PRoF Award abstract – Call 2016

<Project acronym and name>

1. Research Outline

Acronym	B-SARC
Project name in English	Sexual Assault Referral Centres in Belgium
Pitch (1 sentence)	Sexual Assault Referral Centres in Belgium will provide victims with patient-centered forensic, medical and psychosocial support enabling them to recover faster and to be better protected from future revictimisation and/or perpetration.
Executive summary (max. 10 lines)	
Sexual violence (SV) is a public health problem affecting many people of all genders and ages in Belgium. International guidelines strongly recommend provision of holistic (forensic, medical and psychosocial) care to victims through sexual assault referral centres (SARCs). Belgium does not yet dispose of SARCs. Yet, given the long record of ICRH & the Women's Clinic of the Ghent University Hospital in enhancing holistic care for victims of SV in Belgium, the Belgian government now appointed us to study the feasibility of SARCs, to develop a model for pilot-testing in Belgium and to outline how national implementation can eventually be done. SARCs will help victims to recover faster and to be better protected from re-exposure.	

2. Cause and context of the research

Sexual Violence (SV) includes sexual harassment, sexual abuse, attempted or completed rape, sexual exploitation, forced prostitution and SV as a weapon of war or torture. In addition to important adverse effects on the victim's well-being and participation in society; SV may induce long lasting sexual, reproductive, physical and mental ill-health [1-4], primarily affecting the victim yet also potentially harmful to the victim's peers, offspring and community [5-7].

Anybody can become a victim. WHO estimated that 25.4% of European women and girls experience SV by their (ex)partner and 5.2% by non-partners [8]. The Flemish Sexpert study found that 10.7% of boys and 22.3% of girls under the age of 18 and 2.4% of men and 13.8% of women were sexually victimised [9]. A study in young adults (18-27 year) in 10 EU countries (a.o. Belgium) showed that 27.1% of the men and 32.2% of the women were sexually victimised since the age of consenting to sex in their country [10]. For Belgium this regarded 10.1% of male and 20.4% of female respondents. In migrants, higher levels of both male (32%) and female (56%) victimization have been found [11,12]. Another vulnerable group are lesbian, gay, bisexual and transgender people [13]. Finally, it has been robustly demonstrated that people who were personally victimized (=direct exposure) or who witnessed violence during childhood, (=indirect exposure), are not only prone to subsequent (re)victimization but also to perpetration [5-7]. In addition, this has been found to be a precursor for serious mental health problems and to maladaptive parental practices which both feed the intergenerational transmission of violence [6,7].

It has been internationally evidenced that the **healthcare sector has a central role** in provision of **holistic and interdisciplinary care** of victims of SV [14-18]. This means that the required forensic examinations need to be maximally aligned with the medical and psychosocial care for the victim. This holistic approach generates the best outcomes on each of these aspects, leads to better quality of care, a faster recovery of the victim and a better prevention to renewed exposure (as a victim or a perpetrator) [14,18-20].

Since several years, it has been put forward that t**his holistic care is best provided through sexual assault centres** (SAC) as it has been evidenced that offering services in one chain or one centre on a 24/24 – 7/7 basis has clear advantages for both patient and care provider [16,18,21].

There are different variants on the SAC-model. The “integrated care provider”-model, applied in US and Canada, foresees that one single “Sexual Assault Nurse Examiner” (SANE) administers all holistic care [19].

The “integrated referral”-model (also in the US) foresees that within a fixed pathway of care provision the victim is referred from one specialised care provider to another. This multidisciplinary team is called “Sexual Assault Response Team (SART)” [20].

The “integrated service”-model provides all aspects of holistic care at one single place. This is the “Sexual Assault Referral Centre (SARC)” or “one-stop”-model, and consists of a multidisciplinary team assisting the victim. In the UK and Ireland, this model is in use since 30 years [21]; in Denmark since 1999 [22] and in the Netherlands since 2012 [23].

Belgium does not yet dispose of SACs, but since the parliament has ratified the Istanbul Convention [24] in December 2015, our country agreed to develop SARCs as stipulated in article 25 of this convention.

3. Innovation results achieved

Since 2004, the International Centre for Reproductive Health (ICRH) and the Women’s’ Clinic of the Ghent University Hospital have been pioneers in the development of a holistic SV protocol through **interdisciplinary collaboration**. Right from the start disciplines of emergency care, gynaecology, urology, pediatrics, forensic medicine, ARC, psychosocial work and psychiatry were involved. In 2012 the pathways were specified for gender and age, in 2016 an update following the most recent international guidelines is ongoing.

Due to this pioneering, we also generated an **indelible impact on the Belgian healthcare system.** Since 2009 and within the frame of the National Action Plan (NAP) on Violence, the Federal Agency of Public Health asked us to provide accredited basic and in-depth trainings and mentoring to Belgian hospital staff on holistic management of victims [25] and to develop a checklist [26] for optimal care for victims of SV to be used in all Belgian hospitals.

In addition, we advocated for a focus on SV in the NAP of 2015-2019. A suggestion that was taken into account. Furthermore, we organized interdisciplinary SV round tables which contributed to the law of July 20th 2015 on HIV-testing of the suspected perpetrator, which provides us with the opportunity to stop the post exposure prophylaxis for the victim at an early phase.

ICRH also conducted a small feasibility study on SARCs in the Province of Eastern Flanders. This study revealed that although hospitals were receiving many victims every year, only three disposed of a SV protocol. Furthermore, care providers underestimated the prevalence of SV and felt not well-trained to assist victims. The utmost majority was pro SARCs. Although nearly all hospitals in this province could administer the medical care, only less than half indicated to be able to provide the necessary forensic and psychosocial care [27].

These results were taken forward to the political level both during a hearing at the Belgian Senate (Jan. 2015) and at the Belgian Chamber of Representatives (Sept. 2015) as well as in contacts with the Cabinets of the concerned Ministers and State Secretaries. This served as input for discussions on the ratification of the Istanbul Convention and on the need to develop SARCs in Belgium.

This now resulted in the funding of a feasibility study (9/2015-10/2016) that aims to identify which model of SARCs is most appropriate and feasible in the Belgian context. This project started in September 2015 with 2 field visits of a multidisciplinary group of experts to a SARC in London (UK) and another in Utrecht (NI). In addition an in-depth review of international guidelines and different SAC models was conducted.

A second phase of the feasibility study regards the mapping of the current procedures in hospitals, by police and justice. We also interview recent victims on their just-lived experiences with those services. We subsequently will plot the current procedures against the international guidelines and good practices and make a SWOT analysis of potential Belgian models, including their cost effectiveness.

Finally, by November 2016 and in collaboration with a vast number of experts from health and psychosocial care, forensics, police, justice, politics and victims, we will have developed a Belgian SARC model that will be tested in a Flemish, Brussels and Walloon hospital in the 2 subsequent years (2017-2018) before a general implementation in Belgium will be done (from 2020 onwards). In the meantime, we also investigate which higher education programme is needed to train future SARC-care providers.

Finally, this whole process continues to generate quite some **societal impact** as we are frequently asked to assist the press and provide lectures for psychosocial victim support, police and care providers. The organisations of victims of SV call it the ideal future of care

and strongly advocate for a national implementation as soon as possible. **The PRoF Award would allow us to integrate a sub-study with less-recent victims on their recommendations to make the model more victim-centered.**

4. Link to the PRoF values

Value 1: Minimal comfort and Value 7: Respect: Currently, in most hospitals victims need to repeat their story to police and each of the care providers they meet. In addition, they have to undergo a series of forensic examinations that are often experienced as re-traumatising and imposed on them. Subsequently, medical examinations and treatment is started. During this phase their body is considered the “crime scene” on which they have nothing to say until evidence is safeguarded. With the patient-centered SARC model, all of this is well-explained, co-decided and taken care of at the same spot. The model further ensures that police complaints can be filed there if the patient wants so, that victims do not have to repeat their experiences several times and that medical and forensic examinations are coordinated and administered on the pace of the victim.

Value 2: Privacy, Value 3: Security and Value 7: Respect : Currently, victims filing a complaint within 72 hours after the victimization, are brought by the police to an emergency ward. If going to the hospital first, victims are either sent to the police or the police is called to come to the hospital. Flanked by 2 policemen in uniform they have to wait their turn in the waiting room. Several victims reported that they felt as if they were criminals. A SARC would provide the opportunity of not having to wait in a general emergency room where people could recognize and stigmatize a victim, but to have a specific entrance to an interdisciplinary service where people are immediately treated with the care they need while safeguarding forensic evidence. If not wanting to file a complaint, victims can receive the same adequate care and a “pseudo-sexual aggression set” can be conducted.

Value 4: Anti-loneliness: many victims emphasize how lonely they feel to live with the sexual victimization linking this mostly to society seeing them as people who must have induced the victimization by their behavior or who should cope and move on with their lives. Yet, many of them drop out of school, stop working, stop seeing their friends, become depressive and eventually commit suicide. Providing the holistic care within the acute phase or later on when victims feel ready for it, has been proven to enhance their coping and resilience as well as reducing the risk of revictimisation or perpetration later on.

Value 5: Non-stigmatising solutions, Value 7: Respect and Value 8: Flexibility: So far, most SARCs have mostly been addressing sexual victimization in women. As ICRH and the Ghent University Hospital have a proven record on researching and providing care to other vulnerable people as LGBTI, migrants, children and adolescents; we are developing an innovative, respectful and flexible model that provides care for all genders and all ages in an equally high-standing qualitative way.

Value 6: Intergenerational: As explained in the background section, people who were directly or indirectly exposed to SV during childhood, are prone to subsequent (re)victimization and/or perpetration. In addition, when not properly addressed, this can lead to serious mental health problems and to maladaptive parental practices which both feed the intergenerational transmission of violence. The holistic care provided at a SARC could thus have a decisive impact on reducing the risk of renewed exposure for the current victims, their offspring and community.

5. Applicable IPR rules

None

6. Information on the partners

As described in detail above, since 2004, ICRH-Ghent University and the Women's Clinic of the Ghent University Hospital are closely collaborating on developing and finetuning SV protocols and taking the optimal holistic care for victims on the political agenda. This resulted so far in checklists, trainings, research projects and PhDs and currently a feasibility study that will give birth to a model of SARC for Belgium.

Addendum: Contact information

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Reference List

1. Tavara L: **Sexual violence.** *Best Pract Res Clin Obstet Gynaecol* 2006.

2. Jina R, Thomas LS: **Health consequences of sexual violence against women.** *Best Pract Res Clin Obstet Gynaecol* 2013, **27:** 15-26.

3. Macmillan R, Hagan J: **Violence in the transition to adulthood: Adolescent victimization, education, and socioeconomic attainment in later life.** *Journal of Research on Adolescence* 2004, **14:** 127-158.

4. Banyard VL, Williams LM, Siegel JA: **Childhood sexual abuse: a gender perspective on context and consequences.** *Child Maltreat* 2004, **9:** 223-238.

5. Risser HJ, Hetzel-Riggin MD, Thomsen CJ, McCanne TR: **PTSD as a mediator of sexual revictimization: The role of reexperiencing, avoidance, and arousal symptoms.** *Journal of Traumatic Stress* 2006, **19:** 687-698.

6. Williams LM: **Understanding child abuse and violence against women - A life course perspective.** *Journal of Interpersonal Violence* 2003, **18:** 441-451.

7. McCloskey LA: **The intergenerational transfer of mother-daughter risk for gender-based abuse.** *Psychodyn Psychiatry* 2013, **41:** 303-328.

8. WHO: *Global and regional estimates of violence against women:prevalence and health effects of partner violence and sexual non-partner violence*. Geneva: WHO; 2013.

9. Buysse A, Enzlin P, Lievens J, T'sjoen G, Van Houtte M, Vermeersc *et al.*: *Sexpert: basisgegevens van de survey naar seksuele gezondheid in Vlaanderen*. Ghent: Academia Press; 2013.

10. Krahe B, Berger A, Vanwesenbeeck I, Bianchi G, Chliaoutakis J, Fernandez-Fuertes AA *et al.*: **Prevalence and correlates of young people's sexual aggression perpetration and victimisation in 10 European countries: a multi-level analysis.** *Cult Health Sex* 2015, **17:** 682-699.

11. Keygnaert I, Vettenburg N, Temmerman M: **Hidden violence is silent rape: sexual and gender-based violence in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands.** *Cult Health Sex* 2012, **14:** 505-520.

12. Keygnaert I, Dias SF, Degomme O, Deville W, Kennedy P, Kovats A *et al.*: **Sexual and gender-based violence in the European asylum and reception sector: a perpetuum mobile?** *Eur J Public Health* 2015, **25:** 90-96.

13. Mitchell KJ, Ybarra ML, Korchmaros JD: **Sexual harassment among adolescents of different sexual orientations and gender identities.** *Child Abuse Negl* 2014, **38:** 280-295.

14. WHO: **Guidelines for medico-legal care for victims of sexual violence.** 2003:1-155.

15. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015. MMWR Recomm Rep 2015;64. 2015.

16. Cybulska B: **Immediate medical care after sexual assault.** *Best Pract Res Clin Obstet Gynaecol* 2013, **27:** 141-149.

17. Jina R, Jewkes R, Munjanja SP, Mariscal JD, Dartnall E, Gebrehiwot Y: **Report of the FIGO Working Group on Sexual Violence/HIV: Guidelines for the management of female survivors of sexual assault.** *Int J Gynaecol Obstet* 2010, **109:** 85-92.

18. Garcia-Moreno C, Hegarty K, d'Oliveira AF, Koziol-McLain J, Colombini M, Feder G: **The health-systems response to violence against women.** *Lancet* 2015, **385:** 1567-1579.

19. Campbell R, Patterson D, Lichty LF: **The effectiveness of sexual assault nurse examiner (SANE) programs: a review of psychological, medical, legal, and community outcomes.** *Trauma Violence Abuse* 2005, **6:** 313-329.

20. Greeson MR, Campbell R: **Sexual assault response teams (SARTs): an empirical review of their effectiveness and challenges to successful implementation.** *Trauma Violence Abuse* 2013, **14:** 83-95.

21. Eogan M, McHugh A, Holohan M: **The role of the sexual assault centre.** *Best Pract Res Clin Obstet Gynaecol* 2013, **27:** 47-58.

22. Bramsen RH, Elklit A, Nielsen LH: **A Danish Model for Treating Victims of Rape and Sexual Assault: The Multidisciplinary Public Approach .** *Journal of Agression, Maltreatment and Trauma* 2009, **18:** 886-905.

23. Bicanic I, Snetselaar H, de JA, Van de Putte E: **Victims' use of professional services in a Dutch sexual assault centre.** *Eur J Psychotraumatol* 2014, **5**.

24. Council of Europe. Convention on Preventing and Combating Violence Against Women and Domestic Violence. 2011.

25. Keygnaert I, Gilles C, Rozenberg S, Roelens K. Eindrapport Verdiepingsopleiding aanpak van intrafamiliaal en seksueel geweld in de Belgische ziekenhuizen. 1-1-2015. Ghent, ICRH Ghent University.

26. Keygnaert I, Gilles C, Roelens K: *Checklist voor de optimale zorg van slachtoffers van seksueel geweld in de Belgische ziekenhuizen*. Gent: ICRH-Universiteit Gent & FOD Volksgezondheid; 2015.

27. Keygnaert I, Roelens K. Haalbaarheid & Wenselijkheid van het model "referentiecentra seksueel geweld" in de Provincie Oost-Vlaanderen: Onderzoeksrapport . 2015. Ghent, ICRH-Ghent University.