The role of the sexual assault centre

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Sexual Assault Centres provide multidisciplinary care for men and women who have experienced sexual crime. These centres enable provision of medical, forensic, psychological support and follow-up care, even if patients chose not to report the incident to the police service. Sexual Support Centres need to provide a ring-fenced, forensically clean environment. They need to be appropriately staffed and available 24 h a day, 7 days a week to allow prompt provision of medical and supportive care and collection of forensic evidence.

Sexual Assault Centres work best within the context of a core agreed model of care, which includes defined multi-agency guidelines and care pathways, close links with forensic science and police services, and designated and sustainable funding arrangements. Additionally, Sexual Assault Centres also participate in patient, staff and community education and risk reduction. Furthermore, they contribute to the development, evaluation and implementation of national strategies on domestic, sexual and gender-based violence.

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Introduction

In this chapter, we focus on the role of the Sexual Assault Centre (SAC), for the provision of holistic care for adult men and women who have experienced sexual crime. These centres have a broad range

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of titles internationally, but strive to offer a similar model of responsive care for those who need to access services at a time of immense personal crisis. In the Republic of Ireland, they are called Sexual Assault Treatment Units (SATUs) whereas, in the UK, they are generally called Sexual Assault Referral Centres (SARCs). Regardless of the terminology used, it is clear that the ethos must be firmly patient-focused, providing medical and support services, in conjunction with a co-ordinated justice response.

In this chapter, we delineate the necessary components of care provision within SACs, being cognisant that many of these will be discussed in greater detail in other sections of this issue of Best Practice and Research Clinical Obstetrics and Gynaecology. It will also focus, therefore, on other aspects of a cohesive service, including infrastructural and funding considerations, guideline development, data collection, strategy implementation, and internal and external education. In view of our familiarity with the model of care available in the Republic of Ireland, much of the detail will pertain to these local services and recent developments. Nevertheless, this model of standardised, patient-focused care is based on best practice and eminently reproducible in other jurisdictions. Furthermore, we acknowledge the requirement for standardised and responsive services for children but, in the context of this chapter, we focus on care provision for men and women over the age of 14 years.

For the purposes of this chapter, the term SAC will be used throughout, even though it is accepted that a broad range of other descriptive terms (e.g. SATU, SARC) are also used.

**History and evolution of sexual assault centres**

Before the establishment of a defined service, the forensic medical examination of the complainant was conducted in the police station when an allegation of sexual crime was made. As expertise began to develop in relation to the medical examination, health professionals appreciated the inappropriateness of carrying out the examination in the general environs of a police building. Thus, the provision of an acceptable environment for forensic examination in police presence was the genesis of SACs first seen in the USA and then Australia in the 1970s.

The Sexual Assault Treatment Unit of the Rotunda Hospital in Dublin opened in 1985, and was thus the first SAC to provide service in Europe. St Mary’s Unit in Manchester, UK, was established the following year. These hospital-based units were composed of a combined interview and examination room for the purpose of the forensic medical examination, with police interview and aftercare delivered elsewhere.

Internationally, in countries where rape is recognised as a criminal act, services are available for the victim who reports the crime. The initial service has most often been led by a committed professional with a support team that has evolved with the developing expertise of the group such that the nominator of ‘centre of excellence’ would be applied. Further development of a national service has often been the result of recognition of local need for a service. Without a strategic approach to service development, other centres have developed, with expertise available locally but not always with all of the core elements of care provided.

In looking at the current services in a number of European countries, Australia and the USA, service provision is not lacking, but a deficiency can be seen in national, standardised services, such that every person has access to the multidisciplinary expertise of a SAC in all regions of a country. Norway and Ireland have such a national approach to the delivery of care for the adult victim of sexual crime, and new developments in England support the standardisation of SAC services nationally there.

Access to the services of an SAC in many countries is primarily through the police services. Thus, the person must report the crime before having access to the multidisciplinary health, forensic and support services available. Some evidence shows that where access to SAC services does not have the prerequisite of police involvement, that attendance rates are higher, potentially reducing the long-term sequelae of the incident.

The evolution of SAC care has seen the provision of psychological support and facility for police interview for the complainant at time of initial attendance, as well as the development of comprehensive psychological and sexual health aftercare. Taking social, demographic and geographic considerations into account, a nationally agreed level of service, so that all patients are assured of standard practice, is invaluable. Where all the services are delivered within the centre, the term ‘one
stop shop’ has been used. In areas where SACs have been established, evidence shows improved access to forensic and medical examinations and to psychological support for complainants of rape, together with higher levels of user satisfaction with the services provided.\(^8\) Notwithstanding this, it has been acknowledged that ‘SARCs are not the whole answer, but taken together with improvements to the investigation and prosecution of sexual violence cases, and greater investment in the voluntary sector, their development offers a real opportunity to deliver justice to victims’.\(^9\)

Within the Irish context, an emphasis has been placed on development and standardisation of high-quality accessible care.\(^1\) This care is described in detail in a readily available and comprehensive inter-agency document, which aims to ensure that a patient receives similarly responsive and holistic forensic, medical, on-site psychological and follow-up care regardless of which of the six regional SATUs they attend.\(^10\) The core agreed model of care in Ireland also includes a multidisciplinary team, close links with the forensic science service and police service (An Garda Siochana). Defined funding streams are provided by Departments of Health and Justice. Similarly, in the UK context, SACs have been defined as a ‘one stop location where victims of sexual assault can receive medical care and counselling while at the same time having the opportunity to assist the police investigation into alleged offences, including the facilities for a high standard of forensic examination’.\(^11\) In keeping with this, the Home Office has defined an SAC as ‘a dedicated facility to provide immediate and ongoing victim care within the context of a partnership arrangement between police, health and the voluntary sector’; this document also emphasises that an SAC does not just refer to a building, but embraces a concept of integrated, specialist clinical interventions and a range of assessment and support services through defined care pathways.\(^5\) At present, however, the main difference between the UK and the Republic of Ireland is that, although far more SACs have been established in the UK, services are generally less standardised, with a greater disparity in equity and access in some geographic areas than in others.

**Location of sexual assault centres**

Victims of sexual crime need to be able to access appropriate care promptly; however, this care should be provided by professionals who are doing this work sufficiently often to maintain competency and skill. For this reason, it would generally be recommended that services would be regionalised. Minimum standards for Ireland recommend that ‘any victim of rape or sexual assault in Ireland is within a maximum of 3 h drive of a unit’,\(^1\) although another report recommended that an SAC be ideally established within 80 km of any given location.\(^12\) A report of a UK Department of Health Working group on recommendations for service delivery recommended a model in which a regional SARC (where most examinations would be undertaken) would be assisted by a few Local Sexual Assault Referral Centres for those complainants unable to travel to the RSARC. This report anticipated that such arrangements would ensure that the maximum travelling time for a complainant would be 120 min.\(^13\) In the European context, albeit looking at care for women only, it has been recommended that a minimum level of service provision would be one SAC per 400,000 women to enable ease of reporting of recent assaults and to ensure high-quality forensic and medical services.\(^2\)

The designation of a precise location of an SAC in any country is controversial; although these units need to be relatively local to ensure ease of access, they need be accessed sufficiently often in order to be sustainable and to enable staff to retain and increase all relevant professional competencies.\(^13\) Service provision for rural and remote areas is, therefore, inherently difficult. It is important that police services and other agencies in these areas have close links with regional centres to ensure prompt access to care within the SACs. Furthermore, it is important that SACs are not developed into stand-alone projects, but brought into the mainstream and linked to other services through strong partnership across police, health, local authority and independent sector organisations.\(^5\) In the UK, the Government response to the Stern Report\(^14\) acknowledged that a ‘one size fits all model’ may not be suitable for all local areas, and what matters is that victims receive the comprehensive support they need when they need it, so that they can take positive steps to recovery. For example, an area may wish to have a small centre of expertise with a high number of follow-up sites because of its geography. Yet again, this report recognises the importance of involving all relevant partners, including voluntary and community sectors, to ensure appropriate referral and follow-up mechanisms.
In providing services in more remote areas of a country, the issue of sustainability of service with low numbers of attendances is suggested to be a limiting factor in development or maintenance of expertise. With more open access to such a service and developing the professionalism of the service providers beyond the core requirements of an SAC, such a service can build capacity and be a valuable, sustainable clinical service within a community.¹⁵

**Necessary infrastructure**

Sexual Assault Centres must provide a ring-fenced, forensically clean environment for examination to avoid contamination of evidence. Changing and showering facilities should be provided for individuals to access after examination. This facility needs to be available and appropriately staffed 24 h a day, 7 days a week, to ensure that it can be accessed promptly when required.¹⁰ The centre must also have an area for provision of follow-up care, so that the forensically clean environment is only used for acute cases.¹⁶ Furthermore, individuals can find it difficult to return to the clinic room they attended immediately after the acute event when they come for a return visit, as it may cause them to recall some of the negative feelings they experienced at that time of immense personal crisis.

A sufficiently private area for the psychological support worker and crisis worker, with waiting areas for family and members of the police service, must also be considered when developing an SAC. Office space for administrative, nursing and medical staff should also be included, as well access to a meeting room for team or family meetings, peer review meetings and teaching sessions. A secure storage facility for patient records, and forensic samples if a delayed reporting option exists, is also imperative.

Access to a secure information technology system and skills enables development and implementation of an electronic database. Anonymised patient records can be completed for each attendance. This allows for collection of a minimum dataset of demographic and other statistics which facilitates data collection and production of key service activity reports. These reports allow for identification of emerging trends between different SACs and over time. This information may be useful for educational strategies and risk reduction, and also for service planning and funding applications. Performance targets such as time (and any delays) between attendance and examination can also be monitored.

**Funding considerations**

Funding for SAC services should be defined at national level, to allow development and implementation of an integrated strategic plan for service delivery. It is imperative that this care is available free of charge to anyone who wishes to access it. As these services involve close integration and coordination of patients’ health and medicolegal needs, funding may have to come through health and justice routes. The set-up and running costs of SACs may, however, be offset against the likely savings to the wider health economy and the long-term costs to the economy as a whole.⁹ Effective service provision may produce cost savings by reducing multiple assessments and waiting times for individuals who use non-integrated services, and reducing the number of people later referred for specialist services (e.g. mental and sexual health). In addition to this, addressing patient needs early through provision of care within an SAC delivers better health, well-being and quality of life to patients. Long-term productivity savings have been identified when the immediate aftermath of sexual assault is managed effectively and comprehensively.⁵

**Guideline development**

As previously mentioned, development of SACs, ideally in line with a national strategic vision for sexual assault services, also facilitates development and implementation of core agreed models of care. Formal development of inter-agency guidelines and care-pathways facilitates provides consistent, high-quality care. Preparation of these guidelines needs to include input from SAC staff, rape crisis personnel, the police service and forensic science services, enabling production and dissemination of an accessible, multi-agency document to ensure a responsive, evidence-based and comprehensive response to victims of sexual violence.
The experience in the Republic of Ireland has highlighted that the inter-agency links that were established to develop these practice guidelines have ensured an ongoing commitment to an integrated partnership approach to care. On a strategic level, the representatives of the various agencies also contribute to SAC steering groups and management committees, which promote ongoing excellence of service development and delivery of high-quality care.

Role of sexual assault centres

Sexual Assault Centres provide responsive, patient-focused care for men and women over the age of 14 years. They aim to promote recovery and health after a rape or sexual assault, whether or not the individual wishes to report it to the police. Indeed, it has been well recognised that SACs also increase access to services and support for those who do not report to criminal justice agencies. Whether a rape or sexual assault is reported or not, whether the case goes forward or not, whether there is a conviction or not, victims still have a right to services that will help them recover and rebuild their lives. The criminal justice process is important, but getting support and being believed is as important. Seeking support in the aftermath of a rape or sexual assault is a huge challenge, and the work an SAC undertakes plays a vital role in assisting recent victims from a number of perspectives: the collection of forensic clinical evidence for potential future legal cases, the immediate physical and psychological care for the victim, and the referral of victims to appropriate long-term support. In the Republic of Ireland, SAC services can be accessed in a variety of ways (Fig. 1). These clearly defined routes through which a patient can approach the various models of care are vital. Furthermore, details of these routes and models must be widely communicated within the broad range of agencies involved in responding to patients after sexual crime (e.g. police services, rape crisis centres, emergency departments, and primary care), so that people are aware of the existence of SACs and the facilities they provide, and to enable full explanation of the available referral options and ease of access in an appropriate timely manner when required.

Care pathways

As shown in Figure 1, a person may choose to report a recent crime to the police service who will arrange for them to attend their local SAC as soon as possible, as forensic evidence deteriorates rapidly (Table 1). For this reason, SACs should be available and staffed 24 h a day and 7 days a week for care of...
acute cases, although the provision of a timely response must not supercede the victim’s potential need to control the pace of this response.

The reporting of sexual crime to criminal justice agencies should always be encouraged; however, if the person chooses not to report the incident, they can still attend an SAC for health and follow-up care. In these situations, the appointment can generally be given for the next working day as there is less urgency when forensic samples are not being taken. Nevertheless, individuals may still need to be seen relatively urgently to ensure that appropriate care of injury and preventative treatment can be given (e.g. emergency contraception and post-exposure prophylaxis for sexually transmitted infections).

Another pathway that can be considered is that of collection and storage of forensic evidence without immediate reporting to criminal justice agencies. This option facilitates those who may, for a variety of reasons, be uncertain about whether they wish to report an incident of sexual crime. They may perhaps be concerned about embarking on a potentially lengthy legal process, about the effect of such a course of action on friends and family, they may have issues concerning a previous relationships with the alleged assailant or, very simply, they may just be too traumatised to make such a decision at a time of immense personal trauma. In these situations, in many jurisdictions, two options are available as described above: the first is that individuals would report the incident to the police service despite their reservations (in which case forensic samples can be taken); alternatively they can make a decision not to report the event acutely. With this latter option, however, if they initially opt not to report the incident, but subsequently decide to do so, time will have elapsed and forensic evidence, which may have been available had they presented promptly, will have deteriorated. This delay may affect the completeness and success of an investigation and potential prosecution.

To counter this, therefore, many services offer a facility for collection and storage (for a defined period of time) of forensic evidence. A full explanation of the process, and its potential limitations, is outlined to the individual, and evidence is collected according to best practice. In this context, local protocols must be developed to ensure that the chain of evidence for both collection and storage of samples can be maintained if the individual subsequently chooses to report the incident to criminal justice agencies. If a complaint is ultimately made to the police service, these samples can be released for forensic analysis to assist the investigative process. Provision of this additional option could increase the rates of reporting of sexual crime, as people who may be uncertain about their reporting intentions would not make a rapid decision about not reporting the incident, which they might subsequently regret. There is no ‘statue of limitation’ for serious offences, and delayed reporting should, therefore, not affect the credibility of a complainant or be considered an impediment to prosecution. This is seen as an important element in the response to victims of sexual assault because it gives them control over decision making about whether to report to police or not, and allows them to make this decision at some point after the initial crisis.

**Care within a sexual assault centre**

When a person presents to an SAC, they need to be treated in a caring and non-judgemental manner. Depending on the route the patient took to the service, they may need a further explanation of their options of engaging with police services or otherwise. Clear guidelines for appropriate clinical, psychological and forensic care should be followed. In the Irish context, the individual will generally first be met by the forensic examiner (who is either a doctor or clinical nurse/midwife specialist) and a support nurse, who will outline the purpose and progress of the SAC attendance and

<table>
<thead>
<tr>
<th>Site</th>
<th>Time Limits for Examination for Semen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal</td>
<td>7 days</td>
</tr>
<tr>
<td>Rectum</td>
<td>3 days</td>
</tr>
<tr>
<td>Mouth</td>
<td>1 day</td>
</tr>
<tr>
<td>Skin</td>
<td>Semen can persist until washing</td>
</tr>
<tr>
<td>Dead bodies</td>
<td>Semen can persist for a much longer period of time</td>
</tr>
<tr>
<td>Dried seminal staining on clothing</td>
<td>Semen persists until clothes are washed</td>
</tr>
</tbody>
</table>

Washing, douching, bathing or menstruation may accelerate the loss of semen.

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introduce the person to the psychological support worker who provides advocacy, psychological
support and crisis intervention.

Research has indicated that sexual violence survivors receive more and better legal and medical
services when accompanied by rape crisis support. It is vital that reassurance is given that nobody
deserves to be raped, and that the victim is not responsible for the assault. Even if the person perceives
that they made choices they now regret, they need to be reassured that being potentially vulnerable in
no way implies culpability.

Every effort should be made to preserve forensic evidence, and ideally the patient should not eat, drink,
smoke, chew gum or carry out oral hygiene until oral samples are taken, if indicated. Similarly, defecation,
urination and showering should be deferred until appropriate samples are obtained. Collaborative
working relationships with the police services and other relevant agencies and written inter-agency
guidelines will ensure that all those involved in arranging SAC attendances are aware of these recom-
dendations to ensure that the patient receives optimum care. It is important to emphasise that, if
a patient presents to a SAC after a rape or sexual assault with significant physical injury, such injury must
be dealt with as a priority and the forensic medical examination can be carried out after stabilisation of the
patient. For the same reason, if temporary loss of capacity occurs owing to intoxication from alcohol or
drugs, the examination will need to be deferred until capacity to consent has returned.

Further description of the precise content and potential findings at forensic clinical examination is
outlined elsewhere in this issue of *Best Practice and Research Clinical Obstetrics and Gynaecology* and in
other documents; in brief this includes the following: (1) full explanation and documentation of
witnessed, informed consent; (2) history taking to include medical details that may assist in patient
management as well as details of the incident itself to guide examination and evidence collection; (3)
general physical examination; (4) appropriate genital and anal examination with collection of relevant
forensic samples; (5) classification and documentation of wounds and injuries; and (6) toxicology
samples.

A member of the police service remains in the clinical room while the history is being taken and
proximate to the examination room while samples are being taken. This ensures that they can confirm
continuity of evidence. Upon completion of the forensic clinical examination and documentation of
findings, collected samples must be given to the police, who will package them in a tamper evident bag
and arrange transfer to the appropriate forensic science laboratory for analysis. Relevant items of
clothing will also be collected.

**Pre-discharge care**

After examination, the person is offered a shower and provided with fresh clothes if required.
Adjunctive treatment, including emergency contraception, infectious disease prophylaxis (for chla-
mydia, gonorrhoea and human immunodeficiency virus if indicated by risk assessment) and Hepatitis
B immunisation is considered for all attendees at SACs in the Republic of Ireland. Further detail on other
aspects of holistic immediate after care is discussed elsewhere in this issue.

**Follow-up care**

A follow-up schedule should be provided to all individuals who attend an SAC before discharge. The
routine timeline for sexually transmitted infection prophylaxis and follow up is presented in *Table 2.*

The individual also needs to know how to access appropriate post-incident psychological follow up;
they should, therefore, be given contact information for SAC personnel and referral or contact informa-
tion for other locally available services (e.g. Rape Crisis Centre). Written information on all relevant
contacts and follow-up arrangements is recommended to avoid further overwhelming people with
verbal information and advice (*Table 3*). Even if people do not want to seek counselling in the first
instance, it is important that they know where to go to seek this at a later point in time. A person who
has been sexually assaulted needs to have a safe place to go and a safe way to get there when leaving an
SAC; ideally they should be accompanied by a family member, guardian, friend or support person.
Consent to contact the person to remind them of future appointments and follow-up arrangements
should be confirmed and documented before discharge.
Domestic violence and child protection

An awareness of the potential interplay between attendance at an SAC, domestic violence and child protection issues is paramount. If concerns exist about ongoing domestic violence, it may be necessary to offer the person a place of safety as well as offering information and ongoing support about local specialist support services. All SACs should have written information available on local and national services (e.g. Women’s Aid), as well as contact details for local police services. Each SAC also needs to ensure that child protection guidelines appropriate to their jurisdiction are followed.

Risk reduction

Sexual Assault Centres can contribute to educational programmes focusing on both primary and secondary prevention of sexual violence. In providing this education, it is imperative that, although it must be emphasised that being vulnerable to sexual violence is not the same as being culpable, there may be social or behavioural issues that increase a person’s vulnerability, which can potentially be avoided. Although there tends to be significant societal awareness of the issue of drug-facilitated sexual crime, there may be less awareness of the fact that alcohol is the most common drug implicated in sexual violence, and that negative consequences can arise from use and misuse of alcohol. Children and

### Table 2

**Recommended timeline for sexually transmitted infection prophylaxis and follow up in the Republic of Ireland.**

<table>
<thead>
<tr>
<th>Time</th>
<th>Treatment or Procedure</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1 g Azithromycin orally.</td>
<td>Prophylaxis and treatment of <em>Chlamydia trachomatis.</em></td>
</tr>
<tr>
<td></td>
<td>First hepatitis B Vaccine.</td>
<td>Immunisation against hepatitis B.</td>
</tr>
<tr>
<td>1 month</td>
<td>First void urine (if nucleic acid</td>
<td>Screening for <em>C. trachomatis</em></td>
</tr>
<tr>
<td></td>
<td>amplification test available).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Endocervical culture.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urethral and endocervical culture.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Serology</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Second hepatitis B vaccine.</td>
<td></td>
</tr>
<tr>
<td>3 months</td>
<td>Serology</td>
<td></td>
</tr>
<tr>
<td>6 months</td>
<td>3rd Hepatitis B Vaccine.</td>
<td></td>
</tr>
<tr>
<td>8 months†</td>
<td>Serology</td>
<td></td>
</tr>
</tbody>
</table>

* All tests of cure if prophylaxis previously given; † Can be checked by general practitioner or local services. HIV, human immunodeficiency virus.

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### Table 3

**Discharge information given to the patient.**

- Instruction on the care of any injuries.
- Medication instructions, if applicable.
- Information leaflet issued by the SAC, which will include:
  - Contact numbers for the SAC.
  - Garda’s name, Garda (police) station and telephone number.
  - Information about examination and processing of the forensic samples.
  - Information on medication received and follow-up schedule related to this.
- Follow-up appointments with place, dates and times.
- Referral letter, if applicable (e.g. to infectious disease, psychiatry or other required services)
- Letter for general practitioner, if desired.
- Letter for work, college, school, if required.
- Phone number and printed information leaflet (if psychological support worker has not spoken with the patient) from the Rape Crises Centre, which offers psychological support for the patient and her or his family.
- Name with contact number of accompanying Garda (police officer).
- Relevant health promotion information and written information from agencies which deal with issues such as:
  - Domestic Violence.
  - Interpersonal Violence.
  - Drug and Alcohol programmes.
  - Safety Prevention programmes.
  - SAC, Sexual Assault Unit.

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young people are drinking earlier and more often; over one-half of Irish 16-year-old children have been
drunk, with one in five being a weekly drinker.\textsuperscript{23} The average age of first alcohol use in children in
Ireland has reduced from 15 years for those born in 1980 to 14 years for children born in 1990.\textsuperscript{23}
Research into the link between alcohol and sexual violence, supported by clinical experience, show
that considerable quantities of alcohol are often ingested before the incident. Education can also
address other vulnerability factors, such as social competence, risk-taking behaviour and other lifestyle
factors (e.g. age-appropriate boundaries).\textsuperscript{12,24}
Primary prevention can include community and school-based programmes, with consideration also
being given to media campaigns. Secondary prevention (within a patient cohort who have already
sought care from an SAC) can be more individualised, focusing on an individual's specific vulnerability
factors and providing appropriate education and care to reduce the possibility of another incident.
Establishment of an appropriately staffed SAC network facilitates development and delivery of relevant
educational and risk-reduction programmes.

\textbf{Contribution to national strategies and ongoing educational programmes}

Thankfully, in recent years many parts of the world have recognised the significance of sexual
violence and how important it is for the multi-agency response to be appropriate and co-ordi-
nated.\textsuperscript{1,5,9,21,25} Development of SACs was central to the recommendations of many of these reviews. It
is, therefore, anticipated that many countries either have, or will have, a network of these high-quality,
accessible centres to deliver this clinical, forensic and supportive care. As SACs are commissioned and
established, however, it must also be recognised that SACs and their staff are a vital resource in ongoing
evaluation and implementation of such national strategies.

The staff in an established SAC build up a wealth of experience that aids education of more junior staff,
succession planning and indeed education of those interested in becoming involved with the service.
Standardised qualification and training requirements for forensic medical examiners, nurse and midwife
examiners need to be defined and delivered to ensure consistent provision of high-quality care. Inter-agency
educational programmes, between Rape Crisis Centres, police and forensic science services, primary care
and SACs allow for a mutual understanding of every step of the victim's journey and aim to optimise service
delivery and care provision by all agencies. Staff are also a resource that can provide ongoing education for
other service providers (e.g. emergency departments, prison services, women's health and voluntary
projects), to ensure that these services are aware of SAC facilities and how to access these.

In the Republic of Ireland, we have found it useful to develop and distribute a quarterly newsletter,
'The SAFE Way'. This short newsletter is produced by the National SATU service, with contributions
from medical, nursing and support staff from the six SATUs, as well as input from the other public,
independent and voluntary agencies. This document ensures dissemination of relevant updates,
research findings and information about education and training opportunities.

\textbf{Vicarious trauma}

Vicarious trauma describes the professional's trauma reactions and response to patients' traumatic
experiences.\textsuperscript{26} It may result in physical, emotional or behavioural symptoms, work-related issues and
interpersonal problems, and can be responsible for a decrease in concern and esteem for patients
leading to a decline in quality of patient care.\textsuperscript{27}
Agencies that provide services to patients with traumatic histories have a responsibility to help
their employees decrease the occurrence and effects of vicarious trauma.\textsuperscript{28} Peer supervision groups
serve as important resources for normalisation of vicarious trauma experiences, and should be an
essential component of an SAC service. This normalisation lessens the effect of vicarious trauma and
helps maintain objectivity.\textsuperscript{29}

\textbf{The future}

Aims for the future include an international commitment to continued provision of a standardised
package of care regardless of which SAC an individual presents to. This must be underpinned by

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cohesive national strategies to ensure appropriate geographical distribution of high-quality, multidisciplinary services responsive to patients needs. Care for those who chose not to report the incident to criminal justice agencies is also imperative. Care for children affected by sexual crime should also be delivered in such a standardised yet responsive manner. Colocation of paediatric services with adult SACs allows for joint assessment if required, and may also contribute to efficient resource utilisation.

Quality assurance, monitoring and evaluation must also be integrated into ongoing service development and provision. Indicators and metrics to benchmark the quality of care delivered, as well as objective and subjective patient (e.g. clinical, psychological, forensic and legal) outcomes must be encouraged. This commitment to quality assurance allows the service to deliver a measurable standard of excellence and ensures consistency in service provision for patients regardless of where they present geographically.

Conclusion

In this chapter, we have focused on provision of standardised but responsive care within SACs, and have emphasised the many other aspects of a cohesive service. We must concur with Baroness Vivien Stern who eloquently stated that ‘even in a time of scarce resources there must be a recognition of the need to prevent rape, care for victims, protect the vulnerable and work to reduce the long-lasting harm to individuals and families’\(^\text{17}\). We are confident that a well-organised and established SAC network underpinned by strong interagency links and guidelines fulfils these aims. We would argue that to provide best care for all men and women who have experienced sexual violence, we need to embrace a more inclusive and geographically disseminated ‘standard of excellence’ rather than just placing the emphasis on individual ‘centres of excellence’.

Furthermore, in more general terms, the availability of such a multi-agency service can raise awareness of sexual violence and abuse which helps boost public confidence in the health and criminal justice systems.\(^\text{5}\)

### Practice points

- Care for men and women after rape or sexual assault should be delivered in the context of a patient-focused, easily accessible, national, standardised service.
- Inter-agency guidelines and care pathways should be developed and widely distributed to ensure that care is appropriate and responsive to patients’ needs.
- People should be able to access care in an SAC even if they choose not to report the incident to criminal justice agencies.
- SACs also play a role in patient and interagency education, as well as being well placed to contribute to the national strategic vision for prevention of, and care after, sexual violence.
- Ongoing support for staff in SACs is important to reduce vicarious trauma related to working in this potentially stressful environment.

### Research agenda

- Mapping of available SAC services in each country to ensure equity of access.
- Close monitoring of service provision to benchmark quality of care and address any deficiencies identified.
- Monitoring of subjective and objective patient outcomes to assess service provision from patients’ perspective.

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