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Linking Advocates & Researchers

Sexual Assault Service Provision
An Examination of Successes and Barriers

Letter From The Editor

Janet Anderson, Advocacy Education Director, WCSAP

For the past thirty plus years, rape crisis centers and other sexual assault providers have created a variety of sexual assault services including 24-hour hotlines, crisis intervention, medical advocacy, legal advocacy, information and referral, prevention strategies, psycho-educational support groups, individual and therapeutic group counseling, and Sexual Assault Nurse Examiner (SANE) and Sexual Assault Response Teams (SART) programs, to name a few.

As those programs have grown, support from governments, communities, and foundations have supported the expansion of these systems. However, like most funders, they want to know whether the financial resources they contribute are being used to accomplish their intended outcomes. To that end, funders are requiring more and more rape crisis centers and other sexual assault programs to engage in evaluation strategies to determine the efficacy of their services and programs. When many of us hear the word "evaluation," we may feel a sense of trepidation because it requires us to ask questions that perhaps we aren't prepared to answer, or we may become anxious for fear that the evaluation results will present us with feedback that might require us to change the way we are currently operating. In an effort to further this line of inquiry, I decided to use this Research and Digest to examine what sexual assault services are effective and promising, and identify areas of service provision that still need improvement or continue to be barriers for survivors within mainstream organizations. Additionally, because evaluation and taking an in-depth, honest examination of services is crucial to creating high quality programming, I also featured two research projects that outlined evaluation processes that can be replicated by rape crisis direct service providers, rape prevention programs and other sexual assault programs.

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Traditionally, when developing the Research and Advocacy Digest publication, I attempt to review research from a variety of social scientists to have as many perspectives as possible. However, several works featured in this publication are authored by Dr. Rebecca Campbell from Michigan State University as she has done the bulk of research to date focusing on evaluating sexual assault service provision and community responses to rape. The dearth of research in this arena clearly highlights the need for other social scientists to conduct more research examining sexual assault service delivery to expand the scope of viewpoints, voices, and perspectives.

In conclusion, as I reviewed the research for this publication, it became quite clear that much of the work that programs are doing in serving sexual assault survivors is effective and positive. Yet, as the research points out, there is also room for improvement. As a movement, we must constantly be open to new trends and promising approaches, remain cutting edge, continue to engage in social change efforts, and tirelessly work to remove potential barriers that survivors face. Moreover, we must also be committed to asking survivors to identify what services they believe will be most helpful so that our programs remain relevant and applicable. While not always an easy task, examining what we do is crucial so we in the anti-rape movement "stay on top of our game."

Interview with Dr. Rebecca Campbell

Michigan State University

WCSAP: Can you tell us a little bit about yourself and your research interests?

RMC: My research focuses on the community response to rape, looking at what happens after a woman has been sexually assaulted within the medical and mental health systems as well within rape crisis centers and other advocacy organizations. I had been providing advocacy for many years and was a hospital based advocate on and off for about 15 years. I also continued to provide advocacy during my undergraduate and graduate school work and while working as a faculty member and research professor. Because I have both direct service and research experience, much of my research has been informed by my direct service work. I recently moved to Michigan and have stopped providing direct service and now focus my efforts on evaluation and program consultation for sexual assault prevention, intervention, SANE and SART programs.

WCSAP: You obviously have been doing sexual assault work for many years. Can you talk about what we are doing well and what isn't working so well within the movement?

RMC: I need to preface my answer by saying that I entered the movement in 1988 or 1989 and was trained by the founding mothers. Therefore don't feel I can give you a good historical perspective. However, some things that the movement has been successful at has been raising public awareness about violence against women and leveraging financial support from federal and state sources. Another key success has been the fact that the anti-rape movement has worked very hard in addressing issues around inclusiveness as it pertains to race, ethnicity, sexual orientation, disabilities, and other groups. However, there is still a tremendous amount of work that still needs to be done in this area.

As mentioned, a key success has been the ability of the advocacy community to leverage financial resources from the federal and state sources. However, because of this, a natural by-product has been the increased professionalization of organizations and advocacy groups doing anti-rape work. While I don't know if that is necessarily a bad or good thing, I have begun to notice more of a separation between those who are doing direct service work with clients and those who are in administrative positions.

WCSAP: What are some areas that you believe aren't working as well as it pertains to both research and direct service delivery?

RMC: With respect to research, I think that there was some very important groundbreaking research in the 1980's and 90's that established the prevalence and incidence of sexual violence. However, I think that it is important to continue that line of inquiry with respect to underserved and unknown populations. I think that researchers need to move beyond counting and definitions as it pertains to middle class, white women in college. I would like incidence and prevalence studies more expansive than that. I also believe there has been too much research on the mental health impact and mental health treatment around violence against women. I would like to see more research focused on physical health issues and more on working with survivors outside of the mental health context. I don't know what that would be but the research community needs to figure that out.

As it pertains to service delivery, things that I worry about include the divide between the domestic violence and sexual assault community. I want to be clear about what I mean by that. I don't think there is a divide in terms of having competing agendas. I think that the domestic violence movement and the sexual assault movement are clear about wanting to create a world free from violence against women and children. However, with the federal Violence Against Women Act (VAWA), there was a disproportionate amount of money that went to domestic violence research and advocacy versus into the sexual assault arena and I think that has created a long standing struggle and tension between the two movements. With that said, I believe this is now beginning to turn around due to the reauthorization of VAWA. I think there is an effort to bring the two movements together to make sure that the needs of women who are experiencing both forms of violence are being adequately addressed.

While there has been some tension between the two movements, it is critical that we make sure those women who have experienced both intimate partner violence and sexual assault, either within the context of an intimate partner violent relationship or not, need to receive adequate services. Additionally, dual DV/SA programs also need to ensure that they are providing sexual assault services to those who have been sexually assaulted outside the context of intimate partner violence, which may or may not be happening. The other thing to keep in mind is that I don't think women only experience one kind of violence in their lives. There is compelling data that suggests sexual violence in childhood and adolescence is significantly associated with adult victimization and intimate partner violence. Therefore, our services may be more divided than what women's experiences suggest they should be.

WCSAP: One of your studies included some work around an "empowerment model" of evaluation. Can you tell us what that is and what were your findings?

RMC: Traditionally, program evaluation has been done using an independent evaluator outside of the organization. They come in, evaluate the program, and share their findings with the organization. Newer approaches to evaluation have been the move to a more participatory and collaborative approach. One specific type of this participatory and collaborative approach is the empowerment model of evaluation. In this model, the role of the evaluator becomes one of a trainer, advocate, and coach where they teach methodologies to programs so they can evaluate their own programs.

The empowerment model of evaluation provides training and technical assistance to programs so they can evaluate their own programs to enhance their capacity, sustainability, and self-determination and figure out how they want to share that information with funders, their community, and to improve their services. The project that we worked on for six years was to help sexual assault prevention programs and sexual assault service delivery programs by developing manuals, workshops, and providing individual consultation. We found that this approach was well received by the prevention and advocacy community. The findings indicated that the information was successfully used by these organizations to develop, launch and sustain evaluation processes over the long haul. They designed it; they analyzed it and utilized it themselves. One of the key goals was transferability and sustainability within the organizations and we found that that goal was realized.

WCSAP: You also conducted an evaluation project that focused on examining client responses to service delivery as it pertained to hotline services, advocacy and counseling?

RMC: In Illinois we did an evaluation with survivors' experiences with hotline, support and advocacy. This project was indeed very challenging because we needed to ensure that the evaluation did not interfere with the service delivery itself. If the questions in the protocol would in any way jeopardize the relationship that the service provider was trying to establish, then the evaluation was not doing its job; it was hurting rather than helping. In that study we worked with the advocacy community in Illinois for many, many months trying to develop a protocol that was non-intrusive and would not interfere with services. We developed three questions and these questions were rolled right into the process of delivering services and were done very conversationally. If the advocate believed that the client was at a point where they could answer the three questions at the end of the hotline call, meaning they were stable and physically safe enough to stay on the phone, then they would ask questions about the helpfulness of that call. If the advocate felt it wasn't safe to do so or that the crisis was still at a level that indicated it would not be wise to do so, they didn't collect the data. This decision had to be made by the particular person working with the client. From a methodological perspective this was a trade off but one that needed to be done to ensure the safety and confidentiality of the survivor and to protect the integrity of the work.

WCSAP: Because of the inherent nature of the work and some of the difficulties it poses in terms of evaluation, what are some suggestions that you would make to sexual assault programs interested in conducting some levels of evaluation in a meaningful and doable way.

RMC: First and foremost, there needs to be some organizational commitment to evaluation and by that I mean there has to be more than one person interested in doing the evaluation. Additionally, the organization needs to be open to the possibility of negative findings; they need to be open to negative feedback. What they think is happening perhaps may not be; what they think is working, perhaps isn't.

The first step is for the organization to have some honest dialogue about its readiness for evaluation and its interest in engaging in taking a hard look at what they do and whether they are willing to be wrong or off the mark a little bit. In my experience, I have not worked with an organization who has received such drastic feedback that indicated "they are doing it wrong" but all of them have received feedback that highlighted some problems that they weren't aware of.

Another good way to do this with minimal resources is to partner with local evaluators or universities. However, you have to be careful about that since not all evaluators understand the complexities around sexual assault and violence against women. Cris Sullivan at Michigan State has developed a checklist that programs can use to evaluate potential evaluation partners. This method is a good place to start and far less expensive than conducting a large scale empowerment evaluation process. There are also trainings such as the one sponsored by the Office on Violence Against Women (OVW) which trains advocates and programs and I believe that there are more resources coming down for research and evaluation.

WCSAP: Other studies you have done examined the system's response to sexual assault survivors. What are some of the issues survivors are experiencing, particularly as they pertain to secondary victimization?

RMC: For victims living in communities that do not have a SANE program or who don't utilize rape crisis advocates, the risks for secondary victimization from systems (medical and criminal) are extremely high. I have found that the process of trying to get help can really, really exacerbate a victim's stress and trauma. I recently did a study that compared victims' experiences in two hospitals within the same community. While neither hospital had a SANE program, one hospital worked with the local rape crisis center and the other hospital did not have advocates present during the medical exam. The findings indicated that when a rape victim advocate was present, the survivor was significantly more likely to get needed medical attention and had fewer problems with initial reports to law enforcement. This suggests that the role of advocates is not only very critical in service delivery but in preventing or lowering rates of secondary victimization.

Additionally, research is also demonstrating that the combination of having both a rape crisis advocate and a SANE nurse working together is one of the most promising models we have right now. The SANE nurse has the ability to remove the survivor from the chaos of the Emergency Department, has the ability to focus on the survivor's emotional and physical well-being and collect forensic evidence. The advocate, working in conjunction with the SANE nurse, provides much needed emotional support, crisis intervention and information and referral. Therefore the combination of having both a SANE nurse and advocate is very promising for improving service delivery for survivors.

WCSAP: As a movement, where do you see where we need to go? Has your analysis changed? Are you seeing new trends?

RMC: As a movement, we really need to focus our efforts on prevention and work ourselves out of a job. When I talk about prevention, I'm not talking about what curriculum works best because this is not a problem solved by a classroom based curriculum. This is a problem solved by community change and coalition building. There is some real creative work that needs to be done by researchers, advocates, practitioners, and policy makers in trying to think through what are some of the broader systemic changes that need to be done for prevention to be truly successful. In terms of working with survivors, SANE programs are an extremely promising model and have a vital role in responding to survivor needs. I also think SART programs, working in collaboration with SANE programs, are also a promising model. I also think that community collaboration is also very important.

Regarding hotline, crisis intervention and advocacy, we need to do better outreach and marketing of our services because research indicates that utilization rates are still pretty low. The work that rape crisis centers are doing is incredibly important, yet incredibly under-utilized. In terms of the quality of the work, we need to focus more on underserved and marginalized populations.

WCSAP: In some of your work, you speak about vicarious trauma and/or secondary victimization. I wanted to ask you about ways advocates and rape crisis centers can deal with these issues?

RMC: This is a topic that is discussed but is talked about quietly and privately. I think there is a tremendous amount of shame attached to it; the notion that we shouldn't be impacted by it or should be able to handle it. I always say, "Why would we, why should we go to work everyday and hear about the rape, torture and killing of women and children and not be upset by it." Organizations or state coalitions need to be invested in long-term training and support around this. There are a variety of approaches that can be used and it needs to become an on-going focus of state coalitions. I say state coalitions because it is unlikely that individual programs will have the resources to develop and sustain that kind of education and training. The movement needs to take a serious look at the burnout. The work is horrible and painful and while the moments that we have with clients that are positive and empowering are valuable, it is very hard to hold on to those moments in the sea of everything else.

WCSAP: If you have advocates sitting in front of you, what you would like to say and impart to them?

RMC: I would say thank you for the work that you do. Please take care of yourself so you can continue to do it. I would encourage you to build alliances with other anti-oppression groups like anti-poverty and anti-racism groups so our efforts are more effective in a systemic way, as they are two key allies that have been under-utilized. I think we need to remind ourselves to think outside our professional box about what survivors really need and when we do so, we may find that what we are offering may or may not be the kinds of services they need. We constantly need to return to our clients and survivors to find out what works for them and to realize that just because we have been doing it "this way" may or may not be the way we should continue to keep doing it. We need to be constantly open to innovation and change and to make sure we are giving survivors what they need.

WCSAP: Dr. Campbell, I want to thank you so much for your insight, information and for your continued work in the field. Your perspective is very much needed and appreciated.

A Statewide Evaluation of Services Provided to Rape Services

Wasco, Sharon; Campbell, Rebecca; Howard, April; Mason, Gillian; Staggs, Susan; Schewe, Paul; & Riger, Stephanie. Journal of Interpersonal Violence, Vol. 19(2), February 2004, pgs. 252-263.

Although research has shown that the provision of services to rape victims is invaluable, few studies have collected data specifically from the clients themselves.Using a collaborative model, the researchers worked with the staff of 33 community-based sexual assault service programs in Illinois, along with the Illinois Coalition Against Sexual Assault, to develop measures and collect outcome data from their hotline, advocacy and counseling clients. Being sensitive to the fact that evaluating sexual assault services can be challenging due to the inherent nature of the work, the researchers worked collaboratively with the service providers in ways that ensured client safety, confidentiality and that respected their recovery process.

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Services that were evaluated included: 1) the 24-hour crisis hotline, 2) advocacy within the legal and medical systems, and 3) counseling services (both individual and group formats). The Illinois Department of Human Services financed the evaluation project so as to gather "numbers" that the state legislature could use to determine if the funds being spent were being used effectively, and to provide information to service providers to modify existing services if need be.

All participants surveyed were adult women who received sexual assault services from programs in urban, suburban and rural areas. For hotline and advocacy services, evaluators developed a brief interview guide and self-report questionnaire to determine if the services provided: 1) information, 2) support, and 3) help with decision making. For counseling services a self-report survey was used before the start of counseling and again at the end.

Two hundred and fifty-nine (259) callers to the hotline agreed to answer three questions evaluating the service they had received. Of those, 65.6% were survivors and 34.4% were significant others or friends. Of those agreeing to be interviewed, 56.8% reported that they received a lot of information, and 73.4% reported feeling a great deal of support. For those willing to fill out an additional survey, (N=163), 50.9% indicated that they received a lot of information and 54.6% indicated receiving a lot of support. Two hundred and eighty one (281) brief advocacy clients participated in the evaluation and results indicated that most advocacy contacts were positive; 61.9% reported gaining a lot of information and 79.4% feeling supported. Finally, two hundred thirty-one clients receiving counseling completed post-counseling evaluation, (however, only 76 had completed a pre-counseling interview) but all showed positive significant differences between pre and post test counseling measures.

"Of those agreeing to be interviewed, 56.8% reported that they received a lot of information, and 73.4% reported feeling a great deal of support. For those willing to fill out an additional survey, (N=163), 50.9% indicated that they received a lot of information and 54.6% indicated receiving a lot of support."

Although the authors note that this study has many limitations and that evaluating services for sexual assault survivors is indeed challenging, this research project documents the effectiveness of rape crisis services across an entire state. Additionally, the results can be used to help shape public policy and resource allocation as well as to expand upon the findings to evaluate longer-term outcomes for survivors of sexual assault.

Victim Services, Community Outreach, and Contemporary Rape Crisis Centers: A Comparison of Independent and Multi-Service Centers

O'Sullilvan, Elizabethann & Carlton, Abigail. Journal of Interpersonal Violence, Vol. 16(4), April 2001, pgs. 343-360.

Because funding for non-profit agencies is often limited, independent rape crisis centers are being encouraged to combine or merge their services with similar programs like domestic violence agencies, substance abuse agencies, mental health centers, etc. To determine if independent rape crisis centers offer unique benefits to sexual assault survivors and the community at large, this study compared the sexual assault and community outreach services of 16 rape crisis centers in North Carolina.

"The data collected for the years 1994 and 1999 (adjusted for population per 1000), indicated that the independent centers served a median of 210 and 180 respectively, multi-service autonomous serviced 337 and 363 respectively and embedded, multi-service served 63 and 72 victims respectively. The most striking finding here was the low number of primary victims served by embedded programs."

Of the 16 centers, 8 were independent rape crisis (SA), 3 offered combined sexual assault and domestic violence services (SA/DV), 3 were combined with a community crisis line (SA/CL), 2 were housed within Family & Child Services (FAM), and one was housed within a substance abuse agency (DRUG). DRUG and FAM were defined as multi-service, autonomous programs (n-2) while all the SA/DV and SA/CL were described as embedded-multi-service (n=6), meaning their sexual assault services were integrated with other program services for a study sample of 8 independent, 2 multi-service, autonomous, and 6 embedded multi-service programs.The researchers interviewed center directors, staff members, and founding members and asked questions about the following areas: 1) crisis intervention services, 2) advocacy services, 3) community outreach and education, and 4) definitions of rape. Once interviews were completed, all centers were given a draft report for feedback and responses indicated that the centers concurred with the findings. The researchers were also looking to identify whether the programs were accessible and whether they served a variety of clients since the evidence indicates the wide range of people impacted by sexual assault.

The data collected for the years 1994 and 1999 (adjusted for population per 1000), indicated that the independent centers served a median of 210 and 180 respectively, multi-service autonomous serviced 337 and 363 respectively and embedded, multi-service served 63 and 72 victims respectively. The most striking finding here was the low number of primary victims served by embedded programs. Regarding advocacy, the data indicated that independent centers were far more likely to receive routine advocacy calls from medical and legal personnel while SA/DV programs received less routine calls from hospitals and law enforcements for advocates. Additionally, independent centers conducted far more community outreach programs which targeted adolescents and males and had more inclusive definitions of rape thus serving a wider range of survivors: adults, adult survivors of child sexual abuse, males, same-gender sexual assault victims, adolescents, children, etc.

The original question for this study was whether independent rape crisis centers offer a unique benefit to sexual assault survivors and the community. While only 16 centers were studied, the results of this study indicate that they in fact do. Much of their uniqueness is attributed to their autonomy, their exclusive focus on sexual assault and their feminist analysis of rape and social change, thereby making the case for some rape crisis centers to remain independent.

"The original question for this study was whether independent rape crisis centers offer a unique benefit to sexual assault survivors and the community. While only 16 centers were studied, the results of this study indicate that they in fact do."

Volunteers Serving Victims of Sexual Assault

Hellman, Chan; & House, Donnita. Journal of Social Psychology, Vol. 146(1), Feb. 2006, pgs. 117-123.

Because volunteers play such a vital role for many rape crisis centers, it is important to understand the characteristics that lead to volunteer satisfaction and sustainability. While much research has been gathered examining volunteerism in general, little attention has been paid to volunteers working within a rape crisis center and those volunteering within a high stress environment.

"Because volunteers play such a vital role for many rape crisis centers, it is important to understand the characteristics that lead to volunteer satisfaction and sustainability."

Participants included volunteers from a sexual assault program in a large metropolitan city in the south. Although the center utilized 62 volunteers, 28 volunteers responded to the questionnaire and thus represented a 45.2% response rate. The median time served was 5.4 years. Approximately 43% provided medical advocacy only, 35.7% provided crisis line assistance only, and 21.4% volunteered for both. This particular agency responded to 413 rape exams during the previous year with volunteers providing 5,542 hours of medical advocacy and responded to 4,120 crisis calls in which the volunteers provided 5,845 hours of crisis line advocacy. Overall, the volunteers provided approximately 2/3rds of direct service in both crisis line and medical advocacy.

"Results indicated that there was a significant correlation between overall satisfaction and the perceived value of monthly meetings"

The questionnaire measured: 1) overall satisfaction, 2) intent to remain, 3) affective commitment or emotional attachment to the organization, 4) perceived value of monthly meetings (including training), 5) construct of crisis volunteer self-efficacy (confidence in ability to provide service), 6) social support received from family and friends, and 7) perceived experiences with victim blaming.

"Additionally, volunteers who reported higher levels of the value of training and social support also reported higher levels of overall satisfaction."

Results indicated that there was a significant correlation between overall satisfaction and the perceived value of monthly meetings, affective commitment, social support and experience with victim blaming. Volunteers who reported higher levels of overall satisfaction reported higher levels of commitment and higher levels of intent to remain. Additionally, volunteers who reported higher levels of the value of training and social support also reported higher levels of overall satisfaction. Conversely, higher levels of victim blaming experiences were associated with lower levels of satisfaction.

"Although the sample size was small and therefore has limitations, this research project clearly demonstrated that it is important for rape crisis centers to identify and understand the characteristics that increase volunteer sustainability and satisfaction. Overall, this study indicated that the value of on-going training for volunteers serving in a high stress environment warrants careful attention from rape crisis center administrators. "

Although the sample size was small and therefore has limitations, this research project clearly demonstrated that it is important for rape crisis centers to identify and understand the characteristics that increase volunteer sustainability and satisfaction. Overall, this study indicated that the value of on-going training for volunteers serving in a high stress environment warrants careful attention from rape crisis center administrators.

Barriers to Services for Rural and Urban Survivors of Rape

Logan, TK; Evans, Lucy; Stevenson, Erin; & Jordan, Carol. Journal of Interpersonal Violence, Vol. 20(5), May 2005, pgs. 591-616.

This article examines the barriers to health, mental health and criminal justice services for survivors who come from both rural and urban areas. The authors wanted to identify how survivors perceive these barriers and to determine what similarities and differences exist within urban and rural settings.

Using a focus group method, thirty-one women volunteered to participate. The average age for both survivors from urban and rural settings was 37. Within the rural setting, 89% of the women were white and 11% other (biracial or Native American) while the urban sample included 67% white and 33% African American.

Participants were asked questions about: 1) the types of services they thought were available for survivors, 2) services they would use immediately following an assault, 3) services they would use to help cope with the aftermath of trauma, 4) services in which they perceived they would experience a positive and negative experience, 5) barriers that kept women from using mental health services, 6) perceptions about reporting to police and whether the response would be positive or negative, and 6) how services could be improved. All responses were compared to four variables: affordability, availability, accessibility and acceptability.

"barriers that were mentioned in both rural and urban communities as it pertained to medical and mental heath services included affordability and prohibitive costs, limited services and access, staff incompetence and experiencing shame and blame. As it pertained to services within the criminal justice system issues that arose in both urban and rural communities included feeling revitalized, and lack of sensitivity.

The findings indicated several themes and demonstrated that specific barriers were mentioned in rural communities, specific barriers mentioned in urban community only and some barriers mentioned by both rural and urban. More specifically, barriers that were mentioned in both rural and urban communities as it pertained to medical and mental heath services included affordability and prohibitive costs, limited services and access, staff incompetence and experiencing shame and blame. As it pertained to services within the criminal justice system issues that arose in both urban and rural communities included feeling revitalized, and lack of sensitivity.

"Interestingly, women from urban communities indicated that if the term trauma or crisis was in name of the agency, they didn't feel as if they could access it since they may have waited to receive service or believed that they weren't in "crisis" or believed they were taking someone's else's spot who needed immediate service."

The findings mentioned only within the rural communities included limited hours available for mental health and medical services, more stigma being associated with seeking service, accessibility due to transportation, wide geographic spans, and finding public phones. They also indicated that more perpetrators were intimate partners and that made it more difficult to discuss the issue with anyone and that they would experience more community and family backlash. They also mentioned the fear of lack of anonymity and confidentiality as major barriers to seeking services. The women from rural communities also mentioned that turning to the criminal justice system was problematic because of the closed-knit type of communities and the fact that there were more politics involved in terms of arrest, i.e. "who you know determines the outcome rather than the facts of the case."

Interestingly, women from urban communities indicated that if the term trauma or crisis was in name of the agency, they didn't feel as if they could access it since they may have waited to receive service or believed that they weren't in "crisis" or believed they were taking someone's else's spot who needed immediate service. To these women, the name also suggested that no follow-up or continued care would be offered. Bureaucracy was also cited as an issue. For example, having to tell their story over and over to several people to get an appointment was also viewed as a barrier. And finally, they viewed the criminal justice system as mostly negative and felt that handling sexual assault cases was a low priority.

"this study suggests that the context of sexual violence is different in rural versus urban areas."

The results of this study indicate that the experience of sexual assault survivors as it pertains to seeking and utilizing services is predicated upon where the victim lives. Furthermore, this study suggests that the context of sexual violence is different in rural versus urban areas. Implications for this study include the need to better market and explain the services the agency provides, provide better education about the dynamics of sexual assault recovery, and work with systems personnel to positively change norms and attitudes for survivors seeking rape services.

Rape Survivors' Experience with Legal and Medical Systems: Do Victim Advocates Make a Difference?

Campbell, Rebecca. Violence Against Women, Vol. 12(1), January, 2006, pgs. 1-16.

As pointed out by the author, the work of the rape crisis advocate is not only to provide and improve service delivery but also to decrease and stop secondary victimization when survivors seek assistance from the legal and medical systems set up to help them post sexual assault. Therefore, the purpose of this study was to evaluate the effectiveness of advocates' intervention within systems and compare the types of services survivors received and the levels of secondary victimization experienced by survivors when an advocate was present and when an advocate was not present.

Eighty-one (81) female survivors who went to two different hospitals within the same community post assault were recruited for this study. One hospital (Site #1) worked closely with the local rape crisis center and called upon advocates to assist the survivor, while the other hospital (Site #2) did not. Neither hospital had a SANE nurse program. To assess the outcomes of the survivors' experiences and to determine how advocates influenced service delivery and secondary victimization, participants were interviewed right before discharge.

Measures included: 1) service delivery (what services were given or not), 2) secondary victimization behaviors (behaviors of system personnel, such as being discouraged from filing a report, being questioned about their dress, etc.) and, 3) secondary victimization emotions (insensitive and victim blaming treatment that resulted in the victim feeling bad, depressed, distrustful, not wanting to seek further assistance etc.) across both the legal and medical system domains.

Results indicated that those survivors who worked with rape crisis advocates reported receiving more services and less secondary victimization from the legal system. Fewer survivors were discouraged from filing a report in Site 1, fewer were asked about prior sexual history, about choices and dress, and fewer were told that their case was not serious enough to pursue. Conversely, those survivors who did not have an advocate were more likely to experience secondary victimization behavior and emotion by police and were given less service.

"Results indicated that those survivors who worked with rape crisis advocates reported receiving more services and less secondary victimization from the legal system. Fewer survivors were discouraged from filing a report in Site 1, fewer were asked about prior sexual history, about choices and dress, and fewer were told that their case was not serious enough to pursue. "

Regarding the medical system, those who had an advocate not only received an exam but were more likely to be given information on STD's, STD prevention, emergency contraception, information and referral, and were less likely to experience secondary victimization behavior and emotion by the medical system.

The results of this study clearly point to the fact that advocates play a critical and vital role in not only providing meaningful services but also in reducing the rates of secondary victimization that many survivors may experience when accessing medical and legal systems. As the author notes, "*rape victim advocates appear to provide numerous benefits and can prevent serious negative consequences for rape survivors, and it is important that future research and policy efforts continue to find ways to improve the accessibility and availability of advocates' services."*

"The results of this study clearly point to the fact that advocates play a critical and vital role in not only providing meaningful services but also in reducing the rates of secondary victimization that many survivors may experience when accessing medical and legal system"

An Empowerment Evaluation Model for Sexual Assault Programs: Empirical Evidence of Effectiveness

Campbell, Rebecca; Dorey, Heather; Naegeli, Monika; Grubstein, Lori; Bennett, Kelly; Bonter, Freya; Smith, Patricia; Grzywacz, Jessica, Baker, Patsy & Davidson, William. Journal of Community Psychology, Vol. 34(3/4), December 2004, pgs. 251-262.

Rape crisis centers are asked to evaluate their services more and more to determine their effectiveness, yet programs may lack the skills or knowledge to effectively do so. The purpose of this article is to outline a specific evaluation approach called "*empowerment evaluation.*"

Empowerment evaluation is a specific participatory approach where evaluators provide training and consultation to program staff so they can conduct their own evaluations and to ultimately build program capacity.

More specifically, this paper describes a multi-year evaluation project that was conducted with all state-funded rape prevention programs and rape victim services in Michigan, called SARP or the Sexual Assault and Rape Prevention Evaluation Project, with the intention that programs would be better suited to design, implement and sustain evaluation projects within their own agencies and communities.

Empowerment evaluation brings together key stakeholders in local communities and focuses on five processes: 1) training – evaluators teach programs how to conduct their own evaluations, 2) facilitation – evaluators serve as coaches, 3) advocacy – program staff use their self-evaluation tools for advocacy and institutional change, 4) illumination – development of new roles, structures, and programs and, 5) liberation – programs free themselves from old constraints. While this method of evaluation has drawn some critics, the authors note that the philosophical values behind empowerment evaluation (shared power, control and resources), dovetail with the empowerment models that most rape crisis centers are built upon.

Over a six-year period, the SARP team engaged in the following processes: 1) conducted extensive interviews with all the programs to learn about them, 2) developed community-specific evaluation training curricula on an 8-phased evaluation process, 3) provided extensive training opportunities for programs to learn how to conduct this 8-phased evaluation method and, 4) held regional technical assistance sessions on an on-going basis.

To determine the success of the project the authors examined: 1) ratings of participant satisfaction with the SARP training and consultation, 2) objective and subjective reports of whether programs launched their own evaluations after receiving such extensive training and technical assistance, and 3) identifying if results were used to improve program services.

Results indicated that the empowerment evaluation approach used by the SARP team in Michigan was effective in helping programs conduct methodically sound evaluations. Ninety percent (90%) of the rape prevention programs made substantial progress in planning and implementing evaluations and a year after the SARP project ended, these programs were still conducting evaluations.

Although not required by their funders to conduct evaluations like rape prevention programs, 75% of the rape victim service programs successfully launched program evaluations and at one year follow-up, 90% were still conducting evaluations.

Although there are limitations to this method of evaluation, the results indicate that prevention programs showed positive short-term increases in community participants' awareness of sexual violence. Victim service programs found that their advocacy services were consistently rated as very helpful. Counseling programs had significant positive effects in facilitating recovery.

The Effectiveness of Sexual Assault Nurse Examiner (SANE) Programs: A Review of Psychological, Medical, Legal, and Community Outcomes

Campbell, Rebecca; Patterson, Debra; & Lichty, Lauren. Trauma, Violence and Abuse, Vol. 6(4), October 2005, pgs. 313-329.

This article reviews the literature to date on the effectiveness of Sexual Assault Nurse Examiner (SANE) programs through five different lenses: 1) whether they promote the psychological recovery of survivors, 2) whether they provide comprehensive and consistent post-rape care (EC, STD prophylaxis, etc. 3) how well they document forensic evidence, 4) whether they impact or improve prosecution rates, and 5) whether they create community change through collaboration with other agencies and system responders.

In addition to examining the effectiveness in the areas listed above, the article also identifies and outlines why SANE programs are needed, reviews the history and current operations of these programs, and discusses the future of SANE programs and their implications for practice, policy and research.

"SANE programs reflect a "substantial" improvement over more traditional hospital services to rape survivors."

While the authors point out that there is need for more empirical and long-term impact research, this literature review on SANE programs demonstrated effectiveness in all five areas and indicates that SANE programs reflect a "substantial" improvement over more traditional hospital services to rape survivors. Implications for this case study are also discussed. Results of this case study can help provide communities wanting to launch a SANE program with evidence that demonstrates that not only are these programs effective, more comprehensive and cost-effective, but are less traumatizing and yield lower rates of secondary victimization for survivors.

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