



The National Office for the Prevention of Domestic, Sexual and Gender-based Violence
An Oifig Náisiúnta um Fhoréigean Baile, Gnéasach agus Inscnebhunaithe a Chosc

Domestic and Sexual Violence Services in Ireland: *Service Provision and Co-ordination*

Domestic and Sexual Violence

Services in Ireland:

Service Provision and Co-ordination

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Table of Contents

Acknowledgements	<i>ix</i>
Executive Summary	1
Chapter One: Introduction and Background	11
1.1 Introduction	11
1.1.1 <i>Domestic and sexual violence</i>	12
1.2 The system of service provision: State and non-State organisations	12
1.3 Research background, objectives and questions	14
1.3.1 <i>The range of service provision</i>	14
1.3.2 <i>Co-ordination among domestic and sexual violence service providers</i>	15
1.3.3 <i>Improving system effectiveness through co-ordination</i>	16
1.4 The extent and nature of domestic and sexual violence in Ireland	17
1.5 Elder abuse	19
1.6 Reporting and disclosing the violence	20
1.6.1 <i>Informal support</i>	22
1.6.2 <i>Violence and isolation in communities</i>	23
1.7 Conclusions and organisation of the report	24
Chapter Two: Methodology	27
2.1 Introduction and background	27
2.2 Sources of data	27
2.2.1 <i>Supplementary information</i>	28
2.3 A survey of dedicated frontline service providers operating in the domestic and sexual violence sector	28
2.3.1 <i>Interviewing and questionnaires</i>	28
2.3.2 <i>Principal concepts and measurement details</i>	28
2.3.3 <i>Framework for data analyses and reporting</i>	31
2.4 Exploring the co-ordination of domestic and sexual violence service provision in Ireland	32
2.4.1 <i>In-depth interviews</i>	32
2.4.2 <i>Analyses and reporting</i>	34
Chapter Three: Range of services provided by NGOs for victims of domestic and sexual violence	37
3.1 Introduction, research objectives and main concepts	37
3.2 The range of domestic and sexual violence support services	37
3.3 Standards of service provision	38
3.3.1 <i>Regional dispersion and service density</i>	39
3.4 The range of domestic violence dedicated support services in Ireland	40
3.4.1 <i>The number of domestic violence support services in Ireland</i>	40
3.4.2 <i>Breakdown of types of services and activities by domestic violence service providers in Ireland</i>	44

3.4.3	<i>Accommodation and support with accommodation</i>	47
3.4.4	<i>Domestic violence support service admissions/ activity levels</i>	55
3.5	The range of sexual violence support services in Ireland	57
3.5.1	<i>The number of sexual violence support services in Ireland (2007)</i>	57
3.5.2	<i>Breakdown of types of services and activities of sexual violence support services in Ireland</i>	60
3.5.3	<i>Sexual violence dedicated support services activity levels</i>	64
3.5.4	<i>Sexual Assault Treatment Units (SATUs)</i>	65
3.6	Summary	67
3.6.1	<i>Domestic violence dedicated services</i>	67
3.6.2	<i>Sexual violence dedicated services</i>	68
3.7	Council of Europe standards	68
Chapter Four:	A co-ordinated system to improve the safety of victims of domestic and sexual violence: Conclusions from the literature	71
4.1	Introduction	71
4.2	Complementarity among service providers	71
4.3	The management of challenges to inter-organisational work	74
4.3.1	<i>Challenges to co-ordination among organisations and principles for management</i>	75
4.4	Summary: System effectiveness and complementarity as outcomes of co-ordination	78
Chapter Five:	Domestic and sexual violence in Ireland: co-ordination among service providers	81
5.1	Introduction	81
5.2	Approaches to domestic and sexual violence	81
5.3	Justice sector	81
5.3.1	<i>An Garda Síochána</i>	81
5.3.2	<i>The Probation Service</i>	82
5.3.3	<i>The Courts and the Legal Aid Board</i>	84
5.4	Health and environment sectors	84
5.4.1	<i>The Health Service Executive</i>	84
5.4.2	<i>The Department of the Environment, Heritage and Local Government</i>	85
5.4.3	<i>Summary</i>	86
5.5	Gaps and challenges encountered in Ireland's response to domestic and sexual violence	86
5.5.1	<i>Justice sector</i>	86
5.5.2	<i>Health and environment sectors</i>	88
5.5.3	<i>Summary</i>	89
5.6	Co-ordination	89
5.6.1	<i>Introduction</i>	89
5.6.2	<i>Purpose and forms of co-ordination and interagency work</i>	89
5.6.3	<i>Intra-regional and inter-regional co-ordination</i>	90

5.6.4	<i>Horizontal co-ordination</i>	91
5.6.5	<i>Vertical co-ordination</i>	91
5.7	Building and strengthening co-ordination: challenges and responses	93
5.7.1	<i>Network organisations</i>	95
5.7.2	<i>Maintaining co-ordination in the future</i>	95
5.8	Summary	96
Chapter Six:	Summary and Conclusions	99
6.1	Introduction	99
6.2	Research background, objectives and questions	99
6.3	The range of dedicated domestic and sexual violence services in Ireland	100
6.3.1	<i>Range of domestic violence service provision in Ireland</i>	100
6.3.2	<i>Range of sexual violence service provision in Ireland</i>	103
6.4	Co-ordination among organisations and agencies operating in the domestic and sexual violence sector	105
6.4.1	<i>Extent of co-ordination</i>	105
6.4.2	<i>Factors influencing the success of co-ordination</i>	106
6.5	System effectiveness and complementary practices	109
6.6	Future co-ordination research	110
6.7	Study limitations	110
6.8	Final comment	111
Bibliography		113
Appendix 1		127
List of Tables		129
List of Figures		131
List of Maps		133
Acronyms		135

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Executive Summary

This summary of the report is for the convenience of the reader but any conclusion should not be drawn from it without reference to the relevant section of the report.

The main purpose of this study was to secure an up-to-date understanding of how Ireland has been responding to domestic and sexual violence, with the most immediate objective of informing the development and implementation phases of the *National Strategy on Domestic, Sexual and Gender-based Violence 2010-2014*.

The study aimed to address several issues regarding domestic and sexual violence service provision in Ireland.

1. What services are available to victims of domestic and sexual violence in Ireland?
2. How accessible are these services? This involves not only the issue of location but also whether services can provide for people who differ in terms of need?
3. Is the system of service response consistent and integrated? Among others, this examines the extent of co-ordination involved among the services in the sector (both NGO and State) and what issues need to be considered if the current system of response is to be strengthened.

The research was conducted in two principal phases and involved the use of mixed methods. The first phase mainly used existing data sources to examine the range and accessibility of services in Ireland, practically all of which receive core funding from the Health Service Executive. Of central importance to this phase of the study were data sets received from SAFE Ireland and the RCNI. The data sets were for 2007, which was the latest year for which full data sets were available at the fieldwork stage of the study.

The second phase adopted a qualitative research methodology and examined the development of co-ordination among State and non-State organisations and agencies involved in domestic and sexual violence related service provision.

A. Range of services in Ireland for those who have been affected by domestic violence

- There is a wide range of domestic violence services available in Ireland and since 2000 the numbers of service providers offering these services has increased. As a consequence of this, the level of service density (i.e. the ratio of service providers to population levels) has also increased with the effect that activity levels in the domestic violence sector satisfy most of the guidelines set out by the Council of Europe (Kelly and Dubois, 2008). However, what must be borne in mind here is the fact that this information reflects neither the size nor range of

services provided. In 2007 there were no accommodation facilities (i.e. refuges) located in 10 counties in Ireland.

- One organisation in Ireland provides support services dedicated to the needs of men who experience domestic violence. International guidelines and principles for service provision for women are informed by a definition of these problems in gender-based terms. Given this, there is no equivalent framework to guide an understanding of the services and standards that are appropriate for men who experience domestic violence.

Dedicated frontline service providers

Domestic violence support services: In 2007 a total of 49 domestic violence support services were available to those who had experienced domestic violence in Ireland. This translates into 1 domestic violence service for every 36,259¹ women in Ireland. This represents an increase in service density level since 2000 when 31 domestic violence services were operating (1 service per 48,790 women in 2000)².

Types of services provided

a. Domestic violence helplines: In 2007, 44 of the 49 support services provided a helpline facility and 18 of these operated on a 24/7 basis³. In 2000, there were 26 helplines available from support services and 10 refuge helplines were operated 24/7.

b. Domestic violence outreach: A total of 37 organisations provided support on an outreach basis (33 SAFE Ireland network affiliated organisations and 4 non-network affiliated organisations).

c. Counselling: In 2007 a total of 20 organisations provided dedicated counselling services for domestic violence victims in Ireland. This compares to a total of 18 services providing counselling in 2000.

d. Support for children: Individual support for children was given by half (19) of the SAFE Ireland affiliated refuges and support services. Access to education/school placements was given by 20 and 15 provide homework and learning supports. Of the 38 SAFE Ireland affiliated support services, 20 reported providing childcare facilities.

e. Working with perpetrators: The majority (28) of SAFE Ireland network affiliated organisations were working with perpetrator programmes in some way. Nine provided partner support.

¹ The calculation of this figure excluded Amen - the national service provider for men who have experienced domestic violence.

² However, what must be borne in mind here is the fact that this information reflects neither the size nor range of services provided.

³ All of these 18 are refuge facilities.

f. Domestic violence education and training: A total of 26 SAFE Ireland members and 4 non-network affiliated organisations provided training on request. Furthermore, a total of 30 organisations had developed training packs or programmes (28 SAFE Ireland affiliates and 2 non-affiliates) on a broad range of domestic violence related issues.

g. Accommodation: There were 19 domestic violence services in Ireland providing crisis/emergency accommodation at refuge facilities in Ireland, comprising 133 units of accommodation. This represents 1 refuge for every 91,603 women. Where there were refuge services available, the highest service density was in the south-eastern sub-region and the lowest was in the southern sub-region. The range of services provided included accommodation, emotional and practical support, accompaniment and information and helplines. With 4 additional refuges operating in Ireland, refuge service level density increased between 2000 and 2007. Refuges provided a total of 545 permanent beds around the country and of these, 133 were designated for women and 412 for children. When one considers the ratio of the number of beds designated for women to the number of women in the country, this represents one bed per 13,086 women⁴. In 2007, there were 173 (+46 per cent) more beds than in 2000. In total, when one considers the total number of beds available and not just those designated for women only, the bed/population ratio has changed from one bed to 4,066 women in 2000 to one bed to 3,193 women in 2007.⁵

B. Range of services in Ireland for those who have been affected by sexual violence

- There was a wide range of sexual violence services available in Ireland in 2007. There was no substantial change in the number of service providers offering services between 2000 and 2007. The indications are however that in 2007 the level of activity in the area of sexual violence satisfied Council of Europe guidelines (Kelly and Dubois, 2008). However, what must be borne in mind here is the fact that this information reflects neither the size nor range of services provided. There were no sexual violence support services located in 10 counties in Ireland.
- While most service providers make services available to men who experienced sexual violence, there was no equivalent framework to the Council of Europe guidelines to guide the services and standards appropriate for men.

⁴ Kelly and Dubois (2008) in their elaboration of Council of Europe standards refer to the concept of "family space" in refuges where they recommend a minimum standard of "1 family space per 10 000 of the population". However, questions remain as to the exact definition of "family space" and whether or not it is possible to apply this particular standard given that it does not specify the segment of the population involved, (i.e. if the population referred to is the population of women or the population as a whole). This report presents the number of permanent beds available in refuges for women and children who have experienced domestic violence.

⁵ Maunsell (2000) makes no distinction between the number of beds designated for women and those designated for children.

Dedicated frontline service providers

Sexual violence support services: In 2007, a total of 17 sexual violence support services provided support (including counselling), information and advocacy for both male and female victims of sexual violence in Ireland. This represents a total of 1 sexual violence support service for every 102,380 women in Ireland. In 2000 there was 1 sexual violence support service for every 94,530 women in Ireland. Despite the increase of 1 additional support service since 2000 the level of service density (i.e. the ratio of service providers to population levels) had decreased, reflecting an increase in population levels over the period. Overall the range of services provided for victims of sexual violence remained similar to that in 2000.

Sexual Assault Treatment Units (SATUs): In 2007 there were 4 SATUs in Ireland⁶. This amounts to 1 SATU for every 435,114 women in Ireland and represents an increase of 2 SATUs since 2000. There was no SATU in the Western, Mid-Western, North-Eastern and Midlands sub-regions.

Types of services

a. Sexual violence service outreach: In 2007, 9 services were involved in providing support on an outreach basis.

b. Sexual violence helplines: A 24 hour National helpline was operated from the Dublin Rape Crisis Centre (DRCC) and referred callers to all the local services where appropriate. Other than this, all remaining (16) regionally located sexual violence support services provided free-phone helplines operating at varying times.

c. Sexual violence counselling: As was the case in 2000, in 2007 all sexual violence support services provided counselling services for men and women who had experienced sexual violence in Ireland.

d. Sexual violence accompaniment services: Accompaniment to court, An Garda Síochána, hospital or SATUs for victims of sexual violence was a key support offered by all 17 sexual violence support services in 2007.

e. Sexual violence awareness raising: In total, 4,472 individuals received training from RCNI member organisations (which excludes the DRCC) in 2007. The DRCC's Education Department provided 2,392 participant days in 2007.

Sexual violence support service accessibility: Sexual violence support services were provided mostly during normal business hours. However the DRCC offered, in addition, early morning and late evening as well as all day Saturday services.

⁶ There is also a part-time, partial sexual assault treatment service in Limerick, run by Shannondoc which sees about 40 people a year.

C. Services for older people in the community affected by domestic and sexual violence

Established in 1998, the Senior Helpline provides a confidential telephone service for older people for the price of a local call anywhere in Ireland. At the time of writing the lines were open at 13 centres across the country each day from 10am to 4pm, and each evening from 7pm to 10pm, 365 days a year. The total number of registered calls to the Helpline increased from 126 in 1999 to 2,127 in 2003, an 18-fold increase over the period (O'Shea, 2005)⁷.

In 2007, a key development in the State's response to the issue of elder abuse was the establishment of the National Elder Abuse Steering Committee, together with four Area Elder Abuse Steering Groups based in HSE West, HSE South, HSE Dublin Mid-Leinster and HSE Dublin North East. The purpose of this steering committee is to oversee and ensure a nationally consistent approach in the provision of elder abuse services by the HSE in relation to elder abuse detection, reporting and response.

Each administrative area also secured approval to appoint a Dedicated Officer for Elder Abuse. In addition, the HSE approved the appointment of a Senior Case Worker for Elder Abuse in each Local Health Office who would investigate and initiate appropriate responses to allegations of elder abuse. (HSE, 2008).

D. Co-ordination among organisations providing domestic and sexual violence services: a conceptual framework

Service delivery systems working together and sharing resources, rather than operating in isolation of one another, are key to the delivery of high quality services. This is particularly so where resources are limited. By co-ordinating, service providers involved get to increase their ability to deal successfully with clients by controlling and integrating work activity across organisational boundaries. However despite the support in the literature, achieving common understandings and agreements, to avoid conflicting goals and inconsistent approaches, can be difficult to manage.

Existing research outlines a range of inter-organisational challenges that need to be managed if the system of response is to become more integrated. Some of the main challenges include the problem of diverging or perhaps even conflicting interests and dealing with the complexity typically associated with inter-organisational co-ordination (e.g. they can involve change across multiple agencies and across multiple levels within agencies).

The benefit of an integrated system is a greater capacity to meet more victim needs. However, to meet these needs service providers are dependent on one another, thus co-ordinating their activities and approaches is key to a consistent and coherent system of service provision. Frontline domestic violence support services play an important role in coordinating their clients'

⁷ However, what must be borne in mind is the fact that this was a service in constant development with naturally increasing resources and provision of services.

linking in or access to other services such as the community welfare officer, housing officer, legal aid, public health nurses, MABS, etc. Greater co-ordination and collaboration between service providers can help to align stakeholders who have complementary skills (Kreger et al, 2007).

Focussing on the service user perspective, Chapter 4 discusses the interdependency between service providers. The chapter uses examples to illustrate the need for applying complementary practices and approaches in order for service providers to realise their goals. Furthermore, by working in this complementary manner, the services delivered by each of the service providers are more beneficial to the victim than the practices applied separately. In the literature, this is referred to as applying practices that are complementary or creating **complementarities** among practices/services.

Co-ordination in the domestic and sexual violence sector

A qualitative design was applied to this component of the study and in-depth interviews were undertaken with key representatives of State and Non-State Organisations (n=19) relevant to the domestic and sexual violence sector. In-depth interviews were also held with (former) Regional Planning Committee Chairpersons (n=17) and HSE Designated Officers for Violence Against Women (n=13). Focus groups were also conducted with Local Area Networks (n=2) to explore a range of issues regarding co-ordination at the local level.

The explorative aspects of this research required an approach that would facilitate identifying the most salient themes that emerged during the interviews. In order to ensure a systematic and rigorous approach to the analysis of the data, interviews were first transcribed and Jefferson techniques were applied in order to capture how issues were spoken about by the respondents. These techniques are valuable for combining an analysis of what was said and how it was said, particularly where sensitive issues are being discussed. The transcripts were read closely by two researchers in order to identify key themes that emerged. The entire dataset was categorised (indexed) in relation to these themes. Inter-observer methods were applied to test for observer bias. Themes were selected on the basis of inter-coder agreement and sequential analysis.

Reporting: In order to safeguard the identity of respondents only a selection of quotations has been re-produced for this report.

Extent of co-ordination

All indications from this study are that co-ordination among organisations in the domestic and sexual violence sector is at an early stage of development in Ireland. Most co-ordination activities focus on awareness raising and meeting to update. There are no indications of developing an agreed-upon timetable for developing shared protocols and the use of case conferences was rarely mentioned.

Co-ordination along **horizontal** lines occurs more easily i.e. between organisations in similar environments or at similar levels (e.g. *within* local,

regional or national levels). **Vertical** co-ordination on the other hand - i.e. *between* local, regional and national levels - has been more problematic to establish and organise. In line with the findings from the literature, a frequent issue is that of past legacies such as ones arising from different approaches between organisations that had originated under the former health board system.

The **lowest levels** of co-ordination were reported between the State and non-governmental organisations with the highest activity occurring between non-governmental organisations. Low levels of co-ordination were also reported among State organisations in this sector.

Indications of a common position for future co-ordination on domestic and sexual violence

Benefits from co-ordination: This study finds that each of the respondents participating in the study was of the view that addressing domestic and sexual violence is beyond the capacity of any one organisation or group of organisations. There is widespread acknowledgement of the need for greater co-ordination among State and non-State organisations and support for the idea that co-ordination should be considered the '*standard of care*' in service delivery.

The idea of improving service integration was considered by respondents to be an important feature of a co-ordinated system. In particular it was emphasised by many that strong linkages between organisations may be able to establish a continuum among what are currently largely disparate service providers.

However, there was an overall lack of common perspective on how co-ordination could improve things in practical terms for the victim. For many, it was assumed that benefits would naturally follow from a common vision, better communication and an agreed system of referrals.

Factors influencing the success of co-ordination

The literature emphasises that establishing co-ordination is difficult where organisations do not have common positions in matters such as work remit or a past history of working together. The responses from this study were very supportive of this hypothesis.

The literature also emphasises that without common perspectives, stakeholders can be committed to protecting their own professional expertise and this could create problems for the ethos of co-ordination (Nowell, 2009). The support for this idea is clear in the interviews. For example, while some respondents said that joint working on domestic and sexual violence should be guided by a strong victim-centred focus others said that the victim-centred approach would be inappropriate for conducting their work.

There is a broad consensus that co-ordination work has, in the main, been weakly organised among those involved. The issues highlighted in respect of the organisation of this work are summarised below.

a. Demonstrating the success of co-ordination

Research studies find that generally, for parties to take discussions or negotiations seriously and search for an integrative outcome, they must believe that their interests are better served by collaborating with others than by other means. This study found no evidence of tangible plans to monitor/evaluate either the functioning or the impact of co-ordination work among organisations. Being able to demonstrate to those participating as well as to externals, that co-ordination is making a difference may be an important undertaking. It could demonstrate in objective and systematic terms not only how well co-ordination is being organised, but also track bottle-necks or weak spots.

b. Building trust and co-ordination

The collaboration literature contributes important perspectives concerning the relevant qualities of relationships that facilitate co-ordination. When interviewed for this study, respondents frequently referred to the importance of developing trust among organisations.

In line with the literature, respondents said a range of factors helped to build trust. One such factor is ensuring that liaison persons allocated to co-ordination work are committed and have the authority to take decisions. Moreover this greatly supports the development and implementation of co-ordination agreements. Regular attendance at meetings was also said to be an important issue for establishing continuity and momentum in discussions.

Most respondents said they had experienced difficulties with other organisations in the sector with respect to many of these trust-facilitating factors.

c. Leadership and planning for successful co-ordination

The literature is clear that any change in the domestic and sexual violence sector requires commitment from leaders of organisations. It is clear from respondents in this study that commitment from Government to domestic and sexual violence was very welcome. Establishing Cosc (the National Office for the Prevention of Domestic, Sexual and Gender-based Violence) was considered to be a key signal or reflection of this commitment. Given the history in the sector, respondents said it would be critical for a co-ordinating body such as Cosc to provide strong leadership to move beyond problematic issues that had dominated inter-organisational relationships. They also mentioned a role for Cosc with respect to increasing the profile of domestic and sexual violence issues, brokering difficulties and tackling ingrained positions that have emerged.

Some respondents emphasised the value of network organisations to challenge traditional identities, disseminate knowledge, to standardise approaches and to organise. One respondent made reference to the fact that when a network is led at board level by member organisations, this helps its members to think in terms of developing a common purpose, collective goals and objectives. In addition, an outcome evaluation study undertaken by one network organisation was mentioned as a project that would clarify for members the difference good external relations could make to their ongoing work to increase the safety and well-being of victims of domestic and sexual violence.

A respondent said that significant improvements to co-ordination were expected across all regions and levels following the appointment of RAC Chairpersons.

d. Establishing clear roles and inputs

Organisations said that where competition for funding prevails, the possibilities for co-ordination are very often overwhelmed by the need to retain or develop a client base and position in the sector. Some respondents said that co-ordination among NGOs can be difficult as there can be a struggle among these same organisations for status and profile in the sector.

Improving system effectiveness and applying complementary practices

As mentioned earlier, despite the general support for co-ordination across all types of literature, there are many obstacles that need to be overcome. The greatest potential lies in the more advanced forms, where service providers' work is integrated and the practices and activities that are applied are complementary. This means they overcome conflicting goals and build on areas of inter-dependency by applying practices that are mutually reinforcing.

The indications from interviews are that co-ordination among organisations in the domestic and sexual violence sector is not at an advanced stage. For most, the purpose of co-ordination is primarily to network and update one another on developments in their respective areas. There are very few indications of service providers working together to explore areas of inter-dependency or what might be important complementary approaches, skills and knowledge.

It should be borne in mind, however, that until recently, apart from the National Steering Committee on Violence Against Women, there has been no deliberate or formal oversight of the development of more advanced forms of co-ordination work. It appears that co-operation among domestic and/or sexual violence service providers in Ireland has been primarily an emergent phenomenon.

The clarity of the precise roles for State and non-State organisations and the relationship between them, in tackling domestic and sexual violence is an issue that seems to be unresolved. In discussing this problem most

respondents referred to the importance of a central co-ordinating body such as Cosc to tackling the problem.

Chapter One

Introduction and Background

1.1 Introduction

The generally accepted components of comprehensive responses to domestic, sexual and gender-based violence cover a spectrum from primary prevention, through early intervention to crisis responses. These three components do not have sharply defined boundaries and some activities and programmes primarily designed for one will have impacts in another. All of these components - primary prevention, early intervention and crisis responses - must be appropriate, accessible and effective, to ensure a proper, sustainable and effective response for those affected by domestic and sexual violence.

Delivery of domestic and sexual violence services in Ireland occurs through a substantial number of government and non-governmental organisations. Practically all of the non-governmental organisations concerned receive core funding from the HSE. Although many victims (and perpetrators) have received significant services and support from one or more sources in Ireland, prior to the existence of Cosc there was no State-wide mechanism to ensure consistency of services provided, the standards of those services, or their outputs.

From the perspective of the victim there are a number of fundamental questions about the development and delivery of services for domestic and sexual violence:

- Is there a service available?
- Is it accessible?
- Is it comprehensive, in that, for example, will it provide effective linkages to other essential services?
- Is the system of response consistent and integrated?

Until recently, the absence of a national strategic policy framework in Ireland to define the priorities for co-ordinated action to deal with domestic and sexual violence has meant that it is not clear whether resources and interventions are being used in the most effective way. The consequence for the victims is that they are frequently forced to navigate a range of services and processes that may not be properly linked or co-ordinated.

To secure an up-to-date understanding of how Ireland has been responding to domestic and sexual violence, Cosc undertook a study of service provision in relation to domestic and sexual violence in Ireland. The most immediate purpose for this study was to inform the development and implementation phases of the *National Strategy on Domestic, Sexual and Gender-based Violence 2010-2014*. As a result, it was decided that the study should provide an overview of services currently available to women, men and older people

in the community who are affected by domestic and sexual violence. In so doing it was intended that the study would set a baseline for service provision against which future similar studies could be compared. The study commenced in 2008 and most of the fieldwork took place that year. Of central importance to the study were data sets received from SAFE Ireland and the RCNI. The data sets were for 2007, which was the latest year for which full data sets were available at the fieldwork stage of the study.

The importance of co-ordination is widely recognised in the context of service provision in Ireland and it was therefore decided that the study should examine the extent and nature of co-ordination in the domestic and sexual violence sector. For the purpose of this study a review of the international literature was also undertaken with the aim of developing a conceptual framework to explain how greater co-ordination improves the experience of service use for those affected by domestic and sexual violence.

1.1.1 Domestic and sexual violence

Three different dimensions of abuse characterise domestic violence: physical, sexual and emotional abuse. Behaviours that commonly occur in situations of domestic violence include various forms of physical violence such as kicking, punching, slapping, smothering or choking, biting, throwing, and threatening with an object. The use of isolation can be a key device, for example where the abuser restricts communication between the victim and those who are close to the person. Domestic violence often includes the use and abuse of children, as well as economic abuse. Controlling and intimidating behaviour, including threats and blaming the victim, are common forms of emotional abuse. Older people can experience abuse by carers and by those in a position of trust.

Sexual violence refers to assaults that have an explicit sexual content and includes a variety of forms including rape, sexual assault and sexual harassment. These forms of sexual violence can occur in a wide range of relationships and locations. They can be perpetrated by family members, current and former sexual partners, other relatives and friends, acquaintances (including colleagues and clients), those in a variety of authority positions, and strangers. Sexual assaults commonly involve one assailant, although multiple offenders are not uncommon. The ages of the perpetrator and the victim may be similar or vastly different, and many combinations of race, ethnicity, class, status, and sexual orientation can occur. Sexual violence can be in private or public locations, and in terms of rape, for example, can include many forms – marital rape, familial/incestuous rape, acquaintance/date rape, stranger rape, gang rape, custodial rape, and rape as a war crime.

1.2 The system of service provision: State and non-State organisations

Providing an effective system of care and support for victims of domestic and sexual violence requires the involvement of a wide variety of government and

non-governmental organisations, with the non-governmental organisations providing a range of direct frontline services to victims of domestic and sexual violence. In most countries much of the funding for non-government sector activities comes from government departments, with some funding raised by the non-governmental organisations themselves. A wide range of non-governmental organisations have been directly involved in frontline service provision in this sector in Ireland. These include the following:

- Nineteen Refuges
- Twenty-eight Domestic Violence Support Services⁸
- Sixteen Rape Crisis Centres⁹
- SAFE Ireland¹⁰
- Rape Crisis Network Ireland
- One-in-Four
- Senior Helpline
- Amen¹¹

The State organisations involved in supporting frontline service provision in the sector in Ireland and that have been included in this study are as follows:

- The Health Service Executive
- The Department of Health and Children
- The Department of the Environment, Heritage and Local Government
- The Legal Aid Board
- An Garda Síochána
- The Courts Service
- The Probation Service
- Victims of Crime Office
- The Department of Justice and Law Reform
- The Family Support Agency
- The Department of Social and Family Affairs
- The Department of Education and Skills
- The Department of Community, Equality and Gaeltacht Affairs

The remit of Cosc includes domestic and sexual violence against women, men and older people in the community. In terms of informing the National Strategy it was decided that the focus of this study should be on the services outlined above. Within certain constraints (see Chapter 2 for a discussion of the data) this study examined the extent to which these services cover women, men and older people in the community who are impacted by, or may be impacted by, domestic and sexual violence.

⁸ Including Women's Aid Dublin, which operates a national freephone helpline for domestic violence victims. These services differ to refuges in that none of them provide accommodation.

⁹ Including Dublin Rape Crisis Centre and Sexual Violence Centre Cork (non-members of RCNI)

¹⁰ Formerly the National Network of Women's Refuges and Support Services

¹¹ Providing services for men who have experienced domestic violence.

1.3 Research background, objectives and questions

In 2000 a study was commissioned by the National Steering Committee on Violence Against Women to provide an overview of non-governmental service provision for those who were affected by domestic and sexual violence (Maunsell et al, 2000¹²). This study is the most recent one providing an overview of the range of services for those who have experienced domestic and/or sexual violence in Ireland. In many ways this earlier study provides some baseline information about non-State (dedicated) frontline services¹³. However its main aim was to compile a directory of service provision in relation to violence against women across the country. This material did not cover violence against men (VAM) or older people.

1.3.1 The range of service provision

In order to compile more recent and complete data on service provision, Cosc developed a research study with two phases, reflecting two key study objectives. **The first research objective** is as follows.

To examine the range of service provision in Ireland.

Two main aims are associated with this objective.

- (a) To describe the range of services offered by dedicated frontline domestic and sexual violence service providers by region.***
- (b) Where comparisons are possible¹⁴, to describe how service availability has developed over time.***

1.3.1.1 State and non-State domestic and sexual violence service provision: From the perspective of the individual seeking support and help with domestic or sexual violence two different types of services are relevant to their needs. One comprises the frontline, domestic or sexual violence dedicated service provider. Most of these are non-governmental organisations and staff specialise in addressing domestic or sexual violence only. This report presents the results of information collected from these frontline and domestic or sexual violence dedicated organisations and the distribution of these organisations by region and regional population levels. Where possible, the study examines developments in this service provision over the last decade.

As mentioned earlier, the State is also responsible for the provision of a range of facilities, resources and services to victims of domestic and sexual violence. Examples include accommodation/housing, legal services, income

¹² This unpublished report was commissioned by the National Steering Committee on Violence Against Women.

¹³ For the purposes of this current study "dedicated frontline services" is defined as those NGO support services established to provide for the needs of those who have experienced domestic and/or sexual violence.

¹⁴ This study has used pre-existing data (see methodology section for details). It should be noted that these data have been collected for broadly similar purposes but divergence does occur and accordingly, the scope for comparability across the data sets is affected. A limited amount of primary data collection was undertaken and the purpose of these data are outlined in the methodology section.

support, health and medical services. However, in their recording and reporting activities most of these organisations do not distinguish victims of domestic or sexual violence from their other clients or service users. As a result, it is not possible in this report to describe precisely the range of domestic and sexual violence related services or the extent of the activity engaged in by State organisations.

A comprehensive system is one with a full range of services and effective inter-organisational linkages. A more integrated system of services can be of major benefit, for example through services joining up to deliver a more victim focused approach such as through one-stop-shops. This approach allows these services to identify areas of inter-dependency and to ensure that the practices they apply in these areas are complementary. However despite the literature supporting it, considerable barriers can exist before this potential can be realised. This report takes up the issue of co-ordination among those operating in the domestic and sexual violence sector and reports on the perspectives and experiences of State and non-State organisations when co-ordinating with other service providers.

1.3.2 Co-ordination among domestic and sexual violence service providers

It is widely recognised that domestic and sexual violence are problems that are located in the inter-organisational domain. Victims frequently access services from two or more organisations and policy positions and service provision across the system of service providers accordingly needs to be aligned.

Over recent decades progress has been made in the response to domestic and sexual violence. The Task Force on Violence Against Women was established to improve service provision and to co-ordinate services and policies (Report of the Task Force on Violence Against Women, 1997). The National Steering Committee on Violence Against Women (NSC) was established to oversee national, regional and local activity. Regional Committees on violence against women were established in each of the eight former health board regions in order to consolidate an approach to supporting victims of such violence. There have however been few studies examining the extent or nature of co-ordination activity in the domestic and sexual violence sector. The few that have addressed co-ordination have not addressed domestic or sexual violence and furthermore have relied largely on successful cases, for example between children's service providers (e.g. Rafferty and Colgan, 2009). As a result, our understanding of the extent and factors affecting the development of co-ordination among service providers, particularly those in the domestic and sexual violence sector in Ireland, is limited. Consequently, the **second research objective** is as follows.

To explore the development of co-ordination among organisations that operate in the domestic and sexual violence sector in Ireland.

This phase of the study examined State and non-State work in this area, in particular focussing on the issue of co-ordination and explored the extent of co-ordination in the sector and the factors that have facilitated or impeded the success of co-ordination among organisations and agencies. The two main aims which guide this part of the study are the following.

- (a) ***To explore the nature and extent of co-ordination among service providers in Ireland (encompassing State and non-State organisations in the sector).***
- (b) ***To enquire whether there have been specific factors that have influenced the success or failure of co-ordination among service providers operating in the domestic and sexual violence sectors.***

1.3.3 Improving system effectiveness through co-ordination

One of the challenges to improving the effectiveness of the system of response to domestic and sexual violence comes from the fact that the service organisations involved operate in different domains or areas and hence frequently operate with very different remits (for example even within the State sector there are clear differences between justice and health sectors or between education and welfare sectors). Furthermore, numerous levels or tiers of operations (e.g. national, regional or local) mean that greater degrees of co-ordination may be needed to reflect the need to manage the processes and systems that are the responsibility of different organisations.

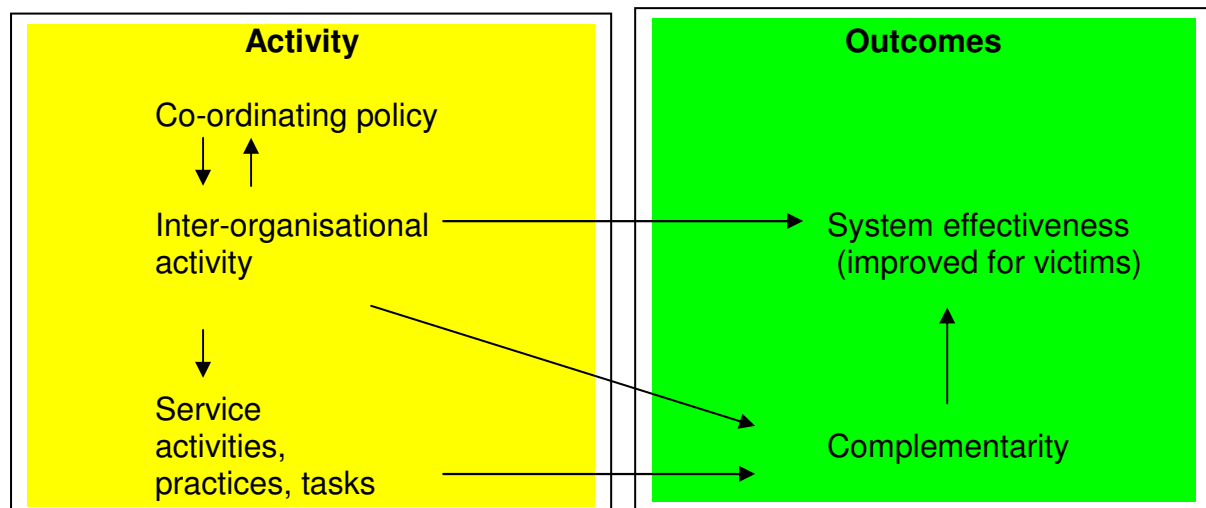
1.3.3.1 Co-ordinating policy and managing inter-organisational activity:

Improving the system of response to domestic and sexual violence involves, among other matters, two areas of activity. The first involves the area of policy and the value of a degree of alignment among what might otherwise be disparate positions regarding domestic and sexual violence. The second is at the level of service delivery. Depending on the constellation and number of stakeholders in the sector and the types of service needs identified, policy discussions can be driven by the need to harmonise, standardise, to differentiate or integrate service delivery. Different policy portfolios as well as activity at different levels (e.g. national and regional) require integrating vastly different perspectives and overcoming a large number of concerns, many of which are deeply engrained.

1.3.3.2 Creating complementarities among service practices: In this report a conceptual framework has been developed to explain how co-ordination among service provider activities (programmes, practices, tasks, etc) results in improvements for the victim using the services. The literature consistently emphasises that through techniques such as agreed case plans and integrated tasks, service providers create what is referred to in the literature as **complementarities** i.e. activities, programmes and tasks that when applied together complement one another, are mutually reinforcing and supportive of one another (e.g. Van de Delbeck and Koening, 1976). When complementary practices are applied together, they create benefits for the service user (i.e. the victim) over and above what would have been gained if these practices had been applied singularly (Mulford and Rogers, 1982). This

effect occurs when practices are combined giving an additive effect (i.e. '*flanking*') or a moderating effect (i.e. '*compensation*'). These ideas and concepts on the link between co-ordination and system effectiveness are depicted in Figure 1 below and are discussed more fully in Chapter Four.

Figure 1: Co-ordinating activity for improved service provision to victims of domestic and sexual violence



1.4 The extent and nature of domestic and sexual violence in Ireland

In Ireland the definition of domestic violence adopted by the government Task Force on Violence against Women (1997: 27) refers to "*...the use of physical or emotional force or threat of physical force, including sexual violence, in close adult relationships*". The report makes clear that domestic violence covers a broad range of behaviours and goes beyond actual physical violence (e.g. punching, slapping, hitting, shoving and other forms of physical and sexual assault). Domestic violence "*...can also involve: emotional abuse; the destruction of property; isolation from friends, family and other potential sources of support; threats to others including children; stalking; and control over access to money, personal items, food, transportation and the telephone*" (ibid., 1997: 27).

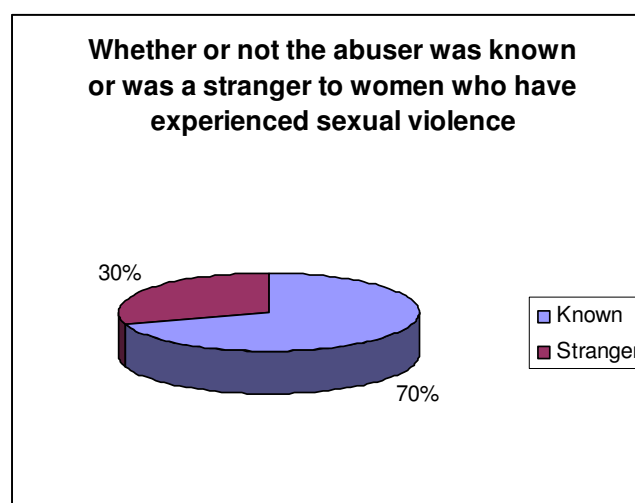
The evidence of the extent of physical, sexual and emotional forms of domestic and sexual violence in Ireland reflects the global picture. The National Study of Domestic Abuse (NSDA) survey in 2003 provides the most recent nationally representative picture of the nature, prevalence and impact of domestic abuse of women and men in Ireland. This study makes a distinction between those experiencing severe abuse and minor incidents of abuse. Severe domestic abuse is defined in the report as "*... a pattern of physical, emotional or sexual behaviour between partners in an intimate relationship that causes, or risks causing, significant negative consequences for the person affected*" (Watson and Parsons, 2005:23). The results show that in Ireland, 15 per cent of women and 6 per cent of men have experienced severely abusive behaviour of a physical, sexual or emotional nature from a

partner at some time in their lives. Nine per cent of women experienced severe physical abuse, 8 per cent experienced severe sexual abuse and 8 per cent experienced severe emotional abuse. The study found that men, in contrast, are less likely than women to experience severe abuse of either a physical, emotional or sexual nature: Four per cent of men experienced severe physical abuse and 3 per cent experienced severe emotional abuse. The numbers who experienced severe sexual abuse are much smaller, at 1 per cent. When severe abuse and minor incidents are combined, 29 per cent of women and 26 per cent of men suffer domestic abuse (Watson and Parsons, 2005).

The Sexual Abuse and Violence in Ireland (SAVI) study finds that 42 per cent of women and 28 per cent of men experienced some form of sexual abuse or assault in their lifetime (McGee et al, 2002). Furthermore, 20 per cent of girls and 16 per cent of boys in Ireland reported contact sexual abuse in childhood.

The report¹⁵ finds that in the case of both women and men who experienced sexual violence, the abuser was most often known to the abused person than a stranger (70 per cent versus 30 per cent for women and 62 per cent versus 38 per cent for men) (see Figure 2 for the breakdown for women and Figure 3 for men).

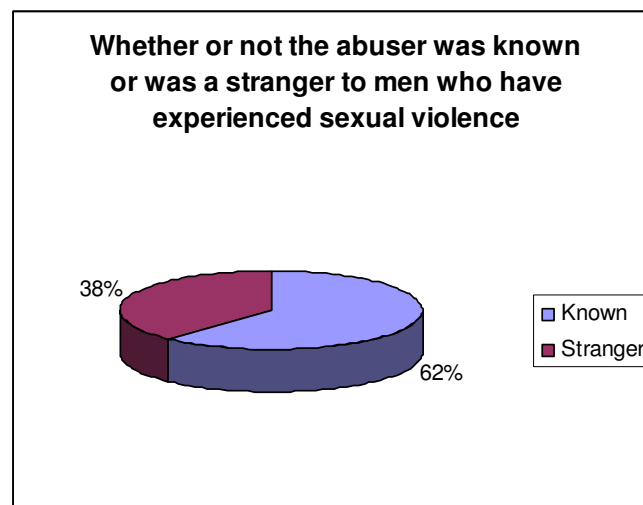
Figure 2:



Source: McGee et al, 2002

¹⁵ Based upon telephone interviews of 3,120 respondents.

Figure 3:



Source: McGee et al, 2002

Almost one quarter of the perpetrators of sexual violence against women as adults was by intimate partners or ex-partners. This was the case for just over one per cent of abused men (1.4 per cent) (McGee et al, 2002).

1.5 Elder abuse

Prior to 2007, there was very little comprehensive data on the incidence of elder abuse in Ireland. However, with the establishment of the dedicated structures to implement the recommendations of "*Protecting our Future*" (Department of Health and Children, 2002), this data gap has now been addressed in relation to cases of elder abuse reported to the HSE. Non-mandatory reporting on elder abuse to the HSE since 2007 has resulted in over 4,000 cases of alleged abuse being documented.

According to the HSE (HSE, 2009), there were 1,840 referrals of elder abuse victims to the HSE in 2008. While 2007 data (927 referrals) did not reflect a full calendar year of reporting, the data nonetheless shows an increase. In 2008 psychological abuse was the most common form of alleged abuse cited (26 per cent), followed by abuse by neglect (19 per cent), financial abuse (16 per cent) and physical abuse (12 per cent). Sexual abuse represented 1 per cent of cases. Other categories, including self-neglect, represented 26 per cent of cases.

The alleged victim of elder abuse was female in 63 per cent of total referrals. The alleged perpetrators are most commonly those with the closest relationship to the client - son/daughter and partner/husband/wife.

Over half of all cases referred related to individuals with at least one possible or suspected health issue. These were predominantly mental and physical

health factors. As explained in the HSE report (HSE, 2009), in relation to physical health, this corroborates with research evidence which has shown that older people in poor health and who have functional limitations are at heightened risk (Beach et al., 2005; Fischer and Regan, 2006).

1.6 Reporting and disclosing the violence

Despite the very serious consequences of domestic and sexual violence, taking the first steps to secure help - either a professional input or more informal support - can be very difficult. In some cases, it may take years before a victim starts to challenge or question the violence and even longer before help is sought (Landenburger, 1989). For the victim, many reasons can be involved - feelings of embarrassment and shame; fearing that the abuse may not be taken seriously, or thinking the abuse is too trivial to tell someone else. This often results in many victims not telling anybody and this seems to be particularly the case where sexual violence is involved (McGee et al, 2002). In Ireland of those who experienced instances of sexual abuse, nearly half (47 per cent) had never told another person before being surveyed (McGee et al., 2002). For older people, in many instances, the abuse may be perpetrated by a close family member, and older people may be fearful of destroying the relationship if the abuse is reported (Teaster et al., 2006).

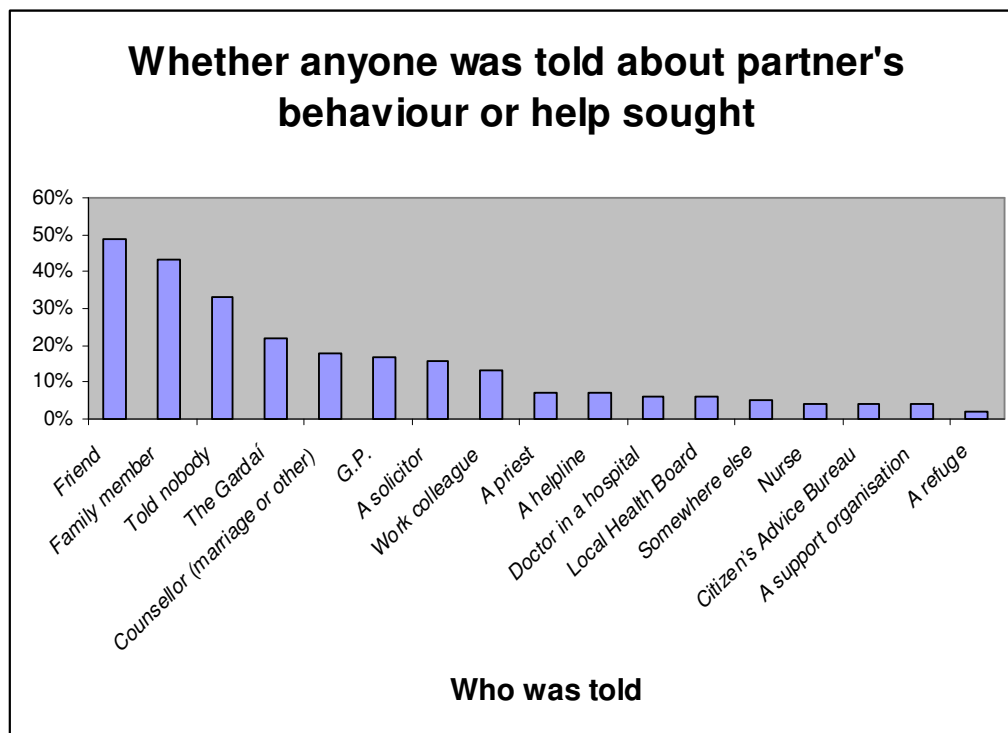
Research consistently shows that, in general, reporting and disclosure of domestic and sexual violence to professionals is strikingly low. For example, domestic violence victims generally do not report their initial experiences of abuse, but typically suffer multiple assaults and/or related abuse before they contact authorities and/or apply for protection orders (Felson et al., 2005). In Ireland, the NSDA shows that, of those who experienced severe domestic abuse, over two-fifths (42 per cent) did not tell anyone until more than a year after the behaviour began (Watson and Parsons, 2005). As can be seen in Figure 4 below, over 1 in 6 of those affected by domestic abuse confided in a General Practitioner with about 1 in 20 confiding in a nurse or a hospital doctor. Just over 1 in 8 told a work colleague. A little under a quarter of those severely affected by abuse told the Gardaí (Watson and Parsons, 2005). Among the other types of organisations approached, the most frequently consulted were solicitors (16 per cent), and counsellors (18 per cent). Fewer than 1 in 10 approach a Health Board¹⁶, helpline or support organisation for help¹⁷. In either case, only a small proportion of either women or men approach support organisations or contact help lines¹⁸.

¹⁶ Former health boards are now incorporated into the HSE.

¹⁷ Apart from counsellors, men and women do not differ significantly in terms of the probability that they will approach support organisations or contact helplines (Watson and Parsons, 2005).

¹⁸ Men are less likely than women to avail of counselling (22 per cent versus 9 per cent).

Figure 4¹⁹:



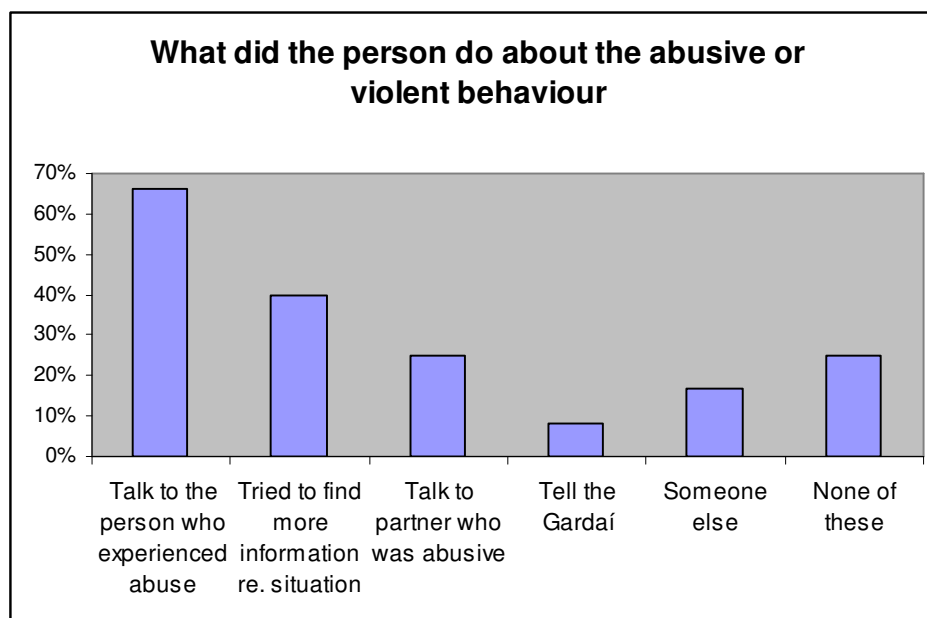
Source: Watson and Parsons, 2005.

Regarding experiences of adult sexual assault, only 1 per cent of men and nearly 8 per cent of women had reported their experiences to An Garda Síochána²⁰ (McGee et al, 2002). Furthermore, this reluctance to tell someone may also apply to friends and family who become aware that abuse is happening to those close to them. As can be seen from Figure 5, of those who learned that a friend/family was being abused, only 8 per cent reported the abuse to An Garda Síochána. The most common response was to talk to the abused person (66 per cent) and to the perpetrator (25 per cent) (Watson and Parsons, 2005).

¹⁹ Includes cases experiencing any severe abuse. Note that more than one person/organisation may have been told about the abuse and so percentages need not sum to 100.

²⁰ The pattern was similar for child sexual abuse (McGee et al 2000)

Figure 5:



Source: Watson and Parsons, 2005

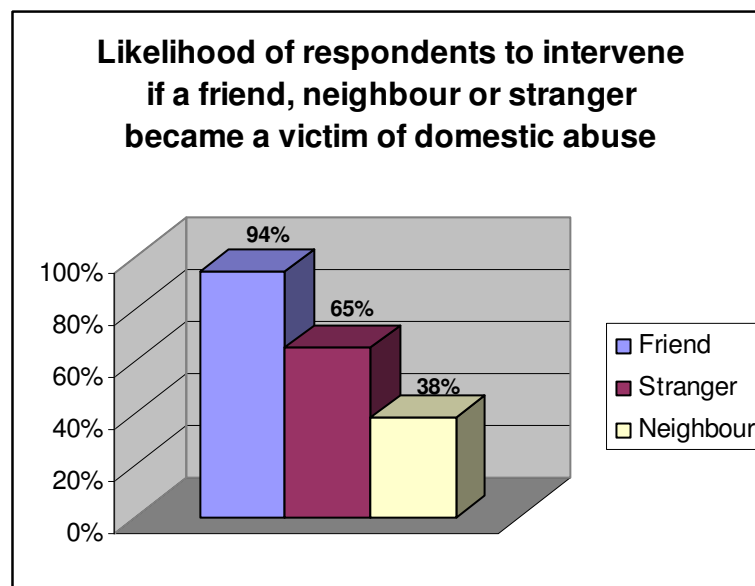
1.6.1 Informal support

Immediate family and friends are most likely to be the first point of disclosure for all those involved. Research in Ireland finds as follows. In the mid-1990's women who had reported experiencing domestic abuse were most likely to have disclosed to a friend (50 per cent) or a relative (37 per cent). Of those who disclosed sexual violence to others, over half first told an immediate family member with over a quarter telling friends (McGee et al, 2002). The NSDA also highlights this point - most often a friend (49 per cent) or family member (43 per cent) is the first to be told about the problem (Watson and Parsons, 2005).

Societal or public attitudes also play an important part in determining the extent of support a person can hope to receive. For example, victim-blaming attitudes, general misunderstandings about the causes and effects of domestic and sexual violence, and concerns about how cases will be handled by professionals (e.g. that they are taken seriously and dealt with in confidence) all underpin our thinking and beliefs around domestic and sexual violence. For dependent older people, public attitudes may play an even greater role in determining the extent of support they receive. This may be particularly so where neighbours or other family members perceive the practical support that the person receives from the abuser as sometimes outweighing the seriousness of the abuse.

Recent research indicates that even when we consider domestic and sexual abuse to be a serious problem, our willingness to help those other than close family and friends may be adversely affected by a reluctance to get involved in private matters: The Survey on Perceptions and Beliefs of Domestic Abuse among the General Population of Ireland (Horgan et al, 2009) finds that domestic abuse is generally perceived as a crime in Ireland, involving physical and emotional abuse, rape and sexual assault. While most respondents (94 per cent) were prepared to help a friend, fewer (65 per cent) said they would help a stranger and fewer again said they would help a neighbour (38 per cent) (see Figure 6). Such a reluctance to help those beyond our inner circle of friends and family underlines how dependant people can be on their closest and immediate network ties. The next section explains, however, that in some communities discussing domestic and sexual violence can be more problematic than in others, further compounding the problem of isolation and vulnerability.

Figure 6:



Source: Horgan et al, 2009.

1.6.2 Violence and isolation in communities

As discussed earlier, physical and emotional isolation are among the most serious obstacles to securing help with domestic and sexual violence. Particularly where the perpetrator and victim live together, a pattern of coercive control is typically established by the perpetrator. This control pervades all areas of the victim's life, from regulating possessions, control over money and pensions, and access to employment, to limiting contact with family and friends. This permeates the victim's personal and social life, making it very difficult to visit services of any kind for help or advice.

The strength of impact of this control is stronger in certain communities than others. For example, in communities where violence against women is

considered to be acceptable, challenging these norms is complicated and doing so will entail a high degree of risk of being rejected by members of one's own community. Barriers to talking about domestic and sexual violence present disproportionately among women in the Traveller community (Watson and Parsons, 2005). Belonging to a community where members experience certain barriers in relation to the wider community, means that women are strongly dependant on the informal and mutual support from other women to cope (Watson and Parsons, 2005). Similar problems are faced by immigrant women from gender unequal cultures (Watson and Parsons, 2005).

Living in rural communities brings additional difficulties, such as access to transportation or to appropriate services. Often in a small community, the professionals that one would approach may know the family well or live nearby. Thus because of the professional's familiarity with both the abuser and the victim, victims and their children can therefore be reluctant to approach them. Under these types of circumstances children learn that abuse in families is something that is not easily talked about, either at home or outside. This makes it harder for them to seek explanations or to ask for help (Spears, 2000; Preston-Shoot and Wigley, 2005).

Some people, for example people with disabilities, may have few if any contacts outside the domestic situation and no means of contacting people to report abuse. If particularly dependent or isolated, people with disabilities may feel disempowered from making complaints, may find it more difficult to communicate, or to be taken seriously if they do complain.

1.7 Conclusions and organisation of the report

From the discussion in this chapter it is clear that domestic and sexual violence are difficult social problems, impacting on women, men, children and older people in society. These problems are persistent and domestic violence in particular almost always involves a multiple victimisation, i.e., that the abuse is rarely a unique event but is rather regularly repeated and frequently escalates in severity.

The report first provides an up-to-date picture of the range of services and the types of activities engaged in by domestic and sexual violence service providers in Ireland. **Chapter 3** presents the reader with the results of the survey of service provision. This chapter provides an overview of services available in Ireland to address the problem of domestic and sexual violence. Specifically the chapter covers issues pertaining to service density and developments in service provision for those affected by domestic and sexual violence over the last decade.

Chapter 4 addresses the role of co-ordination and how it contributes to enhanced service provision. Based on insights from the international literature, the report elaborates on the conceptual framework sketched earlier (and depicted in Figure 1) regarding how enhanced co-ordination is likely to benefit the safety of victims. Chapter 4 elaborates on the key points of the conceptual framework.

Chapter 5 presents the results of the qualitative component of the research. The main concepts identified in Chapter 4 return in Chapter 5 as respondents discuss their organisation's position on domestic and sexual violence, their work with other organisations on these issues and the strengths and weaknesses they encounter, not only in service provision generally, but the factors that they find facilitate or impede their ability to work with potential collaborators.

Chapter 6 completes the report with a summary of findings and a brief discussion of some of the more salient findings. The chapter also discusses future research needs and the key limitations of this study.

The following chapter, **Chapter 2**, outlines the methodological details for both of these empirical studies. The chapter also explains the decisions taken in relation to key methodological challenges.

Chapter Two

Methodology

2.1 Introduction and background

Two main objectives were developed for this study. The first was to provide a current overview of domestic and sexual violence service provision in Ireland and the second was to examine co-ordination among service providers to explore factors that support this co-ordination work.

This research was conducted in two phases and encompasses the use of mixed methods. The first phase used existing data sources to examine the range of services in Ireland. The second phase adapted a qualitative research methodology to address the development of co-ordination among organisations and agencies involved in domestic and sexual violence related service provision.

This chapter outlines the details relating to the two methodologies developed and applied in the research. The following section first presents the details of the survey of domestic and sexual violence service providers in Ireland and the second outlines the methodology applied to examine the co-ordination among service providers in the sector.

2.2 Sources of data

For the purpose of the first component of this study (survey of service provider organisations), information was required on domestic and sexual violence service provision to women, men and children in Ireland. Three sources of information were used for this study. Two sources came from pre-existing data. The first of these existing data sets contains information collected by SAFE Ireland²¹, the network for dedicated frontline domestic violence services in Ireland. This source of data is based on a 2008 SAFE Ireland survey of 38 domestic violence services that work with women and children and which, at the time of data collection, were members of the SAFE Ireland network²². The data were collected using a pre-structured questionnaire and an online survey technique was used for this. An Information Note (prepared by Cosc) was distributed by SAFE Ireland informing network members about the study and Cosc's use of the data.

The second source contains data for the year 2007 collected by the Rape Crisis Network Ireland (RCNI), the network for Rape Crisis Centres in Ireland. This data set contains information on the service provision of 14 Rape Crisis Centres providing services to women and men around Ireland who have experienced sexual violence. All of the organisations included in this data set

²¹ Formerly the National Network for Women's Refuges and Support Services (NNWRSS).

²² As it is not a non-Governmental organisation the Rathmines Women's Refuge is not covered by the SAFE Ireland survey. It is the only refuge in Ireland managed by the HSE. For this reason, it has been included in the Cosc data collection phase of this study.

are members of the RCNI network²³. The data is collected using a web-based recording system.

The third source of survey information for this study came from a primary data collection by Cosc. The aim of this data collection was mainly to supplement the SAFE Ireland and RCNI data sets, including those domestic and sexual violence (dedicated) frontline services that were not members of either network at the time. To this end, Cosc was greatly helped in identifying 14 organisations by SAFE Ireland, the RCNI and other members of the former Regional Planning Committees on Violence Against Women.

2.2.1 Supplementary Information

Finally, Chapters 3 and 4 present relevant supplementary information from sources other than those mentioned thus far (particularly material presented on the range of services provided by NGOs). This supplementary information has also been reported from a variety of well-established sources such as key publications by various domestic and sexual violence organisations such as annual reports and other publications reporting statistics relating to service provision.

2.3 A survey of dedicated frontline service providers operating in the domestic and sexual violence sector

2.3.1 Interviewing and questionnaires

Two pre-structured questionnaires²⁴ were developed by Cosc and each of these was designed in order to provide the same types of information that are in the SAFE Ireland and RCNI surveys. A limited number of other areas of information was added in order to provide information that was considered to be of value for the development of the National Strategy on Domestic, Sexual and Gender-based Violence. Data collection was undertaken by Computer Aided Telephone Interviewing (CATI) and was completed by CM Surveys.

2.3.2 Principal concepts and measurement details

Several concepts were operationalised for the purpose of this study. These are outlined below.

(a) Range of services: In this study, the concept of range of services refers to a number of different service types. The study counted the set of services which have been specified by the international literature to be essential to combat domestic and sexual violence. These services should be provided by, among others, dedicated services such as Rape Crisis Centres, refuges and other domestic and sexual violence support services. The service user

²³ Although a member of the RCNI network at the time, due to their size and their need for formalised data collection prior to other RCCs, information on Dublin RCC was not collated by the RCNI. It is for this reason that information on Dublin RCC is presented here along with those other "non-network affiliated" sexual violence services.

²⁴ One questionnaire for the purposes of surveying non-network affiliated domestic violence services and a second for non-network affiliated sexual violence support services

should be able to avail of a crisis helpline, accommodation, counselling and psychological services, the provision of advocacy, the provision of general information, health care/medical services, (including Sexual Assault Treatment Units (SATUs), outreach work as well as training and education.

(b) Standards of service provision and service level density²⁵:

Standards of service provision refers to specifying not only what services should be available but indicate also their distribution in terms of populations and geography. Recommended levels of activity are specified in the EU literature (Council of Europe Guidelines, Kelly and Dubois, 2008) as the essential elements for a set of standards. These same standards, elaborated upon in section 3.3 of this report have been applied in this study as one indicator of the levels of standards in Ireland. However, while the number of services may satisfy these guidelines, they do not capture differences in regional need which will vary with population levels. Consequently in addition to the Council of Europe service guidelines (Kelly and Dubois, 2008), this study also calculates the ratio of services to population in the various HSE regions in Ireland (see below for these calculations). It should also be noted that, by applying the concept 'service density', no account is taken of important aspects of service provision such as service capacity (e.g. the size of the centres involved or the number of facilities available in the centres) or how effectively services operate. Evidently, the concept neither encompasses an indication of how centres may have developed and changed in these respects over time.

It should be noted that the guidelines outlined above have been developed specifically for the purpose of addressing violence against women. The relevant practitioner and policy literature have not focused on specifying what the appropriate range of services and set of standards would be for men who experience domestic and sexual violence.

(c) Services population ratios: population estimates: The methodological basis for calculating service population ratios used in the earlier research (Maunsell et al, 2000) is unknown and therefore, could not be reconstructed. For the purpose of this study, service population ratios for 2000 and 2007 were calculated based on extrapolations of Census data and CSO population estimates (see tables 1a to 1c below). The relevant population is women 15 years and older²⁶.

While some of these support services (e.g. Amen; One-in-Four; RCCs and SATUs) do provide services to men who have experienced domestic or sexual violence, because neither the standards for support services developed by the Council of Europe nor Maunsell (2000) take account of service availability for men, this study has not calculated service density for men.

²⁵ However, what must be borne in mind here is the fact that this information reflects neither the size nor range of services provided.

²⁶ There is no guidance given in Kelly and Dubois (2008) regarding the definition of the relevant population of women. While some organisations consider this to be 18 years and over, others apply a lower threshold, at 15 years and over. The relevant age category used by the Central Statistic Office in compiling the Census information is 15 years and over.

Since 2006 the Irish population has grown. The figures used for this study are estimates for 2007 and are based on population growth rates derived from CSO population estimates (Table 1a).

Table 1a: Female Population – 15 years and over in 2007 (*estimates based on extrapolations from CSO Census 1996, 2002 and 2006*)

Region	Western			North Eastern		Mid-Leinster	Southern		Total
Sub-Region	NW	W	MW	NE	E	Mlands	SE	S	
Women ²⁷	95,515	168,431	146,055	155,324	635,935	98,865	107,679	332,651	1,740,455
% share of total pop of women	5.5	9.7	8.4	8.9	36.5	5.7	6.2	19.1	100

Table 1b outlines calculations of the changes in female population between 2000 and 2007. These are based on the female population 15 years and over, per county in Ireland, from the CSO's censuses 1996, 2002 and 2006. These were multiplied by the average growth of the female population, 15 years and over in Ireland between 2006 and 2007, according to population estimates in 2009²⁸. The product is the estimated population of women 15 years and over per county in 2007.

Table 1b: Change in Female Population - 15 years+ 2000 to 2007 (*estimates based on extrapolations from CSO Census 1996, 2002 and 2006*)

Region	Western			North Eastern		Mid-Leinster	Southern		Total
Sub-Region	NW	W	MW	NE	E	Mlands	SE	S	
Women in 2000	83,866	144,489	129,244	125,834	562,273	82,484	90,267	293,976	1,512,478
Women in 2007	95,515	168,431	146,055	155,324	635,935	98,865	107,679	332,651	1,740,455
% increase from 2000 -> 2007	14	17	13	23	13	20	19	13	15

Overall there has been an increase of 15 per cent in the population of females aged 15 years and over from 2000 to 2007. The largest increases have taken place in the North-Eastern and Midlands sub-regions, i.e. 23 per cent and 20 per cent respectively.

Table 1c: Regional and Sub-regional Breakdown i.e. What Counties in What Regions

Region	Western			North Eastern		Mid-Leinster	Southern	
Sub-Region	NW	W	MW	NE	E	Mlands	SE	S
Counties	Donegal Leitrim Sligo	Mayo Galway Roscommon	Clare Limerick Tipperary (North)	Louth Monaghan Meath Cavan	Dublin Kildare Wicklow	Westmeath Longford Offaly Laois	Waterford Wexford Tipperary (South) Carlow Kilkenny	Kerry Cork

²⁷ All reference to "women" in this report refers to adult women i.e. women of the age of 15 years and over.

²⁸ $(\text{Population}_{2002} / \text{Population}_{1996})^{4/6} \times \text{Population}_{1996}$ (growth at continuous rate assumed)

(d) Grades of service density levels²⁹: To measure the density of service levels in the HSE regions and sub-regions four separate indices were constructed. Each is a four-level index representing a quartile of service density distribution in the sample. The index is a ratio between the number of services counted in a particular HSE region relative to estimates of population of women aged 15 years and over in a region in 2007 (for calculation of population estimates, see the discussion above).

One index was constructed to measure the *refuge density levels* and a second to measure *bed density levels*. A third entitled *total domestic violence service density levels* was constructed and is based on a count of both refuges and beds in the period in question. The final index was constructed to measure *total sexual violence service density*. This index is based on a total count of sexual violence support services available in the period in question.

(e) Regional and sub-regional divisions: For the analyses of regional divisions, perhaps the most accepted framework is the Nomenclature of Territorial Units for Statistics (NUTS). However, in order to provide a basis for comparison with the results of the earlier study (i.e. Maunsell et al, 2000) it was necessary to apply the regional divisions applied in this work. This regional division follows the eight former Regional Planning Committee areas. The Western region is composed of the North-Western (NW), Western (W) and Mid-Western (MW) sub-regions; the North-Eastern region is composed of the North-Eastern (NE) and Eastern (E) sub-regions; the Mid-Leinster region comprises the Midlands (Mlands) sub-region; and the Southern region is comprises the South-Eastern (SE) and Southern (S) sub-regions. For the region/population breakdown, please see Tables 1a and 1b. For region/county breakdown information please see Table 1c.

(f) Other definitions and measurement details: There are other key concepts used in this study. For convenience, these are outlined in the chapters in which the relevant results are presented.

2.3.3 Framework for data analyses and reporting

The range of services is analysed using the three data sets described above. The SAFE Ireland data set provides the bulk of information relating to the range of domestic violence services in Ireland in 2007. The RCNI data set provides information on the activities and services provided by rape crisis centres. The Cosc data provides complementary information on these issues from organisations/centres that are not affiliated to either of the networks.

The potential to cover the range of domestic and sexual violence service provision is determined by the quality of the data. One principal disadvantage of using different sources of data is that the alignment between data sets involved can be low. Given that the original studies involved were developed in different contexts and with different purposes, it is inevitable that

²⁹ However, what must be borne in mind here is the fact that this information reflects neither the size nor range of services provided.

differences occur in data specification and alignment. Where the data on service provision are comparable, all data sets are used. Where data specification diverges and is not reconcilable, the possibility to use each data set is reduced. In this situation, the most appropriate data set, in terms of focus and data quality is selected. Where the Cosc data provides supplementary information on domestic and sexual violence services, these issues are presented separately in the report.

(a) Developments over time in service provision: As Maunsell et al (2000) is the only source of information regarding service provision in this sector, it is necessary to use this data to provide a preliminary picture regarding the changes in the range and standards of NGO services in the domestic and sexual violence sector. Where possible, comparisons with the results reported by Maunsell et al (2000) are made. However, the criteria for inclusion used in 2000 has not been documented; therefore it has not been possible to access these details for the purpose of replicating the approach used in this earlier work.

Furthermore, it is not clear as to whether or not Maunsell et al's study provides a complete census of services available at that time to those (women) who have experienced domestic or sexual violence³⁰. Consequently the analyses comparing current levels of service availability with those reported in Maunsell et al (2000) should be considered for indicative purposes only.

Within the limits of the data, comparisons in service level density have been undertaken. The changes examined and reported included the following.

- Changes in all service density by region since 2000
- Changes in each of the different types of service density since 2000.

For the reasons discussed above, it has not always been possible to draw comparisons with Maunsell (2000). As far as possible, the results section indicates where these comparisons have not been undertaken.

The following section contains the methodology applied for the second component of this study, exploring the co-ordination of domestic and sexual violence service provision in Ireland.

2.4 Exploring the co-ordination of domestic and sexual violence service provision in Ireland

2.4.1 In-depth interviews

The second component of this study entailed a qualitative design. It is based on in-depth interviews with representatives, key informants, from both State

³⁰ For example Maunsell et al include some non-dedicated domestic and sexual violence services (e.g. Laragh Counselling, Dublin; Lone Parent's Group, Laois; and Ruhama Women's Project in Dublin) and not others. Also worth noting is that some additional support services surveyed for Cosc's study were not surveyed by Maunsell et al.

and non-State organisations operating in the domestic and sexual violence sector. Three different types of key informants were required for this study, each providing an important perspective on the sector as well as vantage points from different levels of the sector - local, regional and national levels.

Key informants were selected by Cosc from: (i) State and non-State sectors and (ii) Chairpersons and HSE Designated Officers on Violence Against Women of all (former) Regional Planning Committees³¹. Each of these individuals was contacted and invited to participate in the study. All of those contacted agreed to participate and were interviewed.

(a) The State interviews were conducted with officials from An Garda Síochána; the Courts Service; the Health Service Executive (2 interviews); the Legal Aid Board; the Probation Service (3 interviews)³²; a Sexual Assault Treatment Unit; the Family Support Agency; the Department of the Environment, Heritage and Local Government; the Victims of Crime Office and the Office for Older People (Department of Health and Children). The Non-State organisation interviews were with representatives of SAFE Ireland and Rape Crisis Network Ireland.

(b) RPC Chairpersons and HSE Designated Officers (VAW): Another important perspective was provided by Chairpersons of (former) Regional Planning Committees (RPCs) and HSE Designated Officers for violence against women. These in-depth interviews were undertaken in order to gain insights regarding the co-ordination work undertaken at regional and local levels.

(c) Local area networks (LANs): Finally, inter-agency initiatives often take the form of a forum among a network of organisations on violence against women, bringing together some or all of the relevant agencies in a locality/area. These usually include among others: Women's Aid, Rape Crisis Centres, refuge organisations, victim support organisations, the Probation Service, An Garda Síochána, Social Services and the Legal Aid Board. Focus groups were conducted with two of these LANs. The LANs were selected for their value as case studies of networks of organisations that have been actively working to co-ordinate their work in relation to domestic and sexual violence in their respective localities. The groups provide specific insights to the experience of co-ordination among front-line service providers in the two regions.

The fieldwork was conducted by CM Surveys and by Cosc. Interview topic guides were prepared in advance of all interviews and group discussions so that a selection of pre-specified key areas would form the core of each interview. It was anticipated that other areas of relevance would also emerge during the interview and this was taken into account in the design and schedule of the interview. A variety of topics were selected, covering a wide range of issues about organisations' work in relation to domestic and sexual

³¹ Since restructured and renamed Regional Advisory Committees.

³² Two of these were with key informants on domestic violence perpetrator programmes and another on sexual violence perpetrator programmes.

violence. The main topic headings included policy related activities; service provision; training and interagency co-ordination and within each of these headings a selection of sub-topics were also covered. The average duration of the interviews was 50 minutes.

2.4.2 Analyses and reporting

The process undertaken for the analysis and interpretation of interview material was largely informed by a qualitative approach. The explorative aspects of this research required an approach that would facilitate an identification of salient themes that emerged during the interviews on co-ordination. In order to ensure a systematic and rigorous approach to the analysis of the data, interviews were first transcribed. The transcription of each interview was examined closely by two researchers in order to identify key themes that emerged. The pre-prepared interview guide guaranteed meaningful comparability of responses, as each respondent was asked to cover the same areas/themes during discussion. Material gathered from Local Area Networks by way of focus groups was collated and analysed in a similar and consistent fashion. Many of the issues raised were mentioned at least once, and most, by multiple respondents.

The entire dataset was then categorised (coded and indexed) in relation to themes that emerged during analysis. Inter-observer methods were applied to test for observer bias. Themes were selected on the basis of inter-coder agreement and sequential analysis was applied where the data were continually checked against the interpretation until the researcher was satisfied that the meaning was correct.

Jefferson techniques were also applied in order to code not just what was said but how issues were spoken about by the respondents (e.g. voice intonation, speed of speech, emphasis). This is a particularly valuable method when it is not just what respondents say that is important, but how issues are spoken about, such as when there are pauses during the conversation. The Jefferson techniques require the researcher to concentrate on the text as a matter of social exchange rather than information sought and supplied (Howitt and Cramer, 2005). Consequently, these techniques foster a more intimate familiarity with the text and this early and detailed familiarity is considered to be one of the analytical virtues of qualitative research.

The identity of all of those interviewed has been protected at all points during the course of this study. Subsequently, where the identity of the person or the organisation they represent is recognisable in an interviewee's response, this material is not presented as direct quotations in this report. Additionally, on a few occasions small adaptations have been made in order to protect the interviewee's identity. This has been done only where the substance of the response would be unaffected by the change. This approach facilitates the reporting of, what for many people and organisations, are sensitive issues that were raised during the interviews.

Finally, in some areas clarification was needed on facts/information that had been provided and recorded during interviews. For this purpose and where it had been agreed, Cosc re-contacted the organisations in question to seek clarification and discuss further the particular issue(s). The assistance and feedback provided by these organisations was extremely helpful in the analysis and interpretation phase of this study.

The following chapter, Chapter 3, outlines the results of the survey of dedicated frontline organisations operating in the domestic and sexual violence sector.

Chapter Three

Range of Services Provided by NGOs for Victims of Domestic and Sexual Violence

3.1 Introduction, research objectives and main concepts

The main objective of the first phase of this study is to present an overview of the range of services available for those who are affected by domestic and sexual violence and to examine how this has changed over time. This involves 3 steps:

1. to describe by region/sub-region the range of service provision (Section 3.2),
2. to examine the standards of service provision including regional dispersion and service density (Section 3.3), and
3. to explore how these have changed over time.

3.2 The range of domestic and sexual violence support services

When victims of domestic or sexual violence seek help, they typically need to rely on a variety of different services. People who have experienced domestic or sexual violence typically will seek help from a variety of sources - public, private, community and voluntary. Legal assistance may be sought from solicitors, medical help from their doctor or a hospital, advice and support from an advice centre or support group, and financial support from social welfare or its agencies. In addition, accommodation may be needed from a housing authority, refuge or support services (e.g. transitional housing).

Specialised provision has its origins in the non-governmental organisation sector and over the years victims have been offered a range of different types of services by many different NGOs. These services and their components, in many ways, are now considered to be essential to the response to domestic and sexual violence (Kelly and Dubois, 2008). These include the following.

(a) Crisis helpline: A crisis helpline offers immediate help to people who have been affected by domestic or sexual violence. A helpline offers a confidential and free telephone line service providing information and support to victims. The helpline can be staffed by volunteers, paraprofessionals and professionals who have received intensive training and have experience of crisis intervention and legal procedures.

(b) Refuge or shelter: Refuges are a source of shelter and safety, exclusively for women and their children, which provide respite, a time to think, an opportunity to review their options and to begin to rebuild their lives with social, legal and medical assistance if needed.

(c) Counselling and psychological services: These services and the facilities they make available mean that abused people, their families and friends can speak to qualified counsellors, to advocates and others about abusive experiences and secure information and resources to address a range of issues. Counselling services can be offered individually as well as in support group settings. The structure and content of counselling services can vary from organisation to organisation (e.g. cognitive restructuring therapy; assertive communication; problem solving; body awareness; gender socialisation; self-esteem building; trauma therapy; grief-resolution-oriented counselling).

(d) Advocacy and information: Advocacy workers accompany and support people as they navigate the legal, medical and social systems, providing an important link between individuals seeking assistance and service providers (e.g. An Garda Síochána; solicitors; medical personnel; housing agencies/organisations).

(e) Rape Crisis Centres (RCCs): Aiming to support women and girls as well as men who have been sexually assaulted in their lives. These services provide helplines, counselling, legal advice, advocacy and self-help groups.

(f) Health care and medical services, (including Sexual Assault Treatment Units - SATUs): Primary healthcare workers play a key role in screening, detecting and treating victims of domestic and sexual violence. These workers are often the first point of contact between the victim and support services. As such, these services are critically placed to support disclosure and referral for further specialist assistance, such as to Sexual Assault Treatment Units.

(g) Outreach: Organisations can provide community- and school-based prevention and outreach services. These are particularly useful for individuals who find it difficult to access services (e.g. individuals with young children, who have mobility problems or other disabilities that restrict their movement or ability to seek help).

(h) Training and education: Education for the community at large (including professionals) and for women and men who seek help is key in both responding to and preventing these forms of violence.

3.3 Standards of service provision

The international community has also proposed the main requirements for domestic and sexual violence service provision. This approach emphasises the importance of violence against women service provision that is based on shelter or refuge provision, supplemented by early and equitable access to support (Kelly and Dubois, 2008). Kelly and Dubois (2008) proposed certain standards of service as the essential elements of this system. In the relevant document there is no discussion of what each service in a region should entail (such as what the capacity needs to be, e.g. indications of size, the number of facilities, etc.). The standards proposed are the following.

- One national helpline covering domestic violence and one covering sexual violence.
- One specialist violence against women (VAW) shelter in each province/region. These should accommodate additional needs - migrant and minority women; women with disabilities; women with mental health and/or substance misuse issues; and younger women needing protection from female genital mutilation (FGM), forced and child marriage, crimes in the name of honour).
- One family space per 10,000 of the population³³.
- One rape crisis centre per 200,000 women³⁴ with at least one centre per region.
- One Sexual Assault Treatment Unit per 400,000 women.
- One advice/advocacy service per 50,000 women (enabling early intervention and access to legal and other support).
- One counselling service per 50,000 women. There should be one specialist VAW counselling service in every regional city.
- Outreach should be designed locally to address the largest local minority groups, women with disabilities and under-served groups.

Source: Kelly and Dubois, 2008

Kelly and Dubois's framework has been adapted for the purposes of this study. It should be noted that these are standards which apply to violence against women only. It was beyond the scope of this study to develop standards for service provision for victims of domestic and sexual violence who are men, children, older people or those who have specific needs. The fact that these standards are not available for this report, and other shortcomings relating to this Council of Europe framework, are discussed later under future study limitations and future research needs.

3.3.1 Regional dispersion and service density

This current study examines and reports on the provision of services per region using service to population ratios as an indicator of service density in a region³⁵. While this information does not reflect the capacity or effectiveness of services it does give an important indication, of service availability across the country on a county-by-county basis. It also provides important insights regarding the developments in service provision since 2000 as it addresses (a) whether absolute levels of service provision have increased or decreased over the last decade and (b) whether service provision, relative to changes in population distribution over this time, has changed. It should be noted also that these descriptions are indicative only. Stronger conclusions could be

³³ Kelly and Dubois (2008) in their elaboration of Council of Europe standards refer to the concept of "family space" in refuges where they recommend a minimum standard of "1 family space per 10 000 of the population". However, questions remain as to the exact definition of "family space" and whether or not it is possible to apply this particular standard given that it does not specify the segment of the population involved, (i.e. if the population referred to is the population of women or the population as a whole). This report presents the number of permanent beds available in refuges for women and children who have experienced domestic violence.

³⁴ Kelly and Dubois (2008) do not define what age constitutes "woman". For the purposes of the current study "women" is defined as females of 15 years and over.

³⁵ However, what must be borne in mind here is the fact that this information reflects neither the size nor range of services provided.

drawn if information was available on the development of the capacity of the service providers over the period by, for example, including information about the extent and nature of outreach operations. See chapter 2 for methodological details pertaining to the analyses implemented.

3.4 The range of domestic violence dedicated support services in Ireland

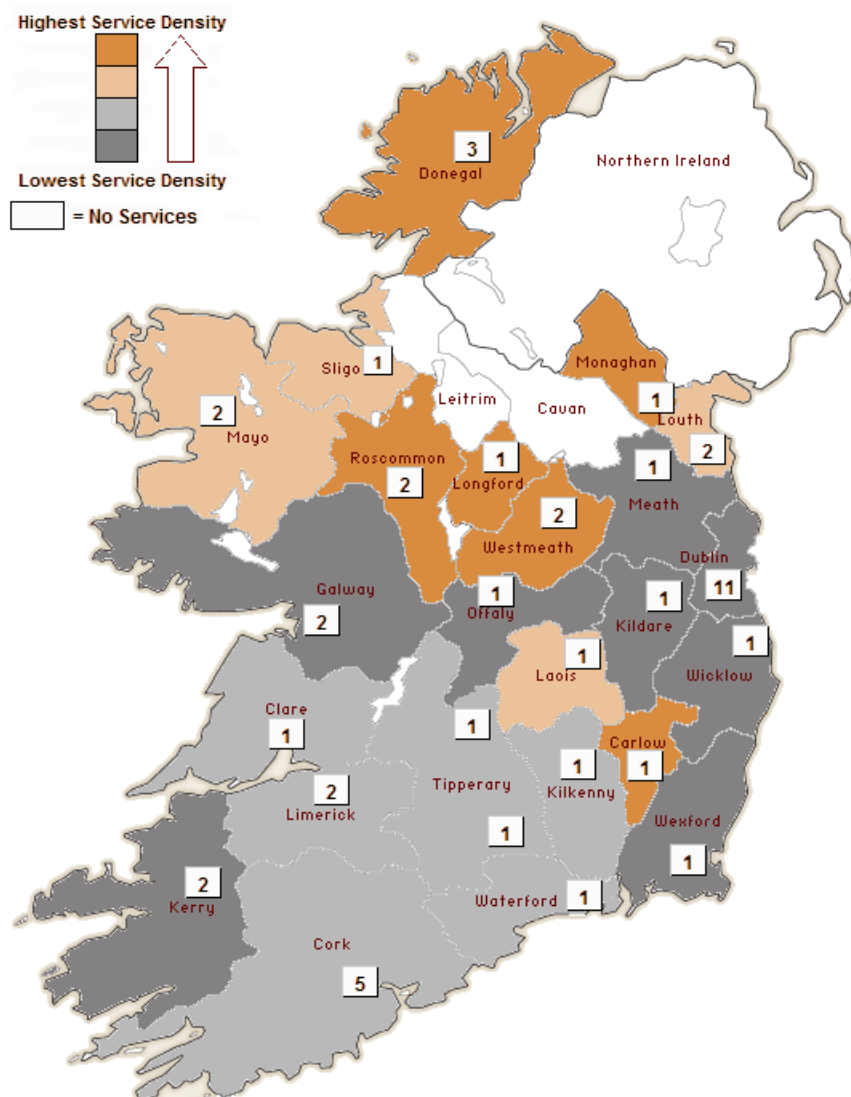
Victims of domestic violence can access support from a range of sources. Some services provide integrated responses, offering a combination of types of support such as, accommodation, advocacy, accompaniment, information, emotional and other general support. These are referred to in this report as 'Domestic Violence Support Services' and they are broken down into support services which provide accommodation (e.g. refuges (n=19) and those which don't (n=30)). Section 3.4.1 examines the number of organisations providing Domestic Violence Support Services, including refuge provision, to victims. Section 3.4.2 provides a breakdown of the types of services and activities delivered by Domestic Violence Service providers. Section 3.4.3 provides details on accommodation and support with accommodation provided by these services. Section 3.4.4 provides an overview of the number of cases of accessing services recorded by Domestic Violence Support Services in 2007.

3.4.1 The number of domestic violence support services in Ireland

The Domestic Violence Support Services provide services users with support, information and advocacy to victims of domestic violence and, in some cases, their children. These are generally available from 9 am to 5pm Monday to Friday. Domestic Violence Support Services are provided by a variety of service providers in Ireland. In total 49 Domestic Violence Support Services are available to those who have experienced domestic violence in Ireland. This comprises 19 refuges (offering accommodation) and 30 (non-accommodation) service providers, including Women's Aid which operates a national freephone helpline for domestic violence victims.

Map 1 highlights those counties within which Domestic Violence Support Services are located. There are no Domestic Violence Support Services located in either Leitrim or Cavan. However, no information is available regarding the catchment areas of services outside Leitrim and Cavan. Moreover, there is no information regarding the areas in which service users normally reside. Consequently it is not possible to determine the extent to which Leitrim and Cavan are provided for by services in other counties.

MAP 1: Counties in Ireland in which Domestic Violence Support Services (including refuges) were located in 2007 and indications of service density per county



Amen is the only dedicated service providing support to male victims of domestic violence. Like many of those services for women it too provides advocacy, information, advice, counselling, etc. as well as a national helpline facility including an after hours contact point if required. Amen does not provide accommodation or refuge facilities.

The Senior Helpline is the only dedicated NGO service available for older people for support with problems of domestic and sexual violence although senior case workers dealing with elder abuse are employed in the HSE to co-ordinate the response to allegations and concerns of elder abuse. Examples of some interventions used in the course of responding to these concerns include increased monitoring of the client in the community, increasing home

support, providing counselling and, less often, respite and admission to long term care.³⁶

Refuges provide the broad range of services to women who avail of accommodation as well as to those who do not. These support services are offered on site at the refuge centre and there is some provision for services on an outreach basis. It is appropriate therefore that when considering the full availability of domestic violence services both accommodation-providing refuges as well as non-accommodation providing services are included. Combining these results in a total of 49 support services available to those who have experienced domestic violence in Ireland in 2007, this translates into 1 domestic violence service for every 36,259³⁷ women in Ireland. In 2000 Maunsell reported 31 domestic violence services i.e. 1 service per 48,790 women³⁸.

The largest number of domestic violence services is found in the Eastern sub-region (13) and the lowest in the North-Western (4) and Mid-Western (4) sub-regions.

In terms of service density, the lowest is in the Eastern sub-region, and the highest is in the Midlands sub-region (Table 2a and Table 2b). Where there are domestic violence services available, those counties with the lowest service density are Kildare, Meath and Wexford (See Appendix 1). However, as stated earlier, it should be borne in mind here that in applying the concept of "service density" no account is taken of important aspects of service provision such as service capacity (e.g. the size of the centre involved) or how effectively they operate.

Table 2a: Domestic Violence Support Services Density Levels (2007)³⁹

Region	Western			North-Eastern		Mid-Leinster	Southern		Total
Sub-region	North-Western	Western	Mid-Western	North-Eastern	Eastern	Midlands	South-Eastern	Southern	
Total no. of non-accommodation support services in 2007	3	4	2	2	9	4	1	5	30
Total no. of refuges in 2007	1	2	2	3	4	1	4	2	19
Total no. of refuges and non-accommodation support services in 2000	4	6	4	5 ⁴⁰	13	5	5	7	49
Ratio of support, information and advocacy services to women in 2007	1:23,879	1:28,072	1:36,514	1:38,831	1:48,918	1:19,773	1:21,536	1:47,522	1:36,259

³⁶ Source: http://www.hse.ie/Elder_Abuse.html

³⁷ The calculation of this figure excluded Amen - the national service provider for men who have experienced domestic violence.

³⁸ As stated earlier, a direct comparison with the reporting of Maunsell et al (2000) is not always possible. One such example here is where Maunsell et al included some non-dedicated domestic violence services (e.g. Laragh Counselling, Dublin; Lone Parent's Group, Laois;) and excluded some of those included in the current study (e.g. Amen; Vita House; and Senior Helpline).

³⁹ The sub-region titles used throughout this report are those used to designate the former Regional Planning Committee areas and, as such, are also those used by Maunsell et al (2000).

Table 2b: Domestic Violence Support Services Density Levels (2000)

Region	Western			North-Eastern		Mid-Leinster	Southern		Total
Sub-region	North-Western	Western	Mid-Western	North-Eastern	Eastern	Midlands	South-Eastern	Southern	
Total no. of non-accommodation support services in 2000 ⁴¹	0	1	1	1	6	2	3	2	16
Total no. of refugees in 2000	1	2	1	3	3	1	2	2	15
Total no. of refugees and non-accommodation support services in 2000	1	3	2	4	9	3	5	4	31
Ratio of support, information and advocacy services to women in 2000	1:83,866	1:48,163	1:64,622	1:31,458	1:62,475	1:27,494	1:18,053	1:73,494	1:48,790

The 30 (non-accommodation) service providers are composed of 21 SAFE Ireland⁴² network members and 9 non-network affiliated organisations (See Table 3 for a list of these service providers). The number of non-accommodation support services has almost doubled since 2000 from 16 to 30.

Table 3: Non-accommodation Domestic Violence Support Service Providers in Ireland (2007) (n=30)⁴³

Region	Western			North Eastern		Mid-Leinster	South	
Sub-region	North-Western	Western	Mid-Western	North-Eastern	Eastern	Midlands	South Eastern	Southern
Name of Domestic Violence Support Service	Domestic Violence Advocacy Service, Co. Sligo Inishowen Women's Outreach, Co. Donegal Letterkenny Women's Centre, Co. Donegal	Achill Domestic Violence Services, Co. Mayo Domestic Violence Response, Co. Galway Family Life Centre, Co. Roscommon Vita House, Co. Roscommon	Ascend Women's Support Service, Co. Tipperary Southhill Domestic Abuse Project, Co. Limerick	AMEN, Co. Meath Tearmann Domestic Violence Services, Co. Monaghan	Dublin 12 Domestic Violence Service, Co. Dublin Inchicore Outreach Centre, Co. Dublin SAVE - Southside Addressing Violence Effectively, Co. Dublin Senior Helpline, Co. Dublin Sonas Housing Association, Co. Dublin SWAN (Southside Women's Action Network), Co. Dublin Teach Tearmainn, Co. Kildare W.O.V.E., Co. Dublin Women's Aid, Co. Dublin	Laois Support Service Against Domestic Abuse Longford Women's Link Offaly Domestic Violence and Support Service Westmeath Support Service Against Domestic Abuse	Carlow Women's Aid	Mná Feasa, Co. Cork OSS Cork Tralee Women's Resource Centre, Co. Kerry West Cork Women Against Violence Project Yana, North Cork Domestic Violence Project

⁴⁰ AMEN - domestic violence support service for men is included here, but was not counted when working out the ratio of service availability to women.

⁴¹ Maunsell et al (2000)

⁴² SAFE Ireland is the network for frontline NGO domestic violence services in Ireland.

⁴³ The following services were not surveyed by Maunsell et al., (2000): Domestic Violence Advocacy Service; Inishowen Women's Outreach; Letterkenny Women's Centre; Domestic Violence Response; Achill Domestic Violence Services; Ascend Women's Support Service; Dublin 12 Domestic Violence Service; SAVE - Southside Addressing Violence Effectively; SWAN - Southside Women's Action; Laois Support Service Against Domestic Violence; Longford Women's Link; Westmeath Support Service Against Domestic Abuse.

3.4.2 Breakdown of types of services and activities by domestic violence service providers in Ireland

Table 4 provides an overview of the different component activities that are provided by Domestic Violence Support Services. Of the 38 SAFE Ireland affiliated Domestic Violence Support Services, all reported providing general support and 35 provide information, emotional support, court and other forms of accompaniment and/or advocacy. A referral to a counselling service is offered by 34 and aftercare by 30 service providers. Seventeen provide support groups to women of which, 9 are non-accommodation support services and 8 are refugees.

Domestic violence support and advocacy services are provided either at the centre or on an outreach basis by 35 SAFE Ireland members. Most of these services are open on normal business hours, 6 can be accessed during the evening and 7 at weekends. Of these, 7 provide a service on a 24/7 basis (5 of these are located in the Southern region).

Table 4: Components of a Support and Advocacy Service by Domestic Violence Support Services in 2007

Region	Western			North-Eastern		Mid-Leinster	Southern		Total
Sub-region (Valid Responses n.35)	North-Western N=3	Western N=4	Mid-Western N=4	North-Eastern N=4	Eastern N=7	Midlands N=3	South-Eastern N=5	Southern N=5	
Information Provision	3	4	4	4	7	3	5	5	35
Emotional Support	3	4	4	4	7	3	5	5	35
Court Accompaniment	3	4	4	4	7	3	5	5	35
Other Accompaniments	3	4	4	4	7	3	5	5	35
Advocacy	3	4	4	4	7	3	5	5	35
Aftercare	2	4	3	3	6	3	5	4	30
Counselling Referral Service	3	4	3	4	7	3	5	5	34
Support Groups	3	2	3	4	2	3	1	1	17

Ten of these organisations facilitate closed groups, 5 facilitate open groups and 2 facilitate both. The services that run the open groups do so on an on-going basis whereas the closed groups generally run once a week lasting between 10 to 14 weeks once or twice a year.

9 non-network affiliated support services provide information to service users, 6 provide some form of advocacy/court accompaniments (4 are involved in Sexual Assault Treatment Unit accompaniment). Five non-network affiliated organisations provide support groups while 5 also reported providing emotional support. All of the non-network affiliated services are available during normal working hours. While two are available in the evenings, none of these organisations provide support services on a 24/7 basis.

3.4.2.1 Helpline service: In 2007, 35 of the 38 SAFE Ireland affiliated support services provided a helpline facility and 18 of these operated on a 24/7 basis⁴⁴. A national freephone helpline is operated by Women's Aid. In 2000, there were 26 helplines available from support services and 10 refuge helplines were operated 24/7.

Half of those providing a helpline service have dedicated staff for this work. In the majority of cases (21) the line for the helpline service is separate from the administrative telephone line. Eight provide a freephone service and 2 use lo-call numbers. There are at least 3 support services available in each region with a helpline available to those who have experienced domestic and sexual violence.

In terms of the 9 non-network affiliated organisations, 6 provide a helpline service. While one provides support at a lo-call rate (North-Eastern), the remainder apply standard telephone rates. Three of these organisations provide telephone support/advocacy specific to the needs of adult male victims of domestic violence: two of these are in the North-Eastern sub-region and the third is located in the Southern region. Five organisations provide telephone support/advocacy specific to the needs of refugees/asylum seekers as well as homeless victims of domestic violence. None of the non-network affiliated organisations provides helpline services on a 24/7 or a weekend bases. Most operate their helpline during normal business hours.

3.4.2.2 Counselling: In total, 20 organisations provide dedicated counselling services for domestic violence in Ireland. Of these 4 are non-network affiliated organisations. This compares to a total of 18 services providing counselling in 2000⁴⁵. Six non-network affiliated organisations provide referrals for counselling. Two provide counselling specific to the needs of adult male victims of domestic violence and 2 provide one-to-one, group and child counselling.

The remaining 16 counselling services are provided to female victims of domestic violence by members of the SAFE Ireland network. The lowest counselling service density is in the eastern sub-region (1:635,935). In total, 22 of the domestic violence services provide counselling referral. All, but one network affiliated organisation provides counselling referral services.

Support groups are available from 17 of 37 SAFE Ireland affiliated support services across the regions. There is no information on this issue from non-network affiliated services. Sixteen support services (including non-network affiliated services) provide training and education to women who access their services.

3.4.2.3 Services for children: Services specifically for children are provided by many of the SAFE Ireland affiliated support services. Individual support is given by half (19) although a total of 13 reported providing therapeutic support

⁴⁴ All of these 18 are refuge facilities.

⁴⁵ Three non-dedicated domestic violence support services, which provided counselling when surveyed by Maunsell et al (2000), have not been covered in 2007.

for children. Group support programmes for children are given by 11 support services. Access to education/school placements is given by 20 and 15 provide homework and learning supports. Six support services reported facilitating supervised access or visits by parents.

Of the 38 SAFE Ireland affiliated support services, 20 support services reported providing childcare facilities. The North-West sub-region is the only region without this provision. In 10 cases, support services are available to children even when their mother does not use the refuge facility. One non-network affiliated organisation provides childcare facilities.

3.4.2.4 Working with perpetrator programmes: The majority (28) of the network affiliated organisations are working with domestic violence perpetrator programmes in some way. Most organisations are involved in either partner support or are on a perpetrator programme steering group. Nine network affiliated organisations provide partner support, but there is no such work reported in the North-West, West, Eastern and Southern sub-regions. Only two such organisations provide partner group support (located in the North-East and South-Eastern sub-regions). A total of 11 organisations (including one non-network affiliated organisation) are involved in perpetrator programme steering groups and 4 provide training to people who work with perpetrators. No organisations reported any one-to-one work with perpetrators. None of the non-network affiliated organisations reported being involved in perpetrator programme work.

3.4.2.5 Education and training to outside agencies: A total of 26 SAFE Ireland network affiliated organisations and 4 non-network affiliated organisations provide training on request. Of the total training provision in 2007, network affiliated organisations gave training to An Garda Síochána (46%), students (69%), social workers (19%), public health nurses (23%), the community sector (42%) and to another non-governmental organisation (31%). Topics covered generally included: awareness and dynamics of domestic violence; understanding and responding to domestic violence; dealing with disclosure and referral; domestic violence and Garda response; skills training for working with women experiencing domestic violence; healthy relationships and dating violence; domestic violence as a mental health issue; and awareness raising with ethnic minorities. Courses are run at different frequencies throughout the year depending on availability of funding and local arrangements.

A total of 30 organisations have developed training packs or programmes (28 network and 2 non-network affiliated organisations). The packs covered a broad range of domestic violence related issues including, domestic violence training manual for health professionals; disclosure and referral training; modules on domestic violence and Garda response; domestic violence as a general health and a mental health issue; dynamics of domestic abuse, power and control, myths, healthy relationships; interagency training pack; volunteers and student placement training packs; helpline training; code of practice training (Community Development Projects and Family Resource Centres); Garda training pack; advocacy and domestic abuse – FETAC level

5; working with children; parenting through domestic violence; and a court accompaniment training handbook for volunteers.

3.4.2.6 Awareness raising: The vast majority of SAFE Ireland network affiliated organisations undertake awareness raising about service provision. The four most frequently used methods are: networking (36), poster distribution (34), information stands (33) and placing advertisements in local newspapers (32). The four most frequently used methods organisations use to raise awareness about domestic violence are: networking (38), interviews on local/national radio (34), press releases to local newspapers (33), and public information stands (30).

3.4.2.7 Outreach support: A total of 37 organisations provide support on an outreach basis (33 network and 4 non-network affiliated organisations). Outreach support services can be provided by appointment only or on a drop-in basis. Of the network affiliated respondents, 16 run dedicated outreach clinics across their catchment area throughout the week. Of these, 12 operate by appointment only and the remaining 4 are by appointment or drop-in. The remaining 17 of the 33 network affiliated organisations that provide outreach meet the woman by appointment at a location of her choice.

If needed non-network affiliated organisations report that they could provide services on an outreach basis to a variety of groups: to adults with children (5), to those with substance use problems (5), mental disabilities (5), or physical disabilities (5) as well as to members of ethnic minority groups (4) and those with English language difficulties (6).

3.4.3 Accommodation and support with accommodation

3.4.3.1 Number of refuge facilities in Ireland

There are 19 domestic violence services in Ireland providing crisis/emergency accommodation at refuge facilities. Almost all are members of SAFE Ireland, the only exception being Rathmines Women's Refuge which is not a non-governmental organisation⁴⁶. For an overview of the organisations involved, please see Table 5. The range of services provided by network affiliated organisations include: accommodation, emotional and practical support to women; support groups; accompaniment; advocacy; information; helplines; outreach; and children's support services.

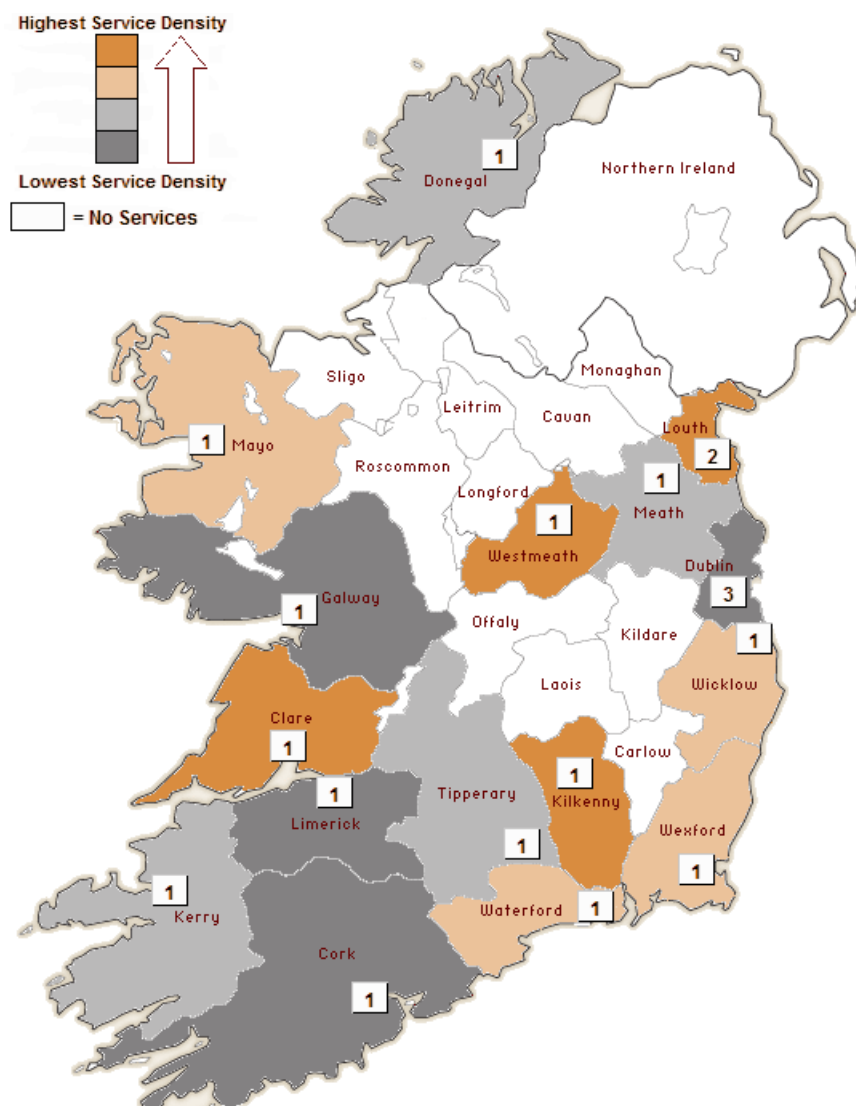
⁴⁶ Rathmines Women's Refuge is the only refuge in Ireland managed directly by the HSE.

Table 5: List of Refuge Facilities in Ireland in 2007 (n=19)

Region	Western			North Eastern		Mid-Leinster	Southern	
Sub-Region	North-Western	Western	Mid-Western	North-Eastern	Eastern	Midlands	South-Eastern	Southern
Name of Refuge	Donegal Women's Domestic Violence Service	COPE - Waterside House Women's Refuge, Co. Galway Mayo Women's Support Service	Adapt Services, Co. Limerick Clare Haven Services, Co. Clare	Drogheda Women's Refuge, Co. Louth Meath Women's Refuge and Support Service Women's Aid, Co. Louth	Aoibhneas Women's Refuge, Co. Dublin Bray Women's Refuge, Co. Wicklow Rathmines Women's Refuge, Co. Dublin Saoirse Women's Refuge, Co. Dublin	Esker House Refuge, Co. Westmeath	AMBER, Kilkenny Women's Refuge Cuan Saor Women's Refuge and Support Service, Co. Tipperary Oasis House Refuge, Co. Waterford Wexford Women's Refuge	Adapt House, Co. Kerry Cuanlee Refuge, Co. Cork

Map 2 provides the number of refugees per county in Ireland in 2007 along with indications of refugee service density per county⁴⁷.

MAP 2: Number of Refugees per county in 2007 and indications of service density⁴⁸



Every HSE region in Ireland has at least one refuge available providing crisis/emergency accommodation. All but one (located in the Western region) is accessible on a 24 hour basis. However, there are 10 counties in which refuge facilities are not located.

The total number of domestic violence services providing refuge facilities has increased from 15 to 19 between 2000 and 2007. Those additional refuges are located in the Mid-Western, Eastern, and South-Eastern regions (Table 6a and 6b).

⁴⁷ Service density is calculated as the ratio of services/refuges available to the female population 15 years and over in each county.

⁴⁸ Those counties with no refuge service available are identified separately to those along the "High" to "Low" scale/measure.

The increased number of services is reflected in a change in service level density. Currently, there is 1 refuge for every 91,603 women. This compares to 1 refuge per 100,832 in 2000. Where there are refuge services available, the lowest service density is in the Southern sub-region (1:166,326). Excluding counties with no refuges available, those counties with the lowest service density are Cork, Dublin and Galway (see Appendix 1). As stated earlier, it should be borne in mind here that in applying the concept of "service density" no account is taken of important aspects of service provision such as service capacity (e.g. the size of the centre involved) or how effectively they operate.

Table 6a: Support Services with Refuge Facility, Service Density Levels (2007)

Region	Western			North Eastern		Mid-Leinster	Southern		Total
Sub-Region	North-Western	Western	Mid-Western	North-Eastern	Eastern	Midlands	South-Eastern	Southern	
Number of support services with refuge facility	1	2	2	3	4	1	4	2	19
Ratio of refuge facility to women	1:95,515	1:84,216	1:73,028	1:51,775	1:158,984	1:98,865	1:26,920	1:166,326	1:91,603

Table 6b: Support Services with Refuge Facility, Service Density Levels (2000)⁴⁹

Region	Western			North Eastern		Mid-Leinster	Southern		Total
Sub-Region	North-Western	Western	Mid-Western	North-Eastern	Eastern	Midlands	South-Eastern	Southern	
Number of support services with refuge facility	1	2	1	3	3	1	2 ⁵⁰	2	15
Ratio of refuge facility to women	1:83,866	1:72,244	1:129,244	1:41,945	1:187,424	1:82,484	1:45,133	1:146,988	1:100,832

3.4.3.2 Types of accommodation facilities: Table 7 presents regional information regarding the types of accommodation provided by refuges. Of the 19 refuges, 4 provide self-contained facilities only (i.e. independent accommodation with own kitchen and sanitary facilities), 8 provide communal facilities only (i.e. bedrooms with either a shared kitchen and/or sanitary facilities) and 7 provide both communal and self-contained facilities. None of the non-network affiliated services provide accommodation, therefore it is not possible to provide comparisons.

⁴⁹ Source: Maunsell et al (2000)

⁵⁰ Maunsell et al (2000) listed Wexford Women's Refuge as not providing crisis accommodation.

Table 7: Types of Refuge Accommodation Provided in 2007⁵¹

Region	Western			North Eastern		Mid-Leinster	Southern		Total
Sub-Region (Valid Responses n.19)	North-Western	Western	Mid-Western	North-Eastern	Eastern	Midlands	South-Eastern	Southern	
Number of refugees with Self-Contained Facilities ⁵²	0	0	1	0	2	0	0	1	4
Number of refugees with Communal Facilities ⁵³	1	0	1	2	2	0	1	1	8
Number of refugees with both ⁵⁴	0	2	0	1	0	1	3	0	7

All domestic violence services interviewed provided information about the different types of accommodation they provide. Seven services provide a total of 98 transitional houses/apartments between them. Six of these providers are refuges and the remaining is a housing association. They are based in the Western, Mid-Western, North-Eastern, Eastern and South-Eastern sub-regions. In terms of the size of these facilities, there are 9 one-bedroom houses/apartments available and all of these are located in the Eastern sub-region. In total 41 two-bedroom houses/apartments, 43 three-bedroom and 5 four-bedroom houses/apartments are available (See Table 8). The majority of these are concentrated in the North-Eastern and Mid-Western sub-regions. In 2007, a total of 78 women and 127 children were accommodated in transitional housing in 2007 (Table 9). Information regarding transitional housing in 2000 is not available.

Table 8: Number of Bedrooms/Houses/Apartments Available in Transitional Housing/Accommodation in 2007

Region	Western			North-Eastern		Mid-Leinster	Southern		Total
Sub-region (Valid Responses n.7)	North-Western	Western	Mid-Western	North-Eastern	Eastern	Midlands	South-Eastern	Southern	
One-Bedroom House/Apartments	0	0	0	0	9	0	0	0	9
Two-Bedroom House/Apartments	0	0	2	4	34	0	1	0	41
Three-Bedroom House/Apartments	0	5	3	4	30	0	1	0	43
Four-Bedroom House/Apartments	1	0	0	0	4	0	0	0	5
Total Number of Houses/Apartments	1	5	5	8	77	0	2	0	98

⁵¹ All of the above categories of accommodation are exclusive to one another i.e. there is no overlap between categories.

⁵² "Self contained" defined as "independent accommodation units with own kitchen and sanitary facilities" (SAFE Ireland)

⁵³ "Communal Facilities" defined as "bedrooms which have either shared kitchen and/or sanitary facilities" (SAFE Ireland)

⁵⁴ Self Contained and Communal

Table 9: Transitional Housing Service Level Activity 2007⁵⁵

Region	Western			North-Eastern		Mid-Leinster	Southern		Total
Sub-region	North-Western	Western	Mid-Western	North-Eastern	Eastern	Midlands	South-Eastern	Southern	
No of Women Accommodated in Transitional Housing in 2007 ⁵⁶	0	5	8	9	54	0	2	0	78
No of Children Accommodated in Transitional Housing in 2007 ⁵⁷	0	10	17	13	85	0	2	0	127

3.4.3.3 Units of accommodation and beds in refuges: There are 133 units of accommodation in refuges in Ireland. This is made up of 76 bedrooms, 42 x 1 bedroom units (2 are studio), 14 x 2 bedroom and 1 x 3 bedroom house. According to SAFE Ireland, it is not the policy of any of the refuges that women are required to share rooms. Only in an emergency, where the refuge is full, and when there are two women without children, will they be asked to share a bedroom/unit over night. Also worth noting here is that children cannot access refuges without being accompanied by their mother.

Table 10 below shows that within those units of accommodation, refuges provide a total of 545 permanent beds around the country and of these, 133 were designated for women and 412 for children. The ratio of the number of beds designated for women to the number of women in the country is one bed per 13,086 women⁵⁸. Most designated beds for women are found in the Eastern sub-region (31) and the fewest are in the North-Western sub-region (2). The lowest service density with respect to beds is in the North-Western sub-region (1: 47,757) (Table 10). There are no beds available in ten counties in Ireland (see Map 3 below). Again, no information is available regarding the catchment areas of these services. Neither is there information regarding the areas in which service users normally reside. Consequently it is not possible to determine the extent to which these areas are serviced by other counties.

Where there are refuges available, those counties with the lowest service density in terms of refuge bed availability are Dublin, Donegal and Cork (See Appendix 1).

⁵⁵ Source - SAFE Ireland 2009

⁵⁶ No of individual women accommodated in Transitional Housing (This is the number of individual women who were accommodated in Transitional Housing in 2007. They were counted only once, even if they were admitted more than once throughout the year).

⁵⁷ No of individual children accommodated in Transitional housing. (This is the number of individual children who were accommodated in Transitional Housing in 2007. They were counted only once, even if they were admitted more than once throughout the year).

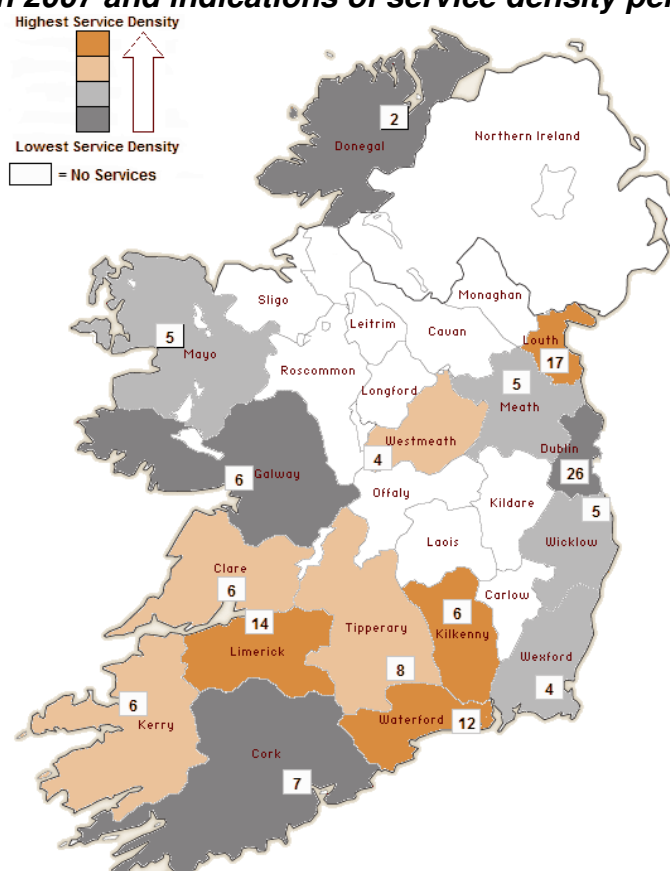
⁵⁸ Kelly and Dubois (2008) in their elaboration of Council of Europe standards refer to the concept of "family space" in refuges where they recommend a minimum standard of "1 family space per 10,000 of the population". However, questions remain as to the exact definition of "family space" and whether or not it is possible to apply this particular standard given that it does not specify the segment of the population involved, (i.e. if the population referred to is the population of women or the population as a whole). This report presents the number of permanent beds available in refuges for women and children who have experienced domestic violence.

Table 10: Number of Permanent Beds Available in Refuges in 2007

Region	Western			North-Eastern		Mid-Leinster	Southern		Total number of permanent beds available
Sub-region (Valid Responses n.19)	North-Western	Western	Mid-Western	North-Eastern	Eastern	Midlands	South Eastern	Southern	
<i>For Women</i> ⁵⁹	2	11	20	22	31	4	30	13	133
<i>For Children</i> ⁶⁰	9	30	63	55	99	16	87	53	412
Total number of beds available in region	11	41	83	77	130	20	117	66	545
% of total permanent beds available	2	7.5	15	14	24	4	21.5	12	100
Ratio of designated women's permanent beds available to number of women	1:47,757	1:15,312	1:7,303	1:7,060	1:20,514	1:24,716	1:3,589	1:25,588	1:13,086
Ratio of total permanent beds available to number of women	1:8,683	1:4,108	1:1,760	1:2,017	1:4,892	1:4,943	1:920	1:5,040	1:3,193

Map 3 provides information regarding the number of beds available per county in Ireland in 2007 and indications of service density per county⁶¹.

MAP 3: Number of beds designated for women available in refuges in 2007 and indications of service density per county.



⁵⁹ Includes fixed beds only which may also be part of a bunk bed. Does not include fold-up/temporary beds.

⁶⁰ Includes fixed beds, bunks (2 bed spaces) and cots. Does not include fold-up/temporary beds.

⁶¹ Service density is calculated as the ratio of refuge beds available to the female population 15 years and over in each county.

Maunsell et al (2000) does not distinguish between the number of beds designated for children and the number designated for women. For comparative purposes here, the ratio of permanent beds to women is calculated using the total number of beds available regardless of whether the bed is designated for a woman or a child.⁶²

Tables 11a and 11b present the relevant information for comparing the provision of beds in 2000 and 2007. Compared to 2000, there were 173 (+46%) more beds in 2007. The largest increase occurs in the South-Eastern sub-region (+134%). No changes in the number of beds occurred in the North-Western or the Midlands sub-regions in this time period.

Between 2000 and 2007 the total bed service level density increased from 1 bed per 4,066 women to one bed per 3,193 women. Despite this, there were reductions in service level density with regard to bed provision in the Midlands, the North-Western and Western sub-regions.

Table 11a: Number of Permanent Beds Available in Refuges in 2000⁶³

Region	Western			North-Eastern		Mid-Leinster	Southern		Total number of permanent beds available
Sub-region	North-Western	Western	Midwest	North-Eastern	Eastern	Midlands	South-Eastern	Southern	
Total number of beds available in region in 2000	11	38	46	57	100	20	50	50	372
% of total beds available	3	10	13	15	27	5	13	13	100
Ratio of women's permanent beds available to women in 2000	1:7,624	1:3,802	1:2,810	1:2,208	1:5,623	1:4,124	1:1,805	1:5,880	1:4,066

Table 11b: Number of Beds Available in Refuges and Changes in 2000 to 2007

Region	Western			North-Eastern		Mid-Leinster	Southern		Total number of permanent beds available
Sub-region (Valid Responses n.18)	North-Western	Western	Midwest	North-Eastern	Eastern	Midlands	South-Eastern	Southern	
Total number of beds available in region in 2000	11	38	46	57	100	20	50	50	372
Total number of beds available in region in 2007	11	41	83	77	130	20	117	66	545
% change 2000 --> 2007	0	+ 8%	+ 80%	+ 35%	+30%	0	+ 134%	+ 32%	+ 46%

3.4.3.4 Disability access at refuge facilities: Of the 19 refuges, 13 reported some level of disability access at the main refuge building, while 9 reported disability access to communal facilities. Of the total 76 bedrooms in refuges

⁶² A breakdown of the number of beds designated for women and children in 2007 is illustrated in Table 10 above.

⁶³ Source: Maunsell et al (2000).

with communal facilities, only 11 have disability access. Of the 57 bedrooms provided in self-contained units, 34 have disability access.

3.4.3.5 Supporting victims to find accommodation: In terms of providing women with support for accessing accommodation, domestic violence services can offer a range of different forms of assistance. Crisis accommodation referral/sourcing is provided by 27 SAFE Ireland affiliated support facilities⁶⁴ and 'Move on'⁶⁵ accommodation is offered by 14 domestic violence services of which 11 are refuges. While a variety of other accommodation services were mentioned, only very few support services provide these.

3.4.4 Domestic Violence Support Services admissions/activity levels

3.4.4.1 Refuges: In total, 2,262 women admissions and 3,943 children admissions were made to refuges in 2007⁶⁶. The Eastern sub-region had the highest (2,172) number of admissions, with 738 admissions of women and 1,434 admissions of children. This was followed by the South-East (932) with 385 admissions of women and 547 children and the Mid-West (874) with 307 women and 567 children admitted. The North-Western sub-region had the lowest number of admissions in 2007 with 81 recorded - 37 women and 44 children (Table 12). A greater proportion of women in the South-Eastern sub-region⁶⁷ were admitted to refuges in 2007 - more than in any other sub-region.

Table 12: Refuge Service Activity Levels 2007⁶⁸

Region	Western			North-Eastern		Mid-Leinster	Southern		Total
Sub-region	North-Western	Western	Mid-Western	North-Eastern	Eastern	Midlands	South-Eastern	Southern	
Total number of admissions of women to refuges in 2007 ⁶⁹	37	224	307	235	738	41	385	295	2,262
Total no admissions of children to refuges in 2007 ⁷⁰	44	393	567	337	1,434	91	547	530	3,943
TOTAL no. of admissions to refuges in 2007	81	617	874	572	2,172	132	932	825	6,205
Population of women in sub-region	95,515	168,431	146,055	155,324	635,935	98,865	107,679	332,651	1,740,453
% share of total population of women	5.5	9.7	8.4	8.9	36.5	5.7	6.2	19.1	100
% share of refuge provision	5.3	10.5	10.5	15.8	21	5.3	21	10.5	100
% share of refuge designated beds for women provision	1.5	8.3	15.0	16.5	23.3	3.0	22.6	9.8	100
% of total number of women admissions (including repeat admissions) to refuge in 2007	1.6	9.9	13.7	10.4	32.6	1.8	17.0	13.0	100

⁶⁴ Of these 18 are refuges who source emergency accommodation when they are unable to accommodate women because they are full.

⁶⁵ The aim of the service is directing individuals to sustainable accommodation offering or referring to appropriate services in the community.

⁶⁶ These figures include repeat admissions. A comparison with previous years is not possible as data is not available.

⁶⁷ 0.24 per cent of the female population in that sub-region aged 15 years and over

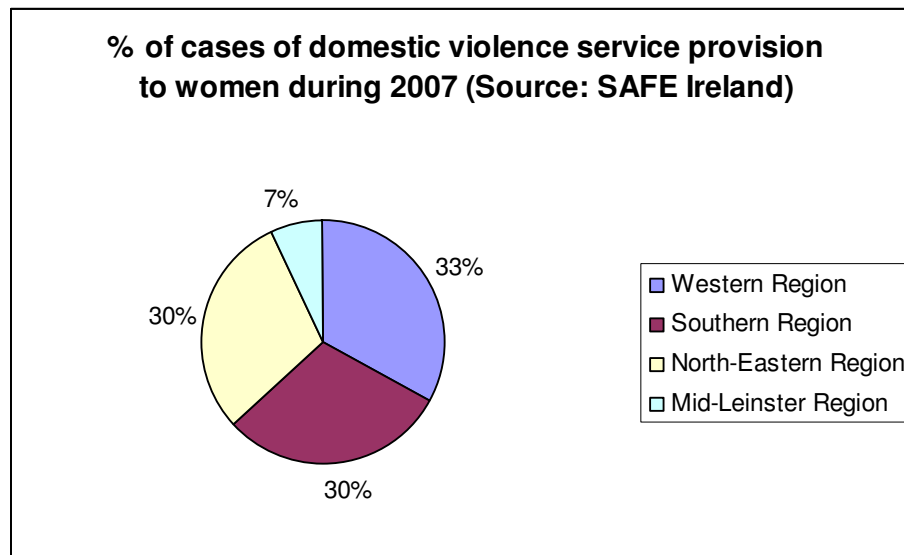
⁶⁸ Source - SAFE Ireland 2009 and includes admission figures from Rathmines Women's Refuge

⁶⁹ Total number of women admissions to refuge in 2007. If a woman visits the refuge 3 times it was counted as 3 admissions.

⁷⁰ Total number of child admissions to refuge in 2007. If a child visits the refuge 3 times it was counted as 3 admissions.

3.4.4.2 Support services⁷¹: In Ireland, a total of 3,792⁷² individual women received support in 2007 by non-accommodation SAFE Ireland network affiliated organisations surveyed. 1,273 of these were recorded in the Western region; 1,102 in the Southern region; 1,145 in the North-Eastern region and 272 in Mid-Leinster. (See Figure 7)

Figure 7:



SAFE Ireland affiliates also recorded 871⁷³ individual children who received support in 2007 by non-accommodation SAFE Ireland members. The highest levels were reported in the North-Eastern region (317) and Mid-Leinster region (300).

No (non-accommodation) support service in the Southern region recorded providing a domestic violence service to children in 2007 (see Table 13).

Table 13: Domestic Violence Dedicated Support Services Activity Levels⁷⁴

Region	Western			North-Eastern		Mid-Leinster	Southern		Total
Sub-region	North-Western	Western	Mid-West	North-Eastern	Eastern	Midlands	South-Eastern	Southern	
No of individual women who received support services in 2007	315	524	434	475	670	272	576	526	3,792
No of individual children who received support services in 2007	14	170	70	242	75	300	0	0	871

⁷¹ The rest of the reporting in this section on domestic violence services does not include information on Rathmines Women's Refuge as it is not a member of the SAFE Ireland network.

⁷² This is the number of individual women who accessed non-accommodation support services. This does not therefore include the women who received support services while in refuge or transitional housing. Also as this is a count of "individual women" each woman who accessed the support service was counted only once, even if they accessed the service more than once throughout the year.

⁷³ This is the number of individual children who accessed non-accommodation support services. This does not therefore include the children who received support services while in refuge or transitional housing. Also as this is a count of "individual children" each child who accessed the support service was counted only once, even if they accessed the service more than once throughout the year.

⁷⁴ Source - SAFE Ireland 2009

Of the 9 non-network affiliated services, 34 cases⁷⁵ of providing domestic violence services to children were recorded. Among these 20 were recorded in the North-Eastern and 10 in the Southern regions. In the region of 1,500 cases⁷⁶ were recorded in connection with support service provision to men who were victims of domestic violence.

3.5 The range of sexual violence support services in Ireland

Victims of sexual violence can access support from a range of sources. These services provide integrated responses, offering a combination of types of support e.g. advocacy/accompaniment, information and emotional support. These are referred to as 'support services'. Section 3.5.1 examines the number of organisations that are involved in providing support services. Section 3.5.2 examines the different types of services/activities that are provided. Section 3.5.3 concludes by presenting an overview of the numbers of people reported to have availed of the services provided by these organisations in 2007.

3.5.1 The number of sexual violence support services in Ireland (2007)

In 2007, there were a total of 17 sexual violence support services for men and women who have been victims of sexual violence in Ireland. This figure is composed of 14 Rape Crisis Network of Ireland (RCNI) affiliated organisations and 3 non-network affiliated organisations (i.e. Sexual Violence Centre Cork, Dublin Rape Crisis Centre and One-in-Four). Since 2000, 1 more sexual violence support service has been counted. Table 14 presents the complete listing of all Sexual Violence Support Services.

⁷⁵ Information on the number of individual women and children who accessed services provided by non-network affiliated services is not available and so the information provided here relates to the number of "cases" (i.e. times a support service was accessed) with no account taken of repeat visits by women/children to these services.

⁷⁶ Information on the number of individual men who accessed services provided by non-network affiliated services is not available and so the information provided here relates to the number of "cases" (i.e. times a support service was accessed) with no account taken of repeat visits by men to these services.

Table 14: Sexual Violence Support Services in Ireland (2007)

Region	Western			North-Eastern		Mid-Leinster	Southern	
Sub-region	North-Western	Western	Mid-Western	North-Eastern	Eastern	Midlands	South-Eastern	Southern
Sexual Violence Support Service	Donegal Sexual Abuse and Rape Crisis Centre Sligo Rape Crisis Centre	Galway Rape Crisis Centre Mayo Rape Crisis Centre	Rape Crisis Midwest	Rape Crisis North East	Dublin Rape Crisis Centre One in Four	Athlone Midland Rape Crisis Centre Tullamore Sexual Abuse and Rape Crisis Counselling Centre	Kilkenny Rape and Sexual Abuse Counselling Centre Carlow and South Leinster Rape Crisis and Counselling Centre Tipperary Rape Crisis and Counselling Centre Waterford Rape and Sexual Abuse Support Service Wexford Rape and Sexual Abuse Support Service	Kerry Rape and Sexual Abuse Centre Sexual Violence Centre, Cork

In 2007, there was 1 sexual violence support service for every 102,380 women in Ireland, twice that recommended by the Council of Europe.⁷⁷ Table 15 presents the regional breakdown and service level density of sexual violence service availability in 2007. The highest levels of service level density are to be found in the North-Western, Midlands and South-Eastern sub-regions. The South-Eastern sub-region had the highest service density (1:21,536). Despite the establishment of 1 extra support service since 2000 (see Table 17), the Eastern region remained the region with the lowest service density (1:317,967)⁷⁸(see Tables 15 and 16). There were no sexual violence services located in ten counties in Ireland (See Map 4). It should be noted, however, that this reflects neither the size nor range of services provided. Nor does this information take account of any geographical outreach services available in some additional counties. In counties where sexual violence services were available, the counties with the lowest service density were Dublin, Cork and Galway (Appendix 1).

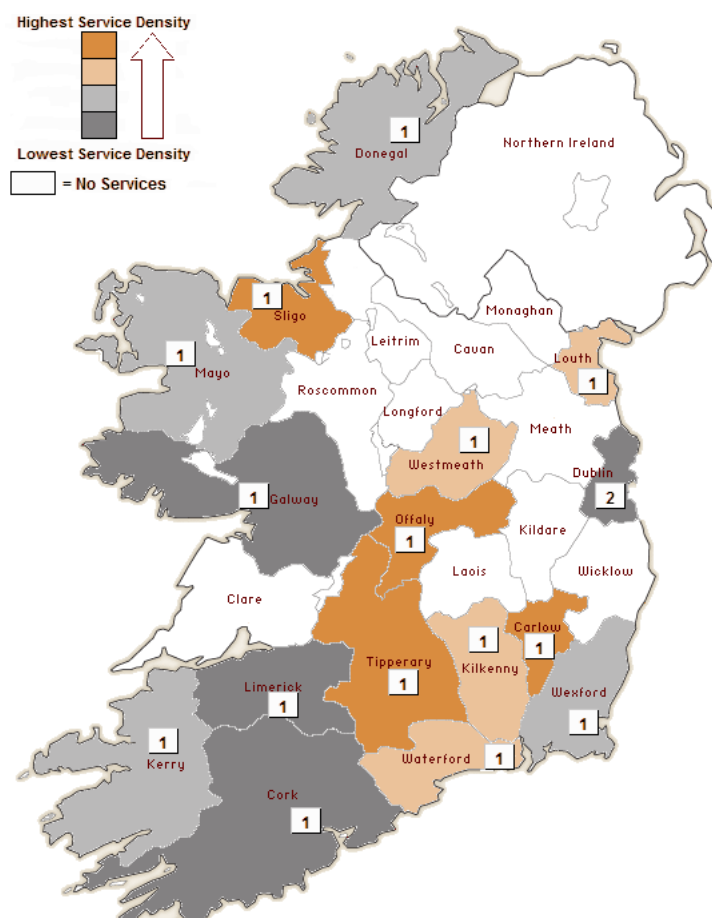
Table 15: Sexual Violence Support Services Density Levels (2007)

Region	Western			North-Eastern		Mid-Leinster	Southern		Total
Sub-region	North-Western	Western	Mid-Western	North-Eastern	Eastern	Midlands	South-Eastern	Southern	
No of Sexual Violence Support Services	2	2	1	1	2	2	5	2	17
Ratio of Services to Women	1:47,757	1:84,215	1:146,055	1:155,324	1:317,967	1:49,432	1:21,536	1:166,325	102,380

⁷⁷ 15% of RCNI affiliated organisations' clients are men (*Source: RCNI, 2009*). However, for the purposes of comparison with Maunsell et al (2000) and so as to be consistent with the analysis of domestic violence services in the previous section, population to service ratios and measures of service density for each sub-region are calculated using numbers of women only.

⁷⁸ However, the concept of service density reflects neither the size nor range of services provided.

MAP 4: Counties in Ireland in which Sexual Violence Support Services were located in 2007 and indications of service density per county.



The pattern is unchanged since 2000 when Maunsell et al reported 16 Rape Crisis Centres (RCCs)⁷⁹ throughout Ireland. There has been a decrease in the level of service density since 2000 (1:102,380 in 2007 to 1:94,530 in 2000, see Tables 15 and 16). The main reason for this is the approximate 15 per cent increase in the population of women from 2000-'07.

Table 16: Sexual Violence Support Services Density Levels (2000)⁸⁰

Region	Western			North-Eastern		Mid-Leinster	Southern		Total
Sub-region	North-Western	Western	Mid-Western	North-Eastern	Eastern	Midlands	South-Eastern	Southern	
Number of Sexual Violence Support Services	2	2	1	1	1	2	5	2	16
Ratio of Services to Women	1:43,433	1:72,245	1:129,244	1:125,834	1:562,273	1:41,242	1:18,053	1:146,988	1:94,530

⁷⁹ Fifteen of which were members of the Rape Crisis Network Ireland at the time.

⁸⁰ Source: Maunsell et al (2000)

3.5.2 Breakdown of types of services and activities of sexual violence support services in Ireland

Overall the possible range of services provided for victims of sexual violence remains similar to 2000. Each of the 17 sexual violence support services reported providing victims of sexual violence with a helpline, counselling services, general advice and information⁸¹. These organisations also provide court and other forms of accompaniment/advocacy support and aftercare to victims of sexual violence. Unlike domestic violence services, none of the sexual violence support services provide accommodation. However, many can and will refer victims who present with accommodation needs to the appropriate service provider.

The 3 non-network affiliated organisations⁸² - 2 of which are rape crisis centres - provide a similarly wide range of services. By way of personal support, these organisations offer counselling referral as well as counselling and emotional support. Support groups are also given by each of these. Two organisations indicated difficulties providing services where substance use is involved and only 1 provides childcare facilities. One organisation expressed difficulty in providing services to adults presenting with children because they have no crèche facility. This same service is the only one of the 3 non-network affiliated organisations that does not accept children affected by sexual violence.

The various services offered by these organisations are discussed more fully below.

3.5.2.1 Accompaniment services: Accompaniment to Court, An Garda Síochána, hospital or Sexual Abuse Treatment Units (SATUs) for victims of sexual violence were key supports offered by all 17 sexual violence support services in 2007. A total of 35 victims were accompanied to An Garda Síochána in 2007 by 5 RCNI affiliated organisations. In 2000, 11 RCNI affiliates could accompany victims to the Garda Síochána but there is no specific information about the number of victims involved.

In 2000, 1 RCNI member offered a legal clinic for victims. In 2007, a RCNI staff member's duties included providing legal information and advice to Rape Crisis Centre staff, volunteers and victims. The specific number of victims who in 2007 utilised the legal service from the RCNI is not available.

In 2007, 7 RCNI affiliated organisations accompanied 39 victims during 82 days in court.

The 3 non-network affiliated support services allocated the equivalent of 190 days to accompanying victims of sexual violence to court (161 days for

⁸¹ General advice and information issued by support services relates to: social welfare entitlements; legal entitlements; reporting to the Gardaí; legal aid; community welfare; school and after school support; as well as other local support services available.

⁸² Although Dublin Rape Crisis Centre was a member of the RCNI in 2007 that centre was using a separate database to collect statistical information at that time. It is for this reason that we include the DRCC information alongside that provided by those non-network affiliated support services in this report.

accompaniment to circuit or district courts and 29 days to the Central Criminal Court). In 2000, 14 of the sexual violence services surveyed said that they could provide court accompaniment and, of those that did, they did so free of charge. Further information on developments in court accompaniment activities since 2000 is not available.

In 2007, two of the 3 non-network affiliated organisations provided risk assessment and housing advocacy.

In the same year, 7 RCNI members provided 29 clients with medical accompaniment. Those medical appointments would have included among others, STI and HIV testing and gynaecological appointments. This compares with 8 RCCs who could provide accompaniment to hospitals in 2000. At that time, a total of 11 indicated they could provide some form of medical service such as the accompaniment of clients to specialised treatment units, the referral of clients to professional medical services and/or the provision of medical advice on request. Further information on numbers of medical accompaniments provided in 2000 is not available.

Currently, both the Dublin Rape Crisis Centre (DRCC) and the Sexual Violence Centre, Cork offer a 24 hour on-call support service to victims of rape/sexual assault who attend their locally-based SATUs in the Rotunda in Dublin and the South Infirmary in Cork respectively.

In 2007, 5 sexual violence support services provided SATU accompaniment to a total of 366 victims of sexual violence: this involved 2 RCNI affiliated services and 3 non-network affiliated services. This number is composed of 320 SATU accompaniments by the DRCC and the remaining 46 by another sexual violence service. During the same year, 12 network affiliated organisations provided no SATU accompaniment.

The DRCC and the RCNI affiliate based in Waterford provided 24 hour coverage for accompaniment to the local SATU. If the victim was from somewhere other than Waterford or Dublin, RCC personnel would put the victim in touch with their local RCC for ongoing support, counselling and advocacy.

The staff and volunteers at the centres closest to the SATUs have specific training regarding SATU accompaniment⁸³. In 2007, however the Donegal RCC was not in a position to provide accompaniment. According to Maunsell et al (2000), half of the Rape Crisis Centres (n=8) at that time were in a position⁸⁴ to provide accompaniment to SATUs; however no further information on SATU accompaniment in 2000 is available.

3.5.2.2 Helpline facilities: All 17 sexual violence support services provide a free-phone helpline facility⁸⁵. Information on the operating times is however

⁸³ Source: RCNI, 2009

⁸⁴ It is important to note that although the service provider may be in a position to provide accompaniment, this does not indicate anything about the extent to which people availed of this service.

⁸⁵ The DRCC helpline is a lo-call number in the middle of the night

not available. Maunsell et al reported 2 services providing 24-hour helpline coverage in 2000 – the DRCC and Waterford RCC. Both of these helpline facilities continue to operate on a 24/hr basis.

In 2007, the DRCC national helpline responded to 13,582 calls - an increase of 5,432 since 2000. The Sexual Violence Centre, Cork answered 3,953 calls to their helpline in 2007.⁸⁶

According to the RCNI hours of helpline operation vary across the country. In 2007, other than Dublin, below are the details of hours of helpline availability.

- 1 RCC 24 hour (staff take turns carrying a mobile)
- 1 RCC 6 days/week – 48 hours/week (9:00 – 5:00)
- 8 RCCs 5 days/week – 40 hours/week (9:00 – 5:00 or 9:30 – 5:30)
- 2 RCCs 5 days/week – 36 hours/week (full days Mon-Thurs, 1/2 day Friday)
- 1 RCC 5 days/week – 15 hours/week (9:30-12:30 Mon – Fri)
- 1 RCC 5 days/week – 7.5 hours/week (10:30-12:00 Mon – Fri)

Comparative figures for 2000 on the number of calls received and hours of operation are not available.

Unfortunately, there is little up-to-date information regarding the standards of helpline service provision available around the country. The most recent picture indicates coverage from most of the centres (14 of a total of 16) was variable both in terms of the capacity to operate the line in person and availability out of hours (Maunsell et al, 2000). For example, helpline operator assistance was available for 2 hours per day in Mayo depending on the availability of staff while several had operators available Monday through Friday/Saturday from 9.30am to 5.30pm. Moreover, at that time, while the vast majority had an answering service available out of hours, 1 centre had a provision for emergency calls to be dealt with via the local Garda station. RCCs were capable of receiving calls from anywhere within Ireland.

3.5.2.3 Counselling and emotional support: As was the case in 2000, all sexual violence support services can provide counselling services for men and women who have experienced sexual violence in Ireland in 2007. Unfortunately, further information in 2000 regarding the types of counselling provided was not available in the data used for this study.

Currently, all 3 non-network affiliated organisations provide referrals for counselling. For these organisations, there is some information regarding the format used: two services provide group counselling to victims of sexual violence and only 1 provides individual and group support or counselling for children.

All 3 non-network affiliated organisations provide telephone and in-person support/advocacy and counselling services for a wide range of different needs. These organisations reported supporting lesbian/bi/gay victims of sexual violence; victims with learning disabilities; victims in psychiatric

⁸⁶ Source: Cosc survey 2009

institutions; members of cultural/ethnic groups; refugees and asylum seekers; women in prostitution; homeless victims of sexual violence; victims in prison; and victims with alcohol problems. Two of the three services indicated that they support both men and women supporters of the victim. In 2007, the number of hours counselling provided by these victim supports varied ranging from 35 to 100 hours per week.

3.5.2.4 Outreach: As well as providing support services at their main facilities, a number of sexual violence services offer outreach support to marginalised groups i.e. those who experience multiple barriers to accessing services. In 2007, 9 services were involved in providing support on an outreach basis: this included 7 RCNI affiliated organisations and 2 non-network affiliated organisations involved in this type of activity. This means that in 2007 there were two fewer services involved in outreach activity than in 2000.

Service delivery is not always confined to regional boundaries. In 2007, RCNI affiliated organisations provided geographical outreaches at a variety of locations within 7 counties and in 8 additional counties. An RCC may have its main office in one HSE area and provide geographic outreach in another HSE area e.g. the RCC in Carlow has 2 outreach services in Co. Kildare. One centre provides telephone counselling by appointment because of a lack of public transport facilities in their catchment area. In terms of examples of outreach to specific groups of victims, one centre was funded through the Department of Community, Equality and Gaeltacht Affairs to operate a refugee and asylum seeker clinic. Another provided counselling and support at a direct provision centre. Another worked with a local Traveller women's group.

Currently, there is little information available regarding the types of work undertaken through outreach activities by sexual violence support services. However, from Maunsell et al (2000) we know that the methods of outreach work at that time included the facilitation of alternative locations for counselling sessions, visiting disabled women at home or women who cannot access the service on site due to a lack of transport. In addition, there were specific outreach clinics run by a small minority of organisations who took their services to areas, which otherwise had limited or no services available to them. In terms of standards, Maunsell et al (2000) also reported some variation in the levels of targeted outreach and specialisation by sexual violence support services in Ireland. It is unclear as to whether this is due to variation in local demand or in support services meeting this demand. Specific outreach services are provided based on local demand tempered by resource limitations.

3.5.2.5 Awareness raising and education/training also feature as part of the services provided by all of the RCNI members and One-in-Four. In 2007, 11 RCNI affiliated organisations provided training/education to students. In total, 4,472 individuals received training from such organisations (excluding the DRCC) in 2007. The DRCC provided 2,392 participant days in 2007. This training included a number of participants from a variety of organisations

including Women's Aid, An Garda Síochána, the HSE and domestic violence services. Other groups covered in this training included general practitioners, second- and third-level students, teachers, youth groups, community groups, homeless groups, refugees, nurses, Traveller health workers, young mothers and other women's groups. Other functions undertaken by all RCCs at that time included interagency initiatives and working with Regional Planning Committees. No RCC at that time worked with perpetrators.

3.5.2.6 Sexual violence support service accessibility

Sexual violence support services are provided mostly during normal business hours, however the DRCC offers in addition, early morning and late evening as well as all day Saturday services. Two to 3⁸⁷ support services can be accessed during weekday evenings, 2 on Saturdays and 1 on Sundays.

A 24 hour National helpline is operated from the DRCC and refers to all the local services where appropriate. Other than this, there is a total of 16 regionally located sexual violence support helplines operating at varying times (see above for details). These include: 14 RCNI affiliated organisations, the Sexual Violence Centre Cork and One-in-Four. SATU accompaniment is also provided by RCCs⁸⁸. Two RCCs (Galway RCC and Rape Crisis Midwest, Limerick) are accessible through the Gardaí at night. Advocacy, counselling and support is available during the day on weekdays. All 3 non-network affiliated support services accept self-referrals; however, 1 of these does not accept clients on a drop-in basis.

3.5.3 Sexual violence dedicated support services activity levels

A total of 3,230⁸⁹ individuals received face-to-face support from a sexual violence support services in 2007, 714 of which were men. Information on regional breakdown for both 2000 and 2007 is not available⁹⁰. In 2007, all 14 Rape Crisis Centres (RCCs) surveyed by RCNI provided services to supporters (i.e. partners, family members, etc.) of victims of sexual violence. Only 1 of the non-network affiliated support services does not provide services for victim supporters.

A face-to-face service is provided to different groups. These figures only reflect victims and supporters who were utilising RCC services in 2007 - not the groups of victims and supporters for whom RCCs are in a position to provide services. Lesbian/gay clients are supported by 11 of the RCNI affiliated organisations and 9 provide support services to clients whose primary language is not English. Seven of the organisations report supporting refugees/asylum seekers in relation to sexual violence problems.

⁸⁷ One of these is available only 2 weekday evenings.

⁸⁸ The term RCC throughout this report may refer to any of the following: the Dublin Rape Crisis Centre, the Sexual Violence Centre Cork, or any of the 14 RCNI affiliated organisations.

⁸⁹ A total of 1,691 attended an RCNI affiliated organisation (excluding the DRCC) in 2007 (*Ref: RCNI National Rape Crisis Statistics 2007*). 592 clients were seen for face-to-face counselling at the DRCC Centre (*Ref: DRCC Annual Report and Statistics 2007*) and the remaining 947 attended either One-in-Four or the Sexual Violence Centre Cork. This figure (3,230) excludes any outreach support offered away from the sexual violence services' main centre(s).

⁹⁰ All general activity levels presented here relate to the provision of face-to-face support services only and does not include any helpline activity.

Fourteen sexual violence dedicated services provide support for teenagers. Of these, 5 can provide face-to-face service for teenagers aged 14 years or more, 8 can provide this service for teenagers aged 15 years or more. One RCNI member indicated that they can give face-to-face support to teenagers who are aged 17 years (or more).

Face-to-face services for members of the Traveller community are provided by 4 RCNI affiliated organisations. Table 17 summarises the services provided by such organisations to specific groups in 2007.

Table 17: Specific Groups provided for by RCNI Affiliated Organisations (2007)⁹¹

Groups	No. of services	
Support to Teenagers		14
• Teenagers 14+	5	
• Teenagers 15+	8	
• Teenagers 17+	1	
Lesbian/gay clients		11
Deaf clients		4
Visually impaired clients		2
Clients with learning difficulties		13
Client wheelchair users		2
Clients whose primary language is not English		9
Refugees/asylum seekers		7
Members of the Traveller community		4
Help to those who support victims of sexual violence		14

During 2007, a total of 40 clients with learning difficulties received support at 13 RCNI affiliated organisations. Of the 17 sexual violence support services, 4 reported some level of disability access at the main centre building. Those centres that are not wheelchair accessible have arrangements for alternative premises that are wheelchair accessible. Two network affiliated organisations provided support to a total of 33 client wheelchair users; 4 were involved in the provision of support to 6 deaf clients; and 2 services supported 2 visually impaired clients.

Information on the provision of support to specific groups in 2000 is not available.

3.5.4 Sexual Assault Treatment Units (SATUs)

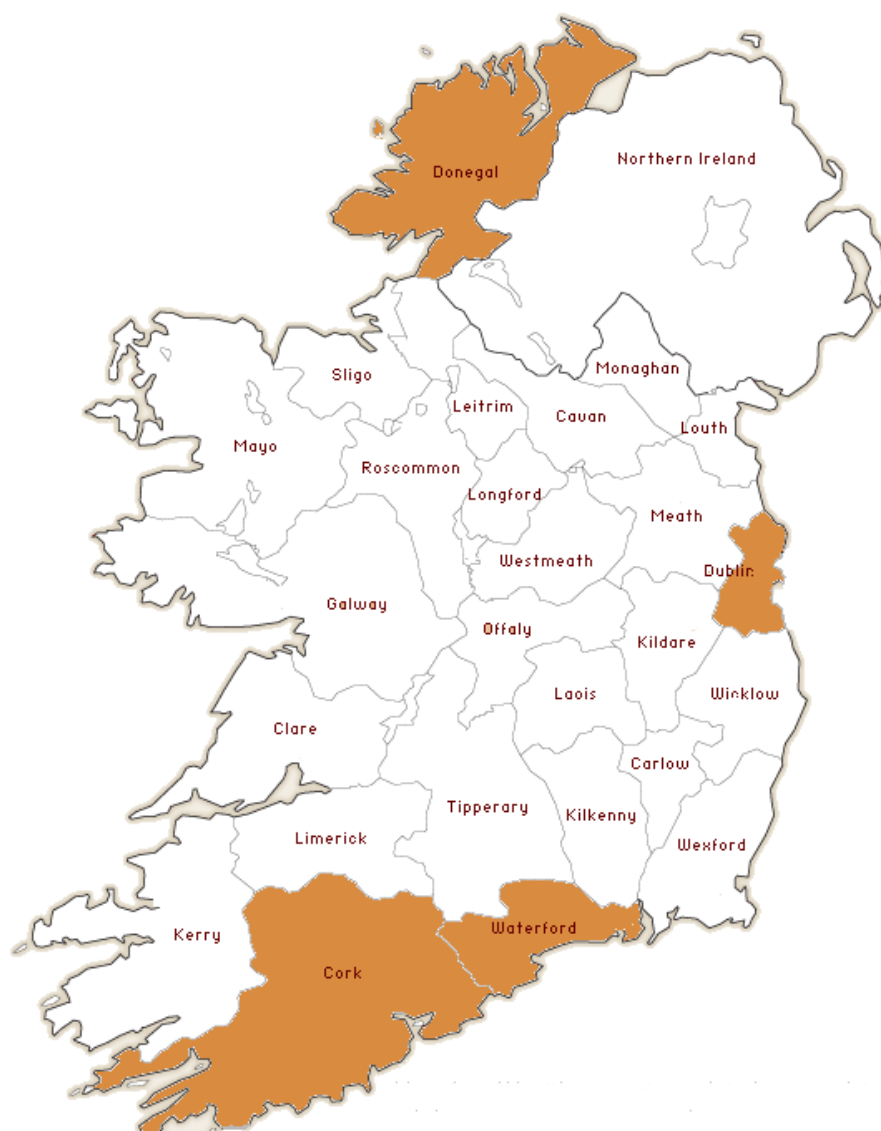
Sexual Assault Treatment Units (SATUs) are services available, normally based in a clinical/hospital setting, to any victim of an alleged rape/assault.

⁹¹ These figures reflect only victims and supporters who were utilising RCC services in 2007 - not the groups of victims and supporters for whom RCCs are in a position to provide services.

Examples of services they provide include: forensic medical examination of recent victims of sexual violence/assault⁹²; treatment for sexually transmitted infections (STI) where possible; and referral for STI screening and emergency contraception. Main sources of referral to SATUs are Rape Crisis Centres and An Garda Síochána.

A review of SATUs in 2006⁹³ described the service provision of sexual assault treatment services in Ireland. At the time there were four SATUs in Ireland, existing in four HSE regions, namely the Eastern, the South-Eastern, the Southern and the North-Western regions.

Map 5: Counties in Ireland in which SATUs were located in 2007



In 2007, there were 4 SATUs across the country. This amounts to 1 SATU for every 435,114 women. Map 5 highlights those counties within which these SATU services are located. These Units are located at each of the following:

⁹² Such an examination is desirable if the case is to be processed by the criminal justice system.

⁹³ O'Shea (2006).

Rotunda Hospital, Dublin⁹⁴; Letterkenny General Hospital, Donegal; South Infirmary Victoria Hospital, Cork; and Waterford Regional Hospital, Waterford. In terms of service density per region, the North-Western region has the highest service density (1: 95,515). The region with the lowest service density of SATU service available is in the Eastern region (1:635,935) (see Table 18). It should be noted, however, that this reflects neither the size nor range of services provided.

Table 18: Sexual Assault Treatment Units in 2007

Region	Western			North-Eastern		Mid-Leinster	Southern	
Sub-region	North-Western	Western	Mid-Western	North-Eastern	Eastern	Midlands	South-Eastern	Southern
Sexual Assault Treatment Unit	Letterkenny General Hospital (<i>est. 1998</i>)	None	None	None	Rotunda Hospital, Dublin (<i>est. 1985</i>)	None	Waterford Regional Hospital (<i>est. 2004</i>)	South Infirmary / Victoria Hospital, Cork (<i>est. 2001</i>)
Ratio of SATUs service to women	1:95,515	N/A	N/A	N/A	1:635,935	N/A	1:107,679	1:332,651

3.5.4.1 SATU activity levels: No up-to-date information was available regarding activity levels across all SATUs for this study. The most recent information is from 2006⁹⁵. At this time, the Rotunda Hospital SATU conducted an average of 300 forensic medical examinations per annum, with approximately 35% of victims accessing the service coming from outside of Dublin. The service is described as being accessible 24 hours a day, 365 days a year. In 2006, the Cork SATU, established at the South Infirmary/Victoria Hospital in 2001 received an average of 115 clients per annum of which an average of 33% were from outside of Cork County. The SATU at Waterford Regional Hospital, established in 2004, saw 52 victims of rape/sexual assault in it's first year of operation. The Unit expected that as awareness of the service grew they would see somewhere between 60-80 clients per annum. The SATU at Letterkenny General Hospital has been functioning on a part-time basis since 1998. Unlike the other 3 SATUs at the time, their services are offered to both adults and children with children being seen by a consultant paediatrician. This Unit had to limit its catchment area to the Donegal region. At that time, the Letterkenny Unit would have an average of 25 clients per annum. A SATU at Tralee General Hospital was established in 2002, but ceased operating in 2004. It saw an average of 25 clients per annum.

3.6 Summary

3.6.1 Domestic violence dedicated services

There are 49 domestic violence support services available to those who experience domestic violence in Ireland. This includes 19 refuges offering

⁹⁴ The Rotunda SATU was the first dedicated sexual assault treatment service of its type in Europe.

⁹⁵ O'Shea (2006).

accommodation to women and 30 domestic violence support services offering information, advocacy and support. Of the 30, one provides support services to men who have experienced domestic violence. There is one support service dedicated to men and one helpline dedicated to older people in Ireland.

Since 2000 there has been an increase in the total number of domestic violence services operating in Ireland and consequently an increase in the level of service density. Service density has also improved in most sub-regions (the south-eastern being the exception). There are no domestic violence support services located in Counties Leitrim or Cavan.

3.6.2 Sexual violence dedicated services

There are 17 sexual violence support services offering information, advocacy and support for men and women who have been victims of sexual violence in Ireland. There are 14 RCNI affiliated service providers and 3 non-network affiliated service providers. All sexual violence services provide a free-phone helpline facility. In 2007 there were 4 SATUs across the country. These services are located in Cork, Waterford, Dublin and Donegal.⁹⁶

Over the last decade few changes have taken place in the number of sexual violence services available in Ireland. Between 2000 and 2007 there was an increase of one in the number of support services reported to be operating in Ireland. Over this time the total level of sexual violence support service density has slightly decreased from what it was in 2000. No sexual violence services are located in 10 counties in Ireland.

It should be noted that with regard to domestic and sexual violence services alike, no information was available on the extent and nature of outreach services being provided to victims. This information would be particularly important to assess the 'reach' of services to victims not only in other counties but who have specific needs.

3.7 Council of Europe standards

In 2007, the levels of domestic and sexual violence services in Ireland satisfied the criteria established by the Council of Europe (Kelly and Dubois, 2008). Table 19 illustrates, where it has been possible and appropriate, to apply these standards to service delivery in Ireland.

⁹⁶ There is also a part-time, partial sexual assault treatment service in Limerick, run by Shannondoc which sees about 40 people a year.

Table 19: Application of Council of Europe Standards to Irish Context

Council of Europe Minimum Standards to Combat Violence Against Women⁹⁷	Ireland 2007
One national helpline covering domestic violence and one covering sexual violence.	✓ 1 x National Domestic Violence Helpline - Women's Aid Women's Aid National Helpline (domestic violence). ✓ 1 x National Sexual Violence Helpline - Dublin Rape Crisis Centre.
One specialist violence against women (VAW) shelter in each province/region ⁹⁸ .	✓ Ireland has at least 1 shelter/refuge in every sub-region and at least 2 shelters/refuges in all but 2 sub-regions i.e. North-Western and Midlands.
In shelters one "family space" ⁹⁹ per 10,000 population.	133 permanent beds designated for women. 412 permanent beds designated for children.
These shelters should accommodate additional needs - migrant and minority women; women with disabilities; women with mental health and/or substance misuse issues; and younger women needing protection from female genital mutilation (FGM), forced and child marriage, crimes in the name of honour.	There is very little information available as to the range of services available to each of the above vulnerable groups in Ireland. Some sexual and domestic violence services reported providing services to those with disabilities; members of minority ethnic groups; those with mental health and substance issues, but the level of detail required to establish the extent and nature of service provision for these vulnerable populations is not available.
One rape crisis centre per 200,000 women ¹⁰⁰ with at least one centre per region.	✓ 1 x rape crisis centre per 108,778 women and at least 1 centre per sub-region.
One Sexual Assault Treatment Unit per 400,000 women.	✓ 1 x Sexual Assault Treatment Unit (SATU) per 435,114 women.
One advice/advocacy service per 50,000 women (enabling early intervention and access to legal and other support). ¹⁰¹	✓ Ireland has 19 refuges, 29 additional domestic violence support services and 17 sexual violence support services all of which provide advice and advocacy to victims. This means Ireland has 1 service per 26,776 women
One counselling service ¹⁰² per 50,000 women. There should be one specialist VAW counselling service in every regional city. ¹⁰³	✓ Ireland has 19 refuges, 29 additional domestic violence support services and 17 sexual violence support services all of which provide counselling services to victims ¹⁰⁴ . This means Ireland has 1 service per 26,776 women ¹⁰⁵ .
Outreach should be designed locally to address the largest local minority groups, women with disabilities and under-served groups.	✓ In 2007, 37 domestic violence services and 9 sexual violence services provided information, advocacy and support on an outreach basis. There is little information as to the exact nature of this outreach work or on what vulnerable populations accessed those services.

⁹⁷ Source: Kelly and Dubois (2008)

⁹⁸ The measure of this standard very much depends on what is meant by "province/region". Kelly and Dubois (2008) make no reference as to what is meant here.

⁹⁹ Kelly and Dubois (2008) in their elaboration of Council of Europe standards refer to the concept of "family space" in refuges where they recommend a minimum standard of "1 family space per 10 000 of the population". However, questions remain as to the exact definition of "family space" and whether or not it is possible to apply this particular standard given that it does not specify the segment of the population involved, (i.e. if the population referred to is the population of women or the population as a whole). This report presents the number of permanent beds available in refuges for women and children who have experienced domestic violence.

¹⁰⁰ Kelly and Dubois (2008) do not define what age constitutes "women". As stated earlier, for the purposes of the current study "women" is defined as females 15 years and over.

¹⁰¹ This Council of Europe standard deals with domestic violence and sexual violence together, but it should be noted that the nature of the advice/advocacy service for the two types of violence may differ.

¹⁰² Kelly and Dubois (2008) do not define what is understood by the term "counselling" and so comparison here is unclear. It is also the case that different organisations and agencies often mean very different things when they use the term "counselling". Some reject the term and prefer to use "providing advice and information". All of this must be borne in mind when considering these findings.

¹⁰³ This Council of Europe standard deals with domestic violence and sexual violence together, but it should be noted the nature of the counselling service for the two types of violence may differ. Kelly and Dubois' (2008) report states that these counselling services can be provided by "existing specialist violence against women groups, such as shelters, rape crisis centres and women's counselling centres" (pg. 38)

¹⁰⁴ Including services which provide counselling referral.

¹⁰⁵ It is unclear in Kelly and Dubois exactly what is meant by "specialist VAW counselling service", or what is meant by "regional city"

Given information currently available and using population estimates for 2007 populations¹⁰⁶, domestic and sexual violence service provision in Ireland, in the vast majority of cases, meets and often exceeds the level of standards identified by the Council of Europe. However, information regarding the extent to which domestic and sexual violence services in Ireland meet the needs of older people, migrant and minority women; women with mental health issues; women with substance misuse issues is not available.

Moreover, the Council of Europe guidelines have been developed for the purpose of addressing violence against women. No account is taken, or minimum standards provided, relating to levels of service availability for men who experience similar violence. In future, relevant practitioner and policy literature should focus on developing the appropriate standards of services to combat domestic and sexual violence against men. Additionally, it is clear in the literature that domestic and sexual violence manifest differently in the lives of older people and standards should be developed to reflect the different issues involved and the corresponding needs.

It should also be noted that by applying the concept 'service density', no account is taken of important aspects of service provision such as service capacity (e.g. the size of the centres involved or the number of facilities available in the centres) or how effectively services operate. Evidently, the concept does not encompass an indication of how centres may have developed and changed in these respects over time.

So far, the report has examined the range of dedicated services for victims who have suffered domestic or sexual violence. The concept of 'range' does not, however, encompass that, in order for a system of service response to operate effectively, the components of the system of service provision must be coherently integrated. The Council of Europe states that a key principle in service provision in Member States should be that "*...Services operate within a context of relevant inter-agency co-operation, collaboration and co-ordinated service delivery*" (Kelly and Dubois, 2008). To date however the Council of Europe have not formulated standards and norms of inter-organisational co-operation and co-ordination.

A comprehensive consideration of this is beyond the scope of this study. However the following chapter does address some of the issues in a preliminary way. Based on a review of the international literature the chapter sketches what is entailed in developing co-ordination, particularly the obstacles and problems that can arise. Acknowledging these problems, there is also a discussion of the potential to build upon the inter-dependency among service providers and harness the potential for complementary approaches and practices.

¹⁰⁶ Extrapolated from CSO Census 1996, 2002 and 2006.

Chapter Four

A Co-ordinated System to Improve the Safety of Victims of Domestic and Sexual violence: Conclusions from the Literature

4.1 Introduction

There are various definitions used in relation to co-ordination. Common to most of these is the concept of process where two or more organisations over time move towards concerted decision-making and dealing collectively with their shared task environment (see Warren et al, 1974; Mulford and Rogers, 1982). Frequently, co-operation and co-ordination are depicted as stages in that process (e.g. Gray, 1989). Where positive informal relationships among organisations have developed, a platform to co-operate with one another and to pursue their respective interests is made possible. As the process develops, the possibilities to pursue collective goals through formalised agreements are established (Gray, 1989). In this sense, co-ordination is referred to in the literature as formal institutionalised relationships among existing and established networks among organisations.

But how do linkages between organisations enhance the system of service provision for the service user? A review of the international literature to examine how benefits from co-ordination are achieved was undertaken for this report. The literature focuses attention on the importance of co-ordinating inter-organisational activity in order, first, to streamline system effectiveness and, second, to integrate service provision. The following section begins with the issue of integrating service provision.

4.2 Complementarity among service providers

When support or advice is sought by victims of domestic or sexual violence, typically a large number of primary agencies and organisations become involved in a variety of capacities and at a number of levels. For example victims of domestic and sexual violence come into frequent contact with a variety of different health professionals such as the GP, hospital emergency services, mental health services (Nudelman and Trias, 1999). In addition to their need for health care, victims have a parallel need for non-medical assistance. For example, an understanding of what the civil and criminal justice response might be should they decide to access legal assistance. They may also need help with finding temporary accommodation or advice on how to keep safe should they decide to return home. Frontline domestic and sexual violence support services play an important role in coordinating their clients' linking in with, or access to other services such as the community welfare officer, housing officer, legal aid, public health nurses, MABS, etc.

The point of departure for this conceptual framework is the inter-play among these services, or more specifically, among the practices they provide to

service users. In the literature, this is referred to as **complementarities** between practices/services.

Flanking: This literature explains that organisational practices or activities inter-relate in three ways. First practices **flank** one another. The effect of flanking arises where one practice adds to, supports or positively reinforces the effects of another. The example below illustrates the value of flanking practices when they facilitate the effectiveness of another¹⁰⁷.

The combination of service provision practices required when a victim of domestic violence decides to leave the abusive situation illustrates the need for flanking. Research shows that exiting an abusive situation is very complicated but is greatly facilitated by putting in place a cluster of circumstances or conditions. The victim's¹⁰⁸ economic security has been identified as the primary reason why, despite wanting to leave an abusive relationship, many nevertheless stay and victims who have left an abusive relationship, end up returning (Barnett et al, 2005). However securing employment may be problematic: for example, where high levels of stress and prolonged emotional trauma prevail. Flanking among services means that the individual's health or emotional well-being should be considered first and as an antecedent to changing the individual's employment position. Moreover, that service interventions offered should be integrated to reflect the relationship between the person's different needs.

Research also indicates that addressing a victim's basic needs is a necessary precursor to delivering an effective criminal justice response. Research indicates that victims need access to adequate and tangible support¹⁰⁹ before certain decisions can be taken to increase their safety such as to pursue prosecution of the perpetrator (Goodman et al, 1999). The difficulty that prosecutors face when they pursue a case without the victim as witness underscores the importance of practices between one organisation flanking and supporting, rather than undermining, the work of another.

Blocking unintended effects: Practices can create complementarities in a second way. Apart from the additive effects described under 'flanking', practices can also interact with one another and this has implications for integration. The different services that can be involved when the victim is deciding whether or not to disclose violence can illustrate how the different practices interact. The context of this decision can involve An Garda Síochána and community-based services such as victim support services. One of the principal effects of making a formal report of violence is to facilitate An Garda Síochána in protecting the victim from further violence. However despite being aware of this intended positive effect, the victim frequently has to consider the possible unintended negative effects of disclosing. There are many possible unintended negative effects that the victim may be worried about.

¹⁰⁷ Adapted from Horgan and Muhlau (2006).

¹⁰⁸ Particularly women, who are more likely to occupy a weaker economic position than men in society.

¹⁰⁹ For example (affordable) childcare, transportation (Gondolf and Fisher, 1988), housing (Kirkwood, 1993) and social support (Hobfoll and Vaux, 1993)

For example, making an arrest and treating the perpetrator as a criminal can be very upsetting and frightening for the victim, particularly where the perpetrator is known to the victim. In the case of domestic violence the perpetrator acquiring a criminal record can have serious consequences in terms of social standing and employment prospects. The victim may fear reprisals or, having revealed violence, might have to leave their home or disclose that children have been the target of, or have witnessed violence. Mothers often fear contacting child protection agencies, believing that they will be blamed and have their children removed. Perpetrators can allege that their partners are equally violent and this can lead to the victim fearing that professionals view the problem as one of 'mutual violence' where there is no identification of a primary perpetrator (Radford et al, 2006). Frequently, the fear of the situation escalating further is a substantial deterrent to reporting violence. The serious nature of these concerns means that the decision to report violence to the police is frequently very difficult for victims (e.g. Felson et al, 2005).

Circumventing these unintended negative effects needs to be an outcome of the integration of services. This calls for the application of services that interact with one another such that they can block or compensate specific negative effects. Such integration between An Garda Síochána and, for example, community-based services, would help these services to reinforce the positions that domestic and sexual violence is a crime as well as protecting people against these forms of violence. Without aligning their respective positions on these issues, the practices of the police and community organisations may work against one another, possibly even undermining the potential of both.

Domestic violence victims generally do not report their initial experiences of violence, but typically suffer multiple assaults and/or related violence before they contact authorities and/or apply for protection orders (Felson et al, 2005). In respect of domestic violence incidents, the police response carries very important messages. A sensitive response is likely to reassure that victim that his/her complaint is a legitimate one, which will be taken seriously and responded to with respect and professionalism. In general reporting domestic and sexual violence to professionals is strikingly low and this includes reporting to the police.

Reporting to the police can in many ways be seen as a 'double edged sword' from the victim's perspective.

The third potential area for complementarity lies in the benefits to be gained from **knowledge transfer**. Over the years domestic and sexual violence professionals have become increasingly aware of strong interdependencies in the services they offer. Victims of domestic and sexual violence can be simultaneously dealing with a variety of problems including financial problems, physical injuries, mental health problems, cognitive disabilities, involvement in substance abuse or prostitution. Arising from these observations, service providers are increasingly aware of the need for training and awareness raising with regard to adapting their response to those who have been

affected by domestic and sexual violence. Consequently in other national contexts complementarities among domestic and sexual violence services are developed through inter-agency teams and multi-agency approaches. In other sectors, such as health, complementarities have become the cornerstone for co-ordinating healthcare and mental healthcare service provision (see Maurey et al, 2006 for a review of this material).

As a basis for developing complementarities the effective management of inter-organisational activities is key to progressing toward the avoidance of service duplication and the planned use of resources. The following section reviews the various inter-organisational challenges and solutions that are involved to achieve this.

4.3 The management of challenges to inter-organisational work

Co-ordination among organisations can take different forms and can develop or change over time. Co-ordination is widely discussed in the literature in terms of stages of co-ordination, for example from low to high levels of activity. Where co-ordination is low, activity among co-ordinating partners would be relatively infrequent and the scope of work involved confined to more basic work such as informal exchanges or discussions, perhaps for networking or updating purposes only. The literature also discusses in a general way how the stagnation of co-ordination in a sector arises mainly from problems in communication and legacies of poor working relationships.

Another important variable is whether co-ordination activity in a sector has come about in a deliberate manner or whether the development has been emergent or spontaneous. Deliberate planning is characterised by careful articulation of goals and objectives as well as clarity of roles and responsibilities across the different stages and forms of co-ordination work, including implementation. Such planning is cited as important to successful co-ordination (Mattessich et al, 2001).

On the other hand co-ordination could emerge spontaneously over time, for instance evolving through the contacts and agreements developed through informal contacts (Huxham and Vangen, 2005). This may be more likely where networks are built up through working with others on other areas.

The nature of co-ordination among organisations, progressing through different stages and forms of co-ordination work, typically require the implementation of key principles of good management of inter-organisational work or activities. These principles are discussed below. This is done by outlining problems that typically undermine inter-organisational co-ordination and what the literature reports can be done to address these.

4.3.1 Challenges to co-ordination among organisations and principles for management

4.3.1.1 The problem of establishing a basis for co-ordinating activities

Co-ordination involves helping members of organisations to see themselves as part of a larger system for addressing the issue of domestic and sexual violence. It involves increasing members' understanding of that system; identifying and recognising their role; respecting the role of others; clarification of the position of different participants; and facilitating the development of new protocols and practices that lead to organisations working together more effectively and efficiently.

a. *Aligning interests:* Where the mutual benefits are clear for both co-ordinating partners the motivation to work together to achieve objectives will be relatively straightforward. However, where the benefits of co-ordination are less obvious, follow-through on co-ordination agreements may be problematic. For example Morley and Mullender (1994) explain that, in relation to police policy on domestic violence, without strong leadership, monitoring and a structure of accountability in the community sector, such policy does not translate into practice.

b. *Building inter-organisational relationships:* Because stakeholders frequently have at least some degree of autonomy in determining the extent to which - and manner in which - they will interact with other organisations or agencies, effective co-ordination is often described as dependent upon participating stakeholders developing co-operative relationships (Foster-Fishman et al 2001). It is often through existing relationships or networks that partners come to learn what they can expect from key stakeholders and to judge the trustworthiness of partners. The more partners have interacted in a positive way in the past, the more social mechanisms will enable co-ordination and safeguard exchanges (Hesterly and Borgatti, 1997). Some research suggests that, where ties are particularly well established, each part in the relationship may be counted upon to act in ways that take into consideration the interests of the other party because, by doing so, the relationship is strengthened (Huxham and Vangen, 2005).

If prior relationships do not exist, then partnerships may emerge if progressed more incrementally, beginning with small, informal exchanges that do not require a strong trust basis (Gulati, 1995).

Partners can build trust through the sharing of information and knowledge and demonstrating competency, good intentions and follow-through; conversely, failure to follow through and unilateral action undermine trust (Merrill-Sands and Sheridan, 1996). For example, Huxham and Vangen (2005) emphasise the effectiveness of achieving 'small wins' together.

4.3.1.2 Facilitating factors in establishing a basis for co-ordination

Where co-ordination activity is in the early stages or has not progressed, the literature highlights several steps that have been found to assist co-ordination.

a. *Early agreements:* establishing early agreements can be very valuable including agreement on the scope of the co-ordination (Carpenter et al 2005; Harker et al, 2004). Establishing clear and realistic aims and objectives that are understood and accepted by all participants facilitate multi-agency working by creating a clear and shared purpose for the group (Sloper, 2004; Lawrence et al, 2003).

b. *Shared vision:* Percy-Smith (2006) reports that shared visions should define the scope and purpose of co-ordination and be based on jointly held values. A shared ideology among participants refers to a coincidence of shared understandings, paradigms and values, which foster agreement among parties (Sloper, 2004).

c. *Role demarcation:* The literature emphasises role demarcation or clarity of the role of each participating organisation, as an important factor facilitating inter-organisational working (e.g. Faye et al, 2005; Carpenter et al, 2005). For example having clear role boundaries and acknowledging professional differences is found to have led to more effective working relationships (Darlington et al, 2004).

4.3.1.3 Managing increasing complexity

With greater levels of integration, the more complex co-ordination becomes. Co-ordination is also more complex where the number of participants increases and particularly where the group of participants becomes less homogenous (work remit, work culture, status differences, etc).

In particular the literature frequently reports that struggles over status levels threaten co-ordination between organisations. There is evidence that where power struggles between co-ordinating parties take place, low morale can result. Gray (1989) argues that not involving key stakeholders is one of the more serious challenges to successful co-ordination. The evidence is that, where key stakeholders are not represented directly, implementation of co-ordination is impaired (Mackenzie, 1996). Furthermore, the absence of those with power to implement the decisions especially reduces the extent of implementation of agreements (Owen, 1989).

a. *Participation etc:* Overcoming these types of problems requires applying principles of participation, ownership and power sharing in co-ordination work.

b. *Commitment:* Gray (1989) advises conveners and mediators to be alert to possible or perceived breaches of faith and misinterpreted signals in order to maintain trust among parties. Negotiating in good faith and having trust in relationships, maintaining good interpersonal relationships with the participants and establishing open lines of communication are all found to

benefit the progress of co-ordination. To strengthen signals of commitment to co-ordinating with others, Whaley (1993) explains that the commitment of one party can be a very important element in successful partnerships and Hartig (1995) argues that the commitment of top leaders can be very important.

Membership turnover may be especially important when powerful players leave, join or alter their level of involvement in the collaboration (Crosby and Bryson, 2005; Blodgett, 1992). This ambiguity is further exacerbated by hierarchies of collaboration in which individuals and organisations are members of multiple and overlapping partnerships.

c. Formalisation: Formalisation helps to support increasing complexity in co-ordination. For instance setting up protocols and procedures for inter-organisational or multi-agency working are found to be key facilitators of joint working (e.g. Atkinson et al, 2002). Informal agreements about the composition, goals and processes can work (Donahue, 2004), but formal agreements have the advantage of supporting accountability. For example, It was found that establishing clear protocols for information exchange can overcome the confidentiality issues associated with some services (Darlington et al, 2004).

d. Supporting structures: Elements of formal agreements might include a broad purpose, mandate, commitment of resources, designation of formal leadership, description of members, decision-making structure and built-in flexibility for dealing with local conditions and changes (Crosby and Bryson, 2005a). Yaffee et al (1996) report that participants in co-ordination activities found the development of decision-making structures such as partnerships, management committees, task forces or some type of co-ordinating body as central to the management effort.

e. Building leadership and governance for successful collaboration: A brokering organisation or a legitimate convener can facilitate collaboration formation (Gray, 1989; Waddock, 1986). Powerful sponsors or brokering organisations draw attention to an important public problem and accord it legitimacy within a stakeholder group (Crosby and Bryson 2005a). Conveners, who are often recognised as boundary-spanning leaders with credibility in multiple arenas touched by the problem, can successfully draw together an initial set of stakeholders (Gray, 1989).

Atkinson et al (2002) found that leadership and drive at a strategic level, including vision and tenacity, enhanced multi-agency working. Clear managerial presence and support, and a specific leader or co-ordinator for the partnership was seen as instrumental (Carpenter et al, 2005; Dickson, et al, 2004). Strong leadership and multi-agency steering or management groups were also identified as facilitators of effective partnerships (Lawrence et al 2003).

The absence of clear leadership and a lack of support and commitment from senior management were found to be damaging to multi-agency work (Harris, 2003). For example Salmon and Rapport (2005) looked at the discourse

emerging from multi-agency meetings and found that professionals can feel unsupported within their own agencies, thus inhibiting the success of multi-agency groups.

A number of sources identified the importance of clear lines of accountability and governance structures (Frost and Lloyd, 2006). Having a clear framework of responsibilities and accountabilities, combined with an environment that gets the most out of the individuals tasked with making the partnership work, was found to be particularly influential (Fox and Butler, 2004).

4.3.1.4 Incentives and performance management

Gray (1989) warns of the need to avoid a situation where parties are at the table but do not believe their interests are best served by co-ordination. It is important to be able to demonstrate to those participating as well as to externals that co-ordination is making a difference. This can be done by designing and implementing evaluation frameworks to measure the impact of partnerships activity (Fox and Butler, 2004; Percy-Smith, 2006). This can be helpful for highlighting the nature and extent of benefits of co-ordination work for those who are participating. Groups should continually **reassess and streamline pragmatic strategies** regarding forms, procedures and other processes (Woodbridge et al, 2001).

4.3.1.5 Resource factors

Various strands of literature identified funding as a key factor for collaboration work. For example, financial certainty and equity between parties are important in that they prevent competition, thereby promoting the possibility to work together (Carpenter et al, 2005).

Staffing has been identified as key to multi-agency partnerships. There is evidence that staff turnover and recruitment difficulties lead to problems in sustaining joint initiatives, in responding to the needs of other agencies and this tends to undermine effective service delivery. Literature also reported shortages of staff, lack of **qualified staff** and salary differentials as inhibiting joint working (Hamill and Boyd, 2001). There is particular mention of the benefits of co-locating staff from different agencies or services.

4.4 Summary: system effectiveness and complementarity as outcomes of co-ordination

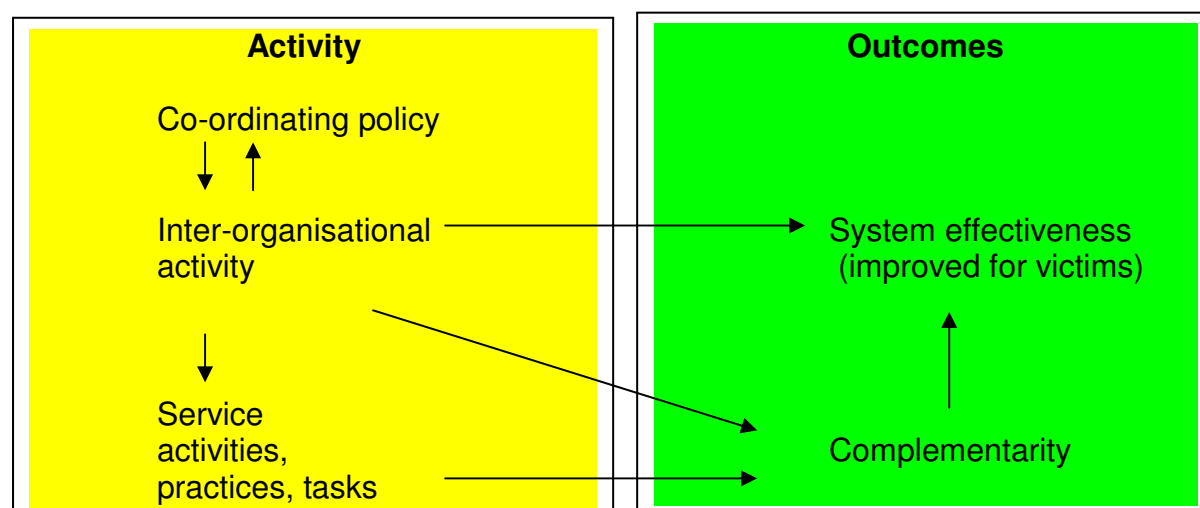
Because victims of domestic and sexual violence present with a wide variety of problems, the system of domestic and sexual violence needs to encompass a wide range of services including social and emotional support, assistance with housing, income maintenance, as well as legal and medical advice. Many problems with consistency and follow-through in service provision are, at least partly, due to the way inter-organisational activity is managed.

However the review of the literature demonstrated that as best practice management is applied to inter-organisational activity, system level effects ensue. For example, as the vertical and horizontal participation of organisations strengthens, the stability of the system's structure improves. Stability is also improved as complex and/or uncertain events are underpinned by greater formalisation. System capacity is upgraded through enhanced inter-connectedness among constituent parts of the system (i.e. among organisations in the sector) and through the effects of complementarities diffusing throughout the system. Finally contingencies and constraints become less salient as problems with power imbalances and competing institutional logics are replaced by interest alignment and unity of purpose.

The chapter began however with the idea that the effective management of inter-organisational activity must also bring benefits to those affected by domestic and sexual violence when accessing support from the relevant services. The chapter pointed out that developments in the sector over the last decade have seen a variety of responses from services arising from differences in focus, approach or in implementation. As a result, scholarly and anecdotal accounts alike are replete with accounts of victims' experiences of discrepancies and variation across service providers. These are less likely to occur as complementarities among service providers develop, resulting in the integration of service practices and the effective management of inter-organisational activities. Inconsistencies are reduced as organisations work together to eliminate conflicting methods and approaches and to develop high levels of compatibility and mutual reinforcement.

This chapter focused on the importance of recognising the potential for complementarities between services provided in relation to domestic violence. In doing so, particular attention needs to be found among co-ordination parties to identifying flanking opportunities, to provide victims with groups of services that reinforce and support effectiveness of others. The ideas discussed in this chapter are depicted in Figure 8.

Figure 8: Co-ordinating activity for improved service provision to victims of domestic and sexual violence



In the following chapter, the results of interviews with State and non-State organisations with regard to their experiences of co-ordinating with others are presented. These are results arising from analyses that aimed to explore first to what extent co-ordination with other organisations on issues of domestic and sexual violence has developed in the sector in Ireland. In addition to this the analyses examined the influencing factors that have featured or played a role in fostering or impeding co-ordination.

Chapter Five

Domestic and Sexual Violence in Ireland: Co-ordination among Service Providers

5.1 Introduction

The previous chapter highlighted key issues that need to be considered when examining issues relating to the co-ordination of domestic and sexual violence service provision. The findings included in this chapter are based on interviews in 2009 with key representatives from State and non-State organisations about co-ordinating with others in the domestic and sexual violence sector. The chapter aims to describe the extent of co-ordination in the sector and to capture the factors that influenced the development of inter-organisational co-ordination.

The first section begins by discussing the extent to which the organisation develops, disseminates and translates its approach to dealing with domestic and sexual violence in the form of a policy. This provides an important foundation and starting point for organisations intending to develop a co-ordinated approach with others in their work.

The chapter continues by describing the extent to which organisations have engaged in co-ordination work with others and the forms which this co-ordination has taken. The chapter also outlines the main challenges that these organisations have encountered with inter-organisational co-ordination.

5.2 Approaches to domestic and sexual violence

It should be noted, that interviewees discussed information with regard to their organisation's experiences of working with others in the sector. Where this information is used in this report, respondents' identities are concealed by discussing these issues in a very general way. As a result while all issues raised have been reported, no indication is given in this report of the respondent's identity or which organisation or sector with which the individual is associated.

5.3 Justice sector

5.3.1 *An Garda Síochána*

Organisations operating in the criminal justice sector vary in terms of whether or not they have developed a formal policy regarding domestic and/or sexual violence. In 1993 the Domestic Violence and Sexual Assault Investigation Unit (DVSAIU) was established at the National Bureau of Criminal Investigation in An Garda Síochána. The DVSAIU is the national unit providing a nucleus of expertise to other Garda units in the investigation of crimes of a sexual nature. The unit has a similar brief in relation to domestic violence. Sexual violence has been a key priority for the Unit. A formal policy

on domestic violence has been developed and specifies the approach as pro-arrest where an arrestable offence has occurred.

The main challenge for policy in relation to domestic violence has been its consistent implementation throughout the organisation and across time. New staff members develop familiarity with the issues around domestic violence and with the organisation's policy - an obligatory component of the new recruit's training. Nevertheless, variation among Gardaí in terms of response is an ongoing problem and this manifests itself in various respects.

First and more generally is the organisation's capacity to manage domestic violence related activity. For example, where an offence has been committed and where domestic violence is involved, an appropriate PULSE system recording should be made. However, in practice, pressures on resources result in inconsistencies in the management of these data. Furthermore, where an offence such as the breach of a court order has been committed and a file sent to the DPP, the prioritising of other areas of crime may mean that following-up with victims can be inconsistent.

All Gardaí are trained to properly investigate sexual offences. The DVSAIU conducts and co-ordinates the more complex or sensitive investigations and provides advice and operational assistance to local Gardaí involved in such investigations. Specialist victim interviewers are available throughout the State to conduct witness interviews with (mainly child) victims of sexual or other violence-related offences. Members of An Garda Síochána also advise and accompany victims of sexual violence to their nearest Sexual Assault Treatment Unit (SATU) in order to secure medical attention and/or forensic examination.

In terms of co-ordination-related activity in the sector, at a national level the Garda Síochána are members of the National Steering Committee on Violence Against Women. At regional level the organisation has participated in the various Regional Planning Committees¹¹⁰ and are also involved in some (local level) Local Area Network (LAN) activity. In general, the Garda Síochána has found that the process of developing a working relationship with front-line service providers has been a productive one and has worked well.

5.3.2 The Probation Service

The Probation Service has established a High Risk Offender Management Team to develop effective practice and supporting systems. The Service has published staff protocols regarding roles and responsibilities. To supplement individual supervision and in conjunction with the Granada Institute, the Probation Service operates three community-based group programmes targeting those who have sexually offended against children (two located in Dublin and one in Cork).

¹¹⁰ Now Regional Advisory Committees.

In addressing the issue of accommodation and as part of the work of the Homeless Agency, the Probation Service participates in a Multi-Agency Group on Homeless Sex Offenders (MAG). This group has twelve partner agencies including the Garda Síochána, the Prison Service, the HSE, local authorities and voluntary agencies and efforts are being made to develop interagency strategies and associated protocols. The Probation Service has committed to delivering a standard process for the risk assessment of sex offenders in keeping with governmental policy. The use of a standard approach is in line with the system implemented on a multi-agency basis in Northern Ireland and Scotland. The aim is that a consistent approach be applied by different agencies and across jurisdictions in order to add to public safety.

Currently one of the main challenges encountered by the Service relates to the need for treatment services to be available in the community on a national basis for sex offenders, following their release from prison. Another key challenge relates to risk assessment and the transfer of relevant information between the Gardaí, the Probation Service, Prison Service and other statutory bodies such as the HSE and the relevant housing authority.

The Probation Service has, until relatively recently, been more involved in the area of sexual, rather than domestic, violence. With the establishment of Cosc and with it, greater visibility of domestic violence as an issue that requires a planned and co-ordinated approach, the Probation Service began the development of a policy with the aim of informing and guiding practice in the Service's work with perpetrators of domestic violence. To this end, it is intended to develop agreed protocols in relation to the assessment and management of perpetrators of domestic violence (e.g. their management while on perpetrator programmes). The protocols aim to ensure that perpetrators are held accountable, that they have the opportunity to change violent behaviours and that victims are safeguarded.

One of the main challenges encountered by the Probation Service in relation to domestic violence relates to the roll-out of significant parts of its policy. In its approach, the Probation Service recognises the importance of working in partnership with other statutory and non-governmental organisations. Most of the perpetrators of domestic violence encountered by the Probation Service are convicted offenders and any possibilities of extending the reach of their work beyond this group will need to be undertaken in conjunction with other key organisations. For example, contacting perpetrators via HSE social workers may be crucial to extending the reach of programmes to perpetrators outside the criminal justice system. Developing a system of referral from the HSE to the domestic violence perpetrator programmes will require collaboration between these organisations. To date, these organisations have established agreements but at the time of interviewing, a process of routine referring had not yet been established. Finally, respondents indicated that in order to enhance the safety of families, working with the perpetrators' partners or spouses will also require greater levels of working with victims support groups.

5.3.3 *The Courts and the Legal Aid Board*

Neither the Courts Service nor the Legal Aid Board has produced a formal policy document in relation to domestic or sexual violence. Both of these organisations seek to retain strict impartiality in relation to all of their clients, aiming to provide a comprehensive and objective service to both victims and perpetrators of domestic violence.

The Legal Aid Board is responsible for the provision of legal aid and advice on matters of civil law to persons unable to fund such services from their own resources. The vast majority of the Legal Aid Board's activity is in family law / civil matters including legal representation to those who have been affected by domestic violence. The Board also provides legal aid or advice to a complainant in certain criminal cases involving prosecution for a range of sexual offences, including rape, aggravated sexual assault and incest. In order to qualify for legal aid and/or legal advice an applicant must pass both the means test and the merits test. Since 2005, the maximum waiting time for an appointment with a legal aid solicitor is four months. However, the Board gives priority to certain categories of cases, such as domestic violence.

The Courts Service meets and interviews people on a daily basis in relation to applications for domestic violence court orders and while it will provide assistance, it cannot provide advice to these people. Additionally, if clients are unable to afford a solicitor it is policy to inform them of the services offered by the Legal Aid Board.

One of the main challenges faced by the Courts Service is to ensure that the assistance provided to applicants is consistent and standardised. For example, in some circumstances applicants for court orders may be given assistance with form filling. Where resources (e.g. staff) are however more restricted, this assistance may not be forthcoming.

The referral of domestic and sexual violence victims from other organisations operating in the sector to the Legal Aid Board has repercussions for the processing of cases through the system. Inappropriate or improper referrals have resulted in delayed procedures, unrealistic expectations and confusion for both service providers and service users.

5.4 Health and environment sectors

5.4.1 *The Health Service Executive*

At the time of interviewing the Health Service Executive (HSE) was in the final stages of developing its policy on domestic and sexual violence. In the meantime, this policy has been completed and adopted. Guidelines were issued for the referral, forensic examination and support of victims of alleged rape and sexual assault. These guidelines were developed to enable a high quality service provision and to enable the HSE and the criminal justice system to develop the infrastructure required for the delivery of an appropriate integrated inter-agency response and care at a local, regional and national

level. The process of formulating the guidelines involved consultation and collaboration between the organisations concerned.

The HSE policy document on domestic and sexual violence outlines goals and actions on preventative measures and on the provision of co-ordinated and integrated service provision for victims and their children. It aims to implement an integrated and co-ordinated health sector response to domestic violence in order to prevent such violence and to ensure that all families experiencing, or at risk of experiencing, the violence will receive a continuum of supports from health and community service providers. To this end, the HSE aims to focus: on promoting primary prevention; on ensuring that frontline staff are equipped to respond appropriately to domestic violence; on ensuring the safety of children in situations of domestic violence; on providing appropriate accommodation where needed; and on working in co-operation with domestic violence perpetrator programmes to establish formal referral procedures and protocols.

In relation to both domestic and sexual violence, the HSE faces the problem of how best to avoid duplication of service provision in the future. To this end, the HSE policy specifies the need to generate data for future planning purposes, to develop a system of continuous monitoring and evaluation and to integrate a strong user involvement component to develop relevant services.

5.4.2 *The Department of the Environment, Heritage and Local Government*

Under the Homeless Strategy¹¹¹ local authorities apply this general policy on homelessness to all its service users, including victims of domestic and sexual violence. One of the aims of the Strategy is to prevent homelessness occurring among high risk groups and the problem of domestic violence could (in the implementation of the Strategy) be an area where preventative measures are taken. First, the Strategy emphasises the importance of homeless services working with other relevant organisations in order to build capacity for the purpose of recognising and intervening with risk groups. Additionally, the *Homeless Strategy National Implementation Plan* recognises that there are clear links at both structural and individual level between homelessness and a range of factors including family breakdown. A Priority Action has been developed to co-ordinate the provision of guidance and monitor actions on issues relevant to the occurrence of homelessness among specific groups, for example, in relation to those experiencing family problems.

The Department of the Environment, Heritage and Local Government (DEHLG) provides funding to local authorities for homeless accommodation, including facilities used to accommodate persons who have become homeless as a result of domestic violence. This funding covers the costs relating to accommodation, while the HSE is responsible for the remaining costs relating to refuge service provision.

¹¹¹ Department of the Environment, Heritage and Local Government (2008).

The main challenge in relation to domestic and sexual violence identified by the DEHLG is to assess need, particularly in relation to refuge provision, for the purpose of re-organising housing arrangements.

5.4.3 Summary

The literature indicates that moving towards joined up thinking in the area of domestic and sexual violence will require role clarity and a common sense of purpose. The organisations' description of their positions on domestic and sexual violence, as reflected in the development and implementation of a policy, suggests a heterogeneous collection of standpoints. While for some, sexual violence has been a priority, most often domestic violence has not been as central. Even where policy documents have been developed, a clear plan of implementation has not, in all cases, necessarily followed from this.

5.5 Gaps and challenges encountered in Ireland's response to domestic and sexual violence

5.5.1 Justice sector

Most respondents were of the view that the health service alone cannot meet all the needs of victims of domestic and sexual violence. The services provided by the legal and law enforcement systems are crucial and in this respect, several areas were identified as problematic.

Seeking legal remedies for domestic and sexual violence in Ireland involves contact with many institutions - the Garda Síochána, legal representatives and the Courts being the three key points of contact for legal redress. Most respondents said that seeking redress through the criminal justice system is difficult. The Garda Síochána may be an important source of help or assistance for example when violence escalates. However, having initiated contact with the Gardaí the victim can change their mind for a variety of reasons including fear or anxiety, regret and/or confusion. As a result the victim may no longer wish to pursue an arrest and/or charge their perpetrator.

While there is recognition by the Garda Síochána of the importance of informing the victim of the relevant services in the area, both statutory and non-statutory, on the ground this practice is not routine nor is it consistently applied regionally.

It was reported that there is ongoing confusion around issues such as the possibilities and limitations of different domestic violence court orders, the entitlements and obligations associated with each of these and even of the processes involved. For example, many respondents said that applicants for orders frequently do not understand the temporary nature of the protection order and that, where evidence needs to be given, this must be done in the presence of the alleged perpetrator, further compounding the confusion and stress experienced.

Most respondents said they felt that the core of the problem is that the institutions involved do not have a sufficiently strong victim-centred focus to their work with clients. Indicators of this were mentioned during interviewing. One view was that family law in Ireland occupies a relatively marginal status (compared to other areas of law) and said that this is reflected in the fact that facilities in public areas of family law courts are not reflective of domestic violence victims' needs.

Another view was that the lack of victim focus in relation to domestic violence arises due to the different and unequal priorities that organisations attribute to the problem of domestic and sexual violence. Many respondents felt that prioritising the victim's needs must be a consistent principle across all points of the response system. While it was said that there are some examples of 'good practice' in relation to this, it was emphasised by many that the victim's experience with legal representatives and courts varies depending on certain local factors such as the extent of local resources (e.g. staff) and the nature of the working relationship between legal representatives and court staff.

Some respondents questioned the appropriateness of a general victim-centred focus to legal proceedings claiming that such an approach would undermine the impartiality and objectivity of the proceedings. There was, however, broad agreement on the importance of good communication between solicitor and client. Good communication is crucial to fostering the client's feeling that they have a sympathetic solicitor and to clients' understanding of the information they are given.

Some respondents felt that improvements to current case management practices may facilitate standardised and clearer communication with all clients, including those affected by domestic and sexual violence.

Some perspectives claim that victim satisfaction with courts tends to stem not so much from their interaction with the criminal justice agencies, but from the support that they receive from the independent advocacy and support services¹¹². Against this backdrop, it is interesting to note that currently legal representatives do not, as part of their routine work, refer clients to victim support services. Respondents in this study described the emotional support from court staff to victims as relatively limited and felt that this should be addressed although there were no clear views about how this might best be done. However some respondents did say that practical help might be inappropriate in all court contexts. They noted that those involved in advocacy and support are not permitted to coach or provide advice to clients. Assistance with form filling in relation to applications for court orders was legitimate and is a necessary support that should be given to victims.

Others questioned the value of advocacy and assistance as part of an appropriate response to domestic and sexual violence. Some emphasised that any evidence victims may need to give in court needs to be given without the presence of a legal representative or other support and, moreover,

¹¹² Hester, M. and Westmarland, N. (2006).

invariably has to be done in the presence of the alleged perpetrator. Consequently, it was felt by some, that victims should be prepared to cope independently with these circumstances.

5.5.2 Health and environment sectors

Introduction: Given that domestic and sexual violence are important risk factors for a range of health problems, there has been growing awareness in practitioner literature of the need for health professionals to be able to respond better where they encounter cases of domestic and sexual violence. They should help to identify victims of such violence and refer them to the services they need¹¹³. Such victims may never seek help from a legal or stand-alone service, but probably will attend a health service during their adult life.

In the light of this, some respondents said that in their opinion the General Practitioner should be seen as a key 'first port of call' in a system of response for those who might need help with problems of violence. While some people may disclose violence without being questioned, others may not openly disclose the cause of their presenting problem¹¹⁴. This underlines the need for all health care professionals who have contact with patients to be aware of the risks of all forms of violence and to be alert to possible indicators of its occurrence.

This point extended to the provision of accommodation. Respondents underlined the point that, just like many other types of people, victims of domestic and sexual violence can be reluctant to be identified as homeless. Currently, the type of accommodation provided to any homeless person depends less on the reason why they present, than to which organisation or agency they present. Unless women and men present to domestic and sexual violence dedicated services, their specific safety security needs and the need to ensure continuity in their children's education, may not be detected or reflected in the decisions made around their accommodation allocation.

It was noted that substantial improvements have been made in Ireland in the forensic components of the response to sexual assault. Specific mention was made of the value of the intensive training of nurses as Forensic Nurse Examiners (FNEs) whose medical training qualifies them to conduct medical forensic examinations in order to collect medico-legal evidence. FNEs play a key role in reducing waiting and assessment times for examination, improving the chain of evidence and assisting the Gardaí in collecting information.

While the value of collecting and documenting medico-legal evidence is clearly valued by respondents, they also felt that in the future greater attention needs to be given to reducing the long-term impact of sexual violence

¹¹³ Colombini et al (2008).

¹¹⁴ The SAVI study (McGee et al, 2002) reports that of those who told somebody about the violence they had experienced, disclosure to medical professionals was 6% for experiences of adult abuse and 4% for experiences of child abuse.

assaults. Two main areas of attention were mentioned. First, sexual violence victims often experience gynaecologic injuries and have elevated levels of sexually transmitted infections. In order to address this respondents felt that routine vaccinations and prophylactic treatment for sexually transmitted infections would need to be implemented. Second, respondents indicated that a more holistic response to victims' health would need to incorporate treatment for psychiatric and/or substance use difficulties with which sexual violence victims can present.

5.5.3 Summary

Among the interviewees there was consensus on the premise that adequately addressing the issues of domestic and sexual violence is beyond the scope of any one organisation or agency and an effective response will require co-ordination and collaboration among the relevant organisations and agencies. The most frequently mentioned challenge was the lack of a common position in the sector with regard to priorities for a co-ordinated approach to domestic and sexual violence. The issue referred to most often was the problems that some organisations had with adopting a victim-centred approach.

The following section presents the prevailing view with regard to the ongoing work that has taken place at national and regional levels in Ireland to co-ordinate services for victims of domestic and sexual violence.

5.6 Co-ordination

5.6.1 Introduction

In the absence of a national strategy on domestic and sexual violence the sector in Ireland developed piecemeal and in a fragmented manner. Consequently, Cosc was tasked by the government with improving the delivery of a well co-ordinated and effective response to domestic, sexual and gender-based violence in Ireland. To assist with this work, this section will provide a first indication of the position in Ireland in relation to co-ordination among organisations in the sector concerned. The section will also describe the types or forms of co-ordination which prevail and the factors associated with the development of co-ordination.

5.6.2 Purpose and forms of co-ordination and interagency work

Co-ordination can provide an important basis/foundation for the effective operation of a complex system such as responding to domestic and sexual violence. Without co-ordination, systems of service provision will most likely develop in a fragmented and unplanned way and reflect decisions made in line with particular or "jurisdictional" interests. Reflecting this point one respondent explained...

"There are examples of duplication everywhere. One county has four different helplines. The lack of co-ordination means also there are examples of refuges full to capacity because housing services have not

been synchronised. This leads to an impairment of the front-line system... and some women having to go into B&B accommodation." (CMS report).

The value of co-ordination work, expressed particularly by front-line service providers and their network organisations, was that it helps both with identifying a common vision and that parties involved were "... *aware of when, where and how to involve the most appropriate other organisations on a case-by-case basis.*" (CMS report). For many, a pre-requisite to providing good services locally for victims is effective co-ordination and linkages among organisations. In particular respondents emphasised that strong linkages among organisations should establish a continuum among what are currently largely disparate service providers. This is an essential step if the system is to meet the wide range of needs with which victims present.

In addition to this, respondents repeatedly referred to the value of awareness raising, information sharing and updating on developments as some of the purposes for their inter-organisational work. While most respondents were of the opinion that this was worthwhile, they indicated that the extent of this work needed to be developed.

In some regions, co-ordinated working also facilitated organisations to expand the capacity of local service provision as they worked together to develop and hold outreach clinics in different parts of what was a large geographic area. The extent of this however was very low.

Respondents indicated that co-ordination occurs more easily among organisations that are horizontally connected, that is, organisations that operate at the same levels - local, regional or national.

5.6.3 Intra-regional and inter-regional co-ordination

Reports of the success of **intra-regional organisational** co-ordination activity were mixed. On the one hand respondents said that organisations operating in the same locality can develop good working relationships. It seems this may occur more effectively in areas that are small enough to allow regular contact:

"The geographical area is small enough for them to have good co-ordination and co-operation..." (CMS report).

Where effective, localised activity sees organisations meeting on a regular basis, including both formal and informal methods, respondents said that formal protocols were rarely developed¹¹⁵.

It appears that **inter-regional** co-ordination has, in the main, been a difficult step for organisations to develop.

¹¹⁵ The only exception to this related to co-ordination work with hospitals.

"There is an issue regarding the provision of services between the HSE areas. Referring clients within an HSE area tends to be the default, but referral across to an adjacent HSE area might sometimes be more in the client's interests..." (CMS report).

By way of explanation, some pointed to an enduring legacy from different approaches to working together that had prevailed under the former health board system. Others suggested this may have come about due to pre-occupations with local concerns and what was very frequently referred to as organisations in areas engaging in *"empire building."* (CMS report).

"Every county wanted their own refuge and transitional housing without doing a needs assessment or sharing provision across counties. There was an unwillingness to share provision or to link into existing services." (CMS report).

5.6.4 Horizontal co-ordination

The idea of horizontal co-ordination was also discussed by respondents in terms of co-ordination among organisations operating in the same institutional context or environment. Responses suggest that co-ordination among State organisations in relation to domestic and sexual violence has been slow in developing. When describing the nature and extent of co-ordination activity, State interviewees referred to representation at the National Steering Committee on Violence Against Women.

State interviewees also referred to difficulties they were experiencing working with other State organisations on domestic and sexual violence issues. However it was reported that co-ordination among those located in the same sector (e.g. among those located in the criminal justice system) tends to be more successful. Greater difficulties in co-ordination arise for organisations that are located in different sectors, for example, efforts to co-ordinate activities as between the criminal justice and health sectors.

5.6.5 Vertical co-ordination

Many respondents indicated that vertical co-ordination, i.e. between local, regional and national levels, tends to be more problematic for organisations generally. When describing these connections, respondents indicated that they often involved weaker and/or more formal relationships, for example involving (and largely confined to) governance/fund management. When speaking about this one respondent said...

"Co-ordination was ... strongest on the ground. Vertical co-ordination between front-line agencies and the higher echelons, reaching up to

the NSC were ... poorer and the Forum¹¹⁶ came under particular criticism as being ineffective."
(CMS report)

"There was also a lack of communication coming down from the NSC to RPCs and a sense that policy makers and leaders were too remote from what was going on on the ground." (CMS report).

In terms of similarity in background or discipline, respondents generally indicated that, on the whole, non-governmental organisations tend to work well together. However, some respondents also said that this can be patchy with some organisations being more dynamic than others in building connections with others. Where there are issues of competition for funding, there can be a struggle among these types of organisations for status and profile in the sector. Some organisations use the media for this purpose more than others.

Some respondents reported that these issues continue to pose problems for the work of some RACs. Others however said they felt that this has become less of an issue in recent times.

"... [X service provider] needed to establish their territory - both geographic and in terms of their service. They needed to build and hold onto a client base. In their early days, such groups were often in competition with each other for territory, clients and funding. When they came together in the early days of the RPCs, this dynamic came with them. At the same time, funding from the HSE was part of the RPC agenda and, as a result, most RPCs suffered in the first few years from dispute and competition for RPC favour and funding. This was not a climate that promoted cooperation and collaboration. It promoted competition instead."
(CMS report).

The lowest levels of co-ordination were perceived to be between the State and non-governmental organisations. Some typical responses provided on this issues are indicated by the following quotations.

"Statutory organisations in the area tend to want autonomy and are not naturally co-operative or co-ordinating. They could share more than they do."

"State and NGO co-ordination can be ad hoc. For example, [in the case of] co-ordination between [State organisation X] and [NGO Y] there is very little best practice. All of it is done on an ad hoc basis."

¹¹⁶ Forum of Regional Planning Committees Chairs and HSE Designated Officers on Violence Against Women, which used to meet twice yearly to discuss matters of common interest in relation to service provision and inter-agency work.

Some respondents referred to a 'them and us' mentality between the sectors. They said that the issue of violence against women has not been a priority for the State and they were concerned that interagency work in this area may not therefore be a realistic aim.

In summary, co-ordination activity may develop more easily among organisations that are similarly located in their respective environments. This means that organisations working in the same localities/regions, the same disciplines or systems or in the same sector were more likely to work together in a co-ordinated way. However, this was not exclusively the case. There was also reference made to slow progress in developing a co-ordinated approach among State organisations in the sector. Similarly, reports on co-ordination among organisations in the NGO sector were mixed. Many State respondents referred to their representation on the National Steering Committee but their involvement in the Committee and the associated work, was rarely referred to in terms of work that facilitated co-ordination with others.

In terms of the problems with developing greater co-ordination with organisations, the results of an analysis of the obstacles encountered by organisations in their work in the sector are discussed in more detail in the following section.

5.7 Building and strengthening co-ordination: challenges and responses

The previous section sketched the situation with regard to the types of co-ordination activity that are occurring in Ireland and the different forms this work can take. The section also outlined what respondents said about the less successful attempts at co-ordinating with other organisations. Given that Cosc's remit is to facilitate the co-ordination of service provision, it is both relevant and necessary to outline what respondents consider the underlying problems to be. This information is particularly useful for the purpose of formulating an approach to supporting and strengthening co-ordination work in the domestic and sexual violence sector.

Almost without exception, all respondents perceive co-ordination as a difficult and complicated undertaking. While they all said co-ordination work is much needed in the sector, for example, to avoid duplication and to streamline service provision, the most common view of co-ordination is that it is a complex process.

"Coordination is a very good idea, but it is difficult in practice. Many organisations such as the Gardaí have strong rules. If they have strong commitment, they will be developing their own protocols. I am not sure all agencies are adequately resourced... When the solution involves engaging with other organisations, it is very difficult."
(State Interviews)

The overwhelming majority of respondents in this study indicated that building or strengthening inter-organisational co-ordination is realistically possible only if the organisations involved are suitably committed or motivated to deal with the problem at hand. Where the focus of commitment differs across organisations, communication between the organisations can vary depending on the individuals involved and the relationships they develop. As individuals move on, for example to other positions, sustaining working relationships becomes problematic. In this regard, respondents pointed out that not all collaborating parties are equally committed to the process or have an equal interest in the outcomes of the process. For example, one respondent said the following.

"We assumed initially we would be equal partners because it was about areas that we are both involved in. But last year's referrals didn't work out... We did a lot of work to build relationships with [Organisation X]. ... We thought we had a commitment from them. ... It didn't work very well. They didn't become a partner in the process. [Organisation X] doesn't see the importance of our work and that was part of the problem". (State interviews). ."

These types of problems, unequal motivation or commitment among parties involved, were clearly more prominent where organisations involved in collaboration had evolved in different contexts; for example, were from different regions with different perspectives, disciplines or sectors or even very different ideological positions.

"We have a different focus. They have a different way of doing things. We feel this is not helpful. You can't have a discussion or tease out the issues. ... You can't communicate well. Because of that the possibilities are more confined. They see our remit as being very different."

It was felt generally among all respondents that if the joint purpose is not established and clear, face-to-face discussion and dialogue cannot meaningfully begin. Establishing clarity of purpose requires the mutual acknowledgement of the issues that join organisations, and building commitment to address these issues through face-to-face negotiations.

"We are responsible for [X] and they are responsible for [Y]. But do you think we can get together and agree a strategy? No. ... We have different ideas about outcomes in mind. People will say 'we don't really see it as our responsibility.' It is not urgent enough for them. That is silo thinking."

In terms of solving problems, respondents' accounts of positive co-ordination suggest the need to establish a clear common definition of the problem or purpose and to do this from the outset.

"People are often speaking a different language. This needs to be worked on at the beginning. A lot of work is needed for interagency

working. Clarity around purpose of working together is essential.”
(State interviews).

5.7.1 Network organisations

Some respondents highlighted the importance of the network organisations in clarifying these issues for members. On the one hand, the fact that a network is led at board level by member organisations (ideally elected annually) helps to develop the board capacity to go beyond traditional paradigms, and demarcations. It was said that these types of organisations foster members to think in terms of developing a common purpose, collective goals and objectives. In addition, an outcome evaluation study undertaken by one network organisation was mentioned as a project that would clarify for members the difference good external relations could make to their ongoing work to increase the safety and well-being of victims of domestic and sexual violence.

Another example mentioned by network organisations of a project which involved strong interdependencies for participant organisations was the HSE pay review. In this project the two network organisations were in a position to work together to co-ordinate securing standardised pay and conditions for staff working in network member organisations. This undertaking not only required high levels of co-ordination among the networks and their member organisations but also between the networks and the HSE.

5.7.2 Maintaining co-ordination in the future

Additionally a respondent said that significant improvements could be expected across all regions and levels in the future given the expertise in organisational structure and thinking at different levels shown by some RAC Chairpersons.

Apart from establishing work between organisations, another important aspect is the need to maintain this co-ordination work. Respondents underlined the importance of meeting together on a frequent basis. A network organisation underlined the value of organising meetings, seminars and workshops on a regular basis to provide an opportunity for member organisations to meet and discuss. Apart from regular contact points, many respondents emphasised the importance of organisations signalling on an ongoing basis a credible commitment to co-ordination work with other organisations. For example, respondents indicated that while organisations may undertake the formal steps, e.g. sending a representative to a meeting, it was felt that this must be followed-up by ongoing signals of support and interest from the organisation's executive. The following quote outlines many of the ideas that were considered relevant for this purpose.

"To agree the outcome, to proceed without baggage and be reasonably creative in a solution, concede some territory, change your own procedures and be willing to take on a bit of extra work. ... [Referring to successful development of a cross governmental strategy in another

area] ...That was undoubtedly a government priority. It had the unfailing support of the political system, that people turned up to the meetings, gave authority to call people to meetings. So it was a high government priority. The needs of the administrative and political systems were all at one. That was what made it work".
(State interviews).

Similarly, a respondent said of co-ordination among State organisations:

"Some RPC representatives from statutory agencies are mandated to attend; they have little personal commitment and often send substitutes. Individual officers should have specific responsibility to represent their organisation"
(CMS report).

Respondents felt that there must be consistency between what the organisation says in terms of its interest in the purpose of co-ordination and what it actually does.

In discussing how to overcome these challenges the networks emphasised the value of cross-organisational projects in helping to solidify organisations' commitment to working with others in the sector. For example some mentioned a project undertaken by the RCNI to implement common standards across organisations. These standards specify building linkages and external relationships as part of an organisation's responsibility and these standards can be adopted in future funding agreements. Another strength of this type of project was the extent of service providers' participation in the conceptualisation stages of the project. This early involvement facilitated the member organisations confidence in and identification with the purpose and outcomes of the work. The recognition by all parties involved that their desired outcomes were inextricably linked to the commitment of others was described as an important basis for maintaining the willingness to work towards greater co-ordination in this project. Noteworthy is that network organisations said that this effect extended to developing stronger linkages between the network organisations and the HSE.

Additionally, a respondent underlined the value of organisations modelling constructive partnership. This entails each organisation pro-actively building opportunities to work together, making a commitment to make a positive contribution to cross-organisational relationships, in particular by committing resources to developing opportunities for interagency work.

5.8 Summary

The chapter presented the analyses of interviews with State and non-State representatives of organisations that operate in the domestic and sexual violence sector. The aim was to explore to what extent co-ordination with other organisations on domestic and sexual violence has developed in Ireland and the experiences which organisations have in these undertakings. The analyses also aimed to examine to what extent respondents identified factors

that facilitate or impede the development of their collaboration with other organisations in the sector.

All indications are that co-ordination on the issues of domestic and sexual violence are at an early stage in Ireland. Activity is mainly nascent, limited to informal discussions and has been highly dependent on the relationships between individual personalities and the levels of interest shown by representatives from participating organisations. All respondents indicated some dissatisfaction with co-ordination work and attributed the problems involved largely to the unwillingness or lack of organisation of the other co-ordinating parties.

Growing co-ordination is a dynamic and often complex process. In Ireland co-ordination among organisations dealing with domestic and sexual violence has developed more easily among those similarly located in their respective environments. This has meant that organisations in the same sector (e.g. the justice sector or health sector), in the same localities or regions, or in the same area (e.g. within the State) were more likely to work together towards greater co-ordination of their activities.

This was not exclusively the case however. Progress in co-ordination was also found to be slow among State organisations and among organisations in the NGO sector it was found to be mixed. Few State respondents referred to their representation on the National Steering Committee as a facilitator of co-ordination.

Research indicates that defining a common purpose can be more easily achieved where the organisations feel working with others helps to realise their own goals. There are many possible advantages to be gained from pursuing co-ordination with another organisation.

Respondents identified many issues which have not been addressed satisfactorily by those operating in the sector. The majority of these issues pertain to the connection (or lack of) between services providers. For example, the lack of policy development by some organisations and problems with consistent policy implementation by others were frequently mentioned. In particular for organisations not dedicated to domestic and sexual violence (such as An Garda Síochána, the Courts Service or the HSE), it was frequently reported that priorities in relation to such violence are not clear and their commitment can be unclear for other organisations.

The literature is clear that a fundamental requirement of an effective system of service provision is that services (interventions, practices, activities) be internally coherent and connect in a positive or valuable way for the victim (i.e. to take account of compensation and flanking interactions among practices). While all respondents supported the principle of co-ordination generally, there were mixed views on the significance of co-ordinating on domestic and sexual violence for their own organisation's needs. Moreover, there was no clear perspective on how co-ordination could translate into more effective outcomes for the service user.

Among the obstacles to co-ordination in the domestic and sexual violence sector, can be a history of some difficulties with working relationships and where low levels of cooperation have existed between organisations. In this regard, the competition among organisations to secure funding and to establish status and service reach in their respective environments were frequently mentioned.

Respondents' views on what helped to overcome these obstacles are in line with the literature. All referred to the need to establish a common vision which all parties can identify with and develop a clear role. The study finds that not all organisations in the sector have the same focus on domestic and/or sexual violence. Some had developed written policies to guide their work in this area. This may have been influenced by a strong indication from respondents of the absence of a shared vision in the sector. In fact, while some emphasised the need for a victim-centred approach to guiding co-ordination, others disagreed strongly with this perspective. The lack of a common perspective among organisations was attributed mainly to the unequal priorities given by organisations to domestic and sexual violence. All respondents underlined the need for solid commitment between parties to inter-organisational work. In line with the main findings in the literature, respondents' suggested key factors that support commitment both at the early stages of co-ordination and as co-ordination activities became more complex.

Respondents felt that it is unlikely that these issues can be tackled without central leadership and an integrating strategy. Many felt that Cosc's role is vital in this. Further support factors identified by respondents included the need to address inequalities in status between participating parties, curb rivalries among organisations, to ensure that arrangements for organisations working together are established and developed on an ongoing basis.

Chapter 6 presents a brief summary of all of the main findings in this report. In doing this, a short discussion of many of these points will be presented.

Chapter Six

Summary and Conclusions

6.1 Introduction

The delivery of domestic and sexual violence services in Ireland takes place through a substantial number of government and non-governmental organisations and agencies. Although many victims (and perpetrators) have received significant services and support from one or more sources in Ireland, there has been no State-wide mechanism to ensure consistency of services provided, the standards of those services, or their results. The consequence for the victims is that they are frequently forced to navigate a range of services and processes that may not be properly linked or co-ordinated.

To secure an up-to-date understanding of how Ireland has been responding to domestic and sexual violence, Cosc (The National Office for the Prevention of Domestic, Sexual and Gender-based Violence) undertook a study of service provision in relation to domestic and sexual violence in Ireland. The most immediate purpose for the study would be to inform the development and implementation phases of the *National Strategy on Domestic, Sexual and Gender-based Violence 2010-2014*.

6.2 Research background, objectives and questions

In order to compile recent and complete data on service provision, Cosc developed and implemented a research study. The study was conducted in two phases, reflecting two key study objectives. **The first objective** is as follows.

To examine the range of service provision in Ireland.

Two main aims are associated with this objective.

- (a) ***To describe the range of services offered by dedicated frontline domestic and sexual violence service providers by region.***
- (b) ***Where comparisons are possible¹¹⁷, to describe how service availability has developed over time (since 2000).***

Recognising the need for a more integrated response to improve the service provision, the **second research objective** for this study is as follows.

To explore the development of co-ordination among organisations that operate in the domestic and sexual violence sector in Ireland.

¹¹⁷ This study has used pre-existing data (see methodology section for details). It should be noted that these data have been collected for broadly similar purposes and where divergence occurs, the scope of this study has been affected. A limited amount of primary data collection was undertaken and the purpose of this is outlined below.

The second phase of this study examined State and non-State work in this area. The two main aims which guide this part of the study are the following.

- (a) *To explore the nature and extent of co-ordination among service providers in Ireland (encompassing State and non-State organisations in the sector).***
- (b) *To enquire whether there have been specific factors that have influenced the success/failure of co-ordination among service providers operating in the domestic and sexual violence sectors.***

6.3 The range of dedicated domestic and sexual violence services in Ireland

Survey data on domestic and sexual violence service provision to women, men and children in Ireland were used for this component of the study. The sources of data were SAFE Ireland (a survey in 2008 of 38 domestic violence services working with women and children and which, at the time of data collection were members of the SAFE Ireland network). Another source of data was Rape Crisis Network Ireland (RCNI) (a survey of 14 Rape Crisis Centres providing services to women and men around Ireland who have experienced sexual violence). The third source of survey data came from a data collection undertaken by Cosc of 9 (dedicated) frontline service providers that are not included in either the SAFE Ireland or the RCNI data sets.

The following provides a summary of the range of domestic and sexual violence services current available in Ireland.

6.3.1 Range of domestic violence service provision in Ireland

There is a wide range of domestic violence services available in Ireland and since 2000 the numbers of dedicated service providers offering these services has increased. As a consequence of this, the level of service density has also increased with the effect that activity levels in the domestic violence sector satisfy most of the guidelines set out by the Council of Europe (Kelly and Dubois, 2008). In 2007 there were no refuge facilities located in 10 counties in Ireland. It should be noted however that the concept 'service density' does not take account of other aspects of service provision such as service capacity (e.g. the size of the centres involved or the number of facilities available in the centres) or how effectively services operate. Evidently, the concept does not encompass an indication of how centres may have developed and changed in these respects over time.

In terms of exploring further the reach of services, no information was available on domestic (or sexual) violence services from the point of view of the extent to which service providers have developed their operations over the last decade.

It should be noted that one organisation in Ireland provides support services dedicated to the needs of men. International organisations identify guidelines

and principles for service provision and these enunciate basic beliefs about the optimal nature of the system of response to domestic and sexual violence (Kelly and Dubois, 2008). These principles represent a certain philosophy about services for victims of domestic and sexual violence which is informed by a definition of these problems in gender-based terms. There is therefore no equivalent framework to guide an understanding of the services and standards that are appropriate for men who experience domestic violence.

6.3.1.1 Dedicated Service Providers

a. Domestic violence support services

Domestic violence support services are provided by a variety of service providers. Some provide accommodation (see refuges below). In total 49 domestic violence support services are available to those who have experienced domestic violence in Ireland. This translates into 1 domestic violence service for every 36,259¹¹⁸ women in Ireland. This represents an increase in service density level since 2000 when 31 domestic violence services were operating (1 service per 48,790 women in 2000).

In 2007, a total of 3,792¹¹⁹ individual women and 871 individual children were recorded as having accessed non-accommodation SAFE Ireland network affiliated organisations. A total of 1,500 cases¹²⁰ were recorded in connection with support service provision to men who were victims of domestic violence. Amen is the only domestic violence service providing support to male victims of domestic violence.

6.3.1.2 Types of services provided

a. Domestic violence helplines

In 2007, 44 of the 49 support services provide a helpline facility and 18 of these operate on a 24/7 basis¹²¹. In 2000, there were 26 helplines available from support services and 10 refuge helplines were operated 24/7.

b. Domestic violence outreach

A total of 37 organisations provide support on an outreach basis (33 SAFE Ireland network affiliated organisations and 4 non-network affiliated organisations).

¹¹⁸ The calculation of this figure excluded Amen - the national service provider for men who have experienced domestic violence.

¹¹⁹ This is the number of individual women who accessed **non-accommodation** support services. This does not, therefore include those women who received support services while in refuges or transitional housing.

¹²⁰ Information on the number of individual men who accessed services provided by non-network affiliated services is not available and so the information provided here relates to the number of "cases" (i.e. times a support service was accessed) with no account take of repeat visits by men to these services.

¹²¹ All of these 18 are refuge facilities.

c. Counselling

In total, 20 organisations provide dedicated counselling services for domestic violence in Ireland. This compares to a total of 18 services providing counselling in 2000.

d. Support for Children

Individual support for children is given by half (19) of the SAFE Ireland network affiliated support services. Access to education/school placements is given by 20 and 15 provide homework and learning supports. Of the 38 network affiliated support services, 20 reported providing childcare facilities.

e. Working with perpetrators

The majority (28) of network affiliated organisations are working with perpetrator programmes in some way. Nine provide partner support.

f. Domestic violence education and training

A total of 26 SAFE Ireland network affiliated organisations and 4 non-network affiliated organisations provide training on request. Furthermore, a total of 30 organisations have developed training packs or programmes (28 network and 2 non-network organisations) on a broad range of domestic violence related issues.

Refuges

There are 19 domestic violence services in Ireland providing crisis/emergency accommodation at refuge facilities in Ireland, comprising 133 units of accommodation. This represents 1 refuge for every 91,603 women. Where there are refuge services available, the highest service density is in the south-eastern sub-region and the lowest is in the southern sub-region. With 4 additional refuges operating in Ireland, refuge service level density has increased since 2000.

Beds

Refuges provide a total of 545 permanent beds around the country and of these, 133 were designated for women and 412 for children. When one considers the ratio of the number of beds designated for women to the number of women in the country, this represents one bed per 13,086 women¹²². In 2007, there were 173 (+46 per cent) more beds than in 2000.

¹²² Kelly and Dubois (2008) in their elaboration of Council of Europe standards refer to the concept of "family space" in refuges where they recommend a minimum standard of "1 family space per 10 000 of the population". However, questions remain as to the exact definition of "family space" and whether or not it is possible to apply this particular standard given that it does not specify the segment of the population involved, (i.e. if the population referred to is the population of women or the population as a whole). This report presents the number of permanent beds available in refuges for women and children who have experienced domestic violence.

In total, the bed/population ratio has changed from one bed to 4,066 women in 2000 to one bed to 3,193 women in 2007.

In terms of admissions, in total 2,262 women and 3,943 children availed of refuges in 2007¹²³.

6.3.2 Range of sexual violence service provision in Ireland

There is a wide range of sexual violence services available in Ireland. There has been no substantial change in the number of service providers offering services since 2000. As a consequence of this, there has not been an improvement in the ratio of sexual violence service providers to population levels (service density). The indications are however that the level of activity in the area of sexual violence satisfies Council of Europe guidelines (Kelly and Dubois, 2008). Nevertheless it is noteworthy that in 2007 there were no sexual violence support services located in 10 counties in Ireland. As there was no data available on the extent or nature of outreach activities for either domestic or sexual violence support services, it was not possible to assess the role that this work could play in extending the reach of service provision.

As mentioned earlier, the Council of Europe guidelines target combating violence against women. While most service providers make services available to men who experience sexual violence, there is no equivalent framework to guide the services and standards that are appropriate for men.

6.3.2.1 Service Providers

a. Sexual violence support services

In 2007, a total of 17 sexual violence support services provide support (including counselling), information and advocacy for both male and female victims of sexual violence in Ireland. This figure comprises 14 Rape Crisis Network Ireland (RCNI) affiliated organisations and 3 non-network affiliated organisations. This represents an increase of 1 support service since 2000 or 1 sexual violence support service for every 102,380 women in Ireland. Despite this additional support service since 2000 there has been a decrease in the level of service density since 2000 when there was 1 sexual violence support service for every 94,530 women in Ireland.

A total of 3,230 individuals received face-to-face support from a sexual violence support service in 2007, 714 of which were men.

Overall the possible range of services provided for victims of sexual violence remains similar to 2000. Each of the 17 support services provided victims of sexual violence with a helpline, general advice and information. These organisations also provide court and other forms of accompaniment/advocacy support and aftercare to victims of sexual violence.

¹²³ These figures include repeat admissions. A comparison with previous years is not possible as data is not available.

b. Sexual Assault Treatment Units (SATUs)

In 2007, there were 4 SATUs across the country. This amounts to 1 SATU for every 435,114 women. There was no SATU in the Western, Mid-Western, North-Eastern and Midlands sub-regions.

6.3.2.2 Types of services

a. Sexual violence service outreach

In 2007, 9 services were involved in providing support on an outreach basis; this includes 7 RCNI affiliated organisations and 2 non-network affiliated organisations involved in this type of activity. In 2000, 11 RCCs reported that they could provide some of their services by way of outreach.

b. Sexual violence service accessibility

Sexual violence support services are provided mostly during normal business hours, however the Dublin RCC offers, in addition, early morning and late evening as well as all day Saturday services.

c. Sexual violence helplines

A 24 hour National helpline is operated from the Dublin RCC and refers to all the local services where appropriate. Other than this, all remaining (16) regionally located sexual violence support services provide free-phone helplines operating at varying times. As was the case in 2000, Dublin RCC and Waterford RCC both continue to operate on a 24/hr basis. In 2007, the DRCC national helpline responded to an estimated 10,000 calls - an increase of 1,850 since 2000. The Sexual Violence Centre, Cork answered 3,953 calls to their helpline in 2007.

d. Sexual violence counselling

As was the case in 2000, all sexual violence support services can provide counselling services for men and women who have experienced sexual violence in Ireland in 2007.

e. Sexual violence accompaniment and advocacy

Accompaniment to Court, An Garda Síochána, hospital or Sexual Abuse Treatment Units (SATUs) for victims of sexual violence is a key support offered by all 17 sexual violence support services in 2007. Thirty-five victims were accompanied to the Garda Síochána in 2007 by 5 RCNI affiliated organisations. In the same year, 7 such organisations accompanied 39 victims during 82 days in court.

The 3 non-network affiliated support services allocated the equivalent of 190 days to accompanying victims of sexual violence to court (161 days for accompaniment to circuit or district courts and 29 days to the Central Criminal Court).

In 2000, 14 of the sexual violence services surveyed reported that they could provide Court accompaniment and, of those that did, they did so free of charge.

Currently, both Dublin Rape Crisis Centre and the Sexual Violence Centre, Cork offer a 24 hour on-call support service to victims of rape or sexual assault who attend their locally-based SATUs in the Rotunda in Dublin and the South Infirmary in Cork respectively. In 2007, 5 sexual violence support services provided SATU accompaniment to a total of 366 victims of sexual violence; this involved 2 RCNI affiliated organisations and 3 non-network affiliated organisations.

f. Sexual violence awareness raising

In total, 4,472 individuals received training from RCNI affiliated organisations (excluding the DRCC) in 2007. The DRCC's Education Department provided 2,392 participant days in 2007.

6.4 Co-ordination among organisations and agencies operating in the domestic and sexual violence sector

A qualitative design was applied to this component of the study and in-depth interviews were undertaken with key representatives of State and Non-State Organisations from the domestic and sexual violence sector. Focus groups were also conducted with two Local Area Networks to explore a range of issues regarding co-ordination at the local level.

6.4.1 Extent of co-ordination

All indications from this study are that co-ordination among organisations in the domestic and sexual violence sector is at an early stage of development in Ireland. Most co-ordination activities involve work on awareness raising and updating. In some regions co-ordinated working had facilitated the expansion of service provision capacity through working with others to develop and hold outreach clinics in different parts of remote areas.

There is little evidence that co-ordination has progressed beyond the early stages. There are no indications of developing an agreed-upon timetable for developing shared protocols and the use of case conferences was rarely mentioned. One of the components of a co-ordinated response would be the development of policies and protocols that reflect a common position on enhancing victims' safety and these are covered in the next section.

This study points to the fact that some of the more basic or simple forms of co-ordination may have been possible among those operating in the domestic

and sexual violence sector. Where increasing complexity arises, however, the challenges involved have not been easily managed.

For example, respondents indicated that co-ordination along **horizontal** lines occurs more easily i.e. with organisations they are familiar with in that they operate in similar environments or at similar levels (e.g. *within* local, regional or national levels). **Vertical** co-ordination on the other hand i.e. *between* local, regional and national levels), has been more problematic to establish and organise.

In addition, respondents indicated that **inter-regional co-ordination** has been a significantly difficult step to take. In line with the findings from the literature, another similar manifestation of the latter issue is overcoming the problem of past legacies - for example, arising from approaches that had originated under the former health board system.

The **lowest levels** of co-ordination were reported between the State and non-governmental organisations with the highest activity occurring between non-governmental organisations. Low levels of co-ordination were also reported among State organisations in this sector.

6.4.2 Factors influencing the success of co-ordination

There is broad consensus that co-ordination work has in the main, been weakly organised among those who have been involved. The issues highlighted in respect of the organisation of this work are summarised below.

a. Demonstrating the success of co-ordination

Research studies find that generally, for parties to take discussions or negotiations seriously and search for an integrative outcome, there must be an understanding that the organisation's interests are better served by collaborating with others. For some organisations, whose main area of responsibility is to address domestic or sexual violence, working with others on these issues can be clearly linked to the organisation's core work. In other organisations a distinction is not made between work relating to victims of domestic or sexual violence and work with any other group of service users. Their focus of responsibility is relatively broader: e.g. tackling all crime, providing a prosecution service, providing a courts service to the general public or addressing the provision of housing for those in need. In these organisations the benefits of co-ordinating with others with a narrower focus can be less apparent.

Perhaps a reflection of this is the fact that this study found no evidence of tangible plans to monitor or evaluate either the functioning or the impact of co-ordination work among organisations. Being able to demonstrate to those participating as well as to other organisations, that co-ordination is making a difference may be an important undertaking. It could demonstrate in objective and systematic terms not only how well co-ordination is being organised, but also track bottle necks or weak spots.

b. Relationships and co-ordination

The collaboration literature contributes important perspectives concerning the relevant qualities of relationships that facilitate co-ordination. For example, these researchers have discussed the degree to which stakeholders communicate, trust one another, view one another as contributing a unique perspective or form of expertise, etc. When interviewed for this study, respondents frequently referred to the importance of these relational issues, particularly the quality of interactions in terms of opportunities to learn what they can expect from potential co-ordinating parties.

Most said that while their own organisation was open and keen to work with others, they said this was frequently hampered by low levels of willingness or interest from potential partners. Most respondents described at least one case where they said the quality of the relationship with an organisation was particularly problematic for progressing co-ordination. These were accounts where negative interaction patterns had set in. Respondents described problems where organisations: diffused responsibility delegated to inappropriate others, withheld information, refused to co-operate in activities such as assessments, prematurely terminated arrangements or reneged on agreements.

Clearly high levels of co-ordination have not yet developed across the sector. It should be borne in mind however that until recently there has been no deliberate or formal management or oversight of these efforts. Co-operation among organisations has in the main been an emergent phenomenon in Ireland. Furthermore the clarity of the precise roles for State and non-State organisations and the relationship between them, in tackling domestic and sexual violence, has also been an underdeveloped issue. Most respondents in these situations referred to the importance of a central co-ordinating body such as Cosc to diffuse these problems.

c. The value of commitment, participation and inclusion

In line with the literature, respondents said that certain factors helped to prevent or overcome the types of relational difficulties described above. Most referred to the need to ensure that liaison persons allocated to co-ordination work are committed and of adequate status in the organisation to be in a position to develop a working relationship and build communication and understandings. Regular attendance at meetings was said to be an important issue for establishing continuity and momentum in discussions.

The status of the liaison person and the authority allocated to them was cited by most respondents as vital for feeding back to the organisation. They found that the involvement of those with power to take decisions greatly supported the development and implementation of co-ordination agreements.

Another issue raised in many interviews was the effect which a particular liaison person could have on the general morale of the group involved in co-ordination. There was frequent reference to the fact that some organisations'

liaison persons are more interested in domestic and sexual violence issues than others. Where interest is high, it seems this helped to allay any concerns there may have been with earlier liaisons regarding the commitment of the organisation involved. However, given that co-ordination in the sector is at an early stage, it is still unclear how robust this would be where more complex types of co-ordination activities were involved.

d. Building leadership for successful co-ordination

The literature is clear that co-ordination can involve change across multiple organisations and across multiple levels within the organisation. This change must be co-ordinated and planned with a commitment from key leaders in co-ordinating partners. As discussed above, it can involve a negotiation of philosophical differences among stakeholders from different systems who bring different goals, principles and values to the table (O'Connor, 2007). It was clear from respondents in this study that commitment from government to domestic and sexual violence was very welcome. Establishing Cosc was considered to be a key signal or reflection of this commitment. Given the history in the sector, respondents said it would be critical for a co-ordinating body such as Cosc to provide strong leadership to move beyond problematic issues that had dominated inter-organisational relationships. They also mentioned a role for Cosc with respect to increasing the profile of domestic and sexual violence issues, brokering difficulties and tackling ingrained positions that have emerged (see 'Activities to support planning' - Section f below - for further relevant points on this issue).

e. Establishing clear roles and inputs

Where competition for funding prevails, the possibilities for co-ordination are very often overwhelmed by the need to retain or develop a client base and position in the sector. Referring to the example of NGOs, some respondents said that co-ordination among NGOs can be difficult as there can be a struggle among these same organisations for status and profile in the sector. Respondents said that organisations may choose to compete in one situation and co-operate in another. But where the competitive stance prevails, the possibilities for co-ordination may become secondary.

The avoidance of service duplication is essential into the future. In order to provide a clear rationale for organisations working together, there will need to be a continuation of the clarification of the necessary components of the support system and the chain of interventions that are needed to deliver the system. Furthermore, care should be taken to ensure that, where organisations have substantial power, co-operative and not competitive strategies, are selected (Mulford and Rogers, 1982).

f. Activities to support planning

Some respondents emphasised the value of network organisations to disseminate practice and to organise. A network organisation, led at board level by member organisations (ideally elected annually) helps to develop the

capacity to go beyond traditional paradigms, demarcations and barriers as well as to think in terms of developing a common purpose, collective goals and objectives. The value of the network was also described in terms of setting up and overseeing joint projects such as standardising data collection procedures, evaluation studies and the promotion of quality standards. Reference was also made to the fact that a network organisation can support co-ordination through organising meetings, seminars and workshops to provide opportunities for member organisations to meet and discuss.

A respondent said that significant improvements were expected across all regions and levels with the appointment of independent and expert RAC Chairpersons. This respondent felt that the expertise in organisational structure and in thinking at different levels associated with these Chairpersons would be very valuable.

6.5 System effectiveness and complementary practices

The system of domestic and sexual violence service provision is composed of a wide range of service providers that operate in different sectors: the needs of those who have suffered domestic and sexual violence are served by a system composed of many State and non-governmental organisations. The effectiveness of this system depends on many factors, but from the perspective of the service user (e.g. the victim of domestic and sexual violence) the extent to which the components of the system are co-ordinated is crucial. At high levels of co-ordination, inter-organisational activity is frequent and with wide scope (e.g. reaching further within and also extending across different sectors). It is characterised by effective management and aims to build on existing inter-dependencies. The outcome for the victim is the delivery of services that are well-aligned with her/his needs. The outcome for the service provider is the roll-out of complementary services and finally, for the system, the outcome is the creation of complementarities. At low levels of co-ordination, inter-organisational activity is limited and confined to within a sector (e.g. within the non-State sector) and the outcomes may be low level activity with limited potential for joint or common approaches to the delivery of goals.

Throughout the interviews, respondents consistently emphasised that most co-ordination activity in the domestic and sexual violence sector is relatively confined; it exists mainly between 'like minded' organisations and the management of work with 'other' types of organisations has not realised effective outcomes, e.g. organisations from a different sector, a different region or policy area. The scope of this work has been to update, network and to solve local problems or unique cases. Reference was rarely made to domestic and sexual violence as areas in which service providers are mutually dependent on one another. Respondents indicated that the victims experience is that certain needs may be met but not others. Moreover, while many service providers work with the same clients, this happens without any account being taken of the extent to which approaches or interventions are complementary.

6.6 Future co-ordination research

Learning to work together collaboratively will be an important component of establishing a co-ordinated system of response to domestic and sexual violence. This is rarely easy as it will require cross-cutting the remits of a very wide range of State organisations and their agencies. However the success of the implementation of the *National Strategy on Domestic, Sexual and Gender-based Violence 2010-2014* will depend on co-ordination resulting in an improvement in the quality of services to those affected by domestic and sexual violence.

a. *The role of stakeholder relationships in co-ordination outcomes:* One of the issues that was most emphasised by those interviewed for this study was the importance they placed on co-operative relationships among stakeholders in the development of potential for co-ordination. This is an issue that is frequently referred to in the literature but despite this, we know little about the role played by stakeholder relationships in the effectiveness of co-ordination. As a result, we know very little about the types of relationships that matter, the extent to which they matter relative to other factors, and the outcomes for which they matter most.

b. *Tracking co-ordination outcomes:* System wide evaluations are necessary to understand the impact of different components of a co-ordinated response, and the effectiveness of the overall response. Evaluating the overall response can be difficult because of the many agencies involved, inconsistency in the system's response and a variety of methodological problems. However a variety of sources of data may be used to measure the effectiveness of the overall response: criminal justice statistics; interviews with victims; observations of the intervention provided; interviews with practitioners; and the administration of standardised tests.

While evidence for the success of individual components of a coordinated response have been modest, there is evidence that combining complementary approaches reduces future incidents of violence. Process evaluation can assist in determining what combinations make for an effective response. However organisations will need to develop information systems that enable them to monitor and evaluate co-ordinated responses to domestic and sexual violence.

6.7 Study limitations

a. *Data*

The data sets informing this study have many points of comparison thereby allowing many of the issues to be examined using all three data sets. However, the three data sets also reflect the fact that the three studies involved differ in terms of purpose and the contexts in which they have been undertaken. Consequently, the issues which they cover and the way they are covered differ. As a result, it is not always possible to use each of the data sets to examine all issues in this study.

It should be noted that the data do not relate to the current situation with regard to service provision. The SAFE Ireland data related to service provision in 2007, as did RCNI data. Cosc data relates to service provision in 2008.

As Maunsell et al (2000) was the only source of information regarding service provision in this sector, it was necessary to use this data to provide a preliminary picture regarding the changes in the range and standards of NGO services in the domestic and sexual violence sector. Where possible, comparisons with the results reported by Maunsell et al (2000) are made. However, the criteria for inclusion used in 2000 has not been documented therefore it has not been possible to access these details for the purpose of replicating the approach used in this earlier work.

b. Coverage of service provision for the population of victims of domestic and sexual violence

Largely due to the underdeveloped levels of dedicated frontline services that provide for domestic and sexual violence against men and the reliance on secondary data, the main focus of this study has been service provision for women. While some of these services (e.g. Amen; One-in-Four; RCCs and SATUs) do provide services to men who have experienced domestic and/or sexual violence, because neither the standards for support services developed by the Council of Europe nor Maunsell take account of service availability for men, this study has not calculated service density for men. Once appropriate standards of service to combat domestic and sexual violence against men have been developed, future research should focus on examining service provision and co-ordination for men.

It should also be noted that by applying the concept 'service density' in this study, no account is taken of other aspects of service provision such as service capacity (e.g. the size of the centres involved, the number of facilities available in the centres) or how effectively services operate. Evidently, the concept does not encompass an indication of how centres may have developed and changed in these respects over time.

6.8 Final comment

To inform the development and implementation of the National Strategy on Domestic, Sexual and Gender-based Violence 2010-2014 an overview of service provision for the victims of these forms of violence was needed. Cosc designed and implemented a research study the focus of which was to describe the availability and accessibility of services to victims. Another key area of concern, particularly for the effectiveness and quality of service provision, was whether the system of service response was one that was co-ordinated and well-integrated. Within the limits of the data available, this information has been presented in this report.

The study and this report cover both State and non-State components of the system of service provision. According to Council of Europe standards on service availability and accessibility, the situation in Ireland would appear to have developed well. It should be noted however that there are many open questions regarding these standards, in particular how definitions are interpreted, and more work is needed to clarify key methodological issues. One of these involves the need to elaborate on standards on service integration. There appears to be a need to reflect on the importance and value of co-ordination to each organisation and for those affected by sexual and domestic violence. Such reflection and understanding would assist in the effective implementation of the National Strategy and the achievement of the key aims to ensure the delivery of an effective system of prevention and response to domestic, sexual and gender-based violence in Ireland. This study shows that co-ordination and the integration of domestic and sexual violence services in Ireland are in the early stages of development. This may reflect the lack of formal oversight prior to Cosc and the National Strategy and if so, the implementation of the National Strategy should see developments in service integration. In this regard the information in this report is valuable baseline information in order to track and monitor the impact on service integration in the future.

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APPENDIX 1:

Service Density Ratios (per County) of Domestic and Sexual Violence Services Available in Ireland

COUNTY	Population of Women Census 2006	Population Growth	Population of Women Estimates 2007	Service Density of Refuges - i.e. 1 refuge for every # women	Service Density of Beds for Women - i.e. 1 refuge bed for every # women	Service Density of All Domestic Violence Services - i.e. 1 domestic violence service for every # women	Service Density of Sexual Violence Services (excl. SATUs) - i.e. 1 sexual violence service for every # women
Carlow	19586	1.023567	20048	None	None	20048	20048
Cavan	24141	1.023567	24710	None	None	None	None
Clare	43049	1.023567	44064	44064	7344	44064	None
Cork	193039	1.023567	197588	197588	28227	39518	197588
Donegal	57050	1.023567	58394	58394	29197	19465	58394
Dublin	498832	1.023567	510588	170196	19638	46417	255294
Galway	92840	1.023567	95028	95028	15838	47514	95028
Kerry	55789	1.023567	57104	57104	9517	28552	57104
Kildare	71222	1.023567	72900	None	None	72900	None
Kilkenny	34083	1.023567	34886	34886	5814	34886	34886
Laois	25218	1.023567	25812	None	None	25812	None
Leitrim	11199	1.023567	11463	None	None	None	None
Limerick	73826	1.023567	75566	75566	5398	37783	75566
Longford	13187	1.023567	13498	None	None	13498	None
Louth	43883	1.023567	44917	22458	2642	22458	44917
Mayo	48711	1.023567	49859	49859	9972	24929	49859
Meath	61735	1.023567	63190	63190	12638	63190	None
Monaghan	21711	1.023567	22223	None	None	22223	None
Offaly	27114	1.023567	27753	None	None	27753	27753
Roscommon	22701	1.023567	23236	None	None	11618	None
Sligo	24896	1.023567	25483	None	None	25483	25483
Tipperary	58012	1.023567	59379	59379	7422	29689	59379
Waterford	43114	1.023567	44130	44130	3677	44130	44130
Westmeath	30893	1.023567	31621	31621	7905	15810	31621
Wexford	51338	1.023567	52548	52548	13137	52548	52548
Wicklow	50103	1.023567	51284	51284	10257	51284	None

List of Tables

Table 1a:	Female Population – 15 years and over in 2007 (<i>estimates based on extrapolations from CSO Census 1996, 2002 and 2006</i>).	30
Table 1b:	Change in Female Population - 15 years+ 2000 to 2007 (<i>estimates based on extrapolations from CSO Census 1996, 2002 and 2006</i>)	30
Table 1c:	Regional and Sub-regional Breakdown i.e. What Counties in What Regions	30
Table 2a:	Domestic Violence Support Services Density Levels (2007)	42
Table 2b:	Domestic Violence Support Services Density Levels (2000)	43
Table 3:	Non-accommodation Domestic Violence Support Service Providers in Ireland (2007)	43
Table 4:	Components of a Support and Advocacy Service by Domestic Violence Support Services in 2007	44
Table 5:	List of Refuge Facilities in Ireland in 2007	48
Table 6a:	Support Services with Refuge Facility, Service Density Levels (2007)	50
Table 6b:	Support Services with Refuge Facility, Service Density Levels (2000)	50
Table 7:	Types of Refuge Accommodation Provided in 2007	51
Table 8:	Number of Bedrooms/Houses/Apartments Available in Transitional Housing/Accommodation in 2007	51
Table 9:	Transitional Housing Service Level Activity 2007	52
Table 10:	Number of Permanent Beds Available in Refuges in 2007	53
Table 11a:	Number of Permanent Beds Available in Refuges in 2000	54
Table 11b:	Number of Beds Available in Refuges and Changes in 2000 to 2007	54
Table 12:	Refuge Service Activity Levels 2007	55
Table 13:	Domestic Violence Dedicated Support Services Activity Levels	56

Table 14:	Sexual Violence Support Services in Ireland (2007)	58
Table 15:	Sexual Violence Support Services Density Levels (2007)	58
Table 16:	Sexual Violence Support Services Density Levels (2000)	59
Table 17:	Specific Groups provided for by RCNI Affiliated Organisations (2007)	65
Table 18:	Sexual Assault Treatment Units in 2007	67
Table 19:	Application of Council of Europe Standards to Irish Context	69

List of Figures

Figure 1:	Co-ordinating activity for improved service provision to victims of domestic and sexual violence	17
Figure 2:	Whether or not the abuser was known or was a stranger to women who have experienced sexual violence	18
Figure 3:	Whether or not the abuser was known or was a stranger to men who have experienced sexual violence	19
Figure 4:	Whether anyone was told about partner's behaviour or help sought	21
Figure 5:	What did the person do about the abusive or violent behaviour	22
Figure 6:	Likelihood of respondents to intervene if a friend, neighbour or stranger became a victim of domestic abuse	23
Figure 7:	% of cases of domestic violence service provision to women during 2007 (<i>Source: SAFE Ireland</i>)	56
Figure 8:	Co-ordinating activity for improved service provision to victims of domestic and sexual violence	79

List of Maps

MAP 1:	Counties in Ireland in which Domestic Violence Support Services (including refuges) were located in 2007 and indications of service density per county	41
MAP 2:	Number of Refuges per county in 2007 and indications of service density	49
MAP 3:	Number of beds designated for women available in refuges in 2007 and indications of service density per county	53
MAP 4:	Counties in Ireland in which Sexual Violence Support Services were located in 2007 and indications of service density per county	59
MAP 5:	Counties in Ireland in which SATUs were located in 2007	66

Acronyms

CATI	Computer Aided Telephone Interviewing
CSO	Central Statistics Office
DEHLG	Department of the Environment, Heritage and Local Government
DPP	Director of Public Prosecutions
DRCC	Dublin Rape Crisis Centre
DVSAIU	Domestic Violence and Sexual Assault Investigation Unit
FGM	Female Genital Mutilation
GP	General Practitioner
HSE	Health Service Executive
LAN	Local Area Network
MAG	Multi-Agency Group
NGO	Non-governmental organisation
NSC	National Steering Committee on Violence Against Women
NSDA	National Study of Domestic Abuse
RAC	Regional Advisory Committee on Violence Against Women
RCC	Rape Crisis Centre
RCNI	Rape Crisis Network Ireland
RPC	Regional Planning Committee on Violence Against Women
SATU	Sexual Assault Treatment Unit
SAVI	Sexual Abuse and Violence in Ireland
STI	Sexually Transmitted Infection
VAM	Violence Against Men
VAW	Violence Against Women

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