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# A MULTIDISCIPLINARY TEAM TO MANAGE REFUGEE AND ASYLUM SEEKER WOMEN

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*SYMBIOSIS*



**Addressing Sexual Violence Against Refugee Women**  
This Project is funded by the Rights,  
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## **Addressing Sexual Violence Against Refugee Women**

Sexual violence against refugee and asylum-seeker women is a dramatic phenomenon across Europe and the Mediterranean countries. Several international agencies and Institutions – like UN, UNHCR, Council of Europe, and European Parliament – have pointed out the urgency to promote specific policy measures addressed to these groups, as sexual related risks make women more vulnerable.

Through training programs and pilot actions, the ASVARW project aimed at raising awareness and building capacity of the professional staff working in the reception of the refugee and asylum seeker women at the local levels, with different roles and competences. It focused on those who have the closest contacts with women and who are trained to deal with sexual gender-based violence.



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## Why a Multidisciplinary Team

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In recent years, some European countries including Italy and United Kingdom, have become important targets for migrant routes of women seeking asylum and victims of violence, who present complex needs. We cannot respond to these needs with interventions that use outdated methods. What is more, we cannot use a one-size-fits-all approach for all the different aspects of the experiences and needs of asylum seekers arriving in Europe (violence, migration, traumas, parenting skills, abilities). If we truly seek to design support interventions with reasonable chances of success, we should attempt to understand the complexity, pool the skills, consider different points of professional views, and place women, their life projects, skills and desires at the centre of our endeavours. It is therefore necessary to construct complex responses, to work in groups and networking, each with their own competence, and with their specific role and mandate. This was the aim of the “Multidisciplinary Team” pilot-action under the project “Addressing Sexual Violence Against Refugee Women”.

## The Context of the Pilot Action

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The pilot action was implemented in Italy and UK. The approach in both countries was different and was based on the specific conditions in the two countries. In Italy, refugee and asylum-seeking

(RAS) women go through a complex system of reception and are mostly hosted in centres and shelters, run by the State or by NGOs on behalf of the State. MondoDonna runs several centres, specifically aimed at women. The Multidisciplinary Team was established to take care of women hosted in those centres.

Unlike the system of reception centres in Italy, refugees and asylum-seekers in the UK are housed and supported in a range of different places, dispersed across the country. For this reason, in the UK, the multi-disciplinary team was piloted in a community setting.

This team was brought together for a meeting to discuss and make an action plan for four cases of RAS women experiencing sexual gender-based violence. Because the professionals in the team were not all working with the same clients in a reception centre setting (and could not therefore carry out specific actions for the woman), the cases discussed were real but not ‘live’.

## The Italian Model

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### PROFESSIONAL ROLES IN THE TEAM

In Italy, this action started with the work done in facilities for asylum seeking women, which are managed by the MondoDonna association. The multidisciplinary team engaged by the MondoDonna association with this pilot action consisted of a working group, which involved key professional figures connected to women seeking asylum and victims of violence, and who were hosted in the facilities run by the association. Our aim was to bring together social workers and professionals - who work independently as a rule - to implement an integrated and multi-dimensional

intervention, one capable of dealing with complex cases of women victims of gender-based violence.

Team roles include:

- Reference contact worker for the woman in the facility,
- Psychologist/psychotherapist of the Antiviolence Centre CHIAMA chiAMA of the MondoDonna association, specialized in transcultural psychology,
- Obstetrician, who is the health contact for MondoDonna's association,
- Legal worker (expert) who manages interviews to gather women's life history, and prepares them for the Commission hearing, which will process their international protection application,
- Anthropologist

The team is not a closed work group but, depending on specific cases and/or problems, members interact with other professionals, who are not usually part of reception centre staff. The model that we seek to implement provides that, depending on the woman's situation, the team can open meetings to further external professionals, including psychiatrists, neuropsychiatrists, lawyers, educators, social workers, general practitioners, gynaecologists, and others.

Professional roles involved were:

#### **Obstetrician**

In the multidisciplinary team, the obstetrician combines the protection of health and psycho-physical well-being when managing women victims of violence. Valuable scientific literature evidences that gender-based violence has impact on physical, mental, sexual and reproductive health in both the short and long term.

For example, it increases two-fold the likelihood of miscarriages, of having a premature birth, and of

low birth weight, whilst doubling the likelihood of depression and alcohol use. Therefore, the role of the obstetrician, embedded in the multidisciplinary team, favours continuity between the health dimension and the emotional and cultural aspects of the phenomenon.

#### **Anthropologist**

In multicultural contexts, such as those found in reception areas of migrant women victims of violence, the anthropologist promotes processes of social integration, facilitating intercultural and interreligious communication. Within the multidisciplinary team, they provide points of view and skills that facilitate the reading of different cultural dimensions and expressions. They can convey the perspective of women survivors, placing their point of view within the wider logic and cultural models in which they may operate. The anthropologist applies a systemic analysis to the problem-focus practices implemented by the multidisciplinary team, so as to increase the effectiveness of intervention strategies.

#### **Transcultural psychologist/psychotherapist**

The transcultural psychologist/psychotherapist uses a psychological treatment approach that takes into account psyche and culture within the dynamic interweaving of bios, psyche and culture, and the constant interconnection between culture, memory, body-mind, subjectivity and experience. The clinical work is based on the use of a perspective that is complementarist - combining a psychological reading lens with an anthropological one - and of cultural decentralization, which works on the differences and complexity of the person to jointly build meanings.

The aim is to capture the psychic suffering of the person through the creation of a therapeutic space, seeking to recover and integrate her identity, as well as to process and overcome the traumatic experience.

**Legal expert**

The legal worker has received legal training and has specific skills and knowledge of international, humanitarian and social protection, the rights and duties of asylum seekers and refugees, the Italian and European legislation of reference, and the procedures and practices to be completed. It also has interdisciplinary skills that can range from a good command of the current geo-political framework and history and culture of the countries of origin, to a basic knowledge of the main concepts of forensic medicine and interpersonal skills. The legal worker undertakes to support the beneficiary during the procedure to ensure the recognition of international protection, if necessary, in collaboration with other professionals (lawyers, for example).

**Contact worker in the facility**

The contact worker is an educator trained on support to attain self-reliance; he/she follows the woman and accompanies her in the different phases of her stay in the facility including medical support, job search, social integration, etc.

**CASES DISCUSSED**

Over 4 months, the team discussed 6 cases of asylum seekers: 4 Nigerian women and 2 Ivorian women aged between 20 and 30. Cases examined were chosen as examples of the most recurrent forms of violence suffered by women seeking asylum. In particular, cases of women victims of trafficking for sexual exploitation or female genital mutilation, sexual or psychological violence or violence based on sexual orientation were identified. Please refer to Annex A for a case example.

**TEAM WORKING APPROACH**

The work of the team was followed by the coordinator, who endeavoured to keep the information together, organised the work, and maintained contacts between reception facilities, where they are housed, and working group professionals.

The multidisciplinary team has been asked to work on identified cases among women housed in asylum seeker facilities managed by the MondoDonna association. To that end, it has developed suitable reporting and management tools. In the following, we describe the working approach and the sequence followed:

1. Contact workers have reported cases to be considered by filling in a specific form with personal data, migration path, reception path, aspects of detected vulnerability, request expressed by the woman and / or the operator, problems encountered by female workers in their relationship with the woman, any previous reception.
2. Once the reports have been collected, the coordinator convenes a meeting with the professionals involved in this action: team members, project coordinator, president of the association and the woman's contact worker. In this first meeting, the support worker presented the cases and provided additional evaluation/observation elements useful for pre-selection purposes: The team selected four cases out of six presented. Afterwards, two further cases were identified.
3. After the first meeting, case-specific meetings were held; this made it possible to carry out a joint analysis of the woman's life history, assess needs and hypothesise the individualized take charge and action plan, enabling the necessary paths both within the team (psychological

support path, socio-health conversations, legal paths, etc.) and external (for example, referring her to the mental health centre, advisory centre, lawyer, etc.). The team met approximately every 15 days, with meetings lasting an average of 3 hours. During the four months of the pilot action, the constant involvement of all professionals led to a collaborative work environment, which favoured the sharing of points of view and languages, and the increase of knowledge and information.

A key element of the work methodology for shared management by the team is this: the need to leave violence behind must start primarily with the woman herself, instead of being perceived exclusively by workers or professionals supporting her in various areas.

This allows the team to keep complexity under control, improving management and identifying support paths suitable to each woman, making her and her will the driving forces:

- Everything revolves around the woman; she is much more than “a victim” and has desires, hopes, and projects;
- The woman regains the ability to be the protagonist of her own history, her own decisions, and her life project.

### **AIMS OF THE SUPPORT PATHS**

- Promote women’s empowerment. Build individualised paths based on women’s resources whilst respecting their vulnerabilities and giving them an active role in overcoming violence.
- Conduct a global management activity, building thus a complex and integrated intervention;
- Promote the integration of skills among the different subjects and professional roles

involved in taking care of the woman.

## **The United Kingdom Model**

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### **PROFESSIONALS IN THE MULTI-DISCIPLINARY TEAM**

A team was put together of key professionals from a range of disciplines who come into contact with RAS women. It included key specialists in sexual violence against women (working in health and victim advocacy services), specialists in supporting refugees and asylum-seekers, and professionals from other key health, criminal justice and support services:

- Police officer
- Victim court support service worker
- General practitioner (GP - family doctor)
- Health visitor
- Independent Sexual Violence Advisor (ISVA)
- Sexual violence counsellor/therapist
- Housing support worker
- LGBTQI+ asylum seekers’ support worker

We also included a new role of Victim Advocate, whose role was to advocate on behalf of the RAS women, and an Independent Chair to guide the discussion and take a record of the actions agreed in the meeting.

The team was quite large – which we felt was useful for engaging lots of different services with the issue of RAS women and sexual violence, but it could be reduced to a core group in future meetings. There were some additional professionals we would like to have had

represented, most notably education (schools), children and adults social care, and immigration lawyers.

The professionals involved in the team were the following:

**Police officer.**

The role of the officer was to advise the team and the RAS woman on her option for pursuing a criminal complaint (e.g. which criminal offences might have been committed, if there were any time limits for gathering forensic evidence, what support and advice the police might offer, information on the criminal investigation process). The police officer could also offer non-criminal protective measures, for instance putting an 'alert' flag on the police database for the woman so that any calls to the police from her address would be treated as urgent, offering a panic alarm or security advice for her address.

**Victim court support service.**

This was a support worker from the local victim and witness care service, which supports vulnerable victims of crime. Such victims are referred to the service from the police, and they support them through the criminal justice and courts process. Their role in the team was to offer advice on the RAS woman's potential needs and vulnerabilities especially as they related to criminal proceedings, or the courts process.

**General practitioner (GP).**

GPs (family doctors) are key in identifying domestic and sexual violence, since often women (and some men) present to them with a range of physical and mental symptoms. The role of the GP was to identify whether the woman was presenting with symptoms which might indicate sexual violence, and to advise on medical questions which the RAS woman should be asked.

**Health visitor.**

This is a maternal health nurse, who visits new parents to help with post-natal support, parenting skills, child development and wellbeing. In the team, the health visitor's role was to assess physical and mental health needs of the RAS woman and her child/ren especially around post-natal depression and wellbeing.

**Independent Sexual Violence Advisor (ISVA).**

An ISVA is a specialist trained advocate who supports women experiencing sexual violence. They provide impartial information to victims/survivors, emotional and practical support, and ensure the safety of victims/survivors and their children. The ISVA assessed the immediate risks and needs to the RAS woman from sexual violence, including safety planning if she was in current danger from perpetrator/s, advice around sexual health, and independent advice on reporting sexual violence to the police.

**Sexual violence counsellor/therapist.**

This was a trained counsellor, employed by a specialist support service for victims/survivors of sexual violence. Their role in the team was to provide advice on specialist trauma counselling and therapy services.

**Housing support worker.**

This was a worker from a specialist charity supporting victims of trafficking and modern slavery. Their role was to advise on options for the RAS woman to access safehouse (shelter) accommodation, and on longer-term options for housing.

**LGBTQI+ asylum seekers' support worker.**

This was a worker from a specialist charity which supports LGBTQI+ RAS. Applications for asylum on the grounds of sexuality are increasing, but LGBTQI+ RAS women face particular barriers

to disclosing violence and accessing support, especially when they have had to cover up their sexuality for many years due to fear of persecution. Their role was to advise specifically on the needs of LGBTQI+ women and identify barriers to these women talking about abuse or accessing help.

#### **Independent Chair and Victim Advocate.**

We drew on best practice in the UK from local MARAC multi-agency meetings which take place weekly to discuss high-risk domestic violence cases. These have a named Chair who chairs the discussion, invites input from colleagues, keeps the time and ensures that specific actions are agreed. MARAC meetings also involve an Independent Domestic Violence Advisor (IDVA) whose role is to advocate on behalf of the victim, representing their voice and wishes at the multi-disciplinary meeting. We replicated this model with our Victim Advocate.

#### **CASES DISCUSSED**

Real cases were selected, but names and personal details anonymised so that individuals could not be identified (we gave the women pseudonyms). The four cases were RAS women who had accessed local sexual and domestic violence services in the past six months and had been supported by the Independent Domestic Violence Advisor who acted as Victim Advocate for our multi-disciplinary team. The criterion for selection was: experience of being RAS women, a variety of ethnicities, backgrounds and needs, having different experiences of sexual gender-based violence (e.g. FGM, trafficking, domestic and sexual violence; sexual torture and abuse in conflict situations), coming from different countries and having different circumstances (e.g. children/no children). The aim was to represent a range of RAS women's experiences in the meeting.

For each case, we provided a maximum one-page

summary of the case, which described:

- The woman's circumstances - age, nationality, country of origin, whether in a relationship, whether she had children
- Her story: violence and abuse experienced in country of origin and/or in transit, and who from
- How she came to the UK, what her current immigration/asylum status was, and any further violence or abuse experienced in this country
- Any obvious impacts of the abuse – e.g. on physical or mental health
- Any factors which kept her in the abusive situation or prevented her from seeking help (e.g. fear of the perpetrator or of the authorities, immigration concerns, intimidation, lack of financial resources)
- Any current legal case (e.g. criminal charge, immigration appeal, court case for children)

Appendix B contains an example case with a summary of the discussion and actions/interventions planned for that case in the team meeting.

#### **WORK METHODOLOGY AND APPROACH**

This team was brought together for a meeting to discuss and make an action plan for the four cases of RAS women. An agenda was provided for all participants, and the Chair was given a script to follow to guide the meeting. The professionals in the team were also given a template document 'Multi-disciplinary team case template' for each case discussed, and asked to take notes for each case against 5 key areas:

- What are the RAS woman's risks and needs
- What are her greatest priorities and wishes (if known)
- Actions agreed (and by whom, and by when)
- Additional referrals to be made

- Any other information

The meeting was run as follows:

1. The Chair explained the aims of the meeting and how it would work. Explained that the aim was to discuss four cases of RAS women who had suffered sexual gender-based violence and, as a team of professionals from different disciplines, to come up with a plan of action to help each woman. For each case, the case study would be read out and the Chair would invite each participant to identify risks and needs of the woman from their professional knowledge. As a team, the professionals would suggest actions to help the women, and the Chair would summarise these action points at the end.
2. Each professional introduced themselves, giving their name and profession, and the service they were representing.
3. Chair and Victim's Advocate roles explained. The Chair explained that the Chair role was to act as independent facilitator, to summarise the discussion and actions (not to represent a particular agency or professional perspective). The Chair explained the Victim Advocate's role was to represent the RAS women's wishes, needs or views.
4. Discussion of cases. For each, case:
  - a. The Chair or Victim Advocate read out the case study
  - b. The Chair invited each member of the team to comment on the risks or needs of the women (and, where relevant, her children) from their professional perspective. The Chair asked for short contributions, focused on each professional's area of expertise.
  - c. After professionals had spoken, the Chair invited the Victim Advocate to add any comments on the woman's perspective or likely wishes.

- d. Once the risks and needs had been identified, the Chair invited the team to suggest key actions which should be taken to protect and support the woman (and, where relevant, her children).
- e. Chair summarises agreed actions, who will carry out the actions, and by when.

For this pilot meeting, because we were discussing 'non live' cases, we invited some other key professionals from health services, sexual and domestic violence services, and RAS support organisations, to observe the multi-disciplinary team meeting. We asked these observers to comment on four questions; their feedback contributed to the recommendations from the pilot:

- Which agencies were not represented round the table which would be useful?
- Were there other actions which could have been taken?
- What barriers are there which might make the actions difficult to achieve?
- What value did the Victim Advocate bring to the meeting?

## Joint Recommendations/ Lessons Learnt in Both Countries

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### WHAT WENT RIGHT?

#### In both countries

All professionals meeting together to discuss cases

- Having a range of professionals in the same meeting meant insights from relevant agencies were brought to the case

- Discussing together as a team, the risks to and needs of the RAS women were identified better
- The team was able to share knowledge of which services were available in the local area
- Professionals in the meeting had direct links with the local services so it was easier for them to refer the woman to support
- The Independent Chair (in UK) and the Coordinator (in Italy) meant that all professionals were able to have their say, but the meeting was kept focused, and there was an agreed action plan at the end

#### The role of subsidiary figures

- Both in Italy and in the United Kingdom, the perspective and needs of women whose stories have been analysed and treated in the meetings were represented through specific roles in the multidisciplinary team. In the British case, this role was played by the “victim’s advocate”, while in Italy this fell on the facility operator. The aim was to safeguard women’s privacy whilst attempting to represent their needs and individualities.

#### In Italy

- The facility operator is the reference person that accompanies refugee women through the reception path and, therefore, knows both their history and personal needs.
- Her main contribution was to bring the discussion back to the specific individual traits of each woman.
- Beyond the contribution of individual professionals, the operator can guarantee continuity and coherence to the intervention.

#### In the United Kingdom

- Professionals and observers thought there was a need for a single RAS Woman’s Advocate role like the one piloted in this meeting. Whilst similar roles already exist for domestic

or sexual violence victims in the UK (IDVAs/ ISVAs), there is no single role advocating for RAS woman, who often have very specific needs and vulnerabilities.

- It was considered that the Advocate role could be fluid, and adopted by different professionals/agencies, depending on who was most connected to an individual RAS woman in a case.
- The idea of a single co-ordinating person to represent the RAS woman, and co-ordinate agencies on her behalf, was positively welcomed by the professionals in the team. It meant a single person could feed back to the RAS woman, and the professionals at the meeting could co-ordinate actions after the meeting through the Advocate.
- The Victim Advocate brought the focus of discussion in the meeting back to the RAS woman’s needs and priorities.
- An Advocate has the opportunity to feed in the woman’s wishes directly

#### WHAT CAN BE IMPROVED?

##### In Italy

- One of the critical issues identified was the lack of professional role who could provide additional ideas for reflection and analysis of cases, as well as for the design of their interventions. In particular, we were unable to involve at this stage a linguistic-cultural mediator, a role which would be appropriate for a subsequent implementation of the team’s activity.
- It has been widely shared by the team that the multidisciplinary working methodology tested in the reception system should be extended to all local services which may come into contact in different ways with refugee women and asylum seekers.

**In the United Kingdom**

- There were professionals/agencies which were not represented in the meeting who would be useful to involve. In particular, schools safeguarding leads, social services, immigration advisors, solicitors/lawyers, and Black and Minority Ethnic support workers ('cultural mediators').
- The pilot team consisted of a large group – a future multi-disciplinary team could be a smaller, core group of professionals, adding other individuals as needed for particular cases.

## ANNEX A: Sample Case, Italy

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**Story**

Young Nigerian woman, born in Ogun State, from Igbo family. She and her mother were abandoned by their father. Afterwards with the mother they moved to the home of a very important man who took away their earnings from agricultural work and also raped, mistreated and beat her, and prevented her from going to school. Following her stepfather's abuse, the young woman discovers she is pregnant; the stepfather, once discovers this fact, beat her up to provoke an abortion. Later, she escaped to a big city and never returned home. In this city, she met a man with whom she later married. After suffering various attacks, they decide to set out for Libya, aided by a man they have come to know in the meantime. In Libya, her husband is imprisoned and she discovers she is pregnant. After some time, they arrive in Lampedusa, where they are transferred to a locality in Lazio; they run away, because they declare not to receive any living means. They go to Milan and then to Bologna,

where the woman gives birth in one of the city hospitals.

**Reception**

Her behaviour in the reception facility was always adequate, she respected the rules and established a good relationship with the operators. Over time, she attended with interest various language courses offered, and asked several times undertake some activity to keep personal problems off her mind. She has always taken care of her son with care and competence.

**DETECTED VULNERABILITIES ASPECTS FOR WHICH SHE HAS BEEN CONSIDERED**

She reports bodily pain and problems of insomnia, frequent headaches and gut and stomach pain.

**Team analysis**

- Sexual violence exerted by the stepfather in her country of origin, Nigeria.
- Given the complex migration path, the woman may have been victim of trafficking (role of the suspect husband).
- Symptoms: Recurrent intrusive thoughts, headaches, difficulty in the sleep-wake rhythm, strong anxiety.
- Supporting Italian family; help / control relationship.

**Needs Assessment**

- Necessity of a psychological support path, of a safe space for herself where the woman can process her personal history and her experiences of violence and trauma.
- Supportive pharmacological therapy.

**Management path and action plan**

- Starting a psychological support path at the CIAMA chiAMA Anti-Violence Centre.

- Referral to the local mental health service to evaluate pharmacological therapy opportunities.
- Joint meeting with the facility's reference worker and the legal advisor for a comparison on the history of the woman, keeping in mind the hypothesis of suspected trafficking for the purpose of sexual exploitation.

#### Roles involved

- Psychologist, legal advisor, support worker, psychiatrist, neuropsychiatrist, general practitioner.

#### Involvement of local services

- Local psychiatric service, primary care physician.

## ANNEX B: Sample Case, United Kingdom

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Agnesa (Name Changed) is a 19-year-old Albanian woman. She was from Tirana and was working in an electronics factory as a casual worker when she was 17. She was not happy with her home life, as she was living with an alcoholic father and 5 other younger siblings who she was supporting with her wage. She found her work hard and was not satisfied with her wage.

One day she was approached by Jarek who also worked in the factory. He was 45 years old. He told her that a beautiful girl like her was wasted as a factory worker in Albania. He offered to help her to go to UK where she could get work as a model or in the hospitality business. He warned her not to tell her family because they may stop her from

leaving as they needed her money.

She agreed to leave with him and her best friend Ana, and they left after a couple of months to England. Upon arrival to the UK she was cautioned by Jarek that she should tell the immigration officers at the border that she and Ana were sisters and that he was their father. She agreed, and once in London, she was forced into prostitution in a brothel where she was repeatedly raped, initially by Jarek and then by clients. In the end she escaped and started begging on the road for survival. She was picked up by the police, and though she was reluctant to do, told them her story. They took her to a refuge for trafficked women and encouraged her to file a complaint against Jarek. Meanwhile she found that she was 5 months pregnant and was unsure if she wanted to keep the baby but decided to do so. After giving birth, she started suffering from post-natal depression, and has frequent nightmares. Her health visitor is concerned about the baby, but Agnesa wants to keep the baby but is finding it hard to look after him.

She has a solicitor who is helping her file a case for asylum, but she is unsure whether to pursue her complaint against Jarek as she is worried about repercussions on her family in Albania.

Below follows the Case Template filled in for Agnesa case.

Case number	Case 2
<p>RAS woman's risks and needs</p> <p><i>Things to consider:</i> Is she currently at risk of abuse or harm? Immediate (safeguarding) and long-term needs Health (physical, sexual, mental) Drugs/alcohol Children Additional risks/needs e.g. language, mental health, BME-specific, disability, cultural issues (e.g. 'honour' Immigration status Income Housing Criminal and civil justice Include identification of who may pose a risk to the victim.</p>	<ul style="list-style-type: none"> <li>• Agnesa may be at ongoing risk from Jarek and the traffickers in the UK</li> <li>• Her family in Albania may be threatened by Jarek and her traffickers</li> <li>• She may need sexual health services/checks – e.g. for Sexually Transmitted Diseases (STIs) due to the repeated rapes</li> <li>• Mental health needs due to trauma and post-natal depression</li> <li>• Baby may need health checks</li> <li>• Housing situation is uncertain – in temporary refuge accommodation, but needs longer-term accommodation</li> <li>• Trafficking charity UNSEEN (based in Bristol) can offer outreach support to Agnesa, and help her with legal advice and to understand any support entitlements</li> <li>• Police may be pressuring her to press rape charges against Jarek and the traffickers – she should be advised that there is no time limit for deciding to pursue a police complaint, and allowed to make her own decisions</li> <li>• Needs asylum decision, and to get leave to remain in the UK</li> </ul>
<p><b>What are the woman's greatest priorities/wishes (where known)</b></p>	<p>Victim Advocate advised that Agnesa's immediate priorities for herself and her baby were likely to be:</p> <ul style="list-style-type: none"> <li>• Housing – needs longer-term stable housing</li> <li>• Needing support as a new mother with post-natal depression</li> </ul>

<p><b>Actions agreed (by whom)</b></p> <p>Actions should be SMART (specific, time bound and with a named lead).</p> <p>Agencies round the table volunteers actions. Chair summarises.</p> <p>Include any additional referrals to be made to other agencies.</p>	<ol style="list-style-type: none"><li>1. Referral to the Health Visitor for post-natal depression and a mental health check (<b>Maternal health nurse</b>)</li><li>2. Ask Agnesa if she's registered with GP – if so (with her consent) inform the GP of her situation; if not, help her to register (<b>Maternal health nurse</b>)</li><li>3. Referral to a local charity supporting new mothers with postnatal depression – e.g. Bluebell or MothersforMothers (<b>Maternal health nurse</b>)</li><li>4. Make sure that Agnesa is supported by the local service for trafficked women (<b>Victim Advocate</b>)</li><li>5. Monitor situation - if necessary, make referral to children's safeguarding for baby (<b>Maternal health nurse &amp; Victim Advocate</b>)</li><li>6. Give Agnesa advice on her options on pursuing a criminal complaint and make clear that it is her choice (<b>Police officer/courts liaison officer, together with Victim Advocate</b>)</li><li>7. SARC/ISVA to offer counselling for sexual violence and trauma (<b>Sexual violence support service/ISVA</b>)</li></ol>
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