Rape Crisis Scotland

The pros and cons of providing dedicated sexual violence services

A literature review

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1. Background

1. About this review

Rape Crisis Scotland (RCS) commissioned this literature review in the context of considering the extent to which the national RCS helpline is integrated with local rape crisis centres in Scotland. This is connected to development work by RCS to clearly specify how the organisation, national and locally, supports survivors of sexual violence and how that might be quality assured. This is important for ensuring high quality services but also for considering future funding in a context of reduced resources and in which other organisations, generic and specialist, also support survivors of sexual violence.

The review considers the pros and cons of providing dedicated sexual violence services. It also summarises information about the nature of sexual violence; the response in Scotland; and what survivors want.

For the purposes of this review 'dedicated sexual violence services' are defined as 'services whose core function is to support adult survivors of any kind of sexual violence. These encompass services for men and women aged over 16.'

For the purposes of the review, 'specialist' is defined, as in the *Rape Crisis Best Practice Model* 2010 as 'provision of services by staff and volunteers with the appropriate skills and expertise to deliver tailored services to survivors with complex needs'. This is consistent with the Council of Europe Minimum Service Standards (Kelly and Dubois 2008).

Given the limitations of the budget and the extent of the literature, the review focuses on the rape crisis response. It draws on academic research, mainly other literature reviews, and some 'grey' literature including previous reports commissioned by RCS including *Scoping for services in West Lothian* (2007); *Development of a funding model for rape crisis centres in Scotland* (2008); *Woman to woman: an oral history of rape crisis in Scotland* (2009); *Rape Crisis Best Practice Model* (2010); *Scoping for services in Highland* (2010); and *Scoping for male survivors* (2011).

As noted above, the literature relating to all forms of sexual violence and to the history and role of the international rape crisis movement is extensive. However, it has not been possible to find any direct comparisons of the pros and cons of dedicated services. The review which follows, therefore, pulls out key themes which might be indicators for discussion and planning about how to proceed.

The literature uses various terms to describe those who have experienced sexual violence including victim, survivor, victim-survivor. This review generally uses the term 'survivor'. When 'victim' or 'victim-survivor' are used it is because these are the terms used in the original source.

The review includes references to US research which include American-English spellings. These are preserved. Outwith Scotland, domestic abuse is often referred to as domestic violence.

2. About rape crisis in Scotland

Rape crisis in Scotland provides a 'dedicated sexual violence service'. As a whole, this includes direct services to survivors and their families, combined with longer-term awareness-raising and preventative work.

RCS is the national office for rape crisis centres in Scotland. It runs a national helpline which provides crisis support to female and male survivors across Scotland. It also undertakes awareness-raising, training and strategic work for example with the police, Crown Office and Scottish Government. A recent example of this is the police referral protocol linked to the national helpline.

There are 13 autonomous member centres providing free confidential support and information for women and girls who have experienced any form of sexual violence. Some centres also support male survivors of sexual violence.

Local rape crisis centres vary but they generally provide both direct services to survivors and education/prevention services including:

- Phone, email or letter support
- Face-to-face support
- Group support
- Information on the law, health and other issues
- Advocacy and accompaniment to clinics, police, court
- Referral to other agencies
- Assistance with reporting to the police
- Training and consultancy to local agencies

The core work is set out in the funding model and the core principles in the best practice model.

3. The context for the review

RCS and local rape crisis centres have adopted national service standards. These are currently being implemented by centres. A best practice model which underpins the service standards is with local centes for consultation.

National service standards

In order to specify the nature and quality of support provided by rape crisis centres, Rape Crisis England and Wales (RCEW) and RCS collaborated to produce *National Service Standards* (RCNSS) which intend to recognise the specific needs of survivors of sexual violence and benchmark the specialisms needed to provide services. These are based on research and consultation and informed by survivors' experience.

The documents state the intention to set out what RCEW and RCS view as making their services different from non-specialist support services because 'much of what distinguishes a rape crisis approach relates…to the value base and feminist ethos which underpins all of our work. Values and principles are crucially important to our model…'

The standards aim to assure that all survivors receive a quality service regardless of their location and also provide necessary evidence to funders.

Best practice model

The best practice model for rape crisis centres prepared by Rape Crisis Network Ireland (RCNI 2010) is an important document because it attempts to specify how centres can operate to a model which reflects the needs of survivors. RCS wishes to adopt this model in Scotland and the document is currently with member centres for consultation. The model is evidence-based and sets out what survivors say is important in support agencies. It states that survivors need to be 'safe, secure and have their dignity explicitly recognised'; that survivors need to be consulted and participate in planning service delivery; and that within a trauma-based context the following are important to survivors:

- 'Being met with warmth and acceptance
- Being offered both emotional and practical support within a safe environment
- Having support from people who understand the impact of sexual violence
- Being validated – reactions to trauma are normal and not sick or maladaptive
- Being believed
- Understanding the need to maintain confidentiality
- Offering assistance in navigating the medical and legal processes
- Being able to regain some degree of control over the process
- Feeling that the choices are theirs'

The model is based on Council of Europe minimum standards (Kelly and Dubois 2008) which state that 'the international knowledge and practice base suggests that services provided by specialist NGOs are consistently the most responsive to women who have suffered violence…They should be core service providers and key partners in the development of more effective interventions by state agencies, especially law enforcement and the legal system.'

The model sets out what makes rape crisis centres unique. These include three guiding principles: feminism; human rights; and equality, and five operating principles: gender-based power; reduced power analysis; survivor-centred approach; trauma-based approach; and hold perpetrators accountable.

Rape crisis centres are the only specialist organisations in the UK and Ireland which offer services to survivors of sexual violence from these guiding principles.

2. Supporting survivors in Scotland

The nature of sexual violence

Women and men of every age, race and religious background are raped and sexually assaulted. Research with women survivors indicates that the perpetrator is often someone they know. One study found that one in three women physically abused by her male partner is also sexually abused (Koss et al 1994) and significant numbers of women experience more than one type of violence (Greenan 2004). Prevalence figures for sexual assaults against women range from one in four to one in ten. However, there is thought to be significant under-reporting of sexual assault and this may be due to lack of awareness among agency staff; the absence of routine enquiry approaches; and/or women's reluctance to disclose if they think they may be disbelieved or harshly judged by agencies. This may be a particular issue for women involved in prostitution or who use substances. Some women, whether through choice or isolation or exclusion or other vulnerability, may never come to the attention of an agency.

Recorded crime statistics indicate that men are also sexually violated. While prevalence of sexual violence against adult men is much lower than for women, they may also be less likely than women to report sexual violence. The fact that many men do not report or seek support, can increase their isolation and trauma. As with female survivors, it is important for men to know that abuse was not their fault, and that sexual violence is a crime of power, control, and humiliation, not sexual orientation or masculinity.

The 2010 Stern Review concludes that 'around eight per cent of recorded rape cases are rape of a man. Men find it very difficult to talk about what has happened to them because of the common view that a man should be able to fight off an attacker. Male victims 'find it less easy to identify as victims and ask for help'.'

However, women and men who have experienced sexual violence are not a homogenous group nor are their experiences, responses or needs the same.

A recent scoping exercise commissioned by Rape Crisis Scotland (Henderson 2011) concluded that here is little Scottish research into the support needs of male survivors of sexual violence, and that what exists is largely about male survivors of childhood sexual abuse (CSA) which is the most common presenting issue for men. However, the evidence suggests that male survivors of sexual violence generally experience the same effects as female survivors: fear, anger, sadness, shame, embarrassment, mistrust and symptoms associated with trauma. Men may experience particular issues relating to masculinity, 'victimhood' and sexual identity associated with the 'meaning' of such violence in the context of society's expectations of men as well as (possibly) their physiological reaction to the abuse.

Commercial sexual exploitation (CSE) includes a wide range of, often linked, sexual activities which harm women and men and are described as sexual violence. Women and men involved in prostitution, are often on low incomes, substance users

and victims of other forms of gender-based violence. One study reported that 70% of women suffered rape in prostitution (Farley 2003); and another that 45% of those involved in prostitution had reported childhood sexual abuse (Home Office 2004).

Those from ethnic minority groups, gypsy travellers; those who are trafficked into sexual exploitation or who are disabled or in some way vulnerable may need types and levels of intervention which are sensitive to their circumstances, culture or ability.

Research into violence against women indicates that significant numbers of women experience more than one type of violence (Greenan 2004). The more complex the previous history, the more complex the response is likely to be. Given this, women need a range of interventions and services.

Identifying these needs and providing for such diversity are major challenges which need to be met by a multi-agency response, in which the rape crisis movement is central.

Providing dedicated services

The historical development of dedicated services for women who have experienced sexual violence is documented in a literature review commissioned by the Glasgow Violence Against Women Partnership (Dutton and Cavanagh 2003). The researchers make the important point that services provided by specialist agencies in the voluntary sector, such as rape crisis, are based on a feminist understanding of sexual violence and its relationship with other forms of violence against women while statutory services are based on the need to provide services to individual women.

This is consistent with Scottish Government policy which uses a feminist analysis and equalities framework to define violence against women, including sexual violence, as gender-based (Scottish Government 2009). The review concludes that women who have experienced sexual violence need a range of interventions including medical, legal, emotional, practical in crisis, short-term and long-term. It states that that no one agency can address all women's needs and so it makes sense for agencies to work together for the benefit of women. Educational and political interventions are also important for longer-term prevention. This multi-agency approach is also government policy.

In identifying what might be good practice given a lack of evaluation of multi-agency and other initiatives, the review cites a Department of Justice report (Kelly 1997) which sets out important factors to include when providing services for women who have experienced rape and sexual assault:

- Ensuring retention of choice and agency for victims
- Varieties of support should be available as rights whenever needed
- Provision of 'effective escape routes' when necessary
- Models should not be based on a purely medical model ignoring cultural and social contexts
- All policies and services should be mindful of the requirements of minority groups

Kelly also argued that integrated agency initiatives should retain a radical goal of eliminating sexual violence rather than merely responding to the short-term effects of victimisation. 15 years later, this still stands.

A report by Reid Howie for three support services in Fife considers the need for a range of support for survivors of 'all forms of sexual abuse' (Reid Howie 2005). It cites a Michigan study which calls for 'access for survivors to crisis support, counselling and advocacy…survivors may have a wide range of specific needs in many different areas of their lives, which require a complex and co-ordinated response' (Michigan Sexual Assault Systems Response Task Force 2001).

A literature review commissioned by the Scottish Executive describes best practice guidelines developed by Rape Crisis Network Europe for non-governmental organisations working with women who have experienced sexual violence. It recommends 'client-centred, accessible services, working with each woman to identify what she needs and then helping her to find appropriate support for her situation' (Greenan 2004). It concludes that some of these elements are 'shared by many other services in supporting survivors of rape and sexual assault' but notes a need for more research which evaluates different interventions. It also cites a study (Campbell 2001) which recommends three approaches to achieve the prevention of secondary victimisation of women; 'increased involvement of rape crisis services; increased training for all service providers; and the development of co-ordinated multi-agency responses'.

The principle of a multi-agency approach is now well understood by both generic and specialist services. It is over 30 years since the rape crisis movement first emerged in Scotland and the UK, and in that time there has been an enormous shift in responses to and attitudes to sexual violence. Although there is still a great deal to be done, the movement has been a prime motivator of and contributor to the network of support now available. This includes specialist approaches within generic services such as:

NHS response

A three-year programme of work to improve the identification and management of gender-based violence across NHS Scotland began in October 2008 with the issue of a chief executive's letter (CEL) to health boards. This letter outlined the areas of development required to fulfil the aim of adopting 'a systems approach to ensure that the NHS in Scotland fully recognises and meets its responsibilities around gender-based violence as a service provider, employer and partner agency'. Four key deliverables were agreed:

- Implementation of routine enquiry of abuse within priority settings
- Dissemination of revised guidance to staff on abuse
- Production of an employee policy on gender-based violence
- Multi-agency collaboration on gender-based violence particularly on child protection and homelessness

This work focused on routine enquiry about sexual and domestic abuse in six key settings including mental health, addictions, and sexual health where prevalence

was highest. Although the initial programme has ended, work continues within NHS Scotland.

Criminal justice response

The report on the Procurator Fiscal Service Review of the Investigation and Prosecution of Sexual Offences in Scotland (2006) made a series of recommendation to improve the response to victims of rape and serious sexual assault within the Crown Office and Procurator Fiscal Service (COPFS). This included publishing a comprehensive information pack for male and female victims of sexual offences, spanning information needs across the entire criminal justice process. Subsequent to the review, the Association of Chief Police Officers in Scotland (ACPOS) set up a working group which published guidance on how the police should investigate sexual offences and introduced a national curriculum on investigating sexual offences. The Sexual Offences (Scotland) Act 2009 introduced a statutory definition of consent and replaced the common-law offence of rape with a broader statutory offence which includes male rape.

Sexual assault referral centres

Sexual Assault Referral Centres (SARCs) were first established in the UK in the 1980s in order to improve services for those, with an emphasis on high quality and consistent forensic examinations. They have the dual aim of meeting both the medical and support needs of victims and the evidential needs of the criminal justice system. There is one centre in Scotland, Archway, which opened in Glasgow in 2007 and provides forensic medical examinations, sexual health screening, follow-up support and counselling to victims of recent serious sexual assault. It works with those, aged 13 and over, who have been assaulted within the previous seven days.

National awareness raising

The Scottish Government has funded Rape Crisis Scotland to run national awareness raising campaigns challenging women-blaming attitudes associated with rape. Funding has also been provided to the Women's Support Project in Glasgow to develop activities to address and raise awareness of commercial sexual exploitation.

Looking ahead

While, there is an improved response to survivors of sexual violence, including survivors of childhood sexual abuse, in the mainstream, and located within generic services, specialist services are as vital as ever. Indeed, the heightened awareness and improved response within the mainstream is, arguably, almost entirely due to the activity of the rape crisis movement and other organisations in the women's voluntary sector. This is because:

- They provide what survivors want
- They are informed by the survivor experience and voice
- They provide support alongside advocacy, at both the micro level with individuals and, at a macro level as agents for change

However, dedicated sexual violence services such as those provided by rape crisis centres, are vulnerable because of their funding status. Largely dependent on government funding, with other ad-hoc charitable income, they face the threat of standstill or decreasing budgets, and pressure to amalgamate with other organisations. Any agency in this position would face a risk to quality though high staff turnover, low wages and burnout.

There is some respite with RCS successfully negotiating funding from the Scottish Government (Rape Crisis Specific Fund) for three further years to 2015. This will support the RCS national office and helpline, and the 13 member centres. The Scottish Government's recognition of the work is vital because a recent rapid evidence assessment concludes that there is 'emergent evidence from the USA and the UK that, where there is no specialist provision, victim-survivors experience secondary victimisation in which loss of control over the process features heavily.' It goes on to say that 'resourcing and underfunding of services is a serious impediment in meeting service users' needs' (Government Equalities Office 2010). Campbell (2008) also notes that, in the absence of specialist provision, 'the majority of reported cases are not prosecuted; many do not receive complete medical care, and most do not have access to quality support services'.

3. What do survivors want?

Survivors of sexual violence are not a homogenous group nor are their experiences, responses or needs the same. These vary according to the intensity, level and frequency of abuse, the support they have, their circumstances and personal resilience.

Those who have been recently raped or sexual assaulted may need immediate medical and police intervention and someone to talk to; they may need counselling and advocacy support and a range of other assistance in the long term. They may need help with housing and welfare benefits, practical support such as safety alarms and applying for criminal injuries compensation. Those who experienced rape or sexual assault in the past may require ongoing health and emotional support. Survivors of child sexual abuse may need a range of interventions to help them cope with long-term physical and mental health consequences. Sexual violence in all its forms is associated with drug and alcohol misuse, a range of physical and mental health problems, self-harming, suicide and parasuicide which call for a variety of responses. For young women, there is a link between sexual abuse and teenage pregnancy (Coy et al 2010).

The Victim Experience Review (2009) found that women who had experienced rape wanted:

- To be believed
- To be treated with dignity
- To be reassured that it was not their fault
- To feel safe and comforted
- Not to feel like a 'victim'
- Services that support them and their family
- To feel in control
- To be able to make informed choices

Research into Sexual Assault Referral Centres (Lovett et al 2004) indicates that what survivors are looking for in the immediate aftermath of rape/sexual assault includes:

- The need to 'feel safe' during the process of reporting rape
- Access to a range of support services beyond forensic and medical services
- Automatic provision of female examiners and support staff
- Proactive follow-up support
- Case tracking
- Advocacy
- Easy access through the telephone to advice and information
- Access to support out of hours, especially in the evening
- Self-defence classes

Across all forms of support, the majority of survivors, including men, express a preference for female staff. Women in areas with no SARC said they not only had to cope with rape and the decision to report but also having to see male professionals. The research also finds that about a third of survivors dealing with recent rapes go to counselling, a far higher proportion value being able to talk to someone in a supportive, but not strictly therapeutic setting, either over the phone or in face to face sessions. It concludes that the needs of service users are not static, and their personal circumstances also differ (access to transport, employment, mobility all of which could be gendered) and that the more possibilities there are to access support at times, and in forms, that suit them – and especially if the model is proactive – the more likely unmet needs will be noticed and met.

A review of sexual abuse services in Fife gives an indication of what service users experiencing different forms of sexual violence are looking for (Reid Howie 2005). This includes:

- 'Provision of safe space
- General support
- Information
- Counselling
- Groupwork and opportunities to meet other survivors
- Telephone support
- Crisis support
- Practical support (e.g. form filling etc.)
- Advocacy
- Befriending
- Liaison with other agencies
- Support to move on
- Opportunities for outings and 'ordinary' events'

This list does not include any reference to sexual health or police/criminal justice agencies. This is consistent with other findings that women tend not to approach formal agencies.

Scottish models

In Scotland, there are various service models which operate within the framework of the violence against women agenda and which provide services to women across the range of sexual violence (for example Rape Crisis) and also on single issues (for example Women's Aid which works with survivors of sexual violence within the context of domestic abuse). There are good examples of multi-agency working across various forms of gender-based violence against women. These include Women and Children First in Renfrewshire and the CARA project in West Dunbartonshire (Challenging and Responding to Abuse).

In the statutory sector, Archway, for example, provides an immediate response to recent sexual assault (see page 9). A recent evaluation of Archway indicates that service users surveyed were highly satisfied with the service; and that the high standard of forensic and other services means that it is likely that the conviction rate

for Archway cases will be higher than the Scottish average. It concludes that the centre has 'undoubtedly improved immediate response to, and aftercare of, victims of sexual assault and may be making an important contribution to reducing attrition'. Although recognised as the gold standard in providing an immediate response to survivors of rape and sexual assault, given the economic climate there are no plans to open SARCs in other areas of Scotland.

Other models in the statutory sector in Scotland include EVA Services which provides a specialist service within NHS Lanarkshire to women experiencing any form of gender-based violence. West Lothian Council has established a service to provide crisis support to women who have been raped or sexually assaulted. The service is co-located with its domestic abuse service with the model mainstreaming the work so that it is less vulnerable to funding cuts. There are specialist sexual offences officers in all Scottish police forces and close cooperation between the police and Rape Crisis Scotland through its police referral scheme.

Rape Crisis in Scotland

Rape crisis centres are the only services in Scotland which offer both crisis and ongoing specialist support services to women over 12 experiencing any form of sexual violence at any time in their lives. Some also work with male survivors. Local centres affiliated to Rape Crisis Scotland work to national model policies and practices. RCS runs a national telephone helpline and provides support to the national network of centres through, for example, training, model policies and standards and developing new centres.

Both survivors and their families contact centres. They are looking for support about many issues including child sexual abuse (often dating back many years), being raped as an adult, sexual assault, sexual harassment at work, commercial sexual exploitation and ritual abuse. Centres are women-only and work from a feminist perspective, recognising that rape and other forms of sexual violence are crimes of violence and abuse of power. Centres provide both short-term and long-term support including telephone support, face-to-face meetings and accompaniment to agencies such as police, medical centres and lawyers. They are also involved in training local agencies; awareness raising, schools education and strategic and operational multi-agency working with local partners.

Rape crisis centres are located within the voluntary sector. Typically, centres run with a core of paid staff but also recruit unpaid workers to provide support to survivors. This is not a low cost option as volunteers need to be recruited, trained, supervised and supported but it is cheaper than running a service with paid staff only.

Defining an effective response to survivors of sexual violence

The value of dedicated services such as those provided by rape crisis centres were outlined, from the research evidence, by Professor Liz Kelly of the Child and Woman Abuse Studies Unit, in a presentation to the Rape Crisis Network conference in February 2010:

- When victim-survivors are asked what services are the most helpful, specialist sexual violence services and rape crisis centres in particular score the highest
- Rape crisis centres are most responsive to victim-survivors
- The presence of an independent service means that there is more likely to be social change work, including community prevention
- Merging domestic abuse and sexual violence services can result in victims of sexual violence being less well served
- What women value is what rape crisis centres attempt to offer – safety, holistic support, when and for as long as they need it
- Women want both better statutory AND women's services

The evidence from previous scoping studies for RCS and the best practice model highlight key requirements of a gold standard approach best exemplified by rape crisis centres and SARCs.

- Those affected by sexual violence have different needs, wants and experiences
- They overwhelmingly want women-only staff (male victims also prefer to speak to a female member of staff)
- It is important to provide for diversity within the population of survivors and the range of their experiences of sexual violence
- Services should take account of those with specific needs e.g. black minority ethnic and disabled women
- Services should be flexible in responding to the broad range of sexual violence
- Agencies should work together to provide the best response to women
- Services should be accessible to women wherever they live
- Training and raising awareness of sexual violence go hand in hand with service delivery

These principles are fundamental to considering the pros and cons of dedicated sexual violence services.

4. The evidence for (the pros of) dedicated sexual violence services

The literature review highlights the following 'pros' of dedicated services. For ease of reading, they are presented under the headings below, but some could sit under several headings.

1. Specialist services are internationally recognised as a core response

Council of Europe minimum standards (Kelly and Dubois 2008) state that 'the international knowledge and practice base suggests that services provided by specialist NGOs are consistently the most responsive to women who have suffered violence…They should be core service providers and key partners in the development of more effective interventions by state agencies, especially law enforcement and the legal system.'

2. Specialist services promote social change and a culture shift as well as supporting individuals

In a recent article, Nicole Westmarland concludes that there is a 'large body of knowledge about what works and what victim survivors want'; an array of policies and strategies, but that specialist services, because of the inconsistency of funding and implementation are 'far from fulfilling their true potential'. She also says that a 'culture of action' needs to replace cultures of 'silence' and 'scepticism and blame'. Specialist services, such as those provided by rape crisis centres are intrinsic to that culture shift. Not only do they provide what survivors need and want, they also challenge norms (Westmarland 2012).

This is well evidenced in Scotland, where the efforts of RCS have made a significant difference both to individual survivors, in negotiating for an expansion of services, and also in raising awareness and pressing for change. For example, RCS is currently campaigning for independent legal representation for complainers of sexual offences.

An evaluation of the current place of the work of rape crisis centres highlights 'poverty and weaknesses' as well as 'astounding strengths and successes'. It suggests that, from literature in the US and experience in the UK, that the future is uncertain. This is partly associated with advances in generic mainstream health, social work and voluntary sector provision. This is attributed both to the work of the feminist-based rape crisis movement but also a general shift towards 'professional counselling'. Rape crisis workers argue that the specialist services they provide are both 'unique' and 'necessary' (Jones and Cook 2008).

A study by Rebecca Campbell (1998) of 168 US centres finds that the rape crisis movement has remained adaptable to social change and notes that independent rape crisis groups may be more likely to continue social change work including community prevention than those which are affiliated with another organisation, despite the financial stability that this might bring.

An assessment of the effectiveness of sexual assault services in multi-service agencies states that rape crisis centres were intentionally independent from other social service agencies in order not to dilute their work on social and political change (Patterson 2009) a view which is also apparent in RCS' account of its early history (Rape Crisis Scotland 2009).

The Map of Gaps 2 notes that women's services (such as rape crisis centres and Women's Aid) have 'delivered on government and UN commitments to empower women and repair the harms violence does to individuals, social networks and communities.'

3. Specialist services benefit both survivors and communities

A history of the rape crisis movement in the US reviews the literature and concludes that it has brought benefits both to survivors and communities and that where there is a centre, the community is more responsive. It indicates that the benefits are extensive and include: better outcomes for victims; increased awareness in the general public; and improved coordination of assistance (Schmitt and Martin 2006).

4. Specialist services provide a critique of and may bring about improvement in mainstream services

In a later study, Martin (2009) states that a specialist organisation is as relevant as ever because, despite all the positive developments in responding to survivors over the past three decades, 'neither rape nor its victims are top priorities in most mainstream organizations'. She concludes, 'RCCs are singular in striving to make visible men's sexual violence against women and to challenge and eliminate it. For this reason, they should be around for some time to come.'

In Canada, 'victim assistance' models answerable to the police, health, criminal justice rather than 'equality mechanisms' are replacing rape crisis centres. They operate as 'extensions of the state' and 'exhibit no overarching commitment to sex equality and little or no capacity …..for women-centred critiques of mainstream institutional responses'. The remaining rape crisis centres are expected to cover a wide range of other social issues which have been cut from government with little funding to do so.' (Lakeman L in Westmarland and Gangoli 2012)

5. Specialist services offer a survivor-centred approach which is valued by survivors

The Map of Gaps 2 indicates that most specialist services are run by voluntary sector organisations although some, such as Sexual Assault Referral Centres exist in the statutory sector. Specialist services in the voluntary sector allow women to:

- Overcome shame and stigma
- Talk about their experiences without fear
- [Have] the possibility to explore their options
- Seek justice

- Repair some of the harm the violence has caused and move on with their lives (page 8)

The report concludes that that there is a need for such services because of the nature of such abuse; its impact; and because specialised services allow women to 'name, address and move on from the violence'. The report also notes the added value such organisations bring.

This is consistent with a 2005 report by the Australian Institute of Criminology which recommended increased support for sexual assault centres and specialised service providers on the basis that women highly value specialised knowledge and support (Lievore 2005) and that specialisation brings particular benefits (Kingi and Jordann 2009).

One study cited in a Government Equalities Office review indicates that only rape crisis centres were able to be 'uncompromisingly victim-survivor-centred' (Campbell and Wasco 2005 cited in Brown et al 2010).

While specialist services in the statutory sector are important, they are patchy and tend to focus on recent rape and sexual assault. Most services come from the rape crisis movement. Treating rape and other forms of sexual violence simply as a 'crime or a health issue ignores that what most women need is to be believed and to be heard' (Jones and Cook 2008).

Also, focusing on a purely medical model, for example, pathologises women as 'victims' and 'belies prevalence studies on the extent of sexual violence' and ignores '…the feminist argument … that violence is everyday, mundane and the world is unsafe' (Kelly 2011).

6. Dedicated rape crisis centres see a broader range of survivors including those who have chosen not to report in the past

Dedicated services successfully reach survivors which other services do not reach. A UN overview of the challenges of 'integrating survivor support programmes' into the healthcare system, noted that rape crisis centres also see a broader group of survivors than those accessing health facility-based services including survivors who have chosen not to report to the police and who are seeking help for abuse that occurred in the distant past (Council of Europe 2008 cited in UN Virtual Knowledge Centre to End Violence Against Women www.endvawnow.org).

7. Survivors themselves are more likely to contact dedicated sexual violence services

Most victim-survivors do not contact or often delay contacting formal agencies such as health but they do tell someone (Kelly 2011).

There is conclusive evidence that survivors of sexual violence approach dedicated women's services such as rape crisis and Women's Aid because their needs are not met in the mainstream. Looking at this evidence in detail, a recent study comments,

'domestic violence and sexual assault agencies offer an important and unique human service' (Macy et al 2011).

8. Rape crisis centres provide survivors with responsive services which meet their needs

Comparing rape crisis centres with mainstream services indicates that centres are both responsive to the needs of survivors and engaged in social change (Campbell, 2006, Campbell and Martin 2001; Martin, 2005 cited in Patterson 2009). They also provide a complete range of services which is important as survivors have multiple needs (Patterson 2009).

The Stern Review (2010) concludes that supporting and caring for victims should be prioritised. With a focus particularly on SARCs and Independent Sexual Assault Advisers, the review emphasises victims' rights to services which will help them 'recover and rebuild their lives. Victims and those who work with them told us that the criminal justice process is important but getting support and being believed is as important.'

9. Survivors rate specialist sexual violence services highly

The key findings from a New York city-wide report which includes survivor perspectives indicate that survivors are more satisfied with specialist services, particularly rape crisis centres (Fry 2007). Findings include:

- Survivors are more satisfied with care they receive at hospitals that have a Sexual Assault Forensic Examiner
- Volunteer rape crisis advocates are an important component of survivor care
- Many survivors did not receive adequate medical care and follow-up from the hospital
- Out of all sectors, survivors were most satisfied with the care they received at rape crisis programmes

A review of research from the USA, New Zealand and Australia notes that when asked to evaluate helpfulness and satisfaction, survivors rate specialist sexual violence services most highly with rape crisis centres scoring highest (Brown et al 2010).

10. Women find specialist services in the non-profit sector more helpful and are more likely to return for further help

A study of women's perceptions of the helpfulness of domestic and sexual assault agencies found that women found non-profit victim services more helpful. This perception was based on the behaviour of staff. For (the small sample) of women contacting sexual assault agencies, the more they felt in control, the more likely it was that they would contact such services again for help (Zweig and Burt 2007).

This is consistent with the minimum standards required to support survivors specified by the Council of Europe (Kelly and Dubois 2008).

11. There are positive effects and outcomes for survivors in contacting dedicated sexual violence services

Fry (2007) concludes that, unlike other services and sectors, rape crisis 'programs' provide 'victim-centred care to promote the healing and recovery from trauma'.

A survey of 35 rape crisis centres in England found that there were positive effects in contacting centres for 'survivors, their loved ones and wider communities'. Survivors reported outcomes including improved mental wellbeing, reduction in self-harming, better interpersonal relationships, ability to return to work or study and ability to reduce or stop medication. Only ten per cent of those contacting centres had contacted the police. Well over half of survivors contacted centres because of sexual violence which happened at least three years previously (Rape Crisis England and Wales n.d.). [Late insertion: the RCS Annual Report 2012 shows that less than a quarter of survivors in touch with rape crisis centres in Scotland have reported to the police. Three in four survivors contacted centres about sexual violence which occurred at least a year previously (RCS 2012).]

A recent literature review (Westmarland et al 2012) looks at the evidence for the value of specialist services over time. Although noting a dearth of longitudinal evidence, she cites evidence into specialist advocacy support which shows that 'women who have access to a sexual violence advocate experienced less distress than those who do not have this support, especially if the perpetrator is known to the victim' (Campbell and Raja 1999) and that having 'specialist advocates led to improved outcomes for victims, including reducing the number of negative responses from the police and health professionals, and buffering against the distress caused by the legal process' (Campbell 2006).

Survivors participating in a Home Office review indicated that specialist women's services played a crucial role in providing them with 'therapeutic individual and group support' which 'aided their recovery ….by addressing…self-esteem and empowerment' (Women's National Commission 2009). Indeed, women want more of these services. It continues: '…women said they valued services provided by women's organisations which are accessible; safe and which respond holistically to their needs, and provide support beyond a crisis, and for as long as women need it to recover from the abuse.'

An assessment of evidence for the Government Equalities Office noted the consistent finding that 'where there is no specialist provision many victim-survivors experience secondary victimisations and poor practice; the majority of reported cases are not prosecuted; many do not receive complete medical care; and most do not have access to quality mental health or support services' (Brown et al 2010). It cites a report by Sampsel et al 2009 which associates specialisation with increased service use: introducing specialisation in a hospital emergency room doubled the number of cases seen.

12. Survivors may be more likely to report the abuse to the police

Access to women's sexual violence support services is 'a significant factor in enabling women to report rape and sexual violence to the police and to support the case through court' (Women's National Commission 2009).

13. Survivors may experience secondary victimisation in other services

There is considerable evidence that victims are often treated poorly by statutory services and systems set up to protect them, associated with increased trauma 're-victimising' the survivor. Campbell cited in Fry 2007 found that victims experienced 'more distress about their contacts with the medical and criminal justice systems than service providers thought they were experiencing'.

A study of 102 rape victims in the USA found that survivors were more likely to tell informal (such as friends and family) rather than formal support providers (such as the police). Victims approaching formal support providers were more likely to receive negative reactions (Ahrens et al 2007).

14. Specialist services are important for coordinating services

Specialist services can provide a vital link across the various agencies which support survivors. Perceptions of helpfulness in specialist services increase when 'victim agencies interact with the legal system and other relevant agencies in their community' (Zweig and Burt 2007).

15. There are different ways of providing specialist sexual violence services

A study comparing Sexual Assault Referral Centres with rape crisis centres showed that each setting had a different emphasis and each had notable benefits for victims. For example, rape crisis centres were able to work with survivors of historical sexual violence; and were seen as being more independent. Survivors saw this as a particular benefit which meant that survivors were more likely to approach them. The study concluded that the two approaches are different yet complementary and that both are important for survivors (Robinson and Hudson 2011).

Having a diversity of services and different 'entry points' is important to increase the likelihood of survivors finding help. Map of Gaps 2 recommends that government and commissioners should aim for this in order to 'ensure multiple routes into support as well as providing targeted services to meet specific needs.'

The Council of Europe's minimum standards for support services also state that 'there are elements of any effective support system which are the responsibility of the state, and without which NGOs cannot operate effectively' such as 'law enforcement and health services in the aftermath of sexual violence' (Kelly and Dubois 2008).

Siting a specialist response within a generic service may improve the latter. An overview of responses emphasises the value of a specialist approach within a generic service, noting that rape survivors receiving hospital help from non-specialised staff receive inadequate and unethical care and reporting on the positive results of the Sexual Assault Nurse Examiner programme in the US (Council of Europe 2008 cited in UN Virtual Knowledge Centre to End Violence Against Women www.endvawnow.org).

16. Independent services are more accepted by service users

Patterson's 2009 review of the literature indicates that 'free-standing programs' are more effective than those which are housed within other services. This is because they are more accepted by service users and others; are more inclusive; provide a wider range of services; and are more engaged in social change activities. They are also seen as beneficial by other agencies, and they are more likely to refer to them than those affiliated to other organisations.

17. Combined services may disadvantage survivors and also education/prevention activities

Patterson (2009) also finds that if 'free-standing programs' are affiliated with other organisations, then those 'affiliated with domestic violence organisations hold the most advantages given their similar missions of ending violence and improving survivors' lives'. However, in this scenario, domestic abuse is likely to be given higher priority and more funding, and the service is more likely to be perceived by the community and other services as a domestic abuse service. There are concerns that merging rape crisis centres with other organisations 'might affect the availability and substance of services'. It is important, therefore, to ensure that a strong focus on sexual violence and separate management is built in from the outset. The same report describes various models for organisational structures and recommends more research given a lack of systematic reviews of the combined effect of organisational affiliation and structure on rape crisis centres' effectiveness.

A study of independent and multi-service centres found that combined 'domestic violence/sexual assault' services were less able to reach sexual assault survivors(particularly teenagers), to educate the community about sexual assault and to work on rape prevention. Dedicated sexual assault services promoted more inclusive definitions of sexual assault, incorporated cultural concerns in their work and initiated education programmes targeted at young people and men (O'Sullivan and Carlton 2001).

Merging rape crisis services into other organisations might affect the availability and the nature of services. Domestic violence services tend to be more time and resource intensive than sexual violence services because they deal with crisis and so the former take priority over the latter (Patterson 2009).

18. Differences between domestic abuse and sexual violence services mean that dual programmes may dilute work on sexual violence

There is not scope here to go into the relative history, approaches and responses of different organisations and services. However, Melissa DeDomeico-Payne (2006) discusses her personal experiences of working in the US in a 'standalone domestic violence program'; a 'standalone sexual assault program' and a 'dual program'. She notes some advantages of dual programmes but concludes that in these, domestic abuse services are prioritised over sexual assault services noting 'only in standalone rape crisis programs have I seen fully staffed sexual assault services with short and long-term support for survivors, civil and criminal justice advocacy, and expansive prevention and education'. While acknowledging that there may be a case for 'joining organisations', this would have to be on an equal footing. There may be more likelihood of achieving equity by forming a new organisation.

Others in the same alliance argue that a joint focus on sexual and domestic abuse can provide comprehensive services for survivors. Yet they also acknowledge that the 'community responds to sexual assault and domestic violence differently', with sexual violence more silenced. Since the community also sees such services as focused on domestic abuse, it is hard to reach survivors (Virginia Sexual and Domestic Violence Action Alliance 2006).

In setting minimum standards for violence against women support services, a report for the Council of Europe, considers specialist sexual violence services noting that 'while there was recognition amongst a minority of respondents that domestic violence and sexual violence were often intertwined, it was sometimes erroneously presumed that domestic violence service providers were able, and did, cover both. Recent research suggests that such assumptions are inaccurate (Ullman and Townsend, 2007), even where the offender is an intimate. Even if it were the case, it would still leave women sexually assaulted by other categories of offenders without protection or support (Kelly and Dubois 2008).

19. Survivors of sexual violence have unique needs which benefit from a unique service, but there is also scope for collaboration

A literature review by Macy et al (2009) found that both sexual assault and domestic violence services assist survivors using similar strategies and that there are ways in which these services could be 'fruitfully combined'. Different agencies may have common goals. For example a review of directors of domestic violence and sexual assault services in North Carolina found that providing emotional support to survivors was a main priority common to both sectors. Other priorities varied but the review suggests that there may be more commonalities than differences (Macy et al 2011).

But Macy et al (2009) also show that the needs of survivors of sexual violence and domestic violence are different and unique and that each requires specialised knowledge. The researchers comment '...it is likely challenging, if not impossible, for an individual service provider to acquire all the knowledge and skills to effectively and equally help survivors of each violence category.' They recommend that specialist services collaborate closely, particularly when a survivor has experienced 'multiple victimisation' so that survivors receive effective support from whichever service they approach.

20. Specialist services represent value for money

Ullman and Townsend 2007 cite a study in Illinois by Wasco et al 2004 which indicates that rape crisis centres are ‘an effective use of taxpayers’ money’.

This is important because the current financial climate may affect funding allocations in Scotland after 2015. The unstable global economy has already meant severe cuts to the public sector and this has serious implications for specialist services in the voluntary sector. It is not known how decisions will be made about future priorities and whether these will be based on social/ethical rather than financial criteria or whether the gendered impact will be acknowledged within decision making.

Financially, there is no doubt that the cost of sexual violence to the public purse is significant. Sylvia Walby concluded that domestic violence alone cost £23 billion in England and Wales in 2001 (updated to £16 billion in 2009) (Walby 2004). These costs are based on the cost of services; lost economic output; and human and emotional costs. She states that the figures ‘do not extend to all forms of gender based violence or violence against women, although they do include the cost of serious sexual assaults within relationships. If these wider forms of violence were to be included, the costs would rise’. The Home Office estimates that the total cost of sexual offences committed in England & Wales in 2003-04 was nearly £8.5 billion with the health-related costs alone of each rape case estimated at £73,487 (Home Office 2005).

The costs of not providing a suitable response to sexual violence have not been quantified. But they are likely to be enormous both in the short and the long-term. Responding effectively, including prevention work, may stop people from falling back into the system or stop a need from ever arising.

5. The evidence against (cons of) dedicated sexual violence services

The literature review found very little which might be interpreted as evidence against dedicated sexual violence services. There is a lack of empirical or 'non-biased' evidence. Discussing a study by Logan et al, one study noted that rape crisis centres may not have referred women with negative experiences of their service as research participants (Logan et al in Ullman and Townsend 2007). Also a literature review by Kingi and Jordann (2009) discussing the benefits of specialist sexual violence services notes that 'few studies include victims/survivors who did not receive help from SSVS'.

The main issues which emerge could be described as evidence for increased funding which, according to Patterson 2009, is critical to sustainability and availability of services to survivors.

1. Vulnerability to cuts

Dedicated services may be vulnerable to funding cuts. A report by Rape Crisis England and Wales notes that securing funding is a 'relentless and constant challenge' which can affect staff morale, the level of services and, in the worst case mean that centres have to close (Rape Crisis England and Wales n.d.) Although the funding situation is different in Scotland, nevertheless there is a global economic crisis and a bleak financial forecast.

2. The effects of this on quality

This could affect quality of service with centres in the above survey indicating that they had to keep costs down in funding applications, with staff salaries for example, 'well below the market value'.

Scarcity of resources limits development in rape crisis centres (Ullman and Townsend 2007 cited in Government Equalities Office 2010).

Ullman and Townsend 2007 also comment on a lack of resources for rape crisis centres and a consequent lack of staff promotion or pay increases, and high staff turnover and burnout. They also mention the need for improvements which could enhance ability (of advocates) within centres, but that these improvements require resources. These comments are not critical of rape crisis centres per se. Indeed they say that support is 'vital given that rape crisis centres are the only support system whose goal is to help victims navigate their recovery and to obtain help from other service systems.'

3. Reliance on volunteers

Rape crisis centres rely on volunteers, for a combination of financial and political reasons. There is a lack of research into the value of volunteers/impact on services

of volunteer turnover retention rates (Ullman and Townsend 2007 cited in Brown et al 2010).

4. Consequences of effects on stability

Given the instability of dedicated services, such as rape crisis centres, being affiliated to other organisation may increase stability. Patterson 2009 notes that sexual assault is more under-funded than domestic abuse and that rape crisis centres affiliated with hospitals have the biggest budgets (although those affiliated with domestic abuse agencies had the least funding for sexual assault.)

5. Rape crisis centres/staff may lack power compared to statutory services

Advocates (and by implication rape crisis centres) have less power than legal/medical staff (Brown et al 2010). This could affect the extent to which they can assist survivors and/or how they are viewed by other services or the community generally.

6. No longer necessary given that other (mainstream) services now exist

Some argue that mainstream organisations treat rape as a legitimate issue and so specialist organisations are no longer relevant. The sources are cited and refuted in Martin 2009.

7. No long-term evidence of the benefits

There is a lack of evidence about long-term impact although this situation is improving (Brown et al 2010). A recent study notes that although rape crisis centres have supported survivors since the seventies, there is little research to demonstrate their impact, particularly long-term outcomes although this has begun to shift (Westmarland et al 2012). The 'taking back control' tool developed by Westmarland for rape crisis centres in England offers a method for collecting longitudinal data. RCS commissioned an evaluation toolkit in 2011 and this will assist local centres to be more rigorous in collecting evidence about their work.

6. Conclusions

This is a brief overview which highlights main themes which emerge consistently in previous research. This includes research into different responses to survivors commissioned by the UK Government and the Council of Europe and which take close account of survivors' views.

The literature review indicates that rape crisis centres offer a unique and vital response for survivors of any form of sexual violence, regardless of when the abuse occurred. This differentiates them from other specialist sexual violence services in the statutory sector which tend to work with survivors of recent assault and other specialist violence against women services.

There are overlaps between specialist services in the voluntary sector (for example between rape crisis and Women's Aid). For example some survivors are common to both; there are similarities in ethos, analysis and goals. However, the evidence also shows that there are differences in goals, approach and also in the experiences of survivors.

This suggests a need for close collaboration between domestic abuse and sexual violence services in order to fully support survivors, for example those who have experienced sexual violence from a partner. This includes cross-training and shared knowledge.

It is not an argument for amalgamation because there is evidence from the US that, in dual services, survivors of sexual violence are disadvantaged; and that work on raising awareness of sexual violence is diluted. Free standing programmes are seen as more accessible; more inclusive; offering a wider range of services; and more engaged in social change. However, if a dual service, affiliation with a domestic abuse agency is more beneficial than with, say, a health agency. There are various models of dual services operating in the US with some specifically maintaining independence including separate budgets for sexual violence.

New organisations rather than merged organisations may serve survivors better, and for all survivors, there are benefits associated with cooperation, collaboration and consistency in whatever service they approach.

The literature makes it clear that non-governmental organisations provide a survivor-led response; are better at responding to historical sexual violence; and can improve take up and quality in mainstream services.

Dedicated services, such as those provided by rape crisis, benefit survivors and the wider community. Survivors rate them highly and express a high degree of satisfaction. Survivors get better help than they do in mainstream services and an advocated route into mainstream services (generic and specialist) should they wish this. Mainstream services may 'revictimise' survivors and may be unaware that they do so.

Survivors of sexual violence benefit from a multi-agency response. Specialist services are vital in ensuring that this response is mediated and coordinated and relevant to survivors across the many types of sexual violence experienced across the lifespan. Dedicated sexual violence services also help to ensure that specialist services in the statutory sector and generic services are geared up to help survivors properly.

Rape crisis centres have a long history, are resilient and have survived against the odds. Despite continuing pressures, partly because they remain independent in spirit and outlook, they provide services which survivors use in numbers, because they provide what survivors say they need: including belief, safety, discretion, not to be judged, expertise, empowerment and advocacy.

Satisfaction is likely to mean improved outcomes for survivors. Examples would include improved long-term physical and mental health; decreased reliance on costly statutory services, including mental health and addictions; and increased productivity in the labour market associated with reduced absenteeism. Despite a lack of evidence about long-term outcomes, this is a changing picture. Rape crisis centres are now developing ways to demonstrate these.

Much sexual violence goes unreported and there is a low conviction rate for those offences which are reported. It is fairly well agreed that this is to do with the nature of such violence and the criminal justice process as well as prevailing attitudes about rape and other forms of sexual violence. This means that there is an ethical case for supporting dedicated sexual violence services because there is a lot of suffering which remains invisible or is exacerbated by an unsatisfactory response.

This does not simply mean doing more of the same for those who come forward, but also doing something for those who are invisible and who do not yet come forward. This is important for longer-term prevention, creating community awareness and for reducing tolerance or acceptance of sexual violence.

Given that survivors, when they do come forward, approach rape crisis services in particular, reducing such services or rendering them less visible is not helpful.

While dedicated services are beneficial for individual survivors and their families, they may also represent a massive cost saving to the public purse. There are threats to standalone services (because of funding). But the evidence is that independent services benefit survivors and maintain a focus on sexual violence. This is important for awareness raising and challenging cultural norms about the acceptability of gender-based violence. This is also a long-term economic benefit.

So, over and above the moral and ethical duty to provide the sorts of services that survivors actually want and which do them some good, and which do not risk re-victimising them, there is an economic argument for them.

The health costs alone are clearly substantial but sexual violence is not simply a health issue or NHS responsibility. Other interventions might not only reduce the health burden/costs but a wide range of other costs to the public purse (for example

from loss of earnings and productivity and homelessness). Costs to the community could be reduced by having more effective services.

Although cheap and cost effective, specialist services for women affected by sexual violence are seriously underfunded, although the picture is healthier in Scotland than the rest of the UK. Despite a recent injection of central government support, the RCS network relies heavily on volunteers. While there are community and individual benefits in using volunteers, it also places constraints on the level and type of service which can be offered.

The costs of not providing a suitable response to sexual violence have not been quantified. But they are likely to be enormous both in the short and the long term. Responding effectively, including prevention work, may stop people from falling back into the system or stop a need from ever arising.

But more than there simply being a cost to the community which could be reduced by maintaining high quality specialist services, supporting them to do their job might make their own and other existing services more effective. It is possible that the right investments, in the right way, might have a multiplier effect. By responding in the right way, it may be possible to make what is currently available more effective. 'Quick fixes' based on a need for short-term savings may do more harm than good.

Dedicated services, such as those provided by rape crisis centres provide an overview of the whole phenomenon of sexual violence, including how attitudes and culture affect it as well as providing a direct service. They spend time and attention on what is good practice. It is not clear than any other organisation would do this.

There is a need for more evidence about the long-term impact of such services on survivor outcomes; and for more evidence of the views of survivors who have chosen not to go to a dedicated service such as rape crisis or are unhappy with the quality or outcome of the response they have had from such services.

The literature sounds a note of caution for rape crisis centres about what might or might not be funded and the impact of a mainstreaming agenda on their services and for survivors who slip through or are excluded from the mainstream.

The literature makes it clear that dedicated sexual violence services are necessary. Survivors need and want the support they offer and it is not available anywhere else. It also suggests that sexual violence is not so well served in merged violence against women services. However, given the current financial climate, there may be potential for rape crisis centres to work in closer alliance with organisations which share similar goals and ethos, and may share some survivors, such as Women's Aid. This could be of particular benefit for survivors who have experienced multiple victimisation and would ensure that they receive effective support from whichever service they approach.

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