criminal justice sectors were often revictimised and did not feel supported.

Acknowledging this gap, in 2010 a proposal was made to government by a multi-sectoral Task Force to set up Sexual Assault Referral Team (SART) bringing police, prosecutors, doctors, nurses, hospital social workers, and rape victim advocates together in one location.

### iv. Romania

The Romanian case study report is based on an assessment of the institutions and organisations dealing with Forensic, Medical, Psycho-social and criminal justice services in the city of Tirgu-Mures. The study found that whilst all the services are available, interventions are provided vertically with no coordination between agencies and none fully met with the standards proposed in the tool. One key aspect the study recommends is the provision of free psychological counselling, which at present is only for minors who have experienced sexual assault.

In the assessment of services from the perspective of users, the study found that current provision does not respond to their needs, there is no clear pathway and guidance to seek help and the response from professionals further victimised women.

The report proposes using the transferable learning from the country's recent experience developing legislation and protocols against Domestic Violence for sexual assault interventions. This work was based on a model of decentralisation which distinguishes the roles of the local and national levels in service provision, designing protocols and implementing policy.

### v. United Kingdom

The case study looks at local service provision in the county of Merseyside in the United Kingdom, where sexual assault services are coordinated through the Sexual Assault Referral Centre (SARC) *SafePlace Merseyside* is one of the UK's 40 SARCs. SARCs can be thought of as victim-centred medical units that aim to co-ordinate and simplify the pathway for victims of sexual assault, improve immediate care, aid recovery and boost conviction rates by supporting victims through the prosecution process. SARCs are considered one of the models of good practice in dealing with sexual assault.

The report discusses the services available for victims of sexual assault in Merseyside within the context of national legislation, and provides details of inter-service coordination and multi-sector collaboration. Client pathways and the important role of Independent Sexual Violence Advisors are discussed. The recommendations are based solely on the assessment of service providers and through results from service satisfaction questionnaires, but there was no direct communication with victims during the study.

# 4 General Recommended Principles of Sexual Assault Service Provision

Combining the project's efforts mapping evidence and interventions, and the work on evaluation in partner countries, this section summarises general principles for sexual assault service provision, which represent the core of COSAI's work.

Overall sexual assault service interventions in any given area has to ensure all the domains of care and support can be met, which includes both the availability of services and collaboration and referral between the services. In terms of evaluating individual services, the COSAI Benchmark & Evaluation Tool details the activities and responsibilities which are recommended by sectors.

The following recommendations are therefore aimed at both policy makers and service providers and should serve as general principles against which to assess how they organise effective and accessible services. These points are complemented by more thorough assessment on the different domains of care in the Benchmark & Evaluation Tool.

1. **Multi-sectoral services are available and have protocols of action to meet to the short-, medium and long-term needs of sexual assault victims.**

The main premise of the COSAI project is that responding to sexual assault requires addressing multiple dimensions of care from medical, psycho-social and legal sectors. The following services should be made available to ensure a comprehensive package of care is provided to women to meet their short-, medium and long-term needs.

**Forensic services** are the responsibility of either the criminal justice system or the health sector, depending on the country. Forensic examinations are performed when authorised by the service user to gather DNA evidence and document injuries. These are used to support cases where a survivor chooses to pursue legal action. Additionally, forensic or medical care providers can give testimony in court.

The health sector has primary responsibility to provide ***medical and some aspects of psychosocial and practical services*** in a way that is respectful and supportive, and ensure all staff are sensitised to specific issues around sexual assault through on-going training. Medical services include in the first instance dealing with physical injuries, offering emergency contraception, HIV prophylaxis and vaccinations against STIs (e.g. hepatitis B) and risk of self-harm assessment. Follow up medical services should be facilitated including pregnancy testing, screening for STIs and assessing coping skills.

***Psychosocial and practical services*** can be provided by a range of sectors including the health sector and NGOs. These offer supportive and on-going psychological and mental health assistance to diagnose and provide treatment for conditions such as Post-Traumatic Stress Disorder (PTSD), depression, anxiety and low self-esteem. Collection, documentation and analysis of a clients needs should be done confidentially and support offered as appropriate, such as counselling, support groups or cognitive behaviour therapy. Furthermore, these services should be able to provide practical support to identify a safe haven for women who choose to leave an unsafe environment; provide hotlines to facilitate support and referral to other community-level support organisations.

The ***police*** are responsible for recording a case of sexual assault and conducting a criminal investigation. Police should ideally be trained and prepared to respond to cases of sexual assault in a way that acknowledges the severity and emotional distress of the survivor and does not further victimise them. Elements of positive practice include: designating private meeting rooms within police stations; providing same-sex police officers to work with women who have experienced sexual

assault; creating specialised units to address cases of sexual violence; offering women information about available support services; and instituting on-going training and supervision of police personnel.

The ***legal sector*** includes both the legislature who set the laws, and those involved in the judicial process in cases of prosecution and advice. Where possible, the legal sector should support attempts to review and revise laws where sexual assault is based on non-consent, which better support and protect victims, as opposed to those that are based on coercion and the use of violence to obtain a sexual act from a woman. Legal counselling and representation to women should be free of charge or at a low cost, and judicial proceedings should ideally be conducted in private, to ensure that they are respectful and safe for victims.

2. **All sectors involved in sexual assault service provision acknowledge all dimensions of care and support required by survivors, which are guaranteed through coordination and referral efforts in a way which makes victims feel in control and knowledgeable of the process.**

Because of the multi-sectoral approach necessary to effectively respond to the needs of women who have experienced sexual assault, one critical responsibility of all sectors involved is to acknowledge all dimensions of the care and support required, and try to coordinate their efforts to ensure women receive the care and support they need, instead of working in silos.

There are different models of coordination:

- Sectors can coordinate service delivery programmes (e.g. Sexual Assault Response Teams (SARTs) in hospital emergency rooms, or Sexual Assault Referral Centres (SARCs)), which bring police, prosecutors, doctors, nurses, hospital social workers, and rape victim advocates together in one location.
- Although in different locations, coordination can involve methods of collaborating and making referrals among and between sectors. Referral networks should focus on providing prompt, confidential, and appropriate services to women. Referral should not only be about 'sign-posting' women to services, but accompanying them through the pathway. The latter can be done through trained individuals who provide crisis intervention, emotional support, practical assistance and help to victims whilst working in a multi-agency partnership[*]. Sexual assault takes control from the victims, therefore the process of going through the pathway and services to receive care and support should give them back control.
- Coordination is often achieved through interagency training programmes aimed to create a common understanding of sexual assault by raising awareness and developing knowledge on all areas of care.
- Finally, there are also community-level advocacy groups, which campaign for change through public education, legislative reform, and public demonstrations. The focus of these is not on service delivery, but rather they aim to change the climate in which service delivery occurs so that it is supportive to women who have experienced sexual assault.

[*] In the UK this role is known as an Independent Sexual Violence Advisor (ISVA).

In all these cases, it is recommended that regular meetings be convened involving representatives of the various sectors to review and update any protocols, proceedings and ensure coordination across the services. In this regard, appropriate coordination and referral also entails having effective reporting mechanisms and confidential information sharing between sectors to contribute to minimise the number of times a woman has to explain her experience with each service provider.

3. **Specialisation on sexual assault interventions is provided, either in the form of a dedicated service or professionals with services, to deal with the sensitive nature of sexual assault and counter prevailing myths and stigmas around sexual violence.**

Victims of sexual assault can be affected by emotional distress when they report their experience and how service providers respond can have very profound consequences for receiving appropriate care and later adjustment and recovery. Furthermore, there are existing myths and stigmas around sexual assault from service providers, the general public and victims themselves, which can also have negative effects in victims reporting and experience accessing services.

Therefore, services and interventions must recognise the rights and needs of women as the most important, in terms of access to respectful and sensitive services, guarantees of confidentiality and safety, and the ability to understand and determine a course of action for addressing all their care and support needs.

In this regard, sexual assault specialisation is recommended, either in the form of a dedicated service (e.g. SARC, special units in the police such as Sapphire) or professionals. The latter involves having the staff of services accessed by victims trained in dealing with sexual assault in a way that acknowledges the severity and emotional distress, does not revictimise[†] survivors and is able to understand the multiple dimensions of care and make appropriate referrals to other services.

4. **Service users' perceptions on the effectiveness and suitability of services and the pathway to care are included in service design and evaluation.**

One important aspect of reviewing and assessing service provision is getting input from the actual users of those services. Whilst a service may adhere to the theory of what constitutes standard of care, this may represent an 'ideal' that is not necessarily adhered to in practice or may not adequately meet the needs of all service users.

Therefore, the reflections of service users should also be sought to consider the effectiveness and suitability of services from the client's perspective, identifying ways in which service provision may differ from the practice model, but also allowing an exploration of what service users feel are the strengths and weaknesses or positives and negatives of sexual assault services available locally.

[†] Revictimisation, also known as secondary victimisation refers to victim-blaming attitudes, behaviours, and practices of community service providers that result in additional trauma for rape survivors.

# 5 Annexes

## Annex 1: Czech Republic Case Study Report

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**Background/Introduction**

This case study is based on information about rapes, sexual violence, support for the victims and a comparison of services for sexually assaulted. In addition, information and recommendations from the interviews with victims of sexual violence, rape and sexual assault, mainly in families, have been used. We need to emphasize the fact that this case study is focused on activities and competencies of some social services which offer an expert help to the victims. Unfortunately, little attention is devoted to investigating these crimes in the Czech Republic. They constitute latent crimes, which, in many cases, are not even reported by the victims mainly due to the fact that they are afraid of the procedures, reaction of the society and all the other things they would have to face.

In the Czech legal system, rape is recognized as a crime against humanity (§185 Act No. 40/2009 Coll., the Criminal Code, as amended, hereinafter referred to as „the Criminal Code"). What is protected under the law are the freedom of choice in sexual decisions, humanity, health (both physical and mental) and the life itself. Additionally, other sexually motivated crimes are described in the Criminal Code (such as sexual harassment and abuse). Crimes of sexual assault or violence are sometimes discovered by the police when investigating other crimes, e.g. sexual abuse and violence in relationships.

In the Czech Republic, about 18.000 rapes are committed annually. However, a mere of 3-8% are reported[‡]. There is a high latency of rapes which are never investigated and punished. At the same time, the surviving victims of rapes are not offered an adequate help and support by the criminal authorities and other services.

Even if the rape is reported, the investigation of many cases is put on hold or stopped as there is not enough evidence. The police investigators often report a high number of false accusations (as high as 25% of the reported rapes). However, it is doubtful whether the number of false accusations is actually so high or the false accusations are classified as such based on common misconceptions about a "real rape".

In the Czech Republic, there is no unified model for sexual assaults and rape reporting. Very often, the victims do not know what kind of service to look for and where to find it. The victims are sent to different institutions and authorities, they have to reiterate their testimonies which lead to their reluctance to the cooperation with the police, prosecutors, etc.

[‡] Čechová, J., Jandová, H. et al.: Stop znásilnění. Analýza pomoci obětem znásilnění v České republice. Persefona, o.s., Brno 2010, s. 12

**Methodology**

We need to emphasize the fact that rapes and sexual assaults are also committed in families which constitute the issue of domestic violence. Prosecution of these crimes was codified in the Criminal Code in 2004 (Abuse of a person living in joint abode). In 2007, with a strong NNO support, police may evict a person from a joint abode for a period of up to 10 days, which is the right they exercise quite often. However, this is only a precautionary measure and not a criminal punishment. The police have been trained, the have an internal methodology and work with other organizations in their regions. In 2007, intervention centres were also created as a social service for people threatened by domestic violence. The Association of Intervention Centres Workers has provided background for the intervention centres. Additionally, a person who feels threatened may apply for a precautionary measure with the civil court, even without the eviction of the violent person. If the court grants the precautionary measure, it issues a restraining order for a period between one month and one year. This legal framework has become the model for dealing with cases of domestic violence, which still is a significant phenomenon in social pathology.

Every region of the Czech Republic may have a different approach to dealing with the cases; that is why an interagency cooperation is essential. A reporting for reporting both domestic violence cases and also other sexual crimes is mandatory for doctors, police officer, medics, government clerks and others.

Doctors, for instance, have been using the Ministry of Health methodology for detection of sexual or domestic violence since 2008. However, the interagency and interdisciplinary cooperation is still inadequate.

**Sexual assault services in Czech Republic**

Intervention centres is a social service according to the Act on Social Services and these centres provide psychological, social and legal counselling to people threatened by domestic violence. The workers of intervention centres are legally required to offer their services to the person threatened. In addition, they may help with writing a court petition, finding accommodation and offering contact details of other supporting organizations. The also offer escort to institutions (e.g. court, police, child services, etc.). It is the intervention centres who may very often get in contact with a victim of sexual assault (e.g. in marriage or a partnership), when the victim seeks a different service (e.g. IC), due to the fact that there are no specialized services for these types of victims.

As far as the IC services are concerned, they seem to be adequate to the needs of their clients. The waiting time is also reasonable, it is usually three days. What is missing, though, is the connectedness of services and institutions and sharing of information and experience about specific cases. Recently, an interdisciplinary cooperation has been emphasized as well as a unification of approaches to domestic violence, mainly in connection with risk assessment.

The victims of rape or sexual assault may also seek a different service, such as a crises centre, counselling, social services, etc. However, as interviews with the clients have shown, these services

do not offer consistently valuable help. The victims may also call non-stop lines of different organizations (DONAlinka, linka Rosy) as well as an emergency police line at 15 which is available 24/7. A support for victims or felonies is also offered by Bílý kruh bezpečí (White Circle of Safety) and help for human trafficking victims is offered by La Strada, o.p.s.

**Presentation of findings from the case study service**

Interviews with the users of social services for sexually assaulted have been used for the case study. Due to the fact, that the interviews were scheduled for summer months, i.e. holidays, only 10 interviews have been conducted in 3 organizations. A summary of some interviews follows.

According to a client (from an interview in an IC) there should be a higher level of connectedness between social services and the police; the client had to repeat her statement many times at the police station, doctor´s, forensic expert, the court, and other institutions. There should also be an option for give statement to a male or female officer, the client had to wait for a very long time and endure an interview which took many hours. The client is then, in effect, forced to repeat her statement to several officer multiple times. She also felt, as if she were bothering the officers, she was treated as an unreliable person; the officers appeared not interested in her case. According to her, there should be a higher level of connectedness of services, the officers (mainly the police and court) should be more open and helpful. The client was not adequately informed as to what would follow and about her rights during this phase of investigation/process. She would also welcome an escort to the institution or a brochure which would help her get perspective. She also mentioned an inadequate availability of services in remote parts of the country (the country, small towns), which leads to her abandoning looking for help. Other clients had very good experience with other services such as crises help, asylum houses and medical examination. What they were still missing, though, was a centralization of services at one place. The behavior and attitude of police officers have been described as very bad and inappropriate.

As has been mentioned above, there is a lack of connectedness and specialization of services for the sexually assaulted in the Czech Republic. Very often, the victims use a different type of service, which brings a low level of information, education and a competence of specialists. We also need to emphasize, that many non-governmental organizations in the Czech Republic is funded from a short-term projects, what is missing is the long-term project funding. There are also no exact calculations as to the cost of one day worth of work with a client. The last study of a non-governmental organization Profem is concerned with the financial cost of domestic violence for the system – i.e. what is the cost of social, medical and other services.

One of the reasons for a high latency of rapes and unwillingness or inability to fully investigate and punish these crimes is the prejudices and myths about rapes which are widespread among the public, media and also the specialists (police, forensic experts, psychologists, and courts). Some of the very common myths among specialists include the opinion that the victim of rape is somehow responsible for it (e.g. provocative behavior, alcohol, inappropriate clothing, seduction of the perpetrator), that the perpetrator is a mentally unstable loner and not someone from the victim´s vicinity, that a rape is usually in the form of an assault, that most rapes are false accusations (although false accusations are also common for other), that a person who does not wish to be

raped (have a sexual intercourse) cannot be raped, that only women are raped and that only men are perpetrators and that the sole motive for a rape is an unfulfilled sexual desire.

**Assessment and recommendations**

Here is the summary of information about services provision and from the services users for a case study:

What seems to be the problem is the inadequate number of specialized centres for the victims of sexually motivated felonies as counseling is also needed for victims which have not reported the crime. There is a very low level of awareness about organizations which are essential to get access to help. What is also needed is the expert competence of counsel centres to help and involve other institutions (interdisciplinary cooperation). What is also necessary is the funding for legal and psychological help (including long-term therapy).

Interagency cooperation has also been rather sporadic, the connectedness of the national police, municipal police, medical centres, social services, courts, probationary services, asylum houses, non-governmental and counseling organizations would significantly help with the information sharing which would lead to a more effective help for the victim as public institutions are inherently incapable of getting everything which may lead to a conviction of perpetrator and to a help and support for the victim.

The rape victims have a limited access to legal help, usually free-of-charge, and they also have access to other services (psychological counseling and support, escort to courts, etc.).

The most common problems include the reiteration of interrogations, contact with perpetrator (which is not always necessary), insufficient protection or a surviving victim of rape (e.g. confidential files), many offices involved in the investigation of the crime, etc. In sensitive cases, where there are special victims, the use of recording devices in interrogations and courts must be considered as this may lead to a further victimization and unnecessary contact with the perpetrator. This may be achieved by both legal and technical means (a separation of the victim from the perpetrator, interrogation rooms, re-use of previous records).

Police officers have inadequate knowledge of the topic and they also lack systematic training. Conferences, seminars and various projects are currently being used to share experience among police officers.

As far as the education of the public is concerned, information campaigns may be used realized via the media, including the internet as well as information materials being made available at the police stations, medical centres, public offices, etc. The role of education is also significant as children should learn about the topic and also about possible defense and protection. Children should be taught by educators who have been trained in dealing with the topic.

The education of experts should include the knowledge and information about competencies of all subjects and officers who may get in contact with the victims of rape or sexual assault. This concerns mainly doctors, nurses, clinical psychologists, the police (both national and municipal), forensic

experts, prosecution, the courts and also the workers offering social services. The training of medical personnel including the standardization and professionalization of help for the rape victims must be continued.

What is necessary is that the government and the governmental agencies are concerned with the problem so that a more effective and systematic interdisciplinary cooperation may be achieved. Access to information for experts must be improved. The action plans and strategies, which already exist, must be better put to practice. The government offices must be more interested and engaged in working with the non-governmental organizations. A material for the more effective punishment of a rape and a support for the rape victims is currently being prepared by a governmental committee for the prevention of domestic violence. This material will be submitted to the government for consideration next year.

Both for the individual case study service, as well as for the experience with all the services, the assessment and any recommendations, should also be examined within the same context as the questions above.

The support of education and gaining new experience from other countries is essential in this field. We present the following measures which should be taken into consideration as the project conclusions:

- Connectedness of services, coordination at one place
- Availability of services in small towns and in villages
- Better information awareness of offices and experts; not sending the victims to different institutions.
- Education of experts, who should also be more engaged in investigating and feel empathy for the victims
- Legal requirements for reporting
- The use of technical means in the legal process which may decrease the discomfort of the victims
- Improvement of information awareness of victims about their rights, about the process, getting an escort to an office, better interagency cooperation between the police and social services
- Public education, involvement, reporting about the topic in media
- If there is a similar institution to intervention centres in other countries, it might be suitable to evaluate their competencies and use their experience.

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## Annex 2: Latvia Case study Report

*Sarma Novicāne Lazdāne*
Consultant, Latvian Association of Gynaecologists and Obstetricians, Latvia

**Background**

This case study on sexual assault service was undertaken as part of the project Comparing Sexual Assault Interventions project which is funded by the European Union through the DAPHNE III Programme 2007-2013. The aim of this case study was to identify the mechanisms that exist and do not exist in each service, like forensic, medical, psychosocial and criminal justice. To get to know the positive and negative impacts of these models of intervention on the health, social and criminal justice outcomes of victims of sexual assault, from the point of view of the victims as well from service providers.

The report is based on partially structured interviews of sexually abused victims that were developed on the grounds of the questions anticipated for the focus groups. The report summarizes the interview data provided by the service providers using the benchmarking & evaluation tool developed by the project.

In Latvia sexual assault is a deeply hidden and unrecognized problem about that the society is not ready to talk and discuss yet. Anonymous questionnaire should be anticipated in the research to find out the opinion from as many as possible sexually abused victims about the available services and their quality.

The main recommendations proposed by this case study are the following:

To organize education activates and inform the society. Regular and planned information and education campaigns of the society in the media environment are needed. Making of stories and advertisement rolls in cooperation with all services to educate professionally and establish emotional attitude of the society.

Develop a training system for the professionals who interact with victims of sexual assault. Protocols and guidelines on sexual assault interventions should be established for each sector as well.

More learning should be encouraged and shared between countries to help understand and support the development of different intervention models.

To develop EU directives with recommendations on the legal, medical and psycho-social provisions, how to deal with sexual assault in a way which protects and promotes victims' rights and well-being.

**Methodology**

Seeing that in Latvia no institution (public or private) like a focal point for women who have been sexually assaulted the meetings was organized with different institutions and organizations that provide services for victims. These institutions and organization included:

Police, which investigates the case;

Legal aid which enforce the law and protect women's rights;

Forensic expertise which collect evidence;

Medical aid, gynaecologists, which treat injuries;

Psychological support for mental health;

The research was made in Riga and the surrounding where half of the inhabitants of Latvia live. Interviews were arranged with: psychosocial and medicine workers, providers of legal services, responsible employees of police and forensic medicine experts. The quality, availability and lacks of the provided services were discussed.

Since it was necessary to talk to women who have suffered from assault, the service providers were asked to give the details. All contacted service providers refused it substantiating that the contact details of the victims is confidential and won't be given.

Psychosocial aid services were the only ones who responded to help to find women. The statistics of the consultation of these services is such that during the last year only 5 of all registered consultations were marked as the cases of sexual assault. It stated that it will be impossible to arrange the focus group for women who have suffered from assault. To reach the target group – women suffered from sexual assault, information was put on the social site www.calis.lv

Interviews in presence with two sexually abused women were arranged in the framework of the project: one responded to the information on the internet site, the other was a client of the crisis centre.

**Sexual assault services in Latvia**

In Latvia all services (police, forensic science, medicine, psychosocial and legal services) work that can ensure the support and investigation for women in case of sexual assault. At the same time there is no organization in Latvia that would provide these services in one place. All these services work independently one from another and their operation is not mutually agreed and coordinated.

If an act of sexual assault has happened, a woman can promptly contact or go to the State Police (10min to 1h), she can call the crisis phone and receive immediate consultation.

1. **Police**

First the woman has to submit an application with detailed information about what has happened so that the police can commence a criminal proceeding about the case of sexual assault. Before to write the application, the procedure is explained to the woman how the criminal proceeding will be advanced.

Having written the application, the victim meets the investigation officer and she tells in detail what has happened. The investigation officer is the one who instructs the operative team to collect the materials and sends the woman to the forensic expertise. When all required proofs are collected the accusation is brought and the investigation officer gives the case to the public prosecutor.

The public prosecutor meets the victim and the woman once again has to tell everything that has happened. The case is supplemented with the required documents and the case is delivered to the court. The public prosecutor is the one who determined whether the hearing will be open or closed, he/she can also determined whether confrontation will be arranged.

At the court the woman also has to give evidence and tell in detail what has happened.

The police try to ensure a separate room where the victim can meet the investigation officer and give evidences. In case it is possible the police ensure that the investigation officer is of the same sex. The documentation of cases is stored in locked cabinets.

All actions performed by the investigation officer are based on the Criminal Proceedings Law. A police officer studies at the academy on how to conduct the investigation procedure in 1-2 days lecture course. Training how to work in cases of sexual assault was arranged several years ago.

The police have the information on the psychological support services and they inform also the woman on the possibilities to attend it.

### 2. Legal aid

At the lawyer who works within the framework of the crisis centre it is possible to receive one free consultation. The lawyer provides information on the rights of the woman, and if necessary, he/she helps to write the application to the police. The lawyer informs the woman on her rights, explains the legislation and informs about the investigation procedure.

The lawyers have no standard forms how to work in cases of sexual assault. Action protocols with other institutions are not agreed and approved. The lawyers ground on their experience and knowledge.

### 3. Forensic expertise

Forensic medicine experts perform expertise according to the instruction of the person directing the proceedings (police). The patient arrives herself or she is brought with the transport of the police.

In Riga the dispensary works from 8:30 – 16:00, in other times the expertise is available in the police office or the expert goes to the reception of the medical institution in case the woman has arrived in the police and she needs also medical id.

Forensic medicine experts provide information to the person directing the proceedings, not to the third person. Forensic medicine expertise centre cooperates only with the police and goes to give evidence also to the court; sending to the psychological aid services is not given.

### 4. Medical aid, gynaecologists

Medical aid in Riga is given by the gynaecologist on duty at the reception. The patient can arrive herself or together with the police. The doctor assesses the bodily injuries and their severity and accurately documents them. In case the woman has arrived together with the police, the forensic medicine expert also participates in the examination – forensic proofs are collected at the same time.

In case the woman has arrived alone, the doctor takes the samples according to the protocol – vaginal discharge from the back cupola on two glass slides and a pledget on that a sample from the back cupola of vagina is taken. The samples are stored – if the woman wants to institute a proceeding, they are delivered to the forensic medicine expertise. The woman is informed about the possibility to turn to the police. The medical institution can inform the police about what has happened if the woman wants it. If she refuses – the police is not informed.

Information about the psychological and social support services is given only if the woman asks it.

### 5. Psychological support

In Latvia psychological support is available both in several crisis and consultation centres and also individually at the psychologists or psychotherapists. Women who have suffered from violence can go to these centres or they can be sent by the police or the social service.

Hotline works day and night where the woman can receive psychological support and also information about other support centres and the police. When calling or meeting at presence, the consultant assesses the self-injury risk of the woman, post-traumatic stress syndrome, necessity for safe shelter for the woman and her children. Standard form is not applied in the assessment; instead they use the experience and knowledge how to work in crisis situations. During the negotiation next times for meetings are planned with the woman. If necessary, the consultant contacts also the persons working in other sectors.

In case the victim attends the consultation centre, the number of times the woman has to tell what has happened is decreased within the framework of the particular institution. Action protocols (verbal) are elaborated inside the institution, and giving support is arranged for the woman – a victim of sexual assault. Patient data safety and confidentiality is ensured. All actions are documented. A team of experts has regular meetings where special cases are discussed and supervisions arranged.

In case the woman attends a consultant for a longer period of time, mutual cooperation is discussed and feedback is given. It is offered to fill in a questionnaire and make entries in the book of gratitude and complaints.

Practically all consultants working with the clients study or have already acquired the bachelors degree in psychology or social work. Training about crisis intervention is arranged regularly that can be attended by the consultants at their own initiative.

Most of the psychological support centre work independently of other service providers. Regular meetings are not determined mutually with the service providers working in other sectors. Internet site google is used as the database about the available services.

In Riga there is only one psychological aid service that receives regular funding from the municipality. Finances and activities of other centres depend on the awarded grants and the target groups they are intended for.

In case information appears in mass media about an extraordinary case, the psychologists give their opinion. On the grounds of the event, articles are also published, with that they try to pay attention to sexual abuse and its consequences.

**Presentation of findings from the case study service**

In Latvia sexual assault against a woman is still a taboo issue. Information about it can be found neither in mass media nor on the internet sites. Since it is not talked about, nor educated about this subject, then of course stereotypes and preconceptions predominate in the society.

Psychological support centre are those that try to activate the issue about the sexual assault. They write projects within the framework of which provision of free consultations, arrangement of training for other experts and information of society are ensured. On the grounds of the fact that the awarded funding is not regular and constant, free consultations are also irregular and the educational work is chaotic and without a joint methods.

In case of sexual assault experts from different fields involve. A woman (victim) in such situation has a difficulty to focus attention, remember the everyday things and finding out the, for example, in the police about all investigation process, she feels even more powerless to remember and implement all bureaucratic requirements.

At the moment in Latvian internet environment only one article can be found where the basic items are described what must be done in case of sexual assault.

As all services: police, forensic medicine, medicine, psychosocial and legal services admit, among them there is no purposeful and structured cooperation. Each professional works in his/her area and knows only general things about other service providers. Mostly the information about other service providers is searched on the internet (google), not in common training or seminars. No model (standard) form is elaborated in the services with that to work in cases of sexual assault. In Latvia there is no service (social rehabilitator) that would provide regular support for the woman and help to complete the required formalities, would listen to, support and encourage.

No protocols and joint standards are elaborated in state or private institutions how to work in cases of sexual assaults. Mainly all representatives of their profession act according to their discretion in case of sexual assault. The employees are not trained how to talk to persons in crisis situations. Their comments and insecurity about themselves lead to that the victim feels not understood and undervalued. Illiterateness, stereotypes, blaming, disbelief, lack of emotional intelligence are those factors that disturb mutual cooperation and qualitative aid.

The greatest lacks are seen in the work of the police. Work of the police is based on the Criminal Law that determines strict limits and procedural operations. On the grounds of the fact that no standard forms are elaborated that would *soften* the investigation in case of sexual assault, the woman is repeatedly victimized when she has to tell several times what has happened. In the police there is great turnover of staff (during the investigation up to 3 inspecting officers can change).

In case a woman has decided to perform a legal procedure, she has to devote very much of the private time. Legal procedure can last even several years, that means that it becomes more public and bureaucratic and even more persons get involved and find out about it. The statistics is such that most of the commenced criminal proceedings are not lead to a court.

Education and interest of the employees of different institutions about the sexual assault against a woman depends on the initiative and general understanding of the employee himself/herself. Documents are kept in safe places and their confidentiality is observed but at the same time standards of ethics are violated when the employees at the presence of the client/patient discuss other cases. It makes a conviction in the victim of sexual assault that his/her case also will be discussed with other unauthorized persons. The victim feels respect and sympathy only at superficial level without a true sensitivity.

In Riga in the crisis centre free psychological support consultations are available five times. A psychotherapy course is required so that a woman could wholesomely return in her life rhythm after what has happened. It means that the victim must invest own financial resources when attending the psychotherapist, psychiatrist (if necessary) and the lawyer so that the aid was lasting and qualitative.

Arrangement of self-aid groups is the initiative of psychotherapists and psychologists. Support groups are arranged rarely when victims of sexual abuse are among several colleagues.

Women are not satisfied with the period of time that must be spent when waiting for a consultation or meeting with an expert. If the registration is in a week, it seems for the victim in a crisis situation as a long and distressful period. In Latvia there have been cases that the psychological expertise is a year and a half after the acts of sexual assault.

In all institutions where the victim is examined, he/she has to tell in detail about the case of sexual assault (it can be up to 9 times). For example, one has to go ambulatory to the control visit at the doctor (if such is necessary), it is not possible to get to the same doctor (so everything must be told once again).

In case the victim wants to do the citizen's duty to protect other women and inform the society about the crime, different obstacles are created so that she wouldn't meet the responsible employees and give the evidence.

From the one side institutions try to ensure the expert of the same sex, but from the other side the woman has no possibility to choose which expert to talk to. It is important in cases if acquaintances or friends of the victim work in the respective institution.

The Criminal Law of Latvia is outdated, the forms of sexual assault are not defined precisely. There are lacks in legislation, for example, a police office can involve the victim in the investigation process to get the required proofs and documents.

Laws that are adopted and approved are not implemented in life, for example, the legal instruments that the oppressor cannot approach the victim's home.

Creation of the public opinion about the sexual assault against a woman is not implemented systematically. This issue becomes topical when an extraordinary event has happened that has come into focus of mass media.

In Riga there are not enough forensic experts women. In case a woman has turned to the reception of a hospital in the evening or at night – the forensic expert will definitely be man.

Emergency contraception is not available in the medical institutions. STI testing in the hospital is impossible – it must be mad ambulatory (also for charge). HIV prevention it is possible to receive only at the Infectology Centre of Latvia.

Although there is a separate room for the inspection by a gynaecologist, the doors are not locked during the inspection.

**Assessment and recommendations**

Based on information from research using the benchmarking & evaluation tool and partially structured interviews, this case study report makes a number of recommendations. These recommendations are aimed to all services providers which respond, support and deal with the different needs of women who have been sexually assaulted.

Police need to improve confidentiality of victim which means to provide that victim is listened by the police officer of the same sex, allow to choose the expert in cases familiar persons work in the institution also provide a separate room where to give evidence;

Police should educate society and give detailed information what is sexual assault and what can be the types thereof as well inform about the procedural operations in cases of sexual assault;

Forensic medical examination need to ensuring an expert of the same sex day and night;

Medicine services should paying more attention to the privacy of victim, for example, lockable inspection room also to receive improvement of STI testing and prevention at the hospital and day and night;

Medicine services need to provide first meeting without time limit because is important to inform victim on the possible physiological and psychological consequences already at the first time;

Psychosocial services should regularly arrange support groups for woman who have suffered from sexual assault;

Each sector need to established **protocols** or **guidelines** on sexual assault interventions and these should include compulsory training on understanding all the dimensions of sexual assault;

All service providers should develop a **standard form** that is complied with in all cases of sexual assault;

Each sector should elaborate a **training** program for their employees so that they would understand the importance of the problem about the sexual assault. On this training focus should be not only to technical aspects but also to crisis intervention and attitude, behaviour and sensitive communication with the victims. Training has to be regularly repeated;

All sector need to activate sexual assault **issues** among the experts to increase the understanding and quality of services and professionals who assisting to victims of sexual assault should be educated;

All professionals need to facilitate the mutual **cooperation** as well service providers should develop inter-institutional procedures for integrated intervention in cases of sexual assault;

All sector together need to clearly designed **client journey** and develop continual support system for victims of sexual assault;

Sexual assault services need to develop and agreed with common indicators for **evaluation** system. Important form service users to get the feedback about the quality of the services;

More learning should be encouraged and shared **between countries** to help understand and support the development of different intervention models;

The EU should require Member States to follow **EU Directives** on sexual violence. These would include recommendations on the legal, medical and psycho-social provisions needed in a country to deal with sexual assault in a way which protects and promotes victims' rights and well-being;

***Education of the society***

Regular and planned information and education campaigns of the society in the media environment. Making of stories, broadcasts and advertisement rolls in cooperation with all services to educate professionally and establish emotional attitude of the society.

In case of sexual assault the society looks for the guilty persons not paying sufficient attention to the victim. To admit that the victim has suffered and provide support so that the victim is able to continue a wholesome life.

Explain what is sexual assault and what its forms can be, for example, touching of sexual organs also is defined as sexual assault. Give explanation that forced sexual relationship between the spouses also is sexual assault.

Confidence of women and trust in them must be promoted. It is important to tell and make conviction in youth of school age that nobody has the right to touch him/her without the consent of the teenager, and if someone is doing it, it is a punishable action.

To make brochures in Latvian and Russian where the basic things are described that must be done in case of sexual assault.

To make an internet site where to summarize information right about the sexual assault against a woman. Information where the information about all services is provided what and why must be looked for, how important it is and how much time it will take. In case a woman has decided to commence a legal procedure, make a description about how the judiciary works, what is the proceeding like and what institutions she will have to visit.

To place descriptions or experience of other persons about the idea and things that help to undergo what has happened. To popularize the aid services of other countries such as USA *online chat*, that can be used by other persons knowing the English language.

It is important the all this information is easy to comprehend and understand because being in a crisis situation it is difficult to focus, perceive difficult information and remember it.

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## Annex 3: Malta Case Study Report

*Dr. Flavia Zimmerman*
Chairwoman & CEO, Three Cities Foundation, Malta

**Introduction**

The aim of the case study is to study the sexual assault services provided by the Three Cities Foundation, an NGO servicing the Cottonera Area. This Foundation offers psychosocial and practical services to victims of sexual assault. The case study was conducted by means of a two level approach, by comparing the results of the service provider interview with that of the victims' interview. The rationale behind this was to compare how the service provision compares with the experiences of the victims.

***Study Sample***

The study entailed in-depth interviews with 9 service users and another in-depth inter view with a service provider. Although the initial terms of reference asked for interviews to be carried out in a focus group, due to fear of exposure by participants, interviews were held individually in a private setting with each interview lasting approximately two and a half hours.

***Geographical Setting***

The participants all hailed from the Cottonera Region, which includes the Three Cities of Cospicua, Senglea and Vittoriosa.

***Summary of Findings***

The majority of the victims of sexual violence interviewed recounted a devastating experience which was not at all helped by the system as well as some of the professionals working in the system. Victims described their experience accessing services as '*it's as if they're looking at a bug*' and '*it gets worse every time'*. There is no coordination between services so this results in women having to recount their experience a number of times. Follow ups are scant and frequently result in the victims having to explain their experience to another professional. Professionals are not specifically trained in dealing with victims of sexual assault and any knowledge they have has been gained through informal means.

The Three Cities Foundation staff and volunteers are periodically given training and follow protocols in dealing with victims. This ensures that victims are not re-victimised when accessing services.

***Recommendations***

It is being recommended that Malta adopts the proposals presented by the Task Force set up to analyse the development of a Sexual Assault Response Team and develops adequate protocols to ensure coordination of current services, both state and non-governmental.

**Methodology**

The Comparing Sexual Assault Interventions lead partner prepared a focus group discussion guide aimed at assisting the partners in carrying out the focus groups in the different partner countries. After consultation with relevant stakeholders, Victim Support Malta decided not to gather the required information from the participants through a focus group, but to hold individual interviews with the participants. This was done in order to further ensure the participants' privacy and confidentiality, and to enable the interviewer to elicit adequate responses.

Victim Support Malta chose to study the sexual assault services provided by the Three Cities Foundation. Eligible participants were identified and invited to participate in the study by staff of the said Foundation. The interviews were held over a one week period. The female interviewer, namely the Chairperson of the said Foundation, had previous experience in discussing sensitive topics with women, and was in fact previously known to all the interviewees through their contact with the Three Cities Foundation. The interviews were held at the offices of the Three Cities Foundation, in full privacy. Prior to each interview, the researcher explained the aims and objectives of the study. The consent forms were also read out and explained to the participants, who were then requested to sign such forms. Interviews lasted on average two and a half hours. Detailed notes were taken. Data was coded and common themes identified.

**Sexual assault services in Malta**

The following services are presently offered in Malta:

***Law Enforcement***

The Vice Squad within the Maltese Police Force is the specialised unit which investigates sexual assault crimes. According to current practice, when a report dealing with sexual assault is received by the Police, the Vice Squad officer on duty accompanies the victim for medical investigations. These medical examinations are usually held at Mater Dei Hospital, which is the main State Hospital, or in State run health centres. Medical authorities and the Police fully co-operate as regards the medical response to sexual assault victims. The procedure to maintain the chain-of-custody, also known as chain-of-evidence, is that the medical officer who examines the victim passes on all the evidence to the court nominated expert in order to conduct the analysis for court evidence purposes. To prevent contamination of evidence, the passing over of evidence is done on the same day of the collection of evidence through the medical examination. Police Officers who deal with sexual assault cases receive no formal training and it is held that officers operate in the right manner through sharing of experiences. Upon the report being lodged, the duty Magistrate is informed, who in turn nominates experts to assist in the inquiry. These experts range from gynaecologists on duty at the hospital, a forensic doctor, to a Police photographer. Medico-forensic examinations are held in the obstetrics unit at Mater Dei Hospital in an examination room within a ward. The nominated experts together with the Police interview the victim in this same room.

***Crime Lab***

Depending on the court expert nominated to collect evidence and analyse it, forensic evidence is either analysed in a private laboratory or at the Malta National Laboratory.

***Hospital and Examination facilities***

The only examination centre for victims of sexual violence is to be found in Mater Dei Hospital since there is no dedicated sexual assault crisis centre. Mater Dei Hospital is a generic hospital servicing the whole population of Malta, which presently stands in the region of 418,000. This population increases substantially in the summer months due to an increase in tourists and foreign students. During 2008 and 2009, there were 23 and 25 cases respectively of sexual assault that were examined at Mater Dei Hospital.

The specialist on duty, a gynaecologist, normally conducts examinations and all the required tests are taken. Through follow up outpatients appointment, the victim is seen again by another doctor.

Specialists do not follow up victims and most are reluctant to draw up court reports which lead to "*waste of time*" in going to court to give evidence.

A specialised doctor at Mater Dei Hospital, who is available on a 24-hour on call basis, carries out forensic examinations in relation to sexual assault cases.

Social work interventions for victims are provided by the social work team at Mater Dei Hospital, however this team is not available on a 24 hour basis. It is up to this social work team to refer victims to one of Aġenzija Appoġġ's specialist services, such as the psychological and or domestic violence services, among others, for further intervention and follow-up of the service user. These services may in turn link up with other entities, such as, Victim Support, Malta, to provide continued support for the service user. However, none of these services operate on a 24hour basis.

***Prosecutors***

In Malta there were 112 sex crimes reported to the police in 2008, and 120 cases reported in 2009. In cases where there are court prosecutions and the perpetrator is found guilty, these were usually punished by imprisonment.

***Non-Governmental Organisations***

There are a number of NGO's which provide support and assistance to victims of sexual assault, amongst others :

Victim Support Malta is a registered NGO aimed at supporting victims of crime by providing emotional and practical support and legal information. Victim Support Malta also regularly participates in a number of projects aimed at researching the situation of crime victims and at raising awareness about victims' rights and services. Victim Support Malta is a member of Victim Support Europe.

The Three Cities Foundation is an independent NGO, firmly based on Civil Society principles. It is committed to advocacy, education and training for marginalised groups and individuals residing in the Cottonera. Programmes are delivered via in-house services, outreach and referrals. The Three Cities Foundation is also an action agency that offers free development resources to other creditable NGOs. Its long term goal is to eliminate the underlying causes of poverty and social exclusion in the Cottonera.

The St Jeanne Antide Foundation (SJAF) is a non-governmental voluntary organisation set up by the Malta Province of the Sisters of Charity of St Jeanne Antide Thouret in collaboration with lay persons. SJAF is a registered NGO with the Office of the Commissioner for Voluntary Organisations. It is run by a Chief Executive under the policy authority of a Governing Board. St. Jeannet Antide Foundation provides support and self-empowerment of socially excluded persons, families and minority groups.

YMCA Malta is a non-profit, voluntary and ecumenical movement seeking to promote the vision to build a more just society. The organisation forms part of the YMCA international movement. The organisation offers a spectrum of social work services to underprivileged individuals, the main specialisation being the support, assistance and rehabilitation of homeless people.

Taking into consideration the fact that a large number of cases of sexual assault occur within the context of an intimate relationship, it is also relevant to point out that there are a number of other NGO's which provide shelter, support and assistance to victims of domestic violence, and hence to victims of sexual assault when the perpetrator is one of the persons including in the legal definition of '*household member*'.

***Proposals to set up a Sexual Assault Response Team***

On the 5th of May 2009 the Commission for Domestic Violence, under the patronage of the then Ministry of Social Policy, convened a group of professionals in their own respective field to propose to the authorities concerned a mechanism to improve systems to respond to sexual assault survivors.

Meetings were held on 05 May 2009, 29 May 2009, 26 June 2009, 22 July 2009, 01 September 2009, 15 September 2009, 28 January 2010 and 09 February 2010.

The members of the task group were as follows:

Insp Louise Calleja (Commission on Domestic Violence) Chairperson
Dr Marceline Naudi (Commission on Domestic Violence)
Ms Anne Cachia (MSOC) (resigned in July 2009)
Ms Joyce D'Amato (MJHA)
Dr Raymond Galea (Gyneacologist)
Ms Maryanne Gauci (FSWS)
Ms Renee' Laiviera (MCWO)
Dr Roberta Lepre' (Victim Support Malta)
Ms Antoinette Martin (Psychologist)
Ms Doris Vassallo (Secretary)

Since the advent of the rape crisis movement in the early 1970's women and men have organised themselves to end sexual violence and to provide comprehensive, quality services for survivors of sexual assault. Malta does not exist in a vacuum from the rest of the world, therefore the Commission on Domestic Violence, in its advisory role to the Minister concerned on all aspects of the problem of domestic violence, highlighted that this phenomenon needs to be exposed and addressed in a concrete and professional manner. The Commission raised the issue of additional concern that victims of sexual assault are often discouraged from accessing help, possibly because of

the fragmentation of the services available, as well as the possible traumatisation and victimisation by the system with the result of lack of empowerment on the part of the victim to seek further treatment and pursuance of the relevant legal rights. Professionals from the Ministry for Health and Mater Dei Hospital, *Agenzija Appogg*, the Police, Victim Support Malta, the Malta Council for Women Organisations and the Ministry for Justice and Home Affairs (see list of members above) worked together to find the most efficient manner of providing a specialised service to respond effectively and sensitively to victims of crimes of a sexual nature and gender based violence amongst which: date rape, stranger rape, sexual assault and sexual abuse from a known partner. The main undertaking of this Task Force was to present a proposal/business plan for coordinating an efficient and holistic service package to deal with the sensitive nature of such situations. This would include the related health services, law enforcement, prosecution and advocacy/support services for the victim. A formalised and coordinated approach was sought, to bring together public and private entities and non-governmental associations to provide survivors of sexual assault with the necessary and immediate services while avoiding duplication of resources which are very limited in these spheres.

The proposal is for a sexual assault response team consisting of a forensic nurse, a gynecologist, a psychologist, a police inspector, a social worker and Victim Support Malta support worker to be on call. When a survivor of sexual assault, presents in hospital, they would be immediately triaged by the forensic nurse in a dedicated room within Mater Dei Hospital while the SART (sexual assault response team) is informed. The on-call SART members would respond promptly to the hospital call to provide a medical and forensic examination and provide crisis intervention and advocacy/support for the survivor. Ongoing longer term support would also be provided through Victim Support Malta. One sexual assault case is one too many, therefore a holistic professional approach may help and additionally end the shame of the many survivors of such assaults. The social validation and legitimization of the traumatic experience may help to transform the physical attack from a shameful, horrifying experience into one of strength. This is not to say that sexual assault is ever a positive experience for any human being, but that it is possible to transcend the victimization and its damaging consequences. The proposal was completed and presented to the authorities in 2010.

**Presentation of findings from the case study service**

Victim Support Malta chose the Three Cities Foundation as a case study service. It is important to note that the Three Cities Foundation is an NGO which is located in the Cottonera Region in Malta. It has two full time staff and six volunteers. It serves approximately 11,000 persons and has an approximate of 427 users annually, with 35 cases of sexual violence.

***Procedures and Modus Operandi***

In principle, the Three Cities Foundation has devised mechanisms and agreements with relevant agencies operating in the region. In practice, protocols are infrequently observed at inter-agency level. In the event that referrals are ignored in the first instance, reminders are formally communicated by the Foundation in order to attempt to achieve compliance. Advocacy and support of victims seeking access to other relevant sectors/agencies constitute a substantial percentage (25%) of the time spent with clients. A correct procedure is not always observed uniformly by other

agencies and depends on individual services providers. Cases may be recorded or alternately dismissed ad hoc at any stage. The standards adopted by the Foundation have not been agreed upon by all sectors and agencies and in fact, have been criticised in the past for being excessively protective of clients' feelings and privacy. Police officers tend to oppose or disregard Good Practice standards proposed by the Three Cities Foundation, especially in relation to sexual assault and domestic violence victims. Professional liaisons are maintained with more empathetic individuals who are willing and capable of helping in a professional context. Individual service providers or agents may also collaborate voluntarily based on personal relationships with colleagues or peers.

The Three Cities Foundation operates independently of other services in the area. It is committed to advocacy, education and training for marginalised groups and individuals residing in the Cottonera. Programmes are delivered via in-house services, outreach and referrals. Its long term goal is to eliminate the underlying causes of poverty and social exclusion in the Cottonera. It is also an action agency that offers free development resources to other creditable NGOs nationwide.

Protocols are not established and adopted by all sectors, however service users' rights to privacy and confidentiality within the Foundation are strictly observed, although they cannot be guaranteed elsewhere.

Inter-agency meetings, consisting of Government agencies, the Catholic clergy, NGOs and local councils from Cottonera are held to discuss and organise service provision. Such meetings are attended sporadically and on an ad hoc basis. Multidisciplinary coordination team meetings between agencies do take place however the lack of commitment and follow-up from agency stakeholders stalls progress and the delivery of services. An up to date directory of organisations providing sexual assault services is available and is in use at the Three Cities Foundation. This directory has been disseminated to and/or adopted by other agencies, with however, little distribution to users.

The Three Cities Foundation organises training sessions twice yearly and some individual self-motivated members of government agencies may attend these sessions. Social workers are the most receptive to this training.

The Three Cities Foundation fundraises specifically for sexual assault services. In future fundraising activities will need to be expanded in order to cope with demand or wound up to avoid duplication with the Sexual Assault Response Team proposed by Victim Support Malta as part of the SART Task Force.

Applications for funding occur on occasion, depending on the type of funding available and the involvement of individuals responsible for funding work.

***Response***

If using other services, a victim of sexual assault has to typically explain her experience to different professionals more than 8 times, however a woman using the Three Cities Foundation's services will typically explain her experience in detail only once. Staff are prepared to carefully and sensitively document information to explicitly prevent overexposure. Forensic services are only available on a national level and not available on a regional level. Medical services are available free of charge, however a victim may need to pay for visits to GPs and for medication.

***Staff Perceptions***

When asked how well does the Three Cities Foundation service work with other services in practice, staff considered that with forensic services, the police and legal services they do not work well at all. Regarding medical services staff considered that their services do not work particularly well and with psychosocial and practical services they considered them to work reasonably well. Services can be improved by provision of forensic services regionally. According to staff the quality of medical services is affected by limited skills, personal bias against and inability to deal with victims of sexual assault and the capability depends on medical staff's personal inclination to deliver an acceptable standard of service and follow protocols.

The provision of adequate psychosocial services is precluded by shortage of staff, practitioners' excessive workload and personal perception of the victim. Among other professional vocations, individuals display the most empathy and commitment to the support and healing of patients, although skills are lacking and individuals will make their responses to cases personal, thus causing feelings of dependency/confusion/rejection in already vulnerable clients.

The quality of police services is affected by limited skills, personal bias against and inability to deal with victims of sexual assault. Capability depends on officers' personal inclination to deliver an acceptable standard of service and follow (or exceed -as necessary) protocols.

Roughly 6% of victims of sexual assault using the Three Cities Foundation's services will see their case advance in the judicial system to the point of consulting a legal professional. Conviction rates are also extremely low.

Some service users tend to defer consulting the Foundation, limiting the NGOs ability to liaise and advocate on their behalf at crucial stages with police and medical services, therefore outreach needs to focus even more on respect of confidentiality and the effectiveness of non-legal advocacy.

Staff also feel that other sexual assault services, with the exception of psychosocial and practical services do not respond well to the needs of service users. Other NGOs such as Victim Support Malta and Dar Merhba Bik (shelter) strive to provide competent, up-to-date and legally current forms of assistance to clients. Both operate on a national level and are located outside the Cottonera region.

***Psychosocial and practical services***

Since the Three Cities Foundation only operates in the field of psychosocial and practical services, only this section was analysed.

The Foundation has various protocols in place in its provision of services. Namely it has protocols and activities in the following fields:

For the provision of counselling, support and referral for woman who have experienced sexual assault.

Has and maintains a directory of organisations dealing with sexual assault and collateral services.

For the coordination amongst psychosocial and practical services.

For response, including intake, counselling, safety planning and secondary trauma.

For record keeping that ensures safety and confidentiality.

Sexual assault sensitisation curriculum and training for all staff.

Staff receive periodic training on the management of women who have experienced sexual assault. This training is updated and conducted on a quarterly basis.

Sensitisation training is carried out and staff are monitored for suitable conduct in relation to all minority groups.

The Foundation has special measures for different population groups. Mediation and advocacy are available to all, with specific provisions made for minors, homeless women, women involved in prostitution and the differently able. Translation services are in place but limited to the most frequent/likely origin of victims in a region with a predominantly homogeneous/autochthonous population, i.e. diversity is lower than the national average (Arabic, Anglophone translation services may be required, most clients are Maltese speakers with limited working knowledge of spoken English).

The Foundation has on-going efforts to sensitise church and community leaders, along with medical and police services. As part of its holistic approach, prevention training and counselling are offered to all applicable clients, with the current focus being on teenage males. Due to limited staff numbers, key groups must be prioritised.

The Foundation is overseen by a Board. Although 40% of the Board are not experts in the field, they have received training which is revised and/or updated twice yearly. The service conducts quarterly evaluations for staff and twice yearly for Board Members.

Service provision quality is assessed by means of analysis of weekly and monthly reports, client files, monthly staff performance assessments, informally and formally gathered feedback from clients. Written surveys have been returned in very low numbers. Many clients are confirmed/suspected functionally illiterate, others have mild to moderate learning disabilities.

Assessment of service user outcomes is carried out by means of progress reports which are regularly updated and maintained. Well-being and mental health outcomes are monitored, adapted and addressed as part of the Foundation's holistic approach to clients' individual needs. Although successful prosecutions are factored into monitoring of victims' recovery, all prosecutions amount to approximately 6% of cases. Successful criminal proceedings are 0.8 in 10. The Foundation addresses each step and possible outcomes in a timely manner with the service user in a way that is understandable and that leaves scope for her emotional and mental health needs.

Taking into account the victims' need for privacy, many victims' negative self-perception (who may often feel they cannot comment freely on the quality of service provision, due to hostile responses from police or other service providers) and the widespread tendency for secrecy in relation to sexual violence, gathering feedback is complex and time consuming. However, staff do gather formal and informal feedback information as a rule.

The Foundation strives to offer its services on as widespread basis as possible, however limited staff numbers may mean on-call staff is not available at all times. Weekday nights can be the harder shifts for which to find trained replacements.

As described above, all staff and board members are trained. Availability of female staff is facilitated most frequently. Shifts are planned to accommodate service users, with providers' well-being and safety in mind, too. The minimum waiting time for service users to receive support is presently 45 minutes, which is planned to being reduced to 30 minutes. The Foundation provides supportive counselling and case management for the victim. An assessment of the following is conducted:

Risk of self-harm

Symptoms of Post-Traumatic Stress Disorder (PTSD)

Symptoms of depression, anxiety, low self esteem

Need for a refuge or safe house

Need for child care or involvement of social services.

The staff document actions and maintains confidential files. Confidentiality is an extremely high priority, due to the close-knit nature of the community, the powerful negative stigma attached to being a victim of sexual violence and the equally negative leverage that undue knowledge of the incident(s) would generate against the victim: for instance, service users might approach the Foundation to report that they were allegedly threatened with public disclosure of the attacks – thus compromising the family's reputation - by a local politician who demands compliance in civic matters.

The Three Cities Foundation staff use telephone, email, sms, and scheduled home visits to ensure follow-up attendance. If consent has been expressly given by the service user, a designated contact person/next of kin may be contacted in case of necessity. As service users seldom present with one incident or one type of trauma, support continues holistically for as long as the service user is assessed as being in need of support.

While the directory of services and organisations is kept current and referrals are made wherever are made wherever necessary and productive, users tend to avoid using services and organisations outside the region, despite being made aware of potential benefits. This leads to occasional duplication of services. The Foundation assists the survivor to interact with other sectors as she desires by initiating contact, although the staff are trained in preventing, identifying and resolving attachment/dependency issues in service users. Service users are accompanied to any service they may require, including police, forensic, medical, and legal services – along with sitting in on visits with social workers, church representatives and other persons or entities providing support. Advocacy and escorting are crucial when dealing with police, forensic and medical services. Correct procedure is not observed uniformly and depends on individual service providers. Cases may be recorded or dismissed *ad hoc* at any stage by police. Examinations are reportedly carried out without clear consent in a manner that service users described as 'rough', 'uncaring', 'more traumatic'. At inter-agency level, information is not forthcoming and poorly managed, thus victims may be led to unwittingly compromise their case against their attacker. Information is shared with

police and community services only a need to know basis and with the explicit clients' approval. Support is offered to family members, partners and friends of women who have experienced sexual assault.

**Assessment and recommendations**

In ***Malta no multi-sectoral and inter-agency mechanisms*** are in place for providing sexual assault services, including protocols. The Task Force which proposed the setting up of a SARTTeam has however included the development of such protocols in its recommendations.

***Forensic services*** are only available on a national level. Waiting time varied between 3 to 24 hours. This was not considered acceptable by the victims, who suggested that waiting time should not exceed 1 hour – it was suggested that victims must be given the opportunity to wash themselves, change their clothes and have a warm or cold drink at the earliest opportunity.

***Medical services*** are available at the local level – health clinics and General Practitioners operate locally, however these have limited capacity and operating hours. Cases of sexual assault are generally transferred to the Accidents and Emergency Unit at Mater Dei Hospital (the state hospital). Waiting time at the Accidents and Emergency Unit varied between 2-7 hours. This was not deemed acceptable by the victims interviewed, who suggested that waiting time should not exceed 1 hour. Victims also highlighted the fact that the lack of acknowledgment, assistance and/or treatment compounds the trauma already experienced.

***Psychosocial and practical services*** are offered at the national level through Agenzija Appogg or similar services offered at the local level, such as 'Access' in the Cottonera. Such services also include the services provided by NGO's. With regards to services offered by the State, it was stated that waiting time can last up to several months since a waiting list is in place. Services provided by NGO's had much shorter waiting time (45-60 minutes for the Three Cities Foundation), however this depends on the availability or otherwise of staff and/or volunteers. Victims generally agreed that immediate referrals and assistance are needed. However, the services lack adequate human resources required to address their needs in an effective manner.

***Legal/Criminal Justice services*** – waiting times at Police stations varied between 30 minutes to over 2 hours. Once again, this was not deemed satisfactory and once again it was stated that immediate assistance is required.

Other services mentioned included Local Catholic Churches – the waiting times for assistance varied. Participants felt that notwithstanding that requests for support and assistance are at their discretion, their decision to access such services or otherwise varied according to their own belief system, their standing in the community and how they perceived this as impacting on the likelihood to received support or otherwise.

In general it was therefore felt that the services provided by both the State and NGO's failed to meet the different needs of women who are sexually assaulted. All participants expressed confusion regarding the services available, their rights and due process. Waiting times generally create re-victimisation and further compound the trauma for the victims. The lack of coordination and lack of

sharing of information amongst the relevant entities was also highlighted. It was also pointed out that services seem to operate *ad hoc* and lack proper structure. Besides the lack of timely intervention, participants also stressed that their need for courtesy, privacy, physical respect and protection of personal dignity are often ignored.

Coordination between the relevant services seems to be *'ad hoc'* and dependant on the individuals responsible for service delivery rather than the service in general. One participant stated that *'It depends on who is working: sometimes you get more help if one of the policemen or a nurse is kind*'. Besides the coordination between the police and hospital services, it appears that there are no referral mechanisms between the different services. This is also the case where NGO's are concerned. With regards to the Three Cities Foundation, referrals by and to other entities and/or practitioners such as doctors are dependant on the rapport with individuals. The pros identified in the way the services are currently provided, include the proximity of the services – *'What we do have for help is not far away'*. The small size of the island helps in the effectiveness of such *'ad hoc'* referral mechanisms and also facilitates rapport building between individuals. On the other hand, the lack of a proper coordination mechanism was perceived as a disadvantage – *'the right hand doesn't know what the left hand is doing*'. Waiting times for all interventions was once again highlighted as a major disadvantage. Other disadvantages highlighted were the lack of communication with the victim and the repeated and unnecessary need to recount incidents – in this regard, participants unanimously agreed that the number of times that a woman has to explain what happened has an effect on her experience of accessing services :

' *It gets worse every time'*

*'It's like they're looking at a bug'.*

With regards to the impact of having to explain the experience multiple times, participants stated that they were fearful of being judged, dismissed or misunderstood. All the women interviewed stated that retelling the experience was exhausting. They described the experience as making them feel '*disgusted*' and '*shameful*'. In general, reliving the event was considered to be a highly distressing experience. For participants who only sought medical help and did not wish to prosecute, the times they had to explain their experience in detail varied from 5 to 9 times. The only participant who prosecuted and managed to secure a conviction against the perpetrator estimates that she had to describe the event in detail around 15 times.

No official or unofficial payment for services were identified/emerged during the interviews.

Victims are not always provided with an option of female or male examiners when accessing forensic or medical services. Participants recounted that they had to *'make do'* with available staff. 2 participants complained individually at the time and each was rebuked for wasting time or being difficult, or even told to *'shut up'* – examinations were consequently carried out by male forensic examiners. Outside of emergency services, 4 participants were aware of and benefited from the services of a '*sympathetic*' and '*helpful'* General Practitioner in the region – a younger male who provided confidential referrals to the Three Cities Foundation.

Participants agreed that being given an option of female or male examiners is very important. All participants stated that in hindsight they should have asked for a female examiner, but at the time

they were in no condition to demand one and the waiting time without being able to shower, get changed or drink water had compounded the trauma.

3 participants expressly asked for details and guarantees about their rights to confidentiality whilst the others were not informed. Only 4 participants recall receiving explanations about the process that will be undertaken, however these were unable to fully comprehend or ask for clarification. None of the participants was offered emergency contraception or knew of its availability. Three participants estimate they became pregnant as a result of the attack. One of the participants was deeply troubled by the fact that her estranged husband applied for custody of their children, including the unborn one she believes was conceived during an attack. Testing for STIs was carried out in 5 cases, with 3 testing positive for chlamydia. Communication of results Communication of results was greatly delayed (average 2 months' waiting time). No counselling was offered or referral services provided. Clients who were already in contact with social workers took the initiative to disclose information about their experiences. Two clients communicated with their respective social workers within one week of the assault, while another victim did not reveal her sustained experience of violence for 24 years – until her husband left her for a new partner. The above were then offered testing through referrals. The participants declared that it is very important to be given information about confidentiality and the process being undertaken although it is hard to understand what is going on after the attack. All participants are afraid that they will be stigmatised and further discriminated against, should knowledge of the attacks be shared.

The participants also held that as above, it is very important to be asked for their consent for examinations at the start and throughout the process, but without professional help and support at the time of the examination, it is hard to know what consent is for.

Women who experienced sexual assault are not confident in the police. All participants experienced ignorance, crude jokes, verbal abuse, discrimination, extreme delays and neglect while under care of police officers. Loss of confidence in the police service was unanimous, although often pre-existing. Cottonera police stations are often unmanned, response time is slow, reports of gender-based violence may often go unanswered. One officer in the region is known to 5 of the participants to be competent and willing to help in cases of sexual or domestic violence, but if he is stationed in one town and if he not the one responding to a local call in his area *"there is little hope for help*".

Women who have experienced sexual assault are not at all confident in the judicial process. The only participant who could pursue legal measures was fearful during the entire proceedings (during which she was harassed and intimidated by the attacker and his family) and disappointed with the outcome, which led to a short sentence for the attacker and no measures being put in place to protect her upon his release. 6 respondents did not get past medical and/or police contact. Of the remaining 3, 2 were informed there would be no prosecution of their attacker (spouse or partner in all 3 cases). Communication with victims was negligible: the former have to pursue their case with tenacity or they will not be informed of developments, court appearances, decisions to release the attacker or prosecute him. 6 participants gave up seeking justice. 4 of them say they were discouraged or pushed away after they sought help, 1 admitted they could not find the strength to keep fighting. 3 participants only sought medical help and never attempted to pursue justice, as it would taint their image and create the *"wrong impression"* about the family. According to participants, the likelihood of reporting an assault was very low (1 out of 9 would persevere in

future). This is in spite of 8 participants expecting to suffer other attacks in future. The participants felt that the overall service failed them. They sought support from NGOs and whenever possible from empathetic individuals in the medical profession or police service.

In 6 cases, participants felt believed. *"It depends on who you find*". But they identified a different challenge: doctors and policemen did not help –allegedly- also because the victims are women from the Cottonera (i.e. perceived to be crude, poorly educated and economically disadvantaged) or because of their appearance. 3 separate women's claims were strongly questioned because their underwear was not torn, therefore there was no use of force. They felt pressured to admit that sex was consensual. 6 participants were asked if they were wearing a provocative outfit or *"decent"* garments at the time of the attack. All participants experienced discrimination, including homophobia, as 2 participants (alleged victims of corrective rape) look *"mannish*" and were assumed to be lesbians by service providers.

Even when professionals believed the incident occurred, they did not appear to care about the victims. During the interviews participants pointed to visible scars or described graphic injuries that were verifiable by physicians and police at the time and did not seem to elicit compassion or timely intervention.

Participants suggested the following steps to improve services in order to render them more respectful, compassionate and sensitive :

Acknowledgement of the problem; Legal/forensic/medical services *"must give importance to the abuse of women. They must recognise it and do their part to help*."

Promptness: "*Help us quicker: the fear, pain and feeling [of helplessness] are terrible and worse than you can imagine*".

Competence: high professional and ethical standards should be maintained, and victims of sexual violence cannot be excluded.

Empathy: participants felt they needed someone to care about them, to listen, give them hope, and take time to explain. The prejudices, profanities and jokes made them feel more vulnerable and isolated.

Dignity: 8 participants still feel intense shame and discomfort. One participant felt that she was "handled", rather than treated.

Participants felt there were barriers to accessing services. These barriers include time constraints, waiting times, lack of competence or due care from staff, too few competent professionals, physical distance from services, absence of 24/7 access to services as well as the provenance and socio-economic profile of victims.

The participants were asked what steps could be taken to overcome barriers. 7 participants struggled to find answers they thought were satisfactory. One participant observed: "*I'm in a mess. [Do] you think I [should] be the one looking for a solution?*"

Ultimately, participants indicated that the following were needed: training, changes in cultural/social/gender perceptions, more resources for entities. 2 participants added that all of the above would be slow to come, as long as males kept females beneath them.

The participants listed place of origin, being of mixed race, having a regional accent, personal appearance, demeanour, and being female as barriers to particular population groups. When asked what steps could be taken to overcome these barriers, participants said: "*But do you mean that we have to change, or that other people have to change*?" and "*If a doctor thinks he's better than me, I don't know what to do.*" One participant stated the importance of perseverance, knocking on doors, talking and not giving up.

Participants identified the following as being the most important qualities of a supportive service:
Forensic

- Speed
- Precision
- Respect
- Communication/explanations

Medical

- Speed
- Good medical/surgical skills
- Dignity of the patient
- Kindness

Psychosocial and practical

- Availability
- Competence
- Strong advocacy

Criminal justice

- Respect for the victim, respect for women
- Speed
- Professionalism, due care and diligence
- Communication
- Commitment to the case

Clients report feeling most at ease and safe with the Cottonera Foundation staff. The range of options and assistance offered within the region is reportedly highly satisfactory. Response time is fairly quick (45 minutes). Services provided adapt to individual requirements.

However staff numbers are too low to guarantee services to all potential service users 24/7. Response time can still be lowered from 45 minutes to 30. Advanced negotiation skills must be practiced by all staff to obtain basic standards of service for victims from other agencies. More time and resources must be invested in promoting a more balanced, non-discriminatory view of sexual assault survivors.

**Recommendations**

As stated above, Malta has already taken the first step towards addressing the shortcomings arising from the limitations in providing services to victims of sexual assault, and this through the setting up of the SART Task Force. This Task Force has looked into the different services available in Malta,

which are sufficient to provide an adequate response to victims if these were properly managed and coordinated. To this end, the document developed by the Task Force, and presented to the Minister concerned, entailed details of how a SART team could be set up and managed. The document also mentions the development of protocols as one of the major pillars on which the SART should function. It is therefore imperative that relevant non-governmental organisations put pressure on Government to implement the proposals laid out in the document. In the meantime, service delivery will remain fragmented, and the effectiveness of the response dependant on the approach of the individuals concerned. Lack of effective resources for managing such cases will continue precluding a satisfactory response.

## Annex 4: Romania Case Study Report

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**Background**

While studies show that 90% of Europeans regard sexual violence against women in the couple as a serious problem, sexual violence seems to be more tolerated and accepted in Romania. According to the 2003 National Research on Domestic Violence and the Workplace[§], 14% of women and 6% of victims stated that „a woman forced her partner to have sex" is not very serious.

Sexual offenses are set out in the Romanian Criminal Code; they are grouped as follows: rape, sexual intercourse with a minor, seduction, sexual perversion, sexual corruption, incest, and sexual harassment. These crimes have as a legal generic object the social relationships whose normal development provides the freedom and morality of the sexual life of a person.

A national study conducted in 2007 on the phenomenon of sexual harassment in Romania[**] showed that only 1 of 9 Romanians experienced or heard of a case of sexual harassment, and none of those who came to court with a complaint prevailed. This attitude of „hiding under the carpet" can be explained also with the professional position, hierarchy and its associated power, often being associated with certain rights inherent to the superior hierarchical position.

The aim of this case study is to evaluate the real situation of the available services in case of sexual assault from both professionals and client perspectives.

The case study is based on the assessment of the mechanisms that exist and do not exist in each service and within the local setting to address sexual assault. The result and analysis identifies strengths and gaps in current service provision, which will assist services to complement and improve their practice and also plan and provide appropriate services for women who have experienced sexual assault.

The case study contains the description and organization of available services for victims of sexual assault, the assessment of the current situation of these services, based on information from their representatives and from other sources, and a chapter of conclusions and recommendations for effective intervention in the event of a sexual assault.

The conclusions of this assessment are that (a) the services for sexual assault in Romania are provided vertically and not as part of a coordinated or integrated model of sexual assault service provision; (b) none of the services assessed in particular meets in full the complex standards of good practice proposed by this project, and (c) there are concrete actions which may be recommended so that these services respond better to the victims' needs.

The most important three recommendations proposed by this case study are the following:

[§] Partnership Centre for Equality, National research on domestic violence and the workplace, 2003.
[**] Partnership Centre for Equality, National study on sexual harassment in Romania, 2007

– Development of inter-institutional procedures for integrated intervention in cases of sexual assault and application of a consistent methodology;
– Development of a training system for the professionals who interact with victims of sexual assault including clear provisions on the conditions for initial and continued training;
– Development of new specialized services or specialization of existing services for improving the professional intervention to assist victims of sexual assault.

**Methodology**

Data for the case study was collected using the benchmarking and evaluation tool and the focus group interview guide developed by the project.

Interviews with representatives of the institutions involved in the intervention in cases of sexual assault were conducted face-to-face by project staff.

The assessment questions were addressed to different institutions and organizations that provide services which should be part of a multi-sectorial approach required to support and deal with the different needs of women who have been sexually assaulted. These institutions and organization included:

1) Forensic services which can collect evidence, if the woman wishes to pursue legal proceedings;
2) Medical services, which treat injuries, potential pregnancy and STIs;
3) Psychosocial services for mental health and well-being support; and
4) Criminal justice services which enforce the law and protect women's rights.

Individual interviews with sexual assault victims were conducted to assess user feedback about the services available locally and whether they met their needs.

Although the methodology proposed originally involved organizing and conducting a focus group discussion, we encountered problems in its organization due to the small number of sexual assaults recorded within the timeframe allocated for producing the case study (the proposed methodology recommended organizing a focus group discussion with 15 women over 18 years old, who were victims of sexual assault). Also, it was impossible to get from women who have suffered sexual assault the agreement to answer the questions from the interview guide and be part of a group. Despite the informed consent and the confidentiality clause, victims felt a barrier to disclose their identity and experiences to the other focus group participants. They also found it difficult to relive the painful and humiliating experience to which they had been subjected in a discussion with other persons. Although victims did not accept interaction with the project investigators and other focus group participants, they agreed to answer the questions in a discussion with the psychologist who offered them counselling and emotional support after sexual assault. Four women were interviewed in total.

This report includes also the key findings and recommendations of the peer learning visit conducted in Romania during 5 – 8 November 2012 by Flavia Zimmermann from the Three Cities Foundation Malta.

**The Domestic Violence program in Romania: transferable learning from development and implementation**

The East European Institute for Reproductive Health established in Romania with UNFPA support an integrated approach to preventing, monitoring and combating domestic violence. The purpose was to integrate the response between institutions in order to give survivors comprehensive care. The system consists of two separate components.

The first is a mechanism for institutional collaboration among institutions/organizations that deal with domestic violence. The model makes domestic violence a priority among institutions and establishes clear steps for action.

A Memorandum of Understanding that commits each institution to work on domestic violence and stipulates roles and responsibilities for addressing survivors' needs has been signed. A county Steering Committee with representatives from each institution was established and meets on a monthly basis to share information, review processes, manage cases, troubleshoot and identify needs to strengthen services, and devise better ways of working together. They collaborate on public awareness events and develop strategies for better servicing survivors and perpetrators. They also work together on individual cases to ensure that services are not duplicated, and that survivors receive the tools they need to move forward. An action plan is agreed, detailing the interface between institutions, including regular meetings, communication about specific cases, data collection and service provision.

Standardized training on domestic violence for up to three days for professionals in each institution is provided by the Institute, tailored to specific functions. Information on domestic violence and services for survivors is disseminated through a newsletter called 'Agora', media campaigns and booths at community functions.

The second component is a computerized tracking system and database with information shared by four institutions – the police, emergency medical services, a forensic department, and a women's shelter. The tracking system allows them to monitor services and share information.

The integrated approach to domestic violence was documented as a good practice by UNFPA in several publications: Programming to Address Violence Against Women. Ten Case Studies. https://www.unfpa.org/public/publications/pid/386 and Partnering With Men To End Gender-Based Violence. Practices that work from Eastern Europe and Central Asia. https://www.unfpa.org/public/publications/pid/4412.

The following success factors, lessons learned and practices that work were identified in these documents.

***Success factors***

The approach builds upon existing efforts at the local level. A clear advantage from the start was the commitment and dedication of the involved institutions in implementing the program, who were already working at the local level.

Having a law on domestic violence gave legitimacy to the project and provided an incentive for local government involvement. Though there is room for improvement in the legislative framework on domestic violence in Romania, the fact that it exists at all was an enormous step forward.

Through a participatory management style, credit and responsibility were shared. A key success factor was the sense that every individual and partner organization had a responsibility for solving the problem of domestic violence and shared in the project's success.

High-quality training was made available for all involved institutions. The training was provided to policemen, social workers, psychologists, legal counsellors, health professionals, forensics, and other professionals. The training not only provided information about domestic violence, but gave participants the opportunity to explore their own attitudes and to develop the skills necessary to communicate with and respond to the needs of both victims and perpetrators.

***Lessons learned***

If the problem of domestic violence is not widely recognized, the first priority should be awareness-raising. If the community and professionals are not prepared to talk about domestic violence, then initial efforts must focus on documenting and communicating the problem. The provision of training and services is important, but there will be no demand if people are in denial that domestic violence exists.

Transforming a culture of domestic violence is ultimately about changing attitudes and behaviours. Novel ways were used to build community awareness about the problem. But most important in changing attitudes and behaviours over the long term is the quality of training provided.

Efforts to combat domestic violence must address not only survivors, but perpetrators. Awareness campaigns were targeted also to men, who are overwhelmingly the perpetrators of domestic violence.

Effective programmes involve male support. One way to gain greater involvement of men in the fight against domestic violence is to solicit partners from a variety of sectors, including law enforcement, which is typically a male domain. Another is to promote positive male role models, who will speak out on the issue.

Partnerships are critical to the success of domestic violence projects, because they offer a wide safety net for support and referral. Success depended on a network of institutions that had achieved consensus about the problem and had together forged a plan to address it. Spelling out in detail, and in writing, the obligations of each partner organization can ensure follow through. Public authorities must be part of the process.

The high standards set by the lead institution tend to be adopted by partners. The seriousness is contagious and tends to create a chain reaction in others.

A sense of trust—and strict confidentiality—must be established before survivors of domestic violence are willing to access services. The shame and social stigma attached to domestic violence, especially in villages and even small cities where little is shielded from public view, reinforces the hidden nature of the problem. A system for safeguarding information about clients was built into the information system used to track cases. Similarly, the locations of shelters are kept secret, to ensure the safety and security of those housed there. In dealing with the survivors of domestic violence, the goal is to help them regain their self-esteem and some sense of control.

Ending domestic violence starts with young people. Among the long-term consequences of domestic violence is transmission of patterns of abuse from generation to generation. Unless the problem is addressed among young people, it is unlikely to be defeated. Prevention programmes can begin as early as the first grade, and encompass not only domestic violence but violence of all kinds, including discrimination.

Counsellors and others who deal with survivors of domestic violence on a daily basis must protect their own energy and well-being and that of their staff. Working on a daily basis with victims of abuse can be emotionally and psychologically draining. Service providers must therefore give priority to safeguarding their own energy as well as that of colleagues. Moreover, staff may need to confront issues of abuse that they are struggling with personally.

***Practice that works***

- Introducing a system to document domestic violence, which is important not only for defining and quantifying the problem, but for tracking and following up on cases.
- Taking a multi-sectoral approach.
- Working at the grass roots and at the highest levels of government.
- Integrating services for victims with prevention efforts and building a network of support.
- Building the management capacity of project staff.
- Using the media as an ally.

**Sexual assault services in Romania**

In the first five months of 2012, there were 960 rapes recorded in Romania[††], which means that every four hours there is a sexual aggression. In most cases the rapists were under the influence of alcohol, drugs or had a sexual complex.

In case of a sexual assault, a victim can address for different types of services to:

- Police, which investigates the case, collects data about the incident, records the statement of the victim, identifies and interrogates the perpetrator, prepares the dossier to be submitted to the Prosecutor's Office, facilitates the victim's access to emergency medical services and to forensic services, reimburses the medico-legal (forensic) examination fee.

[††] Romanian Police General Inspectorate statistics

- Forensic medicine service, which does the forensic examination and the forensic expertise report.
- Health care services. In emergencies one can call the emergency units through the integrated emergency number 112. Emergency medical services provide immediate medical care, emergency contraception, counselling of the victim on possible approaches, notify police and if the victim so decides, accompanies her to her home. Subsequently, the victim may call the family doctor or a specialist for various investigations of her health status following the sexual assault.
- Psychological support services are provided by psychiatric clinics which have in their organizational structure a psychologist, or by private psychologists' clinics. The Centre for Preventing and Combating Domestic Violence Mures is providing psychological support, legal counselling, social support to sexual assault and/or trafficking victims from the central region of Romania.
- Social support services are provided by Child Protection Departments for child victims.
- Legal assistance. In cases of sexual assault, criminal proceedings are initiated by the Prosecutor's Offices attached to Courts, based on investigation files compiled by the Police. The victim may also seek the services of a private attorney to represent her in the lawsuit.
- Psychological and social support is provided also for aggressors under the probation period by The Probation Service attached to the Mures County Court

Although sexual assault represents a problem for Romania, there is no institution (public or private) to act as a focal point (formal or informal) at any level of representation, local or national. Therefore, there is no mechanism for monitoring and evaluating the inter-institutional and multi-sectoral approach to sexual assault, and this work is uncoordinated. There are no regular meetings in which all the institutions involved in the field take part, nor meetings for jointly organizing the provision of services or to discuss and review the assisted cases.

Reaction of the service providers in sexual assault cases is poor. This is due primarily to the lack of an integrated, efficient and uniform approach to the sexual assault situations. There are no national or local protocols defining inter-institutional mechanisms and multi-sectorial service delivery in cases of sexual assault. In case of sexual assault on victims who are minor, a cooperation protocol for intervention was reported at county level between the Police, the General Directorate for Social Assistance and Child Protection and the Forensic Medicine Institute. The General Directorate for Social Assistance and Child Protection provides counselling and psychological evaluation by a specialist to the child victim and the Forensic Medicine Institute collects specific information and data to be included in the forensic report. There is no mechanism for collaboration, referral or intervention agreed by all institutions providing services to victims of sexual assault. There is no public directory of the institutions and organizations providing services to victims of sexual assault.

There are no formal protocols for referral and for the client flow between the sectors involved in the intervention in a sexual assault case. Mechanisms for reporting the case and circulation of confidential information are partially established through agreements between those involved in the case intervention, which are most often verbal and are not part of a written, agreed and signed protocol. There are no standards agreed and adopted by all stakeholders on the safety and ethics of the sexual assault intervention.

**Findings of the case study**

***Services investigated***

Police

Policing is a specialized public service, implemented in the interests of the individual, the community and in support of state institutions, solely on the basis of and serving law enforcement. In carrying out its tasks, the Police cooperate with the governmental institutions and collaborate with non-governmental organizations, as well as individuals and businesses, within the boundaries of the law.

In case of a sexual assault, based on the victim's complaint, the police officer starts the investigation, collects data on the case, collects the statement of the victim and/or witnesses, identifies the perpetrator and records his statement, requires forensic investigation and forwards the case to the Prosecutor's Office. In the form submitted by Police to the Prosecutor's Office, the police officer makes proposals to start or not the prosecution. In case of withdrawal of the complaint by the victim, the file is closed.

The interview was conducted with the criminal investigation department of the Mures County Police Inspectorate. The Inspectorate serves a total of 531,400 people according to the provisional data of the 2011 Census. There were 94 sexual offenses in 2011, including 57 rapes, 37 sexual acts with a minor, one case of sexual perversion and 5 cases of sexual corruption. The Inspectorate has 205 police officers, 838 police agents and 37 contract staff, meaning an average of one policeman to 555 people. Cases of sexual assault are dealt by 7 police staff, of which 2 are dedicated to the investigation of cases of minor victims.

Knowing how to communicate with victims is taught to some extent. Officers may not be trained to exercise empathy, however experience makes them sympathetic. Sympathy for victims is mostly given on the basis of interpersonal skills of the officers. Outreach efforts are made in communicating risk, and due process in case of becoming a victim of crime.

Forensic medicine services

Forensic service are units with legal personality under the Ministry of Health and include 6 Forensic Institutes in main university centres (Bucharest, Cluj, Iasi, Timisoara, Craiova and Tirgu-Mures) covering each several counties. In each county there is also a Forensic Service, subordinated to the County Public Health Directorates and coordinated scientifically and methodologically by the Forensic Institute under whose jurisdiction it falls.

The interview was conducted with the Tirgu-Mures Forensic Institutes. The Institute has a total of 30 employees and serves three counties (Covasna, Harghita and Mures), comprising 1,042,670 people according to the provisional data of the 2011 Census[‡‡]. A total of approximately 5,200 services were offered in 2011. Examination for assessing virginity, defloration, or pregnancy costs 50 RON (11 Euro).

[‡‡] Romanian National Institute for Statistics, http://www.recensamantromania.ro/

The website of the National Institute for Forensic Medicine in Bucharest contains some limited information for victims of sexual assault (rape, sexual perversion) with or without physical aggression.

Medical services

Emergency Room facilities available in Tirgu-Mures are on top in the EU. Although not all wards and facilities are yet in use, this service strives to be technically, structurally excellent. Mures District has the only emergency unit in Europe with a level of resources to include optimal equipment, space for patients, logistics, and range of formal staff specialties. Its 'Telemedicine' department serves as training centre for other ERs, allows direct contact for diagnostics and procedure. Direct contact takes place (via video, x-rays, EKGs) with other local hospitals that send clinical readings interpreted remotely by the relevant specialist. Innovative facilities range further from decontamination, to isolation for infectious emergencies, and a full, specialised children's ER.

In case of a sexual assault, a victim may address to an emergency medical service for the proper treatment of her physical injuries. In the emergency services, the victim of sexual assault is received by the triage coordinator, who notifies immediately the Social Assistance Department of the emergency medical service, which announces immediately the on call forensic specialist and police.

A team made of a nurse and a doctor collects the medical history and relevant data about the situation of the victim. An obstetrics and gynaecology specialist is requested to consult the victim, and the victim's case is presented by the social worker and the emergency room physician, thus avoiding that the victim of a sexual assault should repeat the story. The obstetrics and gynaecology specialist does not collect evidence because, according to the Romanian law, this is permitted only by forensic. The victim is then informed of on-call Police availability and of the upcoming forensic procedure to gather evidence, which social workers will monitor. If the victim agrees, the social worker accompanies the victim to the forensic medicine service to obtain a medico-legal certificate necessary in case of a legal complaint to a Court. If the sexual assault victim is a minor, Police and the Child Protection are notified automatically. When the victim is medically stable, she is accompanied home by a social worker. The social worker informs the victims that they should address to dermato-venerology clinic for epidemiological investigation for STIs, HI and hepatitis A and B, where they benefit from free-of-charge tests and treatment.

Psychological support services

Currently there are no psychological counselling and emotional support service dedicated to victims of sexual assault. These services are provided by therapists who have the right to practice, often in private clinics, and possibly by psychologist employed by psychiatric clinics or departments. In the case of child victims, psychologists within the county General Directorate for Social Assistance and Child Protection intervene in the treatment of the victim, at the request of the Police. The Centre for Preventing and Combating Domestic Violence is providing a wide range of services (free of charge) for sexual assault and trafficking victims at the request of the police department.

There is no special training of the specialists for intervention in cases of sexual assault and, with few exceptions when the therapist agrees to provide services on a voluntary basis; all services are for a fee and not very cheap.

The interview was conducted in a private psychologist clinic. The clinic provided services to 75 beneficiaries in 2011.

Criminal justice services

The interview was done with the representative of the Prosecutor's Office attached to the Mures County Court. The Prosecutor's Office has 27 permanent full-time employees. It serves the population of Mures County (531,400 people according to the provisional data of the 2011 Census). The Office assisted 7 victims of sexual assault services in 2011. All services are free.

The Prosecutor's Offices attached to the Courts have the following duties:

- Prosecute criminal cases within their legal jurisdiction and notify the competent Court;
- Follow the defence of the rights and interests of minors and persons under interdiction;
- Provide the use of forensic technical means in the prosecution activity;
- May attend Court hearings in situations prescribed by law;
- Supervise the prosecution activity performed by criminal investigators;
- Notify the court;
- Provide and follow the preparation and participation of prosecutors in the trial of criminal cases and civil cases in situations prescribed by law;
- Exercise remedies against the decisions of the Court;
- Identify cases of inconsistent application of the law and make reasoned proposals for the promotion of appeal in the interest of law.

Victims of sexual assault can receive for a fee the legal assistance of a lawyer, if they decide to ask for these services for a civil action for compensations for possible damages. Usually, the two trials, criminal and civil, are merged, and the prosecutor becomes a free of charge "victim's lawyer".

**Findings**

All institutions which were included in the evaluation for the case study operate independently of other existing services in the area.

There are no training programs on the organization of services for victims of sexual assault, on sexual assault and ways of communication/relationship with victims of sexual assault, except for Police holding such courses for their staff at 3-4 years interval.

There are no funds (public or donor funds) for the establishment or support of services for victims of sexual assault, and no grant proposals were identified for this purpose by any of the service providers surveyed.

While all the respondents said that the victim must describe what happened only once in their institution, all specified that she must recount the experience undergone 2 to 7 times in different services (medical, police , forensic, lawyer, prosecutor, court, and social assistance services for child victims).

All services interviewed indicated that health services and the police services offered are free. The forensic examination is free for the victim according to the law, and the price is covered by the police. But because the settlements by police of the forensic services are delayed and the release of the forensic reports is made only after the settlement of the service, the victims often decide to pay themselves the forensic costs in order to be able to initiate a legal action.

Legal assistance is free or paid, depending on the case and services required. In case of criminal proceedings, legal assistance is free and offered by prosecutors, but if the victim decides to open a parallel civil lawsuit and considers that she needs a lawyer, these services are chargeable.

Unfortunately, psychological assistance, a component that should be a fundamental intervention in a sexual assault case, is free only for minor victims and provided by the General Directorates for Social Assistance and Child Protection and for few adult victims referred by the police to the Centre for Preventing and Combating Domestic Violence. The rest of adult victims may benefit from psychological counselling only in private clinics and for a fee.

> *„A problem to solve is the lack of free psychological counselling."*
>
> Representative of forensic medicine

Inter-institutional cooperation is judged to be very good or reasonably good by the majority of respondents, except for the private psychological counselling service, which was not working at all with other types of services, and the forensics service which relates only to the emergency medical services and the police. The need for psychological and legal assistance services dedicated to sexual assault cases was also identified by the respondents.

Forensic medicine services

In the forensic service, intervention is inconsistent between the county seat and the rest of the territory, where the victim of a sexual assault victim has to wait until the next day for forensic examination, and during weekends she must wait until Monday. The need to timely settle the payments for forensic expertise in order to resolve expeditiously the cases was raised as an important issue.

At the level of forensic services, the evaluation showed that there are no national protocols for forensic examination of victims of sexual assault and no "rape kits" or "sexual assault evidence collection kits". Confidentiality of personal information is ensured. If the victim addresses first the forensic service, she is recommended to address also to the police, but there is no mechanism for coordination with other sectors and professionals. Victim's consent is not required at any stage of the examination. The examination is made by a forensic medicine specialist physician without special training for sexual assault cases. During the examination, the forensic physician, the nurse and one resident usually assists. Most of the interaction with the victims comes from the nurse who registers the personal data. There are situations when the examination is made by other physicians than the forensic medicine specialist (during weekend or outside office hours and outside the city) and then forensic medicine specialist checks and confirms the data. There is no different approach to groups with special needs or translation services for persons who may require it.

Within forensic services there is no directory of institutions or organizations providing services to victims of sexual assault. Forensic medicine services have no structures specialized in providing services in cases of sexual assault and they do not organize internal reviews or satisfaction or feedback surveys from beneficiaries to be used to improve services. Forensic medicine services are available 7 days a week and 24 hours a day in the county seat and only 5 days a week and during office hours in other cities. When a victim of a sexual assault forensic requests the services, the approximate waiting time until the examination is 15-30 minutes.

Examination is not always held in privacy and at a pace the client is comfortable with, but it respects the client's wishes about interrupting or stopping the examination. There is no standardized form for the forensic report, only the one commonly used for any forensic examination. Forms are kept confidential. The information collected is shared with other institutions (e.g. Police) only if the forensic report is made on their request. Forensic services staff does not testify in Court, they only issue documents with legal value (forensic findings report for the police or forensic medico-legal certificate for the victim).

Victims' level of comfort or satisfaction with the way forensic procedures are carried out could not be evaluated since none of the victims are seen again. It is not necessary to follow victims' progress past examinations.

Criminal justice services

According to the answers given by the Prosecutor's Office attached to the Mures County Court, this institution does not have specific protocols to assist sexual assault cases, special protocols for the collection and preservation of evidence or protocols to protect, assist and support victims of sexual assault during the court process. Prosecutors are trained annually in training courses and seminars.

Medical services are offered to assist victims, if necessary, a defender is allocated ex officio and translation services can be provided when necessary. Prosecutors provide information and legal assistance to victims of sexual assault, and act to support their rights. Court proceedings are initiated depending on the date of the first hearing, which is set electronically as part of the random allocation of cases. The duration of the trial depends on the complexity of the case.

Recording of the victim testimony is possible outside the courtroom, in privacy, including at her home when she cannot come to Court on medical grounds. Hearing of the witnesses under false identity may occur in other locations. The main positive actions identified were: prompt identification of the perpetrators of sexual assault, quick prosecution, and immediate action to include minor victims in specialized counselling programs, appointment of a public defender ex officio, especially in the case of minor victims and when their interests are not adequately supported by her legal representatives.

Psychological support services

In the services for psychological support and psychotherapy, there are no specific protocols for counselling, support and referral of victims of sexual assault. A general protocol for counselling and intervention is used instead. Services in private practice are provided without any connection with other services accessed by the victim, with no collaboration between services or a common plan for appropriate intervention (establishing the therapeutic relationship, installation of feelings of comfort, safety and security, familiarization, outlining the expectations, fears and real needs, approach, etc). Before commencing any counselling or therapeutic approach, a confidentiality agreement is signed bilaterally.

There is no specific training for counsellors to address these types of cases. Special attention is paid to victims who were virgins at the time of aggression. In situations requiring communication in another language (e.g. Hungarian, since Mures County has a large Hungarian minority population) the victim is referred to another Hungarian speaking clinic, as understanding of the accurate meaning of words and mastering of the specialist language is essential.

Clinics do not use a directory of other institutions providing specialized services to victims of sexual assault, do not work with them, do not inform them about the assisted cases, and do not refer them to other services. There is no board or other structure with expertise in providing services in cases of sexual assault.

The degree of satisfaction of beneficiaries is evaluated. Evaluation is done in an unstructured way (no beneficiaries satisfaction questionnaire exist) and is focused mainly on the quality of services provided and only indirectly on other results of other approaches (legal process, physical health, etc.). Issues followed in assessing satisfaction are: safety and comfort degree, perception on privacy, difficulty of themes/tasks received by victim, evaluation of the therapist (language, attitude, and concern), barriers, etc. Services are available only two days a week and 5 hours daily, but the therapist is in permanent telephone contact with the victims assisted. Appointments scheduling is required and the maximum waiting time is 4 days. Victims are asked if they prefer a female or male as a therapist and directed to the respective counsellor. Assessment of the case is following all the issues raised in the questionnaire (risk of self-harm, symptoms of post-traumatic stress disorder,

symptom of depression, anxiety, low self-esteem, need for a refuge or safe house, need for child care or involvement of social services), but not using a standard form.

The therapy counselling program lasts for approximately 6 months, during which follow-up visits are scheduled in early intervention once a week, then less often. Victims are not contacted, participation is completely voluntary and counselling of the family, partners or friends is done only upon request and with the consent of the victim. The most effective aspect of treatment is that it works with themes/tasks for the victim (outside the therapy counselling sessions) to help victims to learn "self-care" skills and significantly reduce response time. The biggest drawback for victims is that they can receive psychological assistance only for a fee, and the prices are quite high.

*„It was good at the psychologist and it helped me, but if my mother had no money, I could not go to the psychologist for therapy. Those who have no money cannot treat themselves right."*

Sexual assault victim

Police

Police does not use a protocol for intervention in cases of sexual assault, but there are regular training courses for police staff involved in handling cases of sexual offenses, including legislative, investigative and interviewing procedures. Courses are organized for new policemen. Police works respecting the codes of professional conduct and there are reporting mechanisms in case of violations.

Police services are available 7 days out of 7, 24 hours per day; the average waiting time of the submission of the victim to the police to start procedures is one hour. The victim is unable to choose a male or female person as investigator. There are no dedicated spaces that respect privacy when the victim's testimony is recorded, except for cases of minor victims when the recording takes place outside police, in the Department of Child Rights Protection with the participation of the institution psychologist. Police does not provide forensic services, does not have a directory of institutions providing specialized services to victims of sexual assault and does not have any intervention protocols to coordinate with other sectors and stakeholders.

Form used for data collection is common to all situations, and the policemen are the ones who collect and keep any evidence related to the incident. Victims' safety plan is made based on professional knowledge and experience of the policeman, not on a structured plan. Victims are directed to other services (forensic nursing, lawyer), but police is not required to provide information about the case other than to the Prosecutor's Office to start criminal proceedings. Policemen have identified as needs for improving services the following: a dedicated space for sexual assault cases, where confidentiality and privacy can be ensured, additional staff involved in handling cases of sexual assault and video recording facilities for victims and witnesses testimonies.

It was mentioned that in rape cases involving a minor (i.e. statutory rape), the offender may try to use the appearance or perceived age of the victim as a justification for initiating intercourse. However, forensics has - and do use materials to draw developmental comparisons for teens.

A psychologist is available to officers, but most prefer their own coping strategies and have informal support groups (colleagues, family). The mental health status of officers is monitored through a psychological test (written and oral), which takes place every 6 months. Psychologists alone have a higher level of support and supervision -when conducting clinical work- in Romania.

When asked whether victims need to assert themselves and whether they are discriminated against, officers were confident that victims were guaranteed safety, with consideration given to family relations, and with minors placed in safe accommodation. Mothers with young children are placed in specialised accommodation. Once the victims' safety is insured, it allows officers to concentrate on the aggressor and preserve the evidence.

As in other cultures the authorities may be more respectful and deferential to affluent victims, it was asked whether that affected Police officers in Romania, who replied that the financial status of victims might influence only quality of legal counsel they could afford to hire. Care is given to the more disadvantaged victims, and if finances do not allow for transport into Tirgu Mures for psychological support (as the district's services are centralised), a car is sent by the Police to allow the victim to commute. On average, a victim will be scheduled to receive psychological help for evaluation within two or three days.

The Probation Service attached to the Mures County Court

Psychological and social support is provided also for aggressors under the probation period by the Probation Service attached to the Mures County Court.

There are several mandatory rules to be respected by the offenders under the probation period (respect the meetings schedule, announce any change of residence or a travel for more than 8 days, announce job change and prove means to earn a living). Depending the crime, there are other rules to be respected (detox programme, not contact specific persons, as established by the victim, a driving ban may have to be observed with the range of travel being limited, along with a bar and restaurant ban and where alcohol is served). Notifications of 2 (minor) infringements are allowed. Underage offenders must also carry out community service.

Group treatment is also available for DV offenders and rapists, but men must respect the group and not attempt to compromise the proceedings.

A programme that runs under the name *Social Skills Development* is a life-skills and reintegration programme that is successful also with domestic violence and sexual assault perpetrators. Positive responses and role-play are encouraged. The programme has 14 modules and is based on positive life style change.

Medical services

Medical services provided to victims do not follow national guidelines or protocols for intervention, informed consent is not required to initiate medical procedures, except for invasive procedures (if any). Records are kept confidential, and referrals to other services are not made on a regular basis.

Victims are explained the possible steps they can make but, if she declines to take action, the social workers from the emergency services merely accompany them home. Emergency contraception is

only provided when available (emergency contraceptives are not available on stock in the emergency medical services and there is no legal provision for that).

Social professionals do not receive special training adapted to the needs of victims of sexual assault; victims are offered the same services like the general population groups and there are no measures available for groups with special needs. Emergency services have a form for assessing patient satisfaction but apply it randomly. Emergency services are available round the clock, but victims cannot always be assisted by health providers of the same sex. Median waiting time from presentation in the emergency room is 3 hours if there is no major emergency, treatment is provided observing privacy, sensitively, and at a pace that the victim is comfortable with, and respecting the victims' wishes. Case evaluation is done using forms which are standard, but not used exclusively for sexual assault cases. Immediate medical care includes the following services: recording the personal history, treatment of physical lesions, provision of emergency contraception when available and assessment of the risk of self-harm (a pharmaceutical company provides pills, as part of its corporate social responsibility programme. Mures emergency service is the only one who have emergency contraception, as there is no national protocol.).

Allegedly, victims from disadvantaged and lower-income backgrounds are more thoroughly investigated to exclude the possibility that they might intend to blackmail their aggressor. Few cases of SA prove positive as clues, indicators, and intuition is used to judge the sincerity of victims.

Prophylaxis and vaccination for HIV and/or hepatitis B are not provided in emergency. The victim is informed about the options to have screening for STIs, HIV and hepatitis A and B and to have a pregnancy test. No STI specialists are available at night on emergency service, when most reported cases take place. Weekend incidents are dealt with on Mondays.

Information provision

Victims do not have clear information about where to turn in case of a sexual assault, the victim's pathway is complicated and inter-institutional guidance is not clear. Limited information about what a victim of sexual assault can do and what alternative routes the victim may follow is found only on the website of the National Forensic Medicine Institute.

> *„If you have health problems go first and take care of your health, probably altered the aggression suffered. In the hospital announce what happened to you. Doctors are obliged to call the police... Do not forget to ask from the hospital medical documents to prove that you were there...*
>
> *If you have no health problems and you are afraid, go to the police first. They will advise you what to do. In addition you will accompany you to an examination of your traumatic injuries in a forensic institution. Do not forget to have money in your pocket, as any forensic examination is for fee... Maybe it would be good to have also a lawyer to advise you. "*
>
> National Forensic Medicine Institute Bucharest, http://www.legmed.ro

Other information was found on the website of a County Police Inspectorate, which describes measures for prevention of sexual assault and a summary of what has to be made in a situation like this.

> *„What do you do if you were raped:*
>
> – *Denounce the rape to the Police as soon as possible.*

- *Go to the hospital and treat immediately any injury. Do not shower or bathe and do not change your clothes. You can destroy very useful information for catching the criminal.*
- *Talk to someone you trust.*
- *Talk to a psychologist. He/she can help you overcome fear and feelings of grief after the assault."*

Gorj County Police Inspectorate, http://gj.politiaromana.ro/furt6.htm

Only the psychological services offered victims the opportunity to choose whether to be counselled by a woman or a man. Otherwise, the services were provided by the professional who was on duty, something that was perceived as an impediment to victims. Information on the procedures to be performed and about emergency contraception were missing, and victims were informed about confidentiality issues and STIs only briefly.

An informed consent was signed by the victim only in certain services, sometimes without the victim being able to read it (except private psychological services), even if this was considered one of the major issues by the victims.

*„The entire system aggresses you in addition to the aggression you went through, and anyway, does not quite do justice."*

Sexual assault victim

**Assessment and recommendations**

Issues that are believed to need improvement regard in the first place the human resources in the existing services, which are insufficient and not properly trained in accordance with the special needs of sexual assault cases. There is a need for training on the specificity of sexual assault, opportunities to intervene in these situations and communication training.

*„Most forensic medicine specialists are men who have no tact, interrogate the victim, and ask unnecessary questions."*

Police representative

The emergency service opinion is that forensics physicians are not needed on site and it is not necessary to take sexual assault victims to the Forensic Institute. Collecting evidence from emergency service (by trained clinical staff), sending to forensics would be better.

The psychologist revealed that the victim's interaction with police was described by the victim as cold, technical, lacking safety and comfort. At the same time, the contact with the psychologist working in the police was considered a positive point, although this interaction is not a routine one, but a random one.

*„She was questioned as if it was a robbery, not a rape."*

Psychologist

Victims' opinion was that the services available to victims do not respond to the needs of people who have experienced a sexual assault. They did not believe they could be better or more efficiently organized if they were integrated in the same location. At the same time, the fact that a person has to report what happened several times was considered unacceptable and may affect the decision to resort to all available services. The possibility to address the police and health services is considered a good thing by the victims, while interaction with professionals from other two services was considered "too hard". Victims felt that for the professionals the incident and the physical condition were more important than the psychologically status of the victims.

*„I was treated like a car accident victim."*

Sexual assault victim

From the point of view of the victims, quality of service received and interaction with professionals is unsatisfactory. In some cases they had to wait a day for forensic certificate because the physician already left the office. The waiting and questioning time at the police was unacceptably long, as the fact that there were many people in the room where the inquiry was conducted, and this created a strong sense of shame and discomfort.

*„There was no privacy and respect, there were too many people there when I needed to tell and to answer questions about something I was ashamed. If such a thing happened to me again, God forbid, I think I would only go to a good psychologist."*

Sexual assault victim

There are still many prejudices about rape in contemporary society, which do nothing but to give the impression that the entire blame for the aggression belongs to the victim:

– Women say "no", but I understand "yes";
– Rape is a sexual fantasy shared both by women and men;
– Man was "provoked" by the woman's behaviour or clothing.

For services to be more respectful, compassionate and sensitive, victims indicated that it would require the following:

– Victims to be understood;
– Victims to be assured that everything is confidential;
– The testimony to be recorded without others present;
– Victims to be respected, not treated as objects;
– Efficient victim's "route" including shortening waiting and response times;
– Availability of free psychological assistance.

Lack of psychological comfort during some services and the relatively high cost of other services may be barriers that limit victim's access to services.

The three most important qualities a service for victims of sexual assault should have are as follows:

- Forensics: be treated with respect, do not wait, be able to schedule, do not feel guilty about asking the services;
- Medical care: do not feel guilty about asking the services, be treated with respect, do not wait;
- Psycho-social support: be able to choose the psychologist, have free-of-charge counselling, psychologists to be specially trained to assist victims of sexual assault;
- Justice system, including police: do not feel guilty about asking the services, have confidentiality, be treated with respect, do not wait, respect privacy, do not repeated indefinitely your story, be able to choose if you want a police woman.

*„To be treated with respect and understanding by people who are prepared to handle these cases, not be treated as a person claiming that her car was stolen... Nobody understood how embarrassing my situation was... This accident destroyed me mentally."*

Sexual assault victim

Professionals' attitude is not perceived as empathic by the victims, discouraging their eventual return to request other services from those institutions. Situations considered to be embarrassing for the victims can deepen psychological affections installed.

*„You are required to prove what happened, and I felt at times that I have committed an illegal act by complaining!*

Sexual assault victim

To improve institutional capacities to address cases of sexual assault, the following measures are required:

- Development of new specialized services or specialization of existing services for improving the professional intervention to assist victims of sexual assault;
- Creation of integrated multi-sectorial mechanisms for the assistance of victims of sexual assault;
- Development of inter-institutional procedures for integrated intervention in cases of sexual assault and application of a consistent methodology;
- Development of a best practice guide for assisting victims of sexual assault;
- Development of a system for monitoring the respecting of the rights of the victims;
- Development of a training system for the professionals who interact with victims of sexual assault including clear provisions on the conditions for initial and continued training;
- Continued and consistent professional training of the professionals who interact and intervene in assisting victims of sexual assault (including the multi-sectorial team members); training courses should focus not only on knowledge but also on attitude, behaviour and sensitive communication with victims;
- Provision of tools for psycho-diagnosis assessment and ensuring that victims have access to psychotherapeutic approaches for trauma recovery;
- Meetings of experts in the field to exchange experiences and case analyses, ensuring the prompt conduct of legal proceedings leading to shortened the time of the trial and sentencing;
- Accessing financing or grants for development of county and local services;
- Enabling consultative structures at local communities levels;

- Development of inter-institutional and multi-sectorial groups for coordination and intervention;
- Conclusion of agreements for cooperation between service providing institutions;
- Carrying out awareness raising campaigns on the issue of sexual assault and its consequences and information on options and recommended behaviours in the case of a sexual assault.

## Annex 5: United Kingdom Case Study Report

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**Purpose of this document**

The *Comparing Sexual Assault Interventions* project aims to explore different models of intervention for female victims of sexual assault aged 16 and over across Europe, in order to develop recommendations for good practice and resources to build capacity and promote excellence. This document provides an illustrative case study of local service provision in the county of Merseyside in the United Kingdom, where sexual assault services are coordinated through the Sexual Assault Referral Centre (SARC) *SafePlace Merseyside*. The case study discusses the services available for victims of sexual assault in Merseyside within the context of national legislation, and provides details of inter-service coordination and multi-sector collaboration. Findings specific to the SARC are presented, triangulating input from national protocols and publications with perspectives from both the service provider and service users in an attempt to provide a complete picture that captures the complexity of sexual assault service provision. Having described the service in light of recommended standards and mechanisms for service provision, the paper brings together recommendations and implications for practice.

**UK Case Study: Safe Place Merseyside**

**Background**

In 2011/12, 53,665 serious sexual offences were recorded by the police in England and Wales.[1] Although steps are continually being made by police and other statutory bodies to foster greater victim confidence and subsequent reporting of sexual offences, indications are that only 11% of victims of serious sexual assault actually tell the police about the incident, with 38% of victims telling nobody at all about their experiences.[2] Survey data suggest that in 2011/12, 3% of women and 0.3% of men in England and Wales were victims of completed or attempted sexual assault.[3] Since the age of 16, it is reported that over 19% of women and 2.7% of men have suffered some form of sexual violence. When individuals do choose to engage with support services, the response of service providers to victims of sexual assault can have a significant impact on their receipt of appropriate care and later adjustment and recovery.[4 5]

Improving services for victims of sexual assault has become a key focus of government policy, following concerns around low rape conviction rates and poor coordination of victim services.[6-8] In England and Wales, a range of legislation, policy and guidance has been implemented to strengthen responses to sexual assault[9-13], including measures to provide immediate ongoing multiagency support and care to victims in order to limit the impacts of sexual assault and help secure convictions. The Government's existing action plan, *Call to end violence against women and girls: Taking action – the next chapter*[14], affirms the role of locally provided Sexual Assault Referral Centres (SARCs) in making healthcare, including forensic examination choices and the criminal justice system, more accessible to victims of sexual violence.

SARCs can be thought of as victim-centred medical units that aim to co-ordinate and simplify the pathway for victims of sexual assault, improve immediate care, aid recovery and boost conviction rates by supporting victims through the prosecution process. In 2012, there were 40 SARCs across England and Wales. The structure and delivery of SARCs varies, although services are typically delivered by a range of public, independent and third sector providers at premises owned by the police or the NHS in urban locations with high population densities. Leadership of SARCs at the regional level is provided by localised steering groups, which feed into a national steering group.

**Methodology**

Three sources of information were used to develop this case study:

***Benchmarking and evaluation tool***

A benchmarking and evaluation tool was used to conduct a structured face-to-face interview with the service provider. Two researchers were present at the interview, with one posing questions and the other taking notes. The tool was designed to assess service provision against a proposed set of standards derived from a literature review and mapping survey and consisted of sections on: (1) sexual assault-specific activities, coordination, efforts and response; (2) forensic services; (3) medical services; (4) psychosocial services; (5) police services; and (6) legal services. The service provider was asked to indicate whether a series of particular features were present, partially present, or not in place within the service. The interviewee was also given the opportunity to provide any additional service information not covered in the tool. The interview was conducted at the service's premises.

***Policy documents, protocols, guidance for practice and official reports***

Documentation and information readily available in the public domain was used to gain a wider understanding of the practice model for UK sexual assault referral services. Such information was used to verify, support and supplement findings established by the benchmarking and evaluation tool and was sourced online from the Home Office, National Police Improvement Agency (NPIA), Association of Chief Police Officers (ACPO) and the Crown Prosecution Service (CPS)[§§].

***Service user interviews***

Whilst the information gained from the two approaches above can help to establish the mechanisms of provision and planning that exist and do not exist in a service, this may represent an 'ideal' that is not necessarily adhered to in practice or may not adequately meet the needs of all service users. Therefore the reflections of service users were sought to consider the effectiveness and suitability of the service from the client's perspective, identifying ways in which service provision may differ from the practice model but also allowing an exploration of what service users feel are the strengths and weaknesses or positives and negatives of sexual assault services available locally.

In an attempt to recruit female service users for interviews or focus groups, three different approaches were used, reflecting the organisations that clients may have contact with at various stages of their journey following sexual assault.

Firstly, postcards providing brief details of the study were left at SafePlace Merseyside. Clients were encouraged to provide their details on the reverse of a card should they wish to take part in the study. A sealed box was provided for completed cards, with the researchers then able to contact any self-referred potential participants to arrange suitable interview times.

Secondly, extensive efforts were made to liaise with the two third-sector organisations providing local Independent Sexual Violence Advisor (ISVA) services (see page 12) in the hope that they could

[§§] The CPS is the Government Department responsible for prosecuting criminal cases investigated by the police in England and Wales and is involved in advising the police, reviewing cases, preparing cases for court and presenting in court.

facilitate participant recruitment by highlighting the research to any of their clients who had utilised the services at SafePlace Merseyside. Although lengthy discussions were undertaken and detailed information was provided on the aims and objectives of the research, the university's ethical approval process, the need for service user input and the nature of interview topics, it was not possible to access clients via this route. One ISVA service failed to return contact and the other was unwilling to assist as they felt that it would never be possible or appropriate to speak with SARC clients who were so recently traumatised and stated that they would be failing in their duty of care if they supported access to them. The ISVA service expressed concerns that service users should not meet one another and suggested that the only way to gain any input from the service users' perspective would be to ask the ISVAs themselves to provide feedback on how clients feel and perceive the levels of service and care. Although the ISVA service initially passed on some negative feedback from one of their advisors, contact thereafter was limited and the research team felt that ISVAs were not an appropriate proxy for service users in this context.

The final approach involved contacting the following local community organisations and asking them to display a poster in their foyer or communal areas advertising the study: a women's refuge, a domestic violence service, a black minority ethic women's group, a charity supporting victims of crime, an organisation running women-only centres, a local authority vulnerable victims advocacy team, an independent advice service and a student wellbeing/counselling service. The poster provided basic study details and a contact address, email address and telephone number for the research team. When initial contact was made, organisations were provided with a more detailed explanation of the aims of the work, the ethical considerations and the importance of focus groups or interviews with service users. The poster was attached in an email but an offer was also made to send a hard copy to avoid the incurrence of printing costs for the organisation. Despite numerous follow-up calls and emails, confirmation was however only received from one organisation that the poster had actually been displayed and no responses were received.

Responses to the above approaches were very limited as services were generally extremely reluctant to support research that involved service users. It therefore proved difficult to reach target populations that were considered likely to include clients of SafePlace Merseyside once they had left the service. Three clients did, however, complete contact cards at the service itself, and were subsequently contacted by the research team. Two clients confirmed their desire to take part in the research and were invited for individual interviews. One client was no longer available on the contact details provided.

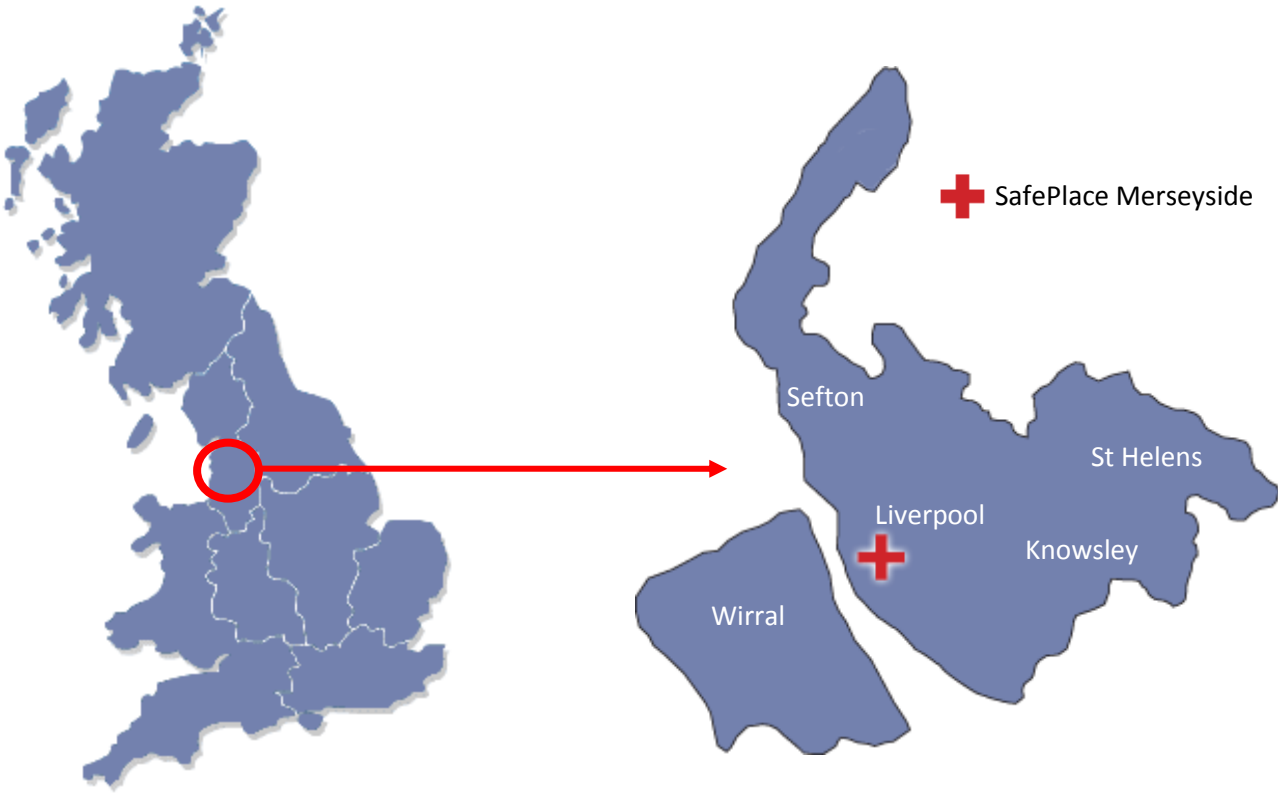
Although arrangements were made with the two clients to hold interviews at times suitable to them, transport to and from the interview was arranged with the safe taxi service used by SafePlace Merseyside, and clients were given the option of having a counsellor either present during the interview or available after should they require a debriefing session, neither client attended their scheduled interview. Despite numerous attempts, researchers were unable to make contact with the clients again.

Due to the outlined difficulties in approaching and interviewing service users, service user interviews were supplemented with input from anonymous Patient Experience Surveys (n=29) that had been collected by SafePlace Merseyside during the first two quarters of 2012.

**Sexual Assault Services in Liverpool, UK**

Liverpool is home to one of the UK's 40 SARCs, named SafePlace Merseyside. Situated in the city centre, SafePlace Merseyside was established in 2008 and serves a core population of around 1.3 million Merseyside residents, covering the five metropolitan districts of Knowsley, St Helens, Sefton, Liverpool and Wirral. With a high rate of tourism in and around the city, three large universities and an established nightlife scene, the SARC also serves a transient population of tourists, students and those visiting the area for business or leisure (e.g. stag and hen parties). All services provided by the SARC are fee-free, as are psychological and practical services. For legal services, free court assistance is provided by the Witness Service and cases are prosecuted by the Crown.

**Figure 1: Location and coverage of SafePlace Merseyside**




SafePlace Merseyside forms part of a co-ordinated model of sexual assault service provision, which provides forensic and medical services and 'contracts out' psychosocial services to local Independent Sexual Violence Advisors (ISVAs) (see section 4.2) working for third sector organisations. Co-ordinated by two full time staff members, the centre is accessible 24 hours a day throughout the year and has 19 on-call crisis workers who together support around 200 service users annually. This figure has risen steadily over previous years as the service has developed and such growth is predicted to continue. The service serves both females and males although 95% of attendees are by female.

Although SafePlace Merseyside will not accept referrals for individuals who are suffering from serious injuries as the centre and its staff are not equipped to provide specialist medical treatment beyond basic first aid, staff may be called to attend at locations such as hospitals or care homes and do so with a mobile examination kit ('grab bag'). Remote support is provided in line with protocols and processes that exist at the SARC and clients are given the option of referral to an ISVA service. Although Liverpool hosts a specialist children's SARC based in Alder Hey Children's Hospital that provides sexual assault services for those under the age of 16, SafePlace Merseyside will take referrals for teenagers in certain situations where an adult-oriented service is considered more appropriate.

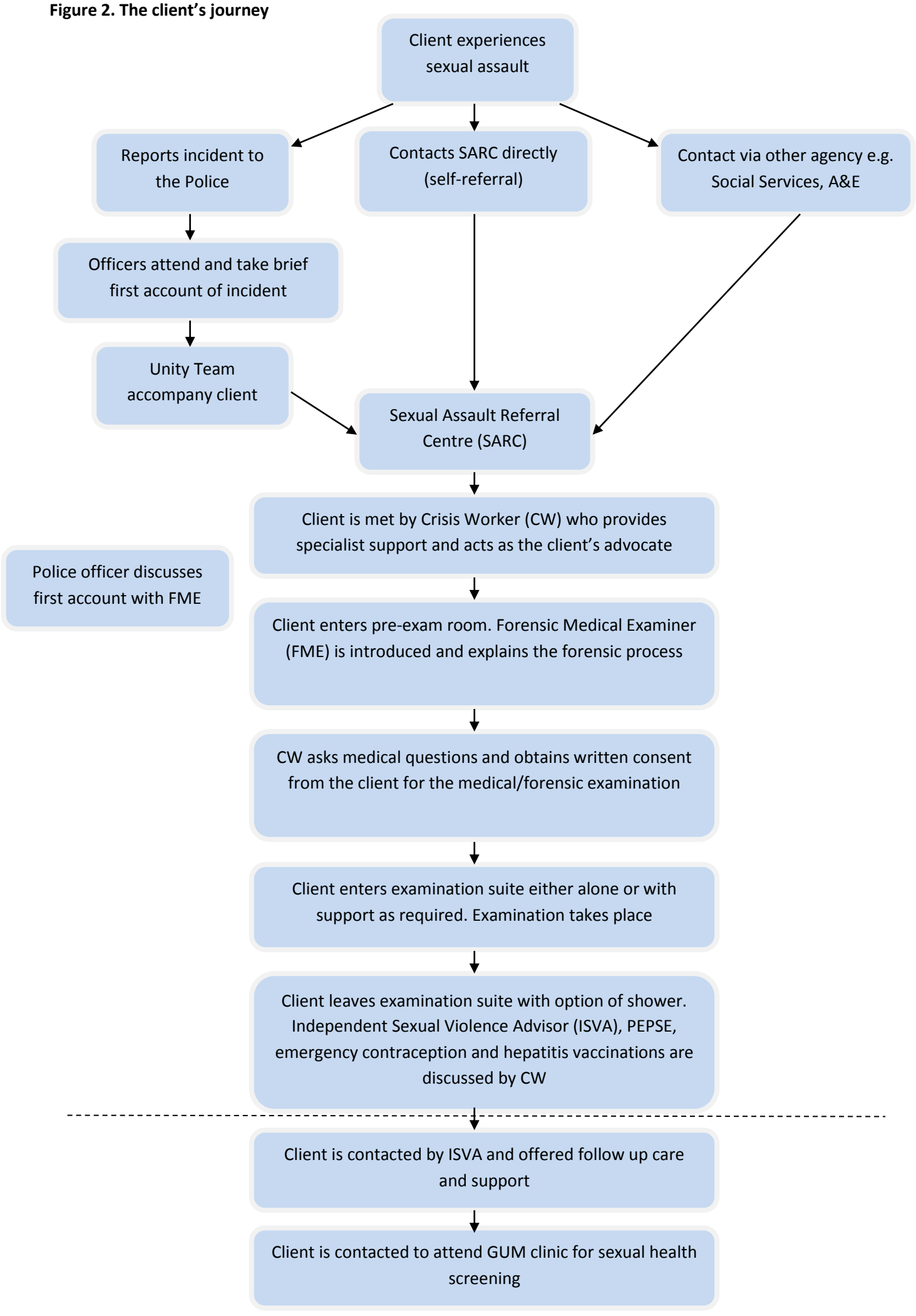
SafePlace Merseyside combines the expertise and services of health professionals and the police, who work with coordinated protocols, practices and reporting processes that have been agreed upon by all sectors and agencies engaged in providing sexual assault-related services. Such protocols encapsulate reporting mechanisms for sexual assault cases and confidential information sharing, client flow and referrals through sectors, as well as ethical and safety standards for coordination.

**The client's journey**

Figure 2 shows the client's journey when accessing sexual assault services in Liverpool. If an individual reports a sexual assault to police, health services or other social services in Liverpool, they will be referred to SafePlace Merseyside. Clients may also self-refer, and information and the telephone number for the service is disseminated via awareness raising materials in public places. However, the physical location of the service is not advertised to ensure confidentiality for those visiting the service. A manager or administrator is present at the service to answer the phone during office hours and outside of these times callers will be connected to an operator service that will then have a crisis worker (CW) call them back as soon as possible. CWs must adhere to a strict procedure when taking self referral calls and do so using a Crisis Worker Toolkit (a folder containing important information on safeguarding, mental capacity assessment, additional support services, client transport, lone working, conflict resolution and self referrals) and a telephone call log sheet. The CW will ask the client how they can help, but ensure that they explain the limits of confidentiality, particularly in relation to safeguarding issues.

If an individual reports a sexual assault to police, they will be taken to SafePlace Merseyside by a specially trained police officer known as a Sexual Offences Liaison Officers (SOLO; see section 4.3). The SOLO will take a brief account of the incident (including details such as who, what, where and when), and will brief the doctor at SafePlace Merseyside prior to the victim's medical examination. A videoed police interview needed to cover the incident in fine detail will take place two to three days later at a police-owned house in a location away from the individual's place of residence, for the purposes of confidentiality. Individuals who are referred to SafePlace Merseyside by other agencies, or who self-refer, can choose whether or not to report the incident to the police (see Box 1).

**Figure 2. The client's journey**



Box 1. Reporting of sexual assaults to the police

Clients attending SafePlace Merseyside are not required to report the incident to the police. However, with consent, the service can collect forensic evidence and verbal information from the client that can be held at the SARC typically for six months and made available should she wish to pursue criminal justice processes at a later point in time. Clients may also choose to provide information about their assault to the staff at the SARC, who can then pass this information on to the police anonymously. This can provide the police with key intelligence that could help to prevent future attacks.

On arrival at SafePlace Merseyside, the client is met by a Crisis Worker (CW) who provides specialist confidential, emotional and practical support and acts as the woman's advocate during her time at the service. If a friend or a relative has attended the SARC along with the client, the CW will initially try to get the client alone to talk through the examination process and services provided by the centre. The friend/relative may, however, stay with the client during the examination if desired. Throughout the client's journey, waiting times are limited wherever possible. Both on-call CWs and doctors are required to be in attendance at the SARC within 30 minutes of receiving a call out and clients must be seen within 60 minutes of the time of referral. A longer wait may be incurred if the client is intoxicated or if another client is in the examination suite. The CW must ensure that the client can understand and speak English well enough to give informed consent to the examination, otherwise an interpreter should be called. The CW will also complete a safeguarding checklist for the client and may be required to contact the Safeguarding Adults Team within Liverpool Community Health (NHS).

In a designated pre-exam room, the CW will introduce the client to the doctor who will be conducting the forensic medical examination. Examinations take place in a dedicated examination room (see section 4.1) and are conducted by specialist doctors (Forensic Medical Examiners; FMEs) who can also provide emergency contraception, vaccinations, post-exposure prophylaxis (PEPSE)[9] and referral to sexual health clinics. Once the FME has given details of the forensic process to the client, the CW will take the client's medical history and obtain written consent for the examination. The client will then enter the examination suite with the FME, the CW and other support as required. If the client has been referred to the SARC by the police, the SOLO will be present in the examination suite to ensure the chain of evidence and forensic integrity, but will remain behind a closed curtain at all times. During the examination, the FME will examine all parts of the client's body and may take specimens such as swabs or blood and urine samples. The client will be asked to give more precise details of her experience to the FME who will conduct a risk assessment for self-harm.

Upon completion of the examination, the client leaves the suite and is given the option of a shower and a change of clothes. In the post-exam room, the FME, the CW and the client are then able to sit down and discuss contraception options and other medical treatment such as PEPSE and vaccination

[9] PEPSE is a treatment that can stop a person becoming infected with HIV after it has entered the body.

for Hepatitis B. If the client is given either form of medication, written information is also provided detailing dosage, potential side effects etc. The CW will ask the client for their signed consent for referral to an Independent Sexual Violence Advisor for continued advice and support (see section 4.2). The preferred method of contact and telephone number(s) will be verified and the CW will check that the client is in possession of their mobile phone (if this is the preferred means of contact). An ISVA is required to contact the client within 24 hours of their attendance at the SARC (excluding bank holidays). For screening and treatment for sexually transmitted infections, clients are referred to a local Genitourinary Medicine (GUM) clinic for follow up, as infections may not be identifiable until up to 14 days after exposure. Suitable transport will be provided for clients to leave the SARC and travel home.

There may be certain occasions when a client in unable to return to their home if it is the scene of a crime and alternative accommodation cannot be accessed immediately. Clients may rest for a short period on a bed settee located in the administration office at SafePlace Merseyside and will be provided with pillows and a duvet. On such occasions, the FME will remain in the SARC until the client is able to leave safely.

Once a client has left SafePlace Merseyside, the support and guidance provided by an Independent Sexual Violence Advisor is ongoing and may continue for as long as is deemed necessary. In cases that go to court, an ISVA will provide support through the criminal justice process and will work alongside the Witness Service to communicate the client's needs and arrange special protection measures in court as required.

**Specific service provision**

This section provides further information on the different aspects of services provided throughout the sexual assault referral centre model in Merseyside.

***Forensic and Medical Services***

Forensic medical examinations are available at SafePlace Merseyside 24 hours a day and are carried out in privacy in a dedicated forensically-approved, cleaned and sealed room. A colposcope is available with appropriate storage for images. Examinations are undertaken by Forensic Medical Examiners (FMEs) - doctors who are specially trained to deal with sexual assault interventions. Clients have the right to choose whether to be seen and treated by a male or female doctor. Examinations are carried out in a uniform way, with clients seen within 30 minutes to an hour.

Protocols for performing forensic examinations are outlined by the Faculty of Forensic and Legal Medicine at the Royal College of Physicians (FFLM), a charity set up to maintain the highest possible standards of competence and professional integrity (see www.fflm.ac.uk). Alongside national guidelines for conducting forensic examinations, standard evidence collection kits and pro formas are used. Mechanisms are in place to ensure that the client gives full informed consent for the forensic examination process (both before and during). The Crisis Worker discusses the examination process and obtains consent from the client before they enter the examination room. They will then

accompany the client during the examination to raise the client's concerns should they wish to stop at any time or withdraw completely. Full client records are generated within 48 hours. These become the property and responsibility of the FME and must meet the confidentiality and information governance requirements of the police and the NHS. If authorised by the client, information may be shared with the police and community services as appropriate. FMEs may then also be called upon to testify in court.

Written information is available to service users regarding the preservation of forensic evidence, both in leaflet form and contained within the *frequently asked questions* page on the SafePlace Merseyside website (www.safeplacemerseyside.org.uk). Additionally, advice can be sought by telephone and clients are able to speak to a Crisis Worker 24 hours a day, 365 days of the year. A telephone number is also provided on the website for individuals who may require this or any other information in a different language.

Within their training FMEs are sensitised to the needs of different population groups. At SafePlace Merseyside, this sensitisation is supported by a variety of special measures to cater for these populations, from cultural issues training and translation services to a fully equipped wet room and hoists for disabled service users. A directory of services and organisations is maintained and used for referrals. This includes organisations in the third sector specialising in support for young people, victims of domestic violence, and ethnic minority groups.

Within what is referred to as the 'modern forensic movement', forensic services are overseen by a Principal FME employed by Merseyside Police Authority. The Principal FME's responsibilities include attending management meetings within the force, ensuring adequate cover and identifying training needs. New FMEs spend a period of time shadowing the Principal FME, observing and assisting on tasks in accordance with a predetermined training syllabus. Each new FME is required to complete a minimum number of particular types of examination before being allowed to operate independently and it is the Principal FME's responsibility to certify that an acceptable standard has been reached. As with all disciplines of medicine, continuous professional development is core to the practice of FMEs and training takes place annually. Revalidation (a formal system for ensuring that doctors remain fit for practise) also occurs every five years through recommendation to the General Medical Council (GMC) on the basis of five consecutive satisfactory annual performance appraisals.

***Psychosocial and practical services***

Although crucial support is provided at the SARC by Crisis Workers, once the client has completed their forensic examination and left the centre, psychosocial and practical services are provided by an Independent Sexual Violence Advisor (ISVA), communication with whom is set up by the SARC. ISVAs are victim-focused advocates who are funded to work with victims of recent or historic sexual crimes and enable them to access the services they need, depending on the client's individual circumstances and requirements. Using a standard reporting form, ISVAs conduct an assessment of the client's risk of self-harm, symptoms of Post-Traumatic Stress Disorder (PTSD), symptoms of depression, anxiety and low self-esteem, need for a refuge or safe house, and need for childcare or the involvement of Social Services. This information is used to develop a bespoke care plan for the client. ISVAs must document all actions and maintain confidential client files, sharing information

with the police and community services where appropriate and authorised by the service user. A client's relationship with their ISVA may continue for weeks or months after an assault, with individuals often receiving support for up to 18 months, particularly when criminal justice proceedings are taking place. The role of an ISVA is multifaceted and includes providing information about the criminal justice system, support and advocacy through the criminal justice process, information and advice about health needs and options, emotional support and/or support to attend related appointments, and referral to other services or agencies. The ISVA may then act as a point of liaison for all other agencies involved with that client. A recent independent review of how rape complaints are handled by public authorities in England and Wales, commissioned by the Home Office (The Stern Review)[1], served to highlight the importance of ISVAs, considering them an 'intrinsic part' of the way rape complainants are dealt with. Up to 2015, funding from the Home Office has been made available at a rate of £1.72m per annum to support ISVAs working in the voluntary and community sector and in SARCs themselves[16].

Skills for Justice (an independent UK wide organisation that exists to tackle the skills and productivity needs of the justice, community safety and legal services sector) has recently worked in conjunction with the Home Office to develop a set of National Occupational Standards for ISVAs. In Merseyside, all ISVAs are accredited practitioners who have undertaken training that encompasses planning and protection, building and maintaining effective partnerships, effective communication, diversity and equality, and actions in court and beyond. As well as this sensitisation to the needs of different populations, specialist ISVA services exist for sex workers and Merseyside has recently seen the introduction of its first male ISVA. As well as sensitising other sectors on sexual assault through their advocacy of victims, ISVAs also work to sensitise the public through social marketing and campaigns for vulnerable or marginalised groups such as adolescents, ethnic minority women and sex workers. ISVA services are overseen and monitored by the Home Office whose quarterly reports evaluate service provision quality and service user outcomes.

Although there is currently no requirement for ISVA services to be available 24/7, it is reported that generally in Merseyside an ISVA's phone will always be on and there is an unwritten understanding that clients may call whenever they feel they need support. Due to a purported lack of services and support in Merseyside for the families, friends and partners of women who have experienced sexual assault, ISVAs do offer support that extends beyond the client, although this is by informal arrangement only and is not within their official role prescription.

***Police services***

The police have a series of comprehensive protocols for both preventing and responding to sexual assaults. Guidance on investigating and prosecuting rape is produced by the National Policing Improvement Agency (on behalf of the Association of Chief Police Officers and the Crown Prosecution Service) and applies to all police involvement, from initial contact (with telephone operators) to first response and criminal trials. Overall this guidance reiterates the premise that victims should receive a 'seamless service' between police, the Crown Prosecution Service, health services and specialist sexual violence services[13].

The multidisciplinary and collaborative nature of sexual assault service provision in Liverpool is exemplified by the innovative Unity Team that was formed by Merseyside Police in 2010. The first of its kind in the UK, this dedicated sexual assault investigation team brings together specialist detectives from the police force and expert rape lawyers from the CPS in one unit, allowing allegations to be dealt with and offenders brought to court more quickly, whilst simultaneously enabling early decision making regarding how best to support victims in court. To ensure that the specific needs of victims of sexual assault are met, some police officers are specially trained for a role as a Sexual Offences Liaison Officer (SOLO). SOLOs will, in the case of incidents reported to the police, accompany a victim to the SARC and act to ensure the chain of evidence and forensic integrity. SOLOs are briefed in recognising post traumatic stress disorder and cognisant of the difficulties victims are likely to face when describing their experiences. Through the National Policing Improvement Agency Specially Trained Officer Development Program, all individuals tasked with the SOLO role are extensively trained in the Sexual Offences Act (2003), interview and investigative procedures for sexual assault, and risk and safety planning for victims, with a focus on those who are vulnerable due to disability, incapacity, location and opportunity. A SOLO will typically assume a coordinating role in communicating with the victim, although the victim is given the option of being updated by the SOLO, the investigating officer (IO) or an ISVA.

Reports of all crimes under the Sexual Offences Act (2003) are graded to receive an immediate response, unless the victim is reporting an event that took place some time ago (and immediate forensic opportunities do not exist). Ensuring there is no delay in police contact with the victim or further sources of evidence should work to prevent any potential loss of evidence. Minor response delays may occur as a result of considering the wishes of the victim - if they do not want a visible police response or are specifying where and when they would like police contact for example - but police services are available 24 hours a day, seven days a week. Whilst female victims will always be provided with same-sex officers trained in sexual assault response, this is not the case for male victims as all SOLOs in Merseyside are female.

At first contact with the victim, a SOLO will ensure the victim's welfare and medical needs are met and take a first account of the incident, whilst a fellow officer will assess the scene and preserve any forensic evidence using an early evidence kit. The SOLO will then ask the victim to accompany them to SafePlace Merseyside for a forensic examination. Colleagues may remain at the scene. If the victim refuses the examination, referral information can be provided for medical aftercare, victim support and counselling. According to the Victim's Code (see section 4.4), police must ensure that victims can access information about local support services (including contact details) as soon as possible after an allegation is made, and no later than five days from the first contact. Information must be provided in a language and format that the victim can understand. In accordance with the Victim Referral Agreement, in cases of sexual offences (as is also the case for domestic violence but unlike other crimes against the person), the police pass the victim's contact details on to Victim Support[10] only when the victim gives explicit consent for them to do so.

[10] Victim Support is a national charity that gives free and confidential help to victims of crime, witnesses, their family, friends and anyone else affected across England and Wales (www.victimsupport.org.uk).

The victim's first account is taken with a series of pre-established questions[15] and the SOLO will begin an investigation log. All reports of sexual assault are recorded in compliance with the Home Office National Crime Recording Standards[16]. Private interviewing spaces are provided in discrete police 'houses' in the case of follow-up video interviews. The timing of these interviews is decided in consultation with the victim, giving some control back to the victim and maximising the potential for recall. In the case of victims presenting to police stations, private on-site interview spaces are provided for gathering initial information.

***Legal services***

Legal services for sexual assault cases are provided in Merseyside by the Unity Team. As a unique working collaboration between the police and the Crown Prosecution Service (CPS), this service provides specialist support in line with a joint national protocol for the handling of rape cases. Co-ordination of investigation and prosecution between these agencies is overseen regionally by a CPS-appointed Area Rape Coordinator. The CPS also provides a network of rape specialist prosecutors who have a responsibility for cases of sexual assault from pre-charge to case conclusion. These specialists are barristers who have completed a CPS accredited course for undertaking rape prosecutions in court, during which they are taught about the myths and stereotypes surrounding sexual assault and the emotional and psychological effects of rape. As soon as possible following the initiation of criminal justice proceedings, the specialist prosecutors will conduct an early consultation with the police, conduct pre-trial interviews with the victim and any witnesses, arrange special measures for giving evidence in court (if necessary for the victim's protection) and work with the police and the courts service (HMCS) to ensure that the victim and witnesses are kept informed as to changes to the bail conditions or custody status of the accused person. Rape specialists then work closely with the investigating officer to build the case for the prosecution, using the Rape Prosecutions Advice/Review Checklist to explore all possible avenues of evidence. Only certain Judges are authorised to hear rape cases. These Judges must have attended a 3-day training course that is renewed every three years.

In working with victims of sexual assault, the police and the CPS must both comply with the responsibilities set out in the Victim's Code. This code represents a minimum level of service and obligations for information sharing for all organisations involved in criminal justice, from the CPS and HMCS, to the police, the Prison Service and the Probation Service. Special consideration is given in the code to vulnerable or intimidated victims. The code also dictates the provisions required of CPS Witness Care Units (WCUs), including court familiarisation visits for victims and additional assistance for non-English language speakers and those with accessibility requirements. At this point, and throughout the legal proceedings, an ISVA may assist in communicating the victim's needs to the CPS. As a result of the specialist services provided by the Unity Team, legal proceedings are conducted with minimum delays, typically within six months. The CPS may request special measures for any victim in court. If granted, this may allow the victim to provide evidence via a videotaped interview, whilst concealed behind a screen, or with greater privacy (i.e. with everyone vacated from the public gallery). Decisions regarding such measures are at the discretion of presiding Judge.

**Service delivery**

This section provides a summary of the structures and activities that allow multiple agencies in Merseyside to collectively address all the dimensions of care and support needed by victims of sexual assault.

***Coordination***

The regional steering group that oversees the Liverpool SARC and coordinates and monitors inter-agency and multi-sector work is health-service led, although this is an 'informal' arrangement that has been assumed over time (the chair of the group is the manager of the first ever SARC, established in Manchester in 1986) and leadership varies across different UK regions. In Merseyside, to maintain a high standard of collaborative work, meetings with all sectors are organised every quarter in the form of the police-led Harm Reduction Forum. Although different agencies do not meet to review individual cases, the forum provides an opportunity to discuss issues surrounding service provision and is complimented by quarterly service planning meetings held by the Strategic Management Group. It is strongly felt within the service provision network in Merseyside that official platforms for case review are not necessary as there is routine coordination between all agencies. If necessary, serious case reviews are held by the police for intelligence sharing, for example in the case of a suspected serial rapist.

***Staff training***

Service coordination is additionally supported by multi-disciplinary training that also takes place every quarter. During these evening sessions, which are attended by ISVAs, medical practitioners, crisis workers and representatives from the police, reflective practice is explored and guest speakers are invited to talk on issues relating to sexual assault and addressing the needs of service users (e.g. cognitive dissonance in violent and abusive relationships). The SARC also conducts additional sexual assault awareness training with ambulance drivers and Accident and Emergency department staff that advises on the preservation of forensic evidence and sensitises staff to the needs of victims.

***Commissioning***

SARC services are commissioned by local authorities and primary care trusts, with funding from the police and centrally from the Home Office. For SafePlace Merseyside, applications for funding are made collaboratively and are led by a health-based lead commissioner from the Primary Care Trust of one of the five metropolitan boroughs (Wirral). Although in recent years sufficient funding has been available to plan sexual assault services across relevant sectors for the short and often medium term, national structural changes are currently placing a limit on such certainty and security. In particular, the potential impact of the incoming Police and Crime Commissioners (due to be elected in November 2012) and the move for Forensic Medical Examiners (FMEs) from employment within police authorities to positions within health services are of note (see Crilly et al, 2011[17]).

***Evaluation***

The SARC regularly conducts evaluations in the form of patient user experience questionnaires which are used to develop and implement new action plans. The questionnaires are anonymous and are

made available in many different languages. Questions focus on the quality of service provision, including whether or not the treatment was explained in a way that was understandable, whether or not the client felt fully involved in decisions about their treatment and care, if the client felt they were treated with dignity and respect, and how they would rate their overall experience. Additional space is provided for any further comments or suggestions clients may have. During the service provider interview, the manager of SafePlace Merseyside highlighted a recent example of an action resulting from this client feedback. Having received a questionnaire that raised concerns about the visibility of drugs prescribed at the SARC, clients are now provided with an unlabelled bag in which they can conceal any medicines or leaflets when they leave the centre.

Activity within the SARC is also measured quarterly, with data including the total number of clients attending, the number attending for specific services only (e.g. forensic only or follow up services only), the key demographics of clients (gender, age, ethnicity and sexual orientation), the referral source for clients, the assault location and their relationship with the assailant. Clinical information is compiled to monitor the proportion of clients who are prescribed PEPSE, the duration of forensic examinations, the number of criminal justice statements provided and the number of clients requesting or requiring psychological or counselling services.

Data collected by the SARC and Merseyside Police concerning the prevalence of sexual assault are routinely compared to those reported by the Crime Survey for England and Wales (formerly known as the British Crime Survey). Local data from other services (e.g. the ambulance service) are also considered to establish rates of referral between services.

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**Perceptions of the service provider**

Whilst much of the information above concerning service provision and the client's journey was identified during an extensive interview with the service provider, the following section serves to highlight some additional key points that were communicated by the manager at SafePlace Merseyside when reflecting on the standards of care and the efficiency and suitability of the SARC model.

When interviewed, the manager of SafePlace Merseyside was confident that their service works well with other services that provide support for victims of sexual assault. This is a belief that had been affirmed by the recent receipt of an award for collaboration from a local PCT. It was therefore reported that great achievements have been made and no additional improvements are required. This purported excellent collaboration was largely attributed to a common ethos of shared ideals and an overriding commitment to the cause in each individual involved in service provision. Individuals choose to apply for specialist police roles and whilst there is limited monetary reward, it is through exceptional drive and motivation to give something back and make a difference that individuals from a wide range of backgrounds are said to put themselves forward for these and other relevant positions, such as crisis workers. For many roles, additional training is required and in the case of ISVAs in particular, the individual themselves may have to make an additional investment in paying to train and to gain accreditation. For those performing on-call roles, other employment is

maintained and duties as a FME or Crisis Worker are undertaken often during antisocial hours and in what would typically be personal or free time.

Among those agencies involved in service provision, information sharing practices are said to have been designed to limit the immediate impact on clients. Once the client has given a detailed description of her experience to the FME during examination, the doctor produces notes that are subsequently passed over to the ISVA to limit the number of times a woman has to give a detailed description of her experience. This negates the need for the client to retell the same information to their ISVA and supports inter-service coordination.

The manager of SafePlace Merseyside was also keen to highlight the ways in which feedback from and cooperation with other follow-on services allows the SARC to respond to engagement or retention issues and client needs. For example, as a result of clients failing to attend follow up appointments, SafePlace Merseyside has recently implemented a system by which clients can opt to have the GUM clinic contact them after a suitable time interval and are then provided with a taxi service to and from the resultant appointment.

Numerous examples were provided of the renown of SafePlace Merseyside, both nationally and internationally. The service is frequently visited by managers and staff from other SARCs across the country who are thought to look to the procedures and protocols at SafePlace as a demonstration of best practice. Keen to support the establishment and development of other centres, the manager at SafePlace Merseyside readily shares both ideas and materials with her counterparts. The SARC has also played host to many international visitors, including forensic medical practitioners from Saudi Arabia and the Turks and Caicos Islands. The staff at SafePlace Merseyside felt that these visits were instrumental in allowing the cross-cultural exchange of ideas.

**Perceptions of service users**

***Patient Experience Surveys***

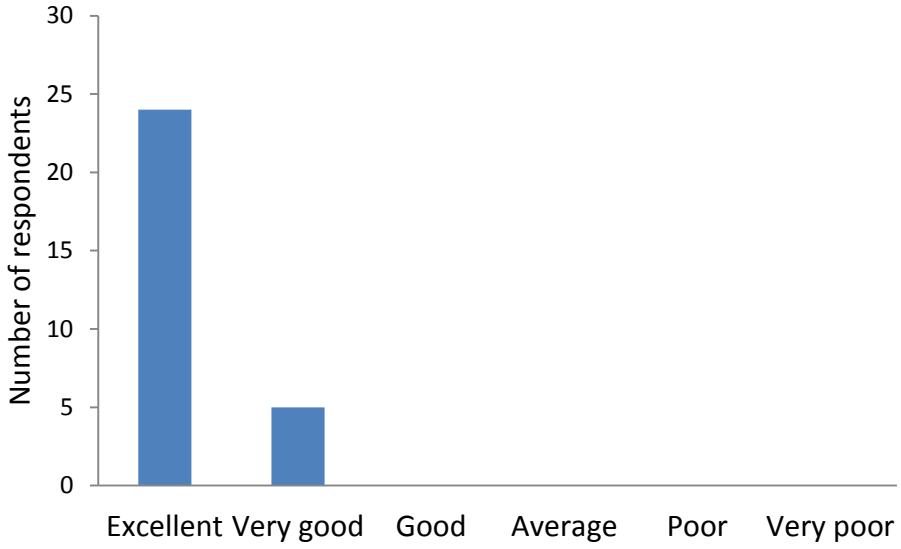
During the first two quarters of 2012, clients at SafePlace Merseyside were invited to take part in survey developed by Liverpool Community Health (NHS). The survey was anonymous and asked clients questions about the quality of service they had received and whether they had any comments or suggestions for service improvement. Of a possible 82 clients who underwent forensic medical examinations during this period, the survey was completed by 29 respondents (35% response rate).

All respondents indicated that the health professionals at the SARC explained their treatment to them in a way that they completely understood and all felt they were as involved as they wanted to be in decisions concerning their treatment and care. All respondents reported that such discussions regarding their condition and treatment were held in private and confidential surroundings. The vast majority of clients completing the survey said they were treated with dignity and respect and had continued confidence and trust in the clinical staff treating them (93.1%). Respondents confirmed both that written information about their care and treatment was provided to them (93.1%), and

that they were told who to contact if they had any worries, fears or questions regarding their condition (96.6%). Of those respondents who reported being on medication, 96.6% said they were told about possible side effects to look out for.

Generally respondents reported that they knew how to make a compliment about the service (82.8% said yes they knew) but were more unsure about how to make a complaint (55.2% said yes they knew), with eight individuals declining to answer the latter question. All respondents said that they would recommend the service to their friends, family members or colleagues. Ratings of respondents' overall experience are illustrated in Figure 3 below.

**Figure 3. How would you rate your overall experience of the service?**




When given the opportunity to make additional comments, one respondent reported feeling "constantly reassured", one noted the "pleasant and relaxing surroundings" and a third respondent described her doctor as "second to none".

**Recommendations**

In the absence of direct communication with service users, it is difficult to determine if the attitudes presented by staff involved in service provision are also supported by service users themselves and if information regarding the effectiveness of service provision and coordination is an accurate reflection of the support provided to victims. Nevertheless, having spent a substantial amount of time exploring the service model and considering forensic, medical, psychosocial, police and legal services independently as well as looking at overall multi-sectoral and interagency coordination, it is possible to put forward the following recommendations for increasing the effectiveness, appropriateness and humanity of sexual assault services, with the caveat that input from service users should be sought when considering any changes to the services that are currently available or the way in which services are delivered and coordinated.

***Sexual assault services in Liverpool***

Although there is a very good working relationship and referral process between SafePlace Merseyside and the organisations that provide local ISVA services, there is a reported lack of understanding as to the role of ISVAs among police forces both locally and nationally. This has particular implications for those individuals who are sexually assaulted in areas beyond their area of residence (i.e. outside of Merseyside), do not attend the SARC, and should subsequently be referred by other police forces to ISVA services within Merseyside. It is imperative to ensure that all police forces across the UK are aware of the aims and scope of ISVA services, the support and guidance they can offer, and the referral mechanisms for victims, particularly as these services are central to the government's plans for future sexual assault service provision. To foster understanding and cooperation across county borders, an ISVA service should first work with their local police force to raise awareness among police staff, challenge any misconceptions and address any barriers to coordination. Meeting and talking to an ISVA could, for example, become a key part of the training programme for new officers.

Throughout discussions with all relevant service providers in Liverpool, concerns were raised surrounding the availability of support for the families and close friends of victims of sexual assault. Although the manager at SafePlace Merseyside indicated that extended support is sometimes provided on an informal basis by a victim's ISVA, discussions with a member of staff from one ISVA service clearly indicated that the current demands for their time are such that individual ISVAs may have up to 50 clients at any given time, significantly limiting their ability to provide any services beyond those which they are formally contracted to. As there is a significant body of literature outlining the profound impact that sexual offences can have beyond the individual victim, it is important to ensure that all those affected this type of crime receive the support that they need, particularly as concerns for the welfare of friends and relatives may factor into an individual's decision to report or seek help following a sexual assault.

It is recommended that additional services are also established to provide specialised psychosocial and counselling support to victims from the lesbian, gay, bisexual and transgender (LGBT) community, as this was identified as a particular need by the manager at SafePlace Merseyside.

Although there are services elsewhere in the North West for gay men who have experienced sexual assault (e.g. see www.survivorsmanchester.org.uk), there are no such services in Liverpool and lesbian women are particularly overlooked. To establish services that meet the needs of homosexual men and women, it will be important to consult with individuals from these target groups to identify ways in which their treatment and support needs may differ from those of heterosexual victims.

The most pervasive conclusion that can be drawn from this exploration of service provision in Merseyside is the need for additional local (and national) research activities. First the issue of how to access service users needs to be considered. This issue is somewhat two-fold as implementation of the proposed methodology for this case study has demonstrated that is it extremely difficult to: (a) reach service users to provide them with details of research studies and opportunities for them to give their feedback, and (b) engage with those individuals who are initially contactable. Key research questions would include: when is the best time to approach victims; who should approach them and by what means; and how should they do this to ensure that the victim is as comfortable as possible and able to make an informed decision as to whether or not to take part in the research. Any such advances may need to be predicated on cultural changes that allow organisations within the sexual assault service model to understand the value of research activities and the desire of researchers to empower victims of sexual assault through their inclusion.

The benefits of SafePlace Merseyside, the Unity Team and ISVA services could be grounded in research evidence with the compilation of data on reporting and conviction rates. As well as establishing how victims perceive the effectiveness, appropriateness and humanity of sexual assault services, the SARC model provides a valuable opportunity to look at which victims chose not to report to the police and their reasons for doing so. Information such as this may assist the police in developing ways of increasing reporting behaviour. Data should also be collected and analysed to look at both the referral rates of sexual assault victims to SafePlace Merseyside, and the onward referral of SafePlace clients to ISVA services. One ISVA service in Liverpool raised concerns that there may be a considerable drop off in service engagement post SARC, and it would therefore be very useful to identify whether this is the case, why these individuals are disengaging, and what could be done to foster greater engagement with support services.

***Transferable learning at the European level***

Producing a case study of sexual assault services in the UK using the benchmarking and evaluation tool has allowed the identification of many key learning points that may help to support the development and enhancement of services elsewhere in Europe. In order for this information to be used most effectively however, it is important to supplement current understanding (as identified in the sections above) with information on the resource implications and requirements of such a model of service provision. Financial considerations would include the costs of both setting up and maintaining the SARC model (including facilities and equipment, staffing and staff training), alongside the potential cost savings derived from a coordinated model and its impact on prosecution rates, long term medical care and psychosocial support etc. To provide a realistic picture to partner

countries and other interested parties within the European Union, further work should consider the cultural and political requirements for bringing about substantial change and introducing a model reliant on multi-sectoral collaboration, drawing on the experiences of those who have helped to achieve this in the UK.

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