REPORT OF THE
DEPARTMENT OF HEALTH

Response to and Prevention of Sexual Assault in the Commonwealth of Virginia

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 18

COMMONWEALTH OF VIRGINIA
RICHMOND
2005

Preface

Authority

Senate Joint Resolution 131 requests the Virginia Department of Health (VDH) to study the statewide response to sexual assault victims and the prevention of sexual assault. It directs VDH to examine the responses, prevention programs and activities of law enforcement, sexual assault crisis centers and other advocacy and support services, medical personnel, and the judicial system and design a plan to provide the General Assembly with recommendations for improvement.

Study Group Members

Susan Carson
MCVH Forensic Nurse Examiners

Kathleen Demro
Victim Services Unit
Department of Criminal Justice Services

Ruth Micklem
Co-Director
Virginia Domestic and Sexual Assault Action Alliance

Rebecca K. Odor
Director of Violence Prevention
Center for Injury and Violence Prevention
Virginia Department of Health

Barbara E. Parker, RN, MPH
Nurse Consultant
Division of Women's and Infants' Health
Virginia Department of Health

Shani C. Reams
Sexual Assault Services Coordinator
Virginia Sexual and Domestic Violence Action Alliance

Tina Simms
Family Violence Surveillance Coordinator
Office of the Chief Medical Examiner
Virginia Department of Health

Jennifer Woolley
Sexual Assault Advocacy Coordinator
Virginia Sexual and Domestic Violence Action Alliance

Study Authors

Cecilia E. Barbosa, MPH, MCRP
Principal, NiCe, LLC

Dianne Cyr Carmody, Ph.D.
Associate Professor and Internship Director
Department of Sociology and Criminal Justice
Old Dominion University

Randy Gainey, Ph.D.
Associate Professor and Graduate Program Director
Department of Sociology and Criminal Justice
Old Dominion University

Brian Payne, Ph.D.
Chair, Department of Sociology and Criminal Justice
Old Dominion University

Stacey B. Plichta, Sc.D.
Associate Professor
School of Community and Environmental Health, College of Health Sciences
Old Dominion University

Gina Sajko
Research Associate
Old Dominion University

Tancy Vandecar-Burdin, MA
Associate Director, The Social Science Research Center
Old Dominion University

Table of Contents

Authority ii
Study Group Members ii
Study Authors iii
Table of Contents iv
Executive Summary v
Introduction 1
Purpose of Study 1
Study Methods 1
Definitions 2
Prevalence and Incidence of Sexual Assault in Virginia 2
Response to Sexual Assault in Virginia 8
State Plan for the Prevention and Intervention of Sexual Violence 8
Review of Law Enforcement and Criminal Justice Response 10
Treatment and Services Provided to Victims by the Health Care System 11
Medical Strategies Regarding the Care of Victims of Sexual Assault 12
Results of the Emergency Department Survey 13
Results of the Primary Medical Practice Survey 18
Recommendations 22
Sexual Assault Crisis Centers 23
Overview 23
Sexual Assault Crisis Center Staffing 25
Services Provided by Sexual Assault Crisis Centers 26
Areas of Challenge for Sexual Assault Crisis Centers 35
Collaborative Efforts from the Perspective of Sexual Assault Crisis Centers 37
Collaboration as Viewed by Representatives of State-Level Organizations 44
Recommendations 45
Sexual Assault at Colleges and Universities 46
Collaboration Issues for College Campus Sexual Assault Centers 49
Gaps in Services 51
Recommendations 51
Summary of Recommendations 52
References 55
Appendices

Executive Summary

Introduction

In 2004, the General Assembly passed Senate Joint Resolution 131, requesting the Virginia Department of Health (VDH) to study the statewide response to sexual assault victims and the prevention of sexual assault. SJR 131 directs VDH to examine the responses and prevention programs and activities of law enforcement, sexual assault crisis centers and other advocacy and support services, medical personnel, and the judicial system and design a plan to provide the General Assembly with recommendations for improvement. Specifically, VDH was to:

- Review law enforcement and criminal justice statistics and interactions with victims, identify inconsistencies and determine causes;
- Determine treatment and services provided to victims by medical personnel throughout the Commonwealth;
- Examine sexual assault crisis center delivery in each locality to determine availability, accessibility and comprehensiveness;
- Determine prevention efforts in communities and across the Commonwealth and how such efforts can be enhanced; and
- Survey collaborative efforts between all agencies and organizations that work with victims of sexual assault.

Study Methods

VDH coordinated the study in collaboration with the Virginia Domestic and Sexual Assault Action Alliance and the Department of Criminal Justice Services. In addition, a team of researchers at Old Dominion University were very instrumental in completing several aspects of the study including a review of data on the prevalence of sexual assault and characteristics of victims and perpetrators; a review of the criminal justice and law enforcement data; a review of state-level plans that address sexual assault; an analysis of data collected by sexual assault crisis centers; surveys of emergency departments and primary care medical practices; a survey of sexual assault crisis center directors and workers; in-depth interviews with sexual assault crisis center workers; and focus group interviews with various professionals involved in the response to sexual assault, including workers from local sexual assault crisis centers, campus officials involved in campus response to sexual assault, and officials working at the state level in agencies that respond to sexual assault.

Sexual Assault in Virginia

According to the Bureau of Justice Statistics 2004 National Crime Victimization Survey (NCVS), in 2002 and 2003, there was an average of over 223,000 incidents of rape or sexual assault per year in the United States, which is a victimization rate of .9/1,000 population. A recent survey by VDH (Masho & Odor, 2003), the only statewide study of sexual assault in Virginia, indicated that one in four women and one in eight men in Virginia have been victims of sexual assault. Eighty-seven percent of female victims and 96 % of male victims were under the age of 18 when they were assaulted. Furthermore, 20 % of female victims and 25 % of male victims reported multiple assaults by the same person.

In Virginia and nationally, incidences of sexual assault continue to be severely underreported. According to the NCVS, in 2003 less than 40 % of victims reported the assault to the police, a lower rate than any other violent crime. Although national reporting rates for sexual assault have

increased dramatically in the past decade, the reporting rate continues to be less than 50 %. In Virginia, only 12 % of female victims and less than 7 % of male victims reported the crime to the police (Masho & Odor, 2003).

Law Enforcement and Criminal Justice Data

When sexual assault is reported to law enforcement, police officers are the first responders and play a critical role in the investigation of a sexual assault, from interviewing the victim, following leads and gathering evidence in a thorough and comprehensive manner. The police response to sexual assault not only represents the first contact a victim has with the criminal justice system, but also continues to have an impact throughout the rest of the process.

Between 1999 and 2001, there were an average of 1,720 reports of forcible rapes in Virginia, of which 503 (29%) resulted in arrest. (Crime in Virginia, 1999 & 2000 & 2001). According to data reported to the Federal Bureau of Investigation (FBI) through the Uniform Crime Reports (UCR), national clearance rates are typically lower for forcible rape cases than for most violent crimes. For example, in 2002, 44.5% of forcible rape cases known to the police were cleared by an arrest or through exceptional means. This is lower than for murder (64%), aggravated assault (56%), and is only higher than robbery (25.7%) among violent crimes for which the UCR collects data.

The Virginia State Sentencing Commission provides an annual report on the number of convictions and compliance with state sentencing guidelines. Between 2001 and 2003 there were, on average, about 225 annual convictions for forcible rape (about 45% of the average arrests for rape). There are on average about twice as many convictions for sexual assault each year (479) than for rape. For sentencing, judges are provided a standard sentence range (a presumptive sentencing range) depending on the type and severity of the offense and the offender's prior record. However, judges can depart from the recommended sentence if they provide a reason in writing. Over two-thirds of both rape and sexual assault cases receive sentencing that complies with guidelines. Of the nearly one-third of cases whose sentences did not comply with guidelines, a large percentage of forcible rape cases received a lower sentence than recommended, while for sexual assault cases, an equal percentage received sentencing above and below the recommended sentence.

The time constraints of this study did not permit additional analysis of law enforcement and criminal justice response. Further study is recommended.

Medical Treatment and Services

Emergency departments (ED) in Virginia were surveyed regarding their response to sexual assault. The survey identified several gaps in service. Half of all EDs do not have a forensic nurse on staff, and 44% do not offer a forensic nurse to all victims. EDs also have significant training needs that are not being met. Almost half (46%) do not have a formal training plan, and only a small minority (14%) report having provided training about sexual assault to medical staff in the past year and over a quarter of EDs rated their training as fair or poor (39%). EDs also need help in implementing universal screening for sexual assault victimization. Only a small minority do so (5%) and about one-third (34%) rate themselves as fair or poor in screening. Further, over a quarter of hospitals do not offer the services of a sexual assault crisis companion/advocate for the victim during the examination, and one in five do not offer to have a sexual assault crisis advocate meet with the victim.

Primary care practices were also surveyed. The most critical finding emerging from the primary care practice survey is that the primary care medical practices, for the most part, do not view sexual assault as an issue for their patients. Many did not complete the survey, stating that 'they don't see rape', or that 'they refer 'that' to the emergency department'. Even among those that responded to the survey, most (75%) do not usually screen for sexual assault, so they probably do not know the extent to which past and current victims make up a part of their patient base. Most practices (89%) do not have any staff trained to assist victims of sexual assault and less than one-third have a relationship with a sexual assault crisis center. The primary medical practices recognize these needs: over one-fourth rated themselves fairly or poorly in training (78%), working with a sexual assault crisis center (41%), screening patients (31%), and working with patients who have been sexually assaulted by intimate partners (28%).

Sexual Assault Crisis Center Delivery

There are currently 37 sexual assault crisis centers in Virginia. Of those 37, only 12 agencies address sexual assault alone. The remaining 25 address both sexual assault and domestic violence with varying degrees of resources specifically allotted to sexual assault. The most common types of counseling/support services the centers provide are individual support, crisis counseling, follow-up counseling, and support groups. Less common are services such as individual therapy, support groups for partners of sexual violence victims, male survivor groups, and teen survivor groups. Personal advocacy, court accompaniment, medical accompaniment, and accompaniment on law enforcement interviews are among the more common accompaniment/advocacy services. Sexual assault crisis centers also routinely help victims file victim compensation claims and fill out victim impact statements. They are rarely involved in providing expert witness testimony or academic advocacy. Additionally, emergency assistance services, emergency clothing, food, shelter, and transportation are provided by about sixty percent of the crisis centers. The centers routinely make referrals to several agencies including mental health providers, medical professionals, the commonwealth's attorneys, legal advocates, victim/witness advocates, substance abuse counselors, food/clothing providers, and transportation assistance.

The sexual assault crisis centers devote much effort to education and public awareness. General community education, agency brochures, volunteer training, and training of allied professionals are the most common types of educational services provided by the centers. Many centers also offer prevention initiatives and sexual harassment training in the workplace. Fewer centers offer peer education groups or advertise their services through marketing techniques such as television, radio, and yellow page advertisements due to lack of resources.

According to results of interviews with staff of sexual assault crisis centers, inadequate staffing presents a challenge for many of the centers. In addition to staffing, many crisis centers often are unable to provide the following types of needed services due to lack of funding: services for specific groups of victims such as partners of sexual assault victims; elder abuse victims; male sexual assault survivors; child victims; and teen victims; public awareness campaign strategies, such as billboard, television, and radio ads to promote awareness about the centers' services and educate the public about sexual assault; and sign-language and foreign language interpreters.

Sexual assault crisis center directors were also asked to identify the major challenges to doing sexual violence work in their communities. The general challenges cited consistently by the

directors were a lack of awareness in the community about sexual violence, need for prevention services, victim-blaming attitudes (blaming the victim for the sexual assault) and a lack of resources.

Prevention
At the state level, Virginia does have a state sexual violence prevention plan that was developed in 2003 by representatives from the Department of Criminal Justice Services (DCJS), VDH and the Department of Education (DOE), and Virginians Aligned Against Sexual Assault (VAASA), Virginia Against Domestic Violence (VADV), the Virginia Campus Task Force Against Sexual Assault, and a local sexual assault crisis center. The five goals of the Virginia Sexual Violence Prevention Plan (VSVPP), completed in 2003, are to ensure that: sexual violence prevention and intervention services are adequately funded; data are used to improve sexual violence prevention and intervention; comprehensive sexual violence services are accessible in every Virginia community; effective and comprehensive sexual violence prevention strategies are implemented across Virginia; and public policies are reformed to respond effectively to sexual violence through prevention and intervention.

Local sexual assault crisis centers are the primary providers of sexual assault prevention services in communities across Virginia**.** Focus groups and interviews with sexual assault crisis staff and campus sexual assault center staff indicated that many of their prevention efforts are school based and focused on young people so as to reach individuals before adulthood when victimization may have already taken place. All twenty-six sexual assault crisis centers that responded to the survey indicated that they provide general community education. However, many centers have few prevention staff to cover a large service area or are lacking funding to carry out adequate prevention programming.

Colleges and universities present a unique aspect of the problem of sexual assault. One of the barriers facing sexual assault campus centers is the institutional support for prevention efforts. Representatives almost unanimously agreed that college and university administrators do not place a great deal of emphasis on actively using educational strategies to prevent sexual assault.

Collaboration
Crisis center directors or their representatives were surveyed to identify problems they had collaborating with various groups (i.e. law enforcement, criminal justice, victim-witness professionals, and health care professionals). Some directors cited positive relationships with law enforcement and praised the work of police but the following were noted as barriers to collaboration: exclusion of advocates from the criminal justice process; inconsistent collection of evidence by law enforcement; questioning the credibility of victims by law enforcement; ignoring acquaintance rape; victim blaming; requesting polygraph tests of victims; denial of occurrence of sexual abuse in communities; misunderstanding the dynamics and sensitivity of sexual assault; and lack of clear policies on response to sexual assault.

Some directors described strong collaboration with criminal justice agencies. Other crisis center directors cited several different challenges they encountered with criminal justice agencies (e.g., courts, judges, prosecutors) including resistance to prosecuting certain sexual abuse cases; judicial understanding of sexual assault; concerns about interpretation of the law, re-victimization and communication problems. Victim-witness professionals are part of criminal justice agencies, but they may have more contact with sexual victims and sexual assault crisis

centers than other criminal justice professionals. Collaboration between sexual assault crisis centers and victim-witness programs was reported as effective in some instances. Other challenges in collaborating with victim-witness professionals as noted by sexual assault crisis center directors include territorialism and loyalty to the criminal justice system; accessibility; communication; and awareness of sexual assault issues.

Some directors reported positive relationships with local health care providers. Distance from the health care providers, referrals, role definitions and awareness of sexual assault as a health issue were reported as challenges.

Sexual assault crisis center directors were asked about challenges they faced when working with mental health workers. Problems that they encountered included role ambiguity, inappropriate referrals, funding related problems, and misunderstanding of sexual assault.

Sexual assault crisis center directors were asked about barriers they encountered working with social services workers. Their comments were limited to a few words, positive and negative and there were no clear patterns.

Summary of Recommendations

The various groups involved in this study made several recommendations on how to improve the sexual assault responses and prevention programs and activities of law enforcement, sexual assault crisis centers and other advocacy and support services, medical personnel, and the judicial system. These recommendations are summarized below:

Collaboration

1. The General Assembly should consider funding for the development and support of strong regional or local sexual assault coalitions to include sexual assault, health, mental health, law enforcement, criminal justice, education, and social services personnel.

2. The General Assembly should consider forming a statewide legislative Commission on Sexual Violence; similar to the 1997 Virginia Commission on Family Violence, to review the findings and recommendations of this report and support implementation activities, or alternatively the Crime Commission might be requested to do so.

Law Enforcement and Criminal Justice

3. The General Assembly should request a review of training for law enforcement and criminal justice personnel and recommend changes and funding to improve the amount and quality of training.

4. The General Assembly should request the Attorney General's Office to conduct a comprehensive review, in cooperation with Action Alliance, of the usage of polygraphs on victims of sexual assault in comparison to other crimes in Virginia and issue an opinion.

5. The General Assembly should require the Department of Criminal Justice Services to provide detailed guidance to law enforcement agencies, Commonwealth's Attorney's offices, victim advocates, and hospitals on the proper authorization and reimbursement for physical evidence recovery kits.

Emergency Departments and Primary Health Care

6. The Virginia Department of Health and the Virginia Sexual and Domestic Violence Action Alliance should work with primary care practices and other health care professionals to assure screening of patients for sexual assault.

7. The Virginia Department of Health should work with the Emergency Departments in the state and the General Assembly to ensure that each victim of sexual assault has access to a forensic nurse examiner in the ED or in sexual assault nurse examiner (SANE) programs.

8. The Virginia Department of Health and Action Alliance should work with professional organizations such as the Virginia Hospital and Healthcare Association (VHHA), the Virginia Nurses Association, and the Medical Society of Virginia (MSV) to raise awareness of sexual assault as a health care issue with health care personnel, in particular those in primary care practice and emergency departments and develop model written policies and training materials on the care of victims of sexual assault for hospital emergency departments and primary care practices.

9. Local sexual assault crisis centers should partner with local primary care practices to provide effective services to current and past victims of sexual assault

Sexual Assault Crisis Centers

10. Virginia Sexual & Domestic Violence Action Alliance should conduct a comprehensive needs assessment in conjunction with Virginia Department of Health and Virginia Department of Criminal Justice Services and make a funding recommendation to the General Assembly.

11. A comprehensive study of law enforcement response to sexual assault should be conducted in cooperation with DCJS, VSDVAA, and the Supreme Court. Representation from law enforcement, the Commonwealth's Attorney office, the courts and victim advocates should be included.

12. The General Assembly to consider allocating funds for public education campaigns in all Virginia communities to raise awareness of the problem of sexual assault with the message that individuals and communities will not engage in or support sexual assault.

13. The Virginia Department of Health, Virginia Department of Criminal Justice Services, Virginia Sexual & Domestic Violence Action Alliance, and local Sexual Assault Crisis Centers should work collaboratively and continue their efforts to expand services, reach out to underserved populations, promote awareness of the problem of sexual assault, promote awareness of the sexual assault crisis centers, and increase collaboration with other agencies

Colleges and Universities

14. The General Assembly should consider appropriating state funds for a statewide position to promote consistency and encourage cooperation, collaboration, and information sharing on sexual assault among colleges and universities in Virginia.

15. The General Assembly should consider appropriating state funds for expansion of services by campus sexual assault centers to prevent sexual assault, increase awareness of the problem and reach underserved students.

Prevention

16. The General Assembly should consider appropriating funds for public education campaigns in all Virginia communities to raise awareness of the problem of sexual assault.

17. The Virginia Department of Health should review sexual assault prevention programs and identify those that show successful outcomes for implementation in select localities.

18. The Department of Education should consider implementing an age-appropriate curriculum to prevent, recognize, respond and refer sexual assault in all schools (kindergarten through higher education) and incorporate sexual assault prevention education in the Standards of Learning.

Further Research

19. Future research should include a survey of pediatric health care providers as a significant percentage of sexual assault victims are children and adolescents who may still be receiving care from pediatricians.

20. The General Assembly should consider requesting a study to assess the emotional and physical health needs of victims of past sexual assault and the ability and requirements of the service system to address these needs.

Introduction

Purpose of Study

In 2004, the General Assembly passed Senate Joint Resolution 131, requesting the Virginia Department of Health (VDH) to study the statewide response to sexual assault victims and the prevention of sexual assault. SJR 131, which is included in Appendix A, directs VDH to examine the responses and prevention programs and activities of law enforcement, sexual assault crisis centers and other advocacy and support services, medical personnel, and the judicial system and design a plan to provide the General Assembly with recommendations for improvement. In conducting the study, VDH is to:

- Review law enforcement and criminal justice statistics and interactions with victims, identify inconsistencies and determine causes;
- Determine treatment and services provided to victims by medical personnel throughout the Commonwealth;
- Examine sexual assault crisis center delivery in each locality to determine availability, accessibility and comprehensiveness;
- Determine prevention efforts in communities and across the Commonwealth and how such efforts can be enhanced; and
- Survey collaborative efforts between all agencies and organizations that work with victims of sexual assault.

Study Methods

Study methods employed to assess the response to sexual assault in Virginia included:

1. A review of surveys and registry reports on the prevalence of sexual assault and characteristics of victims and perpetrators.
2. A review of the criminal justice and law enforcement data.
3. A review of state-level sexual assault plans and other documents.
4. An analysis of data collected by sexual assault crisis centers.
5. Surveys of emergency departments and primary care medical practices.
6. A survey of sexual assault crisis center directors and workers.
7. In-depth interviews with sexual assault crisis center workers, which focused on the services provided by sexual assault crisis centers and the barriers faced by sexual assault victim advocates in Virginia.
8. Focus group interviews with various professionals involved in the response to sexual assault, including workers from local sexual assault crisis centers, campus officials involved in campus response to sexual assault, and officials working at the state level in agencies that respond to sexual assault.

All survey instruments are included in Appendices B-H.

Definitions

The term “sexual assault” can be interpreted and defined in many ways. Legal definitions vary widely and may not include all sexually-based offenses. The following definitions of sexual assault are used nationally and in Virginia:

> “A wide range of victimizations, separate from rape or attempted rape. These crimes include attacks or attempted attacks generally involving unwanted sexual contact between victim and offender. Sexual assaults may or may not involve force and include such things as grabbing or fondling. Sexual assault also includes verbal threats (National Crime Victimization Survey).”
>
> “forcible sex offenses defined as forcible rape (including attempted rape), forcible sodomy, sexual assault with an object and forcible fondling (Uniform Crime Reports).”
>
> “Conduct of a sexual nature which is non-consensual, and is accomplished through threat, coercion, exploitation, deceit, force, physical or mental incapacitation, and/or power of authority (Virginia Sexual And Domestic Violence Action Alliance).”
>
> “rape, attempted rape, inappropriate touching, unable to consent, non-forcible child rape, and non-forcible child molestation (Masho & Odor, 2003).”

Prevalence and Incidence of Sexual Assault in Virginia

At the national level, the National Crime Victimization Survey (NCVS) has been conducted annually since 1992 by the U.S. Department of Justice. Approximately 42,000 households are selected and 76,000 persons ages 12 years and above are interviewed. Respondents are asked about sexual assaults in the past twelve months. According to NCVS, there are an average of 223,000 incidents of rape or sexual assault per year in the United States, a victimization rate of .9/1,000 population.

The Virginia Department of Health commissioned a telephone survey of 1,769 adult females and 705 adult males. The survey was conducted between November 2002 and February 2003 by Virginia Commonwealth University (Virginia Survey).[1] The sample was composed of persons 18 - 92 with an average age of 46. The sample appears similar to the population of Virginia, although the elderly, racial/ethnic minorities, those with the lowest educational attainment, and the poor were somewhat underrepresented. The Virginia survey (Masho & Odor, 2003), the only statewide study of sexual assault in Virginia, indicated that one in four women and one in eight men in Virginia have been victims of sexual assault. Eighty-seven % of female victims and 96

[1] Two independent samples of males and females were drawn to represent a random sample of persons in households with working phones and listed numbers. The study meets the standards of scientific rigor of those reviewed at the national level: multiple call-backs and rescheduling for respondent ease to minimize biases; interviews normally conducted with same sex interviewers, unless the respondent stated they would be more comfortable with someone else; in the case of respondent refusal to be interviewed, they were called again for a second attempt, unless the respondent indicated that they did not want to be called again. Completion rates for females were 36 percent and 21 percent for males.

% of male victims were under the age of 18 when they were assaulted. Further, 20 % of female victims and 25 % of male victims reported multiple assaults by the same person.

Based on the Virginia survey and 2003 population estimates, about 793,442 women and 349,948 men are survivors of sexual assault or 1,145,000 men and women, approximately one out five adults in Virginia. Further, it is estimated that about 28,748 female and 2,713 male adults were sexually assaulted in 2003 and it would be expected that between 31,000 – 32,000 men and women ages 18 and over would be sexually assaulted each year. These estimates stand in contrast to the annual average of about 5,000 victims/year of forcible sex crimes that were reported to the Virginia police in 2000 – 2003 (Virginia State Police Uniform Crime Reports, 2001-2004) or the 9,617 sexual assaults reported in the VAASA Annual Summary in 2003. The prevalence of sexual assault in Virginia, and the resulting short and long-term affects of sexual assault, clearly demonstrate that sexual assault is a serious social and public health issue that affects the lives of many men, women and children across the Commonwealth.

In Virginia and nationally, incidences of sexual assault continue to be severely underreported. According to the NCVS, in 2003 less than 40% of victims reported the assault to the police, a lower rate than any other violent crime. Although national reporting rates for sexual assault have increased dramatically in the past decade, the reporting rate continues to be less than 50 percent. In Virginia, only 12 percent of female victims and less than 7 percent of male victims reported the crime to the police (Masho & Odor, 2003).

Trends in Sexual Assault

Figure 1 provides national estimates of the rates of rape and sexual assault for select years from 1993 to 2002, based upon the National Crime Victimization Survey. The figure suggests that the rate of rape, attempted rape and other sexual assaults declined during the 1990s.

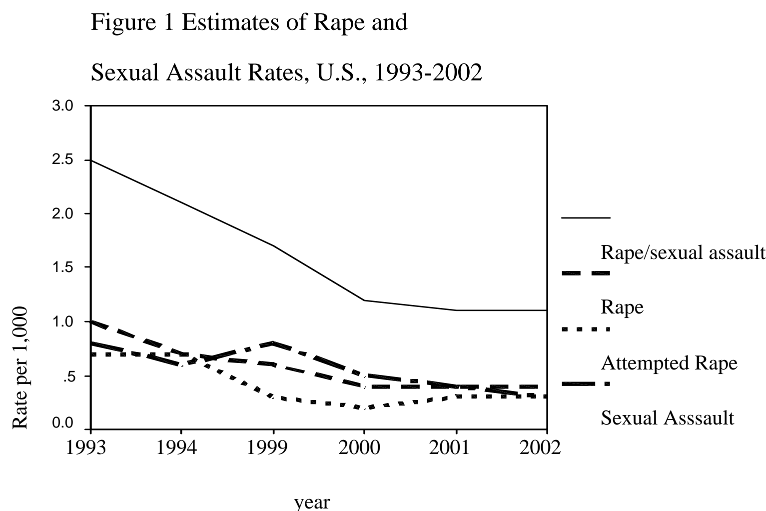


Figure 1 Estimates of Rape and Sexual Assault Rates, U.S., 1993-2002

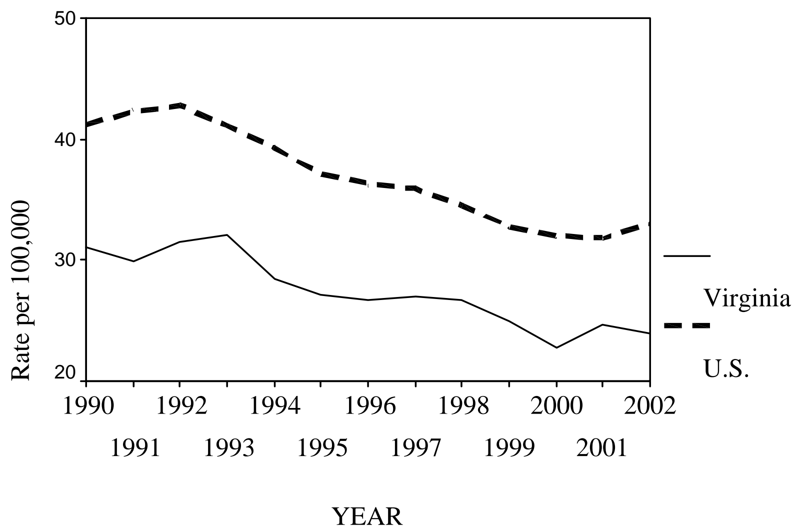
Sources: Rennison, 2002 and U.S Department of Justice, 2003.

There are no such estimates for the Commonwealth; however, there were significant declines in reported forcible rapes throughout the 1990s in Virginia (see Figure 2 which depicts the rates of forcible rapes known to police in the U.S. and Virginia from 1990 through 2001). In addition, there were lower rates of reported forcible rapes in Virginia than in the country as a whole.

Whether this reflects a true lower rate of rapes in Virginia or whether the difference is due to variations in reporting is difficult to assess.

Figure 2: Reported Forcible Rape Rates,

U.S. and Virginia, 1990-2000



Source: Uniform Crime Report. Federal Bureau of Investigation. Accessed at http://fisher.lib.virginia.edu/collections/stats/crime/.

Knowledge of Attacker

Studies at both the national and state level confirm that persons are more likely to be sexually assaulted by someone they know than by a stranger. In Virginia, among female victims, only 11% of offenders were strangers; among male victims 21% of offenders were strangers (Masho & Odor, 2003). This is much lower than the national rate indicated in the NCVS. According to this study, in 2003 30% of female victims and 26% of male victims were attacked by a stranger.

Consequences of Sexual Assault

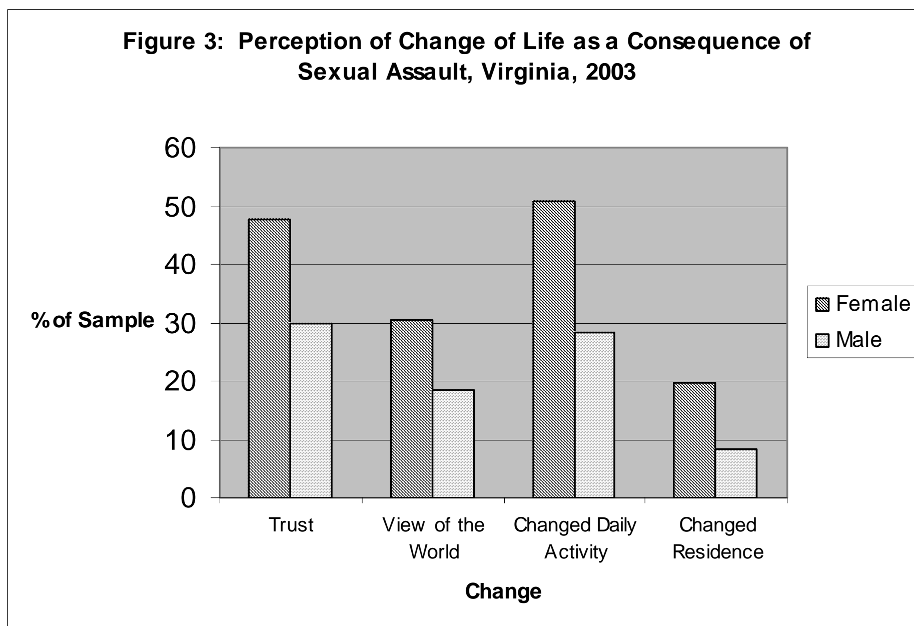
Health Consequences

In the Virginia survey, nearly one-fifth (17%) of females and 9% of males reported a physical injury resulting from their sexual assault. Three percent of female victims reported that they got pregnant as a result of the attack, and 2 percent of female and male victims contracted a sexually transmitted disease during the assault. In addition, sexual assault victims were two times as likely to perceive their health to be poorer than non-victims (Masho & Odor, 2003).

Behavioral Consequences

The Virginia survey found sexual assault to have a profound effect on behaviors and perceptions of victims (Figure 3, next page). This was especially true among female victims, but males were affected as well. For example, over half of females (51%) and 28% of males reported changing their daily activities as a result of a sexual assault and one-fifth of females and nearly one-tenth of males changed their residence. Victims of sexual assault tend to consume more alcohol than

non-victims, and also report that their trust of other people and their view of the world changed for the worse after the attack (Masho & Odor. 2003).



Source: Masho & Odor, 2003

Victimization experiences can be turning points in victims' lives and can lead to negative affective states such as depression. The most common outcomes of sexual or physical abuse are depression and post-traumatic stress disorder but also include impaired social attachments, low self-esteem, substance abuse, and delinquent behavior. In particular, childhood sexual abuse is a risk factor in about 9-20 percent of suicide attempts (IOM, 2002).

Reporting of Sexual Assaults

Similar to national reports, the Virginia survey showed that only 12% of female sexual assault victims reported their victimizations to police, 11% of females reported to doctors, and 3% to hotlines or crisis centers. Among males, reporting was even less common (7% to police, 2% to doctors, and 2% to hotlines or crisis centers). The majority did, however, talk to someone they knew like a friend or family member (62% of males and 58% of males). Counselors were also seen relatively frequently by females (34%) but less by males (15%).

Age and Race/Ethnicity

National and Virginia surveys differ in how data on sexual assault are collected, but all findings are consistent in identifying youth up to age twenty-four as the age group at greatest risk for sexual assault. In Virginia, forty-six (46%) percent of female victims reported that they were victimized before 13 years of age and the vast majority of female victims (78%) reported that they were victimized before they were 18. Among males, 44% were victimized before 13 years and another 94% before 18 years of age. The negative correlation between age and victimization is also consistent with national level data (Tjaden and Thoennes, 1998; U.S. Department of Justice, 2003).

Nationally, the population with the highest prevalence of sexual assault appears to be Native Americans. In Virginia, the lifetime prevalence is about equal among all races. As for ethnicity, adult females of Hispanic origin have a lower lifetime prevalence than non-Hispanic females. Among adult males, those of Hispanic origin or "other" races have the highest lifetime prevalence for sexual assault (Table 1).

Table 1 Lifetime Prevalence of Sexual Assaults by Race and Ethnicity, Virginia, 2003

Race/Ethnicity	Female	Male
Race		
White	28	12
African-American	27	12
Other	29	22
Ethnicity		
Hispanic	18	23
Non-Hispanic	28	13

Respondents were 18 years and older, but reported on incidents, which may have occurred before 18 years of age, in the past 12 months or during the lifetime.
Source: Masho & Odor, 2003.

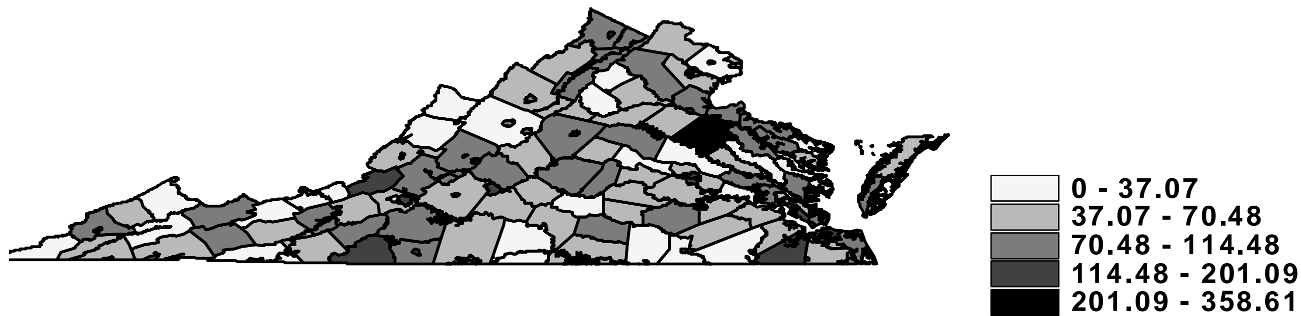
College Students

A recent report by the Bureau of Justice Statistics (Hart, 2003) utilized the NCVS data to study violent victimizations among college students, ages 18 – 24, and compare them to the like-aged non-college population. Data from 1995 to 2000 showed that college students were equally likely as the non-college population to experience rape/sexual assaults (4.1 per 1,000). Among college students, the sexual assault perpetrator was usually known to the victim (74%) and in about 41% of cases the attacker was perceived to have been using drugs or alcohol. Weapons were rarely involved in sexual assaults against college students (approximately 11%). Another study using the NCVS shows that 8.3% of female college students had been raped in the prior twelve months (Fisher, et al., 1998). Finally, a study conducted by the Centers for Disease Control and Prevention of 4,838 college students found that 20% of women reported having been raped in their lifetime and 15% since they were 15 years of age (Brenner et al., 1999).

Geographical Location

Figure 4 shows the reported rates of rape by city and county in Virginia between 1999 and 2001. No clear geographical pattern emerges.

Figure 4. Reported Rape Rates Averaged from 1999-2001



Numbers refer to the Rape Rate per 100,000 population

Source: Uniform Crime Reports

Response to Sexual Assault in Virginia

State Plan for the Prevention and Intervention of Sexual Violence

In 2002, a committee formed to develop a strategic plan for sexual violence prevention in Virginia. This committee was composed of representatives from the Departments of Criminal Justice Services (DCJS), Health, and Education (DOE), and Virginians Aligned Against Sexual Assault (VAASA), Virginia Against Domestic Violence (VADV), the Virginia Campus Task Force Against Sexual Assault, and a local sexual assault crisis center. The draft plan was reviewed by stakeholders around the state. A key recommendation was the creation of the Sexual Violence State Planning Advisory Board to guide the implementation of the state plan. The Board, with representatives from the Departments of Health, Criminal Justice Services, and Education, and VAASA, VADV[2], the Virginia Campus Task Force Against Sexual Assault, and a local sexual assault crisis center has been formed and meets quarterly.

The five goals of the Virginia Sexual Violence Prevention Plan (VSVPP), completed in 2003, are to ensure that:

- Sexual violence prevention and intervention services are adequately funded.
- Data are used to improve sexual violence prevention and intervention.
- Comprehensive sexual violence services are accessible in every Virginia community.
- Effective and comprehensive sexual violence prevention strategies are implemented across Virginia.
- Public policies are reformed to respond effectively to sexual violence through prevention and intervention.

According to the Plan, to ensure that sexual violence services are adequately funded:

- A planning team should create an agreement between appropriate statewide agencies to develop the roles and responsibilities needed to meet the objectives of the VSVPP.
- The planning team should identify agencies, other than sexual assault programs, that could provide services to prevent or respond to sexual violence incidents.
- The state sexual violence coalition[3], in conjunction with other state agencies (e.g., DCJS and VDH) should be charged with building an infrastructure for applying for and obtaining federal and other grants relevant to sexual assault. This will involve securing increased funding for sexual violence prevention and intervention efforts, including funding for data collection efforts, sexual violence coordinators for higher education institutions, and a state sexual violence coalition.
- Federal Victims of Crime Acts (VOCA) guidelines should be expanded to cover sexual violence victims charged with crimes (such as sex workers and victims in prison) and the cap on federal VOCA funds should be raised or eliminated.

---

[2] VAASA and VADV are now merged as the Virginia Sexual and Domestic Violence Action Alliance (VSDVAA).

[3] The State Sexual Violence Coalition was composed of representatives from Virginians Aligned Against Sexual Assault (VAASA) and Virginia Against Domestic Violence (VADV), now combined as the Virginia Sexual and Domestic Violence Action Alliance (VSDVAA).

To ensure that data can effectively be used to improve sexual violence prevention and interventions, the state sexual violence coalition should:

- Consolidate all sexual violence data in a report, identify gaps, and develop a plan to collect better data.
- Establish a technical assistance information center on "best practices" in sexual violence prevention and intervention.

To make sure that comprehensive sexual violence services are accessible in every Virginia community and that at least half of Virginia's sexual assault crisis centers will be able to provide 100% of the comprehensive services (long-term objective), the state sexual violence coalition should:

- Form a task force to develop a key set of comprehensive services that each sexual assault crisis center can provide.
- Identify standards for allied professionals as well as obstacles to providing state-of-the-art services.
- Work in conjunction with local sexual assault crisis centers to ensure that all Virginians have access to culturally appropriate services by identifying and removing the obstacles that certain groups face.

To ensure that effective and comprehensive sexual violence prevention strategies are implemented across Virginia, the state coalition should:

- Promote sexual assault awareness so that everyone recognizes, responds to and/or refers victims of sexual assault. This will be accomplished through public awareness campaigns, training in the recognition of and appropriate responses to sexual assaults, and provision of an age-appropriate curriculum in schools.
- In conjunction with other groups (e.g., VDH, Sex Offender Program Action Committee (SOPAC)), develop a hotline to provide information for callers who suspect someone of being sexually violent or for perpetrators themselves.
- Promote implementation of effective prevention strategies in the workplace.
- Identify and promote change of policies that support or tolerate sexual violence.

The planning team should:

- Focus on training allied professionals to recognize and respond to attitudes and behaviors associated with sexual violence. In conjunction with SOPAC, it will also work to ensure that treatment for sex offenders is available and effective in every region of the state.

The DOE and VDH should:

- Develop prevention strategies for school and college-age youth.

To ensure that public policies are reformed to respond effectively to sexual violence through prevention and intervention:

- The State Sexual Violence Coalition with DCJS, and the Virginia Crime Commission should study and recommend changes to criminal codes and sentencing guidelines. They should request the General Assembly to adopt legislation to standardize minimum sex offender sanctions and promote legislation that requires training of judges, Commonwealth's Attorneys, and probation and parole officers.
- A legislative Commission on Sexual Violence Reduction should be convened to recommend needed legislative and policy changes to prevent sexual violence and support the needs and rights of sexual violence victims.

Review of Law Enforcement and Criminal Justice Response

This section provides general information on law enforcement, criminal justice and sexual assault. A more comprehensive review of the law enforcement and criminal justice response to sexual assault is still needed. Such an examination is critical to our understanding of the statewide response to sexual assault and should be conducted in the near future.

Law Enforcement

When sexual assault is reported to law enforcement, police officers are the first responders and play a critical role in the investigation of a sexual assault, from interviewing the victim, following leads and gathering evidence in a thorough and comprehensive manner. The police response to sexual assault not only represents the first contact a victim has with the criminal justice system, but also continues to have an impact throughout the rest of the process.

Between 1999 and 2001, there were an average of 1,720 reports of forcible rapes in Virginia, of which 503 (29%) resulted in arrest. (Crime in Virginia, 1999 & 2000 & 2001). According to data reported to the Federal Bureau of Investigation (FBI) through the Uniform Crime Reports (UCR), national clearance rates[4] are typically lower for forcible rape cases than for most violent crimes. For example, in 2002, 44.5% of forcible rape cases known to the police were cleared by an arrest or through exceptional means. This is lower than for murder (64%), aggravated assault (56%), and is only higher than robbery (25.7%) among violent crimes for which the UCR collects data.

Criminal Justice

The Virginia State Sentencing Commission provides an annual report on the number of convictions and compliance with state sentencing guidelines. Between 2001 and 2003 there were, on average, about 225 annual convictions for forcible rape (about 45% of the average arrests for rape). There are on average about twice as many convictions for sexual assault each year (479) than for rape (Table 2, next page). For sentencing, judges are provided a standard range sentence (a presumptive sentencing range) depending on the type and severity of the offense and the offender's prior record. However, judges can depart from the recommended sentence if they provide a reason in writing. Over two-thirds of both rape and sexual assault cases receive sentencing that complies with guidelines. Of the nearly one-third of cases whose sentences did not comply with guidelines, a large percentage of cases received a lower sentence than recommended for forcible rape, while for sexual assault cases, an equal percentage received sentencing above and below the recommended sentence.

[4] Clearance rates are the number of crimes cleared by actual arrest or exceptional means (e.g., death of an offender, victims' refusal to cooperate with the prosecution after an offender has been identified, or the denial of extradition) divided by the total number of arrests, multiplied by 100.

Table 2 Forcible Rape and Sexual Assault Convictions and Sentences[5] (FY 2001-2003)

Forcible Rape or Sexual Assault	No.Cases	% Comply with Guidelines	% Lower Sentencing	% Higher Sentencing
Forcible Rape FY 2001	206	67	24	9
Forcible Rape FY 2002	242	66	29	5
Forcible Rape FY 2003	228	70	21	9
Sexual Assault FY 2001	487	70	15	15
Sexual Assault FY 2002	462	67	18	15
Sexual Assault FY 2003	487	68	16	16
Average # of Forcible Rape Convictions			225	
Average # of Sexual Assault Convictions			479	

Source: Virginia State Sentencing Commission

Treatment and Services Provided to Victims by the Health Care System

Sexual assault victimization has immediate and long-term health complications (Plichta & Falik, 2001; Rentoul & Appleboom, 1997; Cloutier, Martin & Poole, 2002; Bohn & Holz, 1996), yet only a minority of victims in Virginia (10.8% of females and 2.2% of males) seek medical care immediately after an assault (Masho & Odor, 2003) and it is unclear what percentage seek health care for assault-related issues later on. It is striking that the percent of women seeking post-assault medical care in Virginia is lower than that reported in national studies (26.4%) (Resnick et al 2000). However, no study has yet examined the extent to which the health care system in Virginia is prepared to assist victims with both immediate and long-term health complications and few studies have examined these factors nationwide. This portion of the statewide study on sexual assault, therefore, seeks to fill the gap in knowledge about the role of the health care system in assisting victims of sexual assault in Virginia.

One factor that complicates the exploration of services for victims of sexual assault is that there is still no definitive standard of medical care for victims that is widely accepted and commonly used in the U.S. (U.S. Agency for Health Research and Quality). However, the American Medical Association (AMA 1995) has published evidence-based strategies for the care of victims in the U.S. These guidelines recommend two different clinical management patterns, one for the Emergency Department (ED) and for those physicians that see the victim within 72 hours of the assault and another for the primary care physician that may see the victim after that time-period (including years later). In addition, the President's DNA Initiative released *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents,* authored by the Office on Violence Against Women, in September, 2004. It is too early to determine the effect of these protocols on sexual assault medical examinations.

There is a nursing specialty, the forensic nurse examiner (FNE) (also known as the Sexual Assault Nurse Examiner or SANE nurse) that is dedicated to the care of victims of sexual assault (www.sane-sart.com) and that has developed extensive guidelines for both the care of victims and for evidence collection (Ledray 1999). These guidelines generally are in agreement with the

[5] Sexual assaults in this table do not include rapes.

AMA strategies, although they are more extensive and detailed regarding evidence collection and the psychosocial care of victims.

Most of the care of sexual assault victims in the ED is provided by nurses working under the supervision of a physician, although these nurses may or may not have forensic nurse training. The limited literature on the subject recommends that the medical care of sexual assault victims be coordinated by a specially trained nurse (Talbert et al 1980, Ledray & Arndt 1994; Hutson 2002) and a recent study confirms that sexual assault evidence collection is more accurate when completed by sexual assault nurse examiners (Sievers, Murphy & Miller 2003).

Medical Strategies Regarding the Care of Victims of Sexual Assault

In the ED and other acute care settings, the nursing and AMA strategies are similar (AMA 1995; Ledray 1999). Both recommend that the health care provider medically stabilize the victim and then obtain the necessary medical and sexual history and conduct a physical and evidence examination. They also recommend placing the patient in a quiet and safe area, not leaving them alone, and asking permission to call a friend, family member or sexual assault crisis advocate. In the forensic and medical exam, it is recommended that the health care provider know their state guidelines (these vary), and be prepared to: obtain informed consent, obtain a history of the sexual assault, obtain information about current pregnancy status, collect clothing, collect blood samples for typing and DNA, collect a urine sample to screen for pregnancy or drugs, collect samples of the victim's hair, examine the orifices involved for trauma and to collect sperm/seminal fluid, collect fingernail scrapings, comb the victim's pubic hair for foreign hair and matter, document all injuries on a body map and to use a Woods light (where available) to examine the victim's body for sperm and seminal fluid that might have dried and been missed on examination. Both sets of strategies recommend that a number of services be discussed with victims and made available where medically indicated. These services include: emergency contraception, sexually transmitted diseases (STD) testing and STD prophylaxis, HIV testing and arranging follow-up visits to re-test for STDs and HIV where indicated. The Centers for Disease Control and Prevention (CDC) also recommends STD/HIV testing and prophylaxis for victims when indicated (CDC 2002).

The AMA strategies for primary care setting are somewhat different. They recommend that patients be routinely screened for sexual assault exposure on a regular basis, as does the American College of Obstetrics and Gynecology (ACOG, 2004; ACOG 1997). Both ACOG (1997) and the AMA (1995) note that several clusters of symptoms are more likely in those who have been sexually assaulted, and they recommend that primary care physicians be educated and aware of what these symptoms are. Both also recommend providing patients with testing and counseling for STD's, individual and couples counseling, referral to a victim's support group, and treatment with a multi-specialty team.

Methods

All hospital emergency departments in Virginia were surveyed on their response to sexual assault victims. Of the 83 EDs in Virginia, 57 (response rate 69%) responded to the survey. Respondents are similar to the entire population of EDs from across the state in terms of location, size and whether or not they are a teaching hospital. The proportion of the sample from

each of the five health planning regions is similar to the proportion of hospitals in those planning regions.

Primary Care practices in Virginia were also surveyed. Of the 238 primary care practice (PCP) offices with good contact information, 53 offices responded (22%) to the survey. The PCPs that responded are from all across the state. The average responding office had 2.4 physicians and 3.0 nurses working in the practice. It is difficult to say if these practices are representative of the larger population of Virginia primary care practices as no profile of the total group of primary care practices could be located.

Results of the Emergency Department Survey

Number of Victims Served

Over one-quarter (26%) of the EDs could not estimate how many victims of sexual assault or rape they serve each year. The remaining forty-two EDs estimate that they served a total of 1,629 victims in the past year, with half reporting serving less than 18 victims a year. The great majority of victims seen are women (87%), either adult (49%) or adolescent (38%). Men comprised 13% of the victims but half of the EDs report no cases of male victims at all. Slightly less than half (46%) of the sexual assault cases seen in the ED are adolescents (ages 12-17).

Policies and Protocols

Emergency Departments vary greatly in policies and protocols (Table 3). Over one in seven (15%) do not have a written protocol in place regarding the treatment of sexual assault victims, and almost half (46%) do not have a formal training plan regarding the care of victims. Over half (54%) do not provide training to new staff, and the great majority (86%) did not provide any training to current staff in the past year. An interesting model of care was uncovered, with one in seven EDs referring victims to a sister hospital that is better equipped (according to the hospitals) to provide care (note that in the city of Fairfax this is by city ordinance). Limited qualitative data from these EDs suggest that these hospitals provide almost no training to their staff and depend entirely upon their sister hospital to assist victims of sexual assault or rape.

Table 3 Hospital Emergency Department Policies and Practices Regarding Sexual Assault and Rape, Virginia, 2004

Policies and Practices of the Emergency Department	% Yes	% No
Written protocol regarding the care of victims of sexual assault or rape in place	85	15
Formal training plan regarding the care of victims of sexual assault	54	46
Provides sexual assault or rape training to new medical staff as part of mandatory orientation	46	54
Provided training on sexual assault or rape to members of the medical staff in the past 12 months	86	14
Routinely refers victims to another hospital	14	86

Source: Survey of the Emergency Department Practices and Policies for Victims of Sexual Assault, Virginia, 2004

The great majority (71%) of EDs do not have a standardized screening protocol in place (Table 4, next page). Further, most do not routinely screen for sexual assault or rape and the screening protocols appear to be different for men and women. The screening protocol for women is

reported as follows: only 5% of the EDs routinely screen all women for sexual assault or rape, and then only within the context of screening for domestic violence. 39% screen all women with injuries of unknown origin, 48% only screen when sexual assault or rape is suspected, 5% only screen women when sexual assault or rape is disclosed by the woman to the health care provider and 2% do not discuss sexual assault or rape at all. The screening protocol for men is reported as follows: 6% of the EDs routinely screen all men for sexual assault or rape, 27% screen all men with injuries of unknown origin, 52% only screen when sexual assault or rape is suspected, 11% only screen men when sexual assault or rape is disclosed to the health care provider, and 5% say that they do not discuss sexual assault or rape with men at all.

Table 4 Screening Protocols of Participating Emergency Departments Regarding Sexual Assault and Rape

ED uses a standardized instrument to screen for rape and sexual assault	% of EDs
Yes[1]	23
Intimate partner violence screen only, but for every patient	5
No standardized instrument is used	71
Screening Protocol for Women	
All women are asked about sexual assault and rape (in the context of a domestic violence screening question)	5
All women with injuries of unknown origin are asked about sexual assault and rape	39
Women are only screened when rape or sexual assault is suspected	48
Women are only asked about sexual assault and rape when they disclose it to the health care provider	5
Women are not asked at all	2
Screening Protocol for Men	
All men are asked about sexual assault and rape (in the context of a domestic violence screening question)	5
All men with injuries of unknown origin are asked about sexual assault and rape.	27
Men are only screened when rape or sexual assault is suspected	52
Men are only asked about sexual assault and rape when they disclose it to the health care provider	11
Men are not asked at all.	5

[1]31% of the screens are not on a medical record form but are asked verbally
Source: Survey of the Emergency Department Practices and Policies for Victims of Sexual Assault, Virginia, 2004

Available Resources

The EDs do not appear to have the resources in place to provide the specialized care needed by victims of sexual assault (Table 5, next page). Half of all EDs do not have a forensic nurse examiner or SANE nurse on staff, and almost two-fifths (39%) do not have any employees on staff that are trained to assist victims of sexual assault or rape. Even among those with a forensic/SANE nurse, 31% report that the nurse is not available during all shifts. The majority of EDs report that they do not have a relationship with their local sexual assault crisis center, nor do they offer the services of a rape crisis advocates/companion from a local sexual assault crisis center One-third (34%) of those EDs that do offer the service use these services for less than half of all victims.

Table 5 Resources in Emergency Departments for Victims of Sexual Assault and Rape, Virginia, 2004

Resources Available to the Emergency Department	% with	% without
Employee who is trained to assist victims of sexual assault or rape	61	39
Forensic nurse examiner or SANE nurse on staff	49	51
Rape crisis advocates/companion services of a local sexual assault crisis center offered to victims (all were available 24-7)	16	84
Relationship with a sexual assault or rape crisis center	25	75
Participates on a Sexual Assault Response Team within the community	37	63

Source: Survey of the Emergency Department Practices and Policies for Victims of Sexual Assault, Virginia, 2004

Characteristics of Services and the Forensic Exam Offered to Victims of Sexual Assault

The EDs generally offer the medical care that is recommended by guidelines (CDC, AMA, SANE/FNE Nurses) but are less likely to have the recommended personnel or to offer comfort care (Table 6). In terms of medical care, most offer emergency contraception, pregnancy testing and STD/HIV testing/prophylaxis. However, over half (54%) do not follow-up with the victim within 48 hours. Almost half (44%) do not offer a forensic nurse examiner to all victims, about one-quarter (26%) do not offer a sexual assault crisis advocate/companion that can be in the room with the victim and about one-fifth (20%) do not offer sexual assault crisis advocates/companions to meet with the victims. Further, almost one third (30%) do not offer fresh clothing for the victim (clothing sometimes needs to be collected as evidence) and close to one-half (45%) do not offer the victim a place to shower.

Table 6 Services Routinely Offered to Victims of Sexual Assault or Rape at Emergency Departments, Virginia, 2004

Types of Services	Offered by:		
	Hospital %	Outside Agency %	Not offered %
Personnel			
Forensic Nurse Examiner available to all victims	41	15	44
Sexual assault crisis advocate/companion in the room with the victim during the examination	35	39	26
Sexual assault crisis advocate/companion available to meet with victim	18	64	19
Medical Care			
Follow up phone call within 48 hours	18	29	54
Emergency contraception	86	4	11
HIV testing	82	11	7
Prophylactic HIV treatment	65	20	15
Mental health assessment	69	28	4
STD testing	96	0	4
Prophylactic STD treatment	96	0	4
Pregnancy test	96	0	4

Table 6 cont'd

Comfort Care			
A place for the victim to shower after the exam	55	0	45
Fresh clothing for the victim	65	6	30
Substance Screening			
Blood and urine screening for date rape drugs	68	13	19
Screening for the presence of drugs or alcohol	96	0	4
Referrals			
Referral to a local sexual assault crisis center	66	22	13
Referral for safe housing	57	36	7
Referral for follow-up counseling	71	26	4

[1]Services offered by an outside agency are offered to most victims, but may or may not be offered in the ED setting. If the hospital reported the service is not offered then it is not offered to the patients at all, not even as a referral.
Source: Survey of the Emergency Department Practices and Policies for Victims of Sexual Assault, Virginia, 2004

EDs generally perform the majority of items in the sexual assault exam recommended by medical authorities (Table 7). Two items that are not performed by about a fourth of the EDs are obtaining written consent from the victim (24% do not do this) and creating a body map of the injuries (20% do not do this). One-fourth of EDs also do not take photographs of the injuries although this is not included in the guidelines of the American Medical Association.

Table 7 Components of the Sexual Assault Exam,[1] Emergency Departments, Virginia, 2004

Components of Exam[2]	% Yes	% No
Obtain written consent from the victim	76	24
Take photographs of injuries	75	25
Create a body map of injuries	80	20
Complete fingernail scrapings	85	15
Collect the victim's blood for type and DNA screen	88	12
Examine orifices involved for trauma and collect sperm and seminal fluid	89	11
Combing pubic hair for foreign hair and matter	89	11
Collect torn or stained clothing	88	11
Getting an assault history of the current assault	94	6
Obtaining pertinent medical information about current pregnancy status	96	4

[1]All except taking photographs of injuries are recommended by the AMA
[2]Eds perform an average of 8.6 of these items 19% perform 7 or fewer of these 10 items as part of their exam.
Source: Survey of the Emergency Department Practices and Policies for Victims of Sexual Assault, Virginia, 2004

ED Self-Rating of Performance in Caring for Victims of Sexual Assault

In a self-evaluation, the Emergency Departments noted a need for improvement (Table 8). Training was the area where the EDs clearly felt they could improve, with 36% rating themselves as fair or poor on providing training to staff. Other areas where the EDs did not rate themselves well included screening (36%), assisting families of victims (25%), working with the local sexual assault crisis center (22%), assisting patients who were assaulted by intimate partners (20%), and collecting evidence (18%). As for training needs, Table 9 shows the topics that were identified as "very important" by over three-quarters of EDs.

Table 8 Emergency Departments' Self-Rating of Performance in Sexual Assault and Rape, Virginia, 2004

Type of Assistance	% Rating their ED as:		
	Excellent or Very Good	Good	Fair or Poor
Providing training to the staff on how to assist victims	36	28	36
Screening patients for sexual assault and rape	36	28	36
Assisting the families of victims	56	19	25
Working with the local sexual assault crisis center	60	18	22
Working with patients who have been sexually assaulted or raped by intimate partners	52	28	20
Collecting evidence from sexual assault and rape victims	70	12	18
Making victims feel as comfortable as possible	66	25	9
Working with the police on sexual assault and rape cases	76	16	8
Preserving the confidentiality of the victim	90	6	4

Source: Survey of the Emergency Department Practices and Policies for Victims of Sexual Assault, Virginia, 2004

Table 9 Perceived Importance of Training Topics, Emergency Departments, Virginia, 2004

Perceived Importance of Training Topics (n=46) (% rating each item as very important or less than very important)	% Very important	% Less than very important
How to talk with victims and their families	85	15
Sexual assault/rape crisis services	83	17
How to collect evidence	81	19
How to testify in court	83	17
How to work with police	82	18
How to help special populations (e.g. male victims)	76	24
Cultural awareness	76	24

Source: Survey of the Emergency Department Practices and Policies for Victims of Sexual Assault, Virginia, 2004

Results of the Primary Medical Practice Survey

Number of Victims Served

Almost one-fifth (19%) of the practices could not estimate how many victims of sexual assault and rape they serve each year. The remaining practices estimate that they served 172 victims in the past year, although 26% of the practices reported seeing no victims of sexual assault or rape at all and 50% report seeing only one to four victims each year. The majority of victims seen were adult women (71%) followed by adolescent women (27%), adolescent males (1%) and adult males (0.6%).

Protocol, Policies and Resources

Only one of the practices surveyed has a written protocol in place regarding the care of victims of sexual assault or rape. The great majority of the practices (89%) do not have an employee on staff who is trained to assist victims of sexual assault or rape, and most (70%) do not have a relationship with a sexual assault crisis center.

The great majority (87%) of the practices do not have a standardized screening instrument in place (Table 10). One-quarter routinely screen women for sexual assault and rape and almost 10% screen all men, although the AMA recommends that all patients be screened routinely in the primary care setting. However, a substantial number of practices do not discuss sexual assault with women (30%) or men (40%) at all.

Table 10 Primary Medical Practices' Screening Protocols Regarding Sexual Assault, Virginia, 2004

Office uses a standardized instrument to screen for rape and sexual assault	**%**
Yes, for every patient	13
No standardized instrument is used	87
Screening Protocol for Women	
All women are asked about sexual assault and rape as part of their health history	26
All women with injuries of unknown origin are asked about sexual assault and rape.	18
Women are only screened when rape or sexual assault is suspected	18
Women are only asked about sexual assault and rape when they disclose it to the health care provider	9
Women are not asked at all about sexual assault and rape	30
Screening Protocol for Men	
All men are asked about sexual assault and rape	10
All men with injuries of unknown origin are asked about sexual assault and rape.	12
Men are only screened when rape or sexual assault is suspected	29
Men are only asked about sexual assault and rape when they disclose it to the health care provider	10
Men are not asked at all about sexual assault and rape	40

Source: Survey of the Emergency Department Practices and Policies for Victims of Sexual Assault, Virginia, 2004

Most of the practices generally provide medical care to victims as recommended by the AMA (Table 11), with some important exceptions. Almost half (44%) of the practices do not offer the services of a sexual assault crisis advocate, and two-thirds do not have a sexual assault crisis advocate/companion in the room with the victim. Approximately one-third do not provide prophylactic HIV treatment or emergency contraception and one-quarter do not provide a mental health assessment.

Table 11 Services Routinely Offered to Victims of Sexual Assault by Primary Medical Practices, Virginia, 2004

	Offered by:		
Type of Services (n=50)	**Practice**	**Outside Agency**	**Not offered**
Personnel			
Sexual assault crisis advocate/companion in the room with the victim during the examination	17	17	66
Sexual assault crisis advocate/companion available to meet with the victim	10	46	44
Medical Care			
Follow-up phone call within 48 hours	44	15	42
Emergency contraception	65	6	29
Mental health assessment	35	41	24
Pregnancy test	82	4	14
STD testing	84	6	10
Prophylactic STD treatment	72	10	18
HIV testing	82	8	10
Prophylactic HIV treatment	33	37	31
Referrals			
Referral to a domestic violence shelter	43	37	20
Referral to a local rape/sexual assault crisis center	42	40	15
Referral for follow-up counseling	43	43	14

Source: Survey of the Emergency Department Practices and Policies for Victims of Sexual Assault, Virginia, 2004

The practices provide almost no training for their staff (Table 12, next page). Only one practice surveyed has a formal training plan, the other 98% do not. The great majority (92%) do not provide training about sexual assault to new staff. When asked what training needs were very important to them, at least half of the practices identified how to talk to victims and their families, how to collect evidence and testify in court, how to work with the local sexual assault crisis centers, and increasing cultural awareness, especially in working with special populations.

Table 12 Characteristics of Sexual Assault Training by Primary Medical Practices, Virginia, 2004

Medical Practice's Training (n=52)	**% Yes**	**% No**
Has a formal training plan about sexual assault	2	98
Has provided training on sexual assault to new staff in the past year	8	92
Training Needs Identified as Very Important (n=45)		
How to talk with victims and their families	75	25
How to collect evidence	58	42
How to work with local sexual assault crisis centers	57	53
Cultural awareness	53	47
How to testify in court	50	50
How to help special populations (male victims, disabled victims, etc.)	50	50

Source: Survey of the Emergency Department Practices and Policies for Victims of Sexual Assault, Virginia, 2004

In a self-evaluation, the practices noted a need for improvement (Table 13). Training was the area where the practices clearly felt they could improve, with 78% rating themselves as fair or poor on providing training to staff. Other areas where the practices did not rate themselves well included screening (31%), working with the local sexual assault crisis center (40%) and working with patients who were assaulted by intimate partners (28%).

Table 13 Primary Medical Practices' Self-Rating of Performance in the Area of Sexual Assault

	% Rating their practice as:		
Type of Assistance (n=42)	**Excellent or Very Good**	**Good**	**Fair or Poor**
Providing training to the staff on how to assist victims	7	15	78
Working with the local sexual assault crisis center	26	33	41
Screening patients for sexual assault and rape	19	24	31
Working with patients who have been sexually assaulted or raped by intimate partners	38	33	28
Assisting the families of victims	32	37	24
Making victims feel as comfortable as possible	44	33	21
Preserving the confidentiality of the victim	76	18	8

Source: Survey of the Emergency Department Practices and Policies for Victims of Sexual Assault, Virginia, 2004

Gaps in Resources and Services

Several critical findings came out of the ED survey. First, half of all EDs do not have a forensic nurse on staff, and 44% do not offer a forensic nurse to all victims. Even the hospitals that do have a forensic nurse on staff cannot always provide 24-hour access. Forensic nurses are trained

to follow medical protocols for caring for sexual assault victims (Ledray & Arndt 1994; Hutson 2002) and have been shown to be superior to other health care providers in collecting evidence of sexual assault (Sievers, Murphy & Miller 2003). Hospitals that adopt sexual assault nurse examiner (SANE) programs report significant improvements in clinical care quality indicators for sexual assault victims, as well as increased quality of evidence collection and better working relationships with law enforcement (Derhammer et al, 2000; Smith et al, 1998; Sievers, Murphy & Miller 2003).

Emergency Departments also have significant training needs that are not being met. Almost half (46%) do not have a formal training plan, and only a small minority (14%) report having provided training about sexual assault to medical staff in the past year and over a quarter of emergency departments rated themselves fairly or poorly in training (39%). EDs also need help in implementing universal screening for sexual assault victimization. Only a small minority do so (5%) and about one-third (34%) rate themselves as fair or poor in screening.

Further, over a quarter of hospitals do not offer the services of a sexual assault crisis companion/advocate for the victim during the examination, and one in five do not offer to have a sexual assault crisis advocate meet with the victim. Sexual assault advocates are able to provide focused attention and care to the victim while they are at the hospital, to help them navigate the complex legal and medical systems with which they may interact after an assault, and to address needs that are specific and unique to victims of sexual assault.

The most critical finding emerging from the primary care practice survey is that the primary care medical practices, for the most part, do not view sexual assault as an issue for their patient base at all. Many did not complete the survey, stating that 'they don't see rape', or that 'they refer 'that' to the emergency department'. Even among those that responded to the survey, most (75%) do not usually screen for sexual assault, so they probably do not know the extent to which past and current victims make up a part of their patient base. The Virginia survey would suggest that almost all practices have at least some victims of sexual assault among their patients.

Primary care practices, as well as some EDs, need written policies about the care of sexual assault victims. Worth considering is the work done by the Ohio Department of Health, which developed an ED protocol for the treatment of victims using a multi-disciplinary approach. The protocol was later followed by training materials and was distributed to all Ohio hospitals. Both the protocol and training materials were reported to be beneficial by the hospitals (Lewis et al, 2003). Similar work has not yet been done for primary care practices, but is needed.

Not surprisingly, most practices (89%) do not have any staff trained to assist victims of sexual assault and less than one-third have a relationship with a sexual assault crisis center. The primary medical practices recognize these needs: over one-fourth rated themselves fairly or poorly in training (78%), working with a sexual assault crisis center (41%), screening patients (31%), and working with patients who have been sexually assaulted by intimate partners (28%). Primary care practices are not likely to have the resources to provide specialized care and counseling to sexual assault victims, but they may welcome a partnership with organizations that can provide such services.

Recommendations

- The Virginia Department of Health and the Virginia Sexual and Domestic Violence Action Alliance should work with primary care practices and other health care professionals to assure screening of patients for sexual assault.

- The Virginia Department of Health should work with the Emergency Departments in the state and the General Assembly to ensure that each victim of sexual assault has access to a forensic nurse examiner in the ED or in SANE programs. Worth examining is the model of care used by some Virginia EDs of centralizing forensic nursing services at one hospital within a system of hospitals. This model may have potential, but its current effectiveness is unknown.

- The Virginia Department of Health and the Virginia Sexual and Domestic Violence Action Alliance should work with professional organizations such as the Virginia Hospital and Healthcare Association (VHHA), the Virginia Nurses Association and the Medical Society of Virginia (MSV) to:
    - Raise awareness of sexual assault as a health care issue with health care personnel, in particular those in primary care practice and emergency departments. Awareness raising activities could include distributing findings on sexual assault in Virginia and nationally via conferences, publications, and electronic means and by offering training to staff both at EDs and primary care practices.
    - Develop model written policies and training materials on the care of victims of sexual assault for hospital emergency departments and primary care practices.

- Primary care practices should partner with local sexual assault crisis centers, modeled on the strong partnerships in place with some of the EDs, to provide effective services to current and past victims of sexual assault.

- Future research should include a survey of pediatric health care providers, as a significant percentage of sexual assault victims are children and adolescents who may still be receiving care from pediatricians.

Sexual Assault Crisis Centers

Overview

The first Virginia sexual assault crisis center, then termed "rape crisis center", opened in 1973 with virtually no funding and began to grow through grass roots organizations. As public consciousness grew, so did sexual assault crisis centers in Virginia. In 1980, Virginians Aligned Against Sexual Assault (VAASA) was formed to bring together all crisis centers in the state. In 2004, VAASA merged with Virginians Against Domestic Violence (VADV) to form Virginia Sexual and Domestic Violence Action Alliance.

There are currently 37 sexual assault crisis centers in Virginia. Figure 5 (next page) shows the distribution of the centers. Of those 37, only 12 agencies address sexual assault alone. The remaining 25 address both sexual assault and domestic violence with varying degrees of resources specifically allotted to sexual assault.

The sexual assault centers are private, non-profit organizations funded through a combination of private sources and federal, state and local government funds. VDH administers federal funds to partially support the state sexual assault coalition and contracts with local sexual assault centers for community based prevention services. The state coalition, centers, VDH and many other agencies and groups routinely collaborate to address the problem of sexual violence in Virginia.

Figure 5: Locations of Virginia Sexual Assault Crisis Centers

Source: Virginia Sexual and Domestic Violence Action Alliance, 2004

The Sexual Assault Crisis Centers offer a variety of services including, but not limited to:

- 24 hour crisis-intervention hotlines for victims of sexual violence, their families, and friends,
- Intensive one-on-one crisis counseling and long-term support counseling for women, children, and men,
- Victim advocacy and personal accompaniment to medical exams, law enforcement interviews, and court proceedings,
- Support groups for sexual assault survivors and their families and friends,
- Systems advocacy,
- Emergency shelter,
- Community referrals,
- Education programs for allied professionals and community members, and
- In-school youth education and prevention programs.

The Virginia Sexual & Domestic Violence Action Alliance provides the following services in support of the sexual assault crisis centers and communities or individuals interested in addressing sexual assault:

- Statewide 24-hour hotline for victims, their families and friends and other concerned Virginians, as well as to support local sexual assault crisis hotlines,
- Certification of Virginia's sexual assault crisis centers,
- Technical assistance and training to sexual assault crisis centers,
- Allied professional and law enforcement training and technical assistance,
- Public policy monitoring and development on a state and national level in the areas of sexual assault, child sexual abuse, and funding,
- Written resources for victims, significant others, and professionals,
- A resource library on sexual assault related issues,
- Compilation and analysis of data on sexual assault center services,
- A semi-annual newsletter on relevant state and national sexual assault issues,
- A state and national directory of sexual assault crisis centers and coalitions, and
- Information, referrals and support to all those providing services to victims of sexual violence.

Sexual Assault Crisis Center Staffing

The centers employ, on average, 1.8 direct service staff for sexual assault work (Table 14, next page). About the same number of staff was assigned to administrative tasks (0.67) and prevention/education duties (0.68). Sexual assault crisis centers also utilize trained volunteers to provide certain services to clients. The bulk of volunteers provide direct services, with fewer volunteers available for administrative or prevention/education needs. Centers that completed the survey served between ten and 1,390 of primary victims of sexual assault in fiscal year 2003. The average number of primary[6] and secondary victims

[6] Primary victim: the victim of the sexual assault. Secondary victims are family members and significant others who are also affected by the crime.

served was 262 and 51, respectively, for an estimated 11,600 victims served by the 37 centers in 2003[7].

Table 14 Staffing and Victims Served by the Sexual Assault Crisis Centers, Virginia, 2004

Paid Staff for Sexual Assault Work (FTEs*)	**Average**	**Range**
No. of Direct Service Staff	1.8	0.75 – 4
No. of Administrative Staff	0.7	0 – 2
No. of Prevention/Education Staff	0.7	0 – 2
Volunteers		
No. of Monthly Direct Service Volunteer Hours	156	0 – 1000
No. of Monthly Administrative Volunteer Hours	14	0 – 160
No. of Monthly Prevention/Education Volunteer Hours	15	0 – 200
No. of Sexual Assault Victims Served, Fiscal Year 2003		
Primary sexual assault victims	262	10 – 1390
Secondary sexual assault victims	51	0 – 320

*FTEs: Full-time equivalent staff
Source: Survey of Sexual Assault Crisis Centers, Old Dominion University, 2004

According to results of interviews with staff of sexual assault crisis centers, inadequate staffing presents a challenge for many of the centers. While one center representative described a relatively large staff (17 staff, 25 volunteers), most of the centers studied struggled to provide services with minimal staffing – most had only 1 full time person addressing sexual assault in the program. In many rural areas, this meant that a handful of service providers were responsible for several counties. This staffing shortage also impacts urban areas. As one interviewee pointed out, “There are no sexual assault offices in Chesapeake or Virginia Beach; victims must go to Norfolk.” Many agreed that, “we need to look at the service areas, because some programs serving multiple counties don’t have a physical presence in those counties, therefore they cannot adequately meet their needs. The bottom line is that this is a resource issue.”

Although many centers are revamping their training for staff and volunteers, all agencies require a minimum of 30-40 hours of training prior to contact with victims and require yearly continuing education of their staff and volunteers. This training encompasses the history of the sexual assault movement, crisis counseling, the hospital process, the criminal justice system, hotline, stalking, secondary victims and working with children.

Services Provided by Sexual Assault Crisis Centers

The most common types of counseling/support services the centers provided are individual support, crisis counseling, follow-up counseling, and support groups. Less common are services such as individual therapy, support groups for partners of sexual violence victims, male survivor groups, and teen survivor groups. Personal advocacy, court accompaniment, medical accompaniment, and accompaniment on law enforcement

[7] Note that this estimate is not precise as it is based on survey data from 26 centers extrapolated to the 37 centers, and may reflect some duplication that could occur among centers, that is, two or more centers providing services to the same individual, but counted twice.

interviews are among the more common accompaniment/advocacy services. Sexual assault crisis centers also routinely help victims file victim compensation claims and fill out victim impact statements. They are rarely involved in providing expert witness testimony or academic advocacy. Additionally, emergency assistance services, emergency clothing, food, shelter, and transportation are provided by about sixty percent of the crisis centers.

The sexual assault crisis centers devote much effort to education and public awareness. General community education, agency brochures, volunteer training, and training of allied professionals are the most common types of educational services provided by the centers. Many centers also offer prevention initiatives and sexual harassment training in the workplace. Fewer centers offer peer education groups or advertise their services through marketing techniques such as television, radio, and yellow page advertisements due to lack of resources.

Services Provided to Adults

Detailed data regarding client advocacy from 2000 through 2003 were provided by Action Alliance to conduct more sensitive analyses.[8] Over half of adults were provided individual advocacy or counseling, information on sexual assault services, and child care. About one-third were provided information on domestic violence services, safety planning, and victim education (Table 15).

Table 15 Services Provided to Adults by Sexual Assault Crisis Centers, Virginia, 2000 - 2003 (excludes services provided to < 10% of the clients)

Services	Services Provided	
	Number of Cases	Percent
Individual Advocacy/Counseling Support	9,825	61%
Information on Sexual Assault Services	5,702	58%
Child Care	5,306	54%
Information on Domestic Violence Services	3,615	37%
Safety Planning	3,381	34%
Victim Education	3,038	31%
Program-Sponsored Group	2,747	28%
Accompaniment	1,775	18%
Referral to Mental Health Provider	1,565	16%
Therapy	1,181	12%
Referral to Legal Services	1,117	11%
Food/Nutrition	1,103	11%
Housing	1,045	11%

Source: Virginia Sexual & Domestic Violence Action Alliance

[8] The data are slightly biased geographically because, given time limitations of the study, some centers were not able to provide the permission necessary to release the data. Furthermore, there was missing data on a large number of victims. Many victims may be hesitant to provide detailed data on issues that currently seem irrelevant or intrusive.

Services Provided to Children

About half of the services provided to children were individual support services and safety planning (Table 16). Around 40% received group support services, communication skills, stress management, and education about issues and close to a third were provided conflict resolution and help working with family. In addition to sexual abuse, children experienced a number of other types of victimizations: violent assault (77%), violence in the home (31%), witnessing violence (28%), harassment (24%), and emotional abuse (21%). Much more rarely reported was neglect (9%), stalking (4%), gang related (1%) and other abuses (4%).

Table 16 Services Provided to Children by Sexual Assault Crisis Centers, Virginia, 2000 - 2003 (excludes services provided to <10% of the cases)

Services	Number of Cases	Percent
Individual support services	2,293	52%
Safety planning	2,214	50%
Group support services	1,779	40%
Communication Skills	1,775	40%
Stress management	1,693	38%
Education about issues	1,691	38%
Conflict resolution	1,611	36%
Working with family	1,423	32%
Accompaniment	677	15%
Play sessions	544	12%

Source: Virginia Sexual & Domestic Violence Action Alliance

Between 2000 and 2003, the sexual assault crisis centers spent over 2,300 hours answering over 8,200 hotline calls per year (Table 17). In addition, over 13,800 hours were spent giving extended individual advocacy service to 1,705 adults for an average of 8 hours/case. An annual average of nearly 37,000 hours of service to clients was performed by the centers. Of these, nearly 60% of contact hours were spent in individual or group advocacy to adults, 21% in individual or group advocacy to children, 13% in brief advocacy[9] contact, and 6% of hours responding to the hotline.

Table 17 Average Number of Hours of Service Provided by Sexual Assault Crisis Centers, Virginia, 2000 - 2003

Services	Average Number of Hours	% of Total Hours
Hotline Calls	2,325	6.3%
Brief Advocacy	4,674	12.6%
Adult Extended Advocacy		
Individual	13,802	37.4%

[9] Brief advocacy contact refers to a person-to-person contact with a victim that is usually a one-time occurrence (e.g. a hospital accompaniment in which further services are not requested by the victim).

Table 17 cont'd

Services	Average Number of Hours	% of Total Hours
Group	8,214	22.2%
Children Extended Advocacy		
Individual	3,884	10.5%
Group	4.027	10.9%
Total Hours	**36,926**	**100%**

Source: Virginia Sexual & Domestic Violence Action Alliance

Education Services

Some types of educational programs are provided by most of the centers (Table 18). Topics covered somewhat regularly are definitions relating to sexual assault, consequences, and forms of sexual assault; options for sexual assault victims; support for sexual assault victims; risk reduction; child sexual abuse and teen dating violence; and rape trauma syndrome. Less common topics are child sexual assault prevention and self-defense. Less than twenty percent of the centers provide education on self-defense for children facing the risk of child sexual abuse.

Table 18 Types of Educational Programs Provided by Number of Sexual Assault Crisis Centers (n=26), Virginia, 2004

Educational Programs Provided	Number of Centers
Self Defense for Children	5
Self-Defense	10
Child Assault Prevention	18
Rape Trauma Syndrome	21
Child Sexual Abuse	23
Risk Reduction	23
Health Issues	24
Sexual Harassment	24
Effects of Sexual Assault	25
Forms of Sex Violence	25
CJS and Sexual Assault	25
Options for Victims	25
Teen Dating Violence	26
Definitions of Sexual Assault	26
Responding/Supporting	26

Source: Sexual Assault Crisis Center Survey, ODU, 2004

Referral Services

According to those interviewed, the centers routinely make referrals to several agencies including mental health providers, medical professionals, commonwealth's attorneys, legal advocates, victim/witness advocates, substance abuse counselors, food/clothing providers, and transportation assistance.

Sexual Assault Prevention Efforts in the Schools

Focus groups and interviews with sexual assault crisis staff and campus sexual assault center staff indicated that many of their prevention efforts are focused on young people: this is to reach individuals before adulthood when victimization may have already taken place. All twenty-six sexual assault crisis centers that responded to the survey indicated that they provide general community education. However, many centers have few prevention staff to cover a large service area or are lacking funding to carry out adequate prevention programming. The average is less than one full-time person for prevention and education tasks.

A comment from one center staff member illustrates some of the challenges:

> Our agency has little or no prevention money, we get very few grants to do anything with prevention, and we've had a half-time staff for about 6 months that was prevention funded.

Family Life Education (FLE) has not been required in Virginia public schools since 1997. As a result, sexual assault prevention programs differ widely from one school to the next. There is varied success in gaining access to the public school population. Those who have been successful may utilize peer programs and others have been able to tie sexual assault prevention and education to the Standards of Learning (SOLs). Some comments:

> Pretty extensive school based program in the high schools and the middle schools. We cover dating violence, sexual harassment, and healthy relationships; run thirty-two groups a week in the four jurisdictions. We clearly believe that early prevention efforts, early education, lead to prevention. We do similar kinds of work on the campus, but how do you measure whether it works?

> We're pretty fortunate, we do Child Assault Prevention Program (CAP) for all of [ ] County, and we also have an adolescent program coordinator who does basically high schools and she goes around and does presentations in health classes and parent workshops, which are important pieces when talking about prevention, or risk reduction.

> CAP actually goes so far as to tie it to Standards of Learning (SOL). The CAP program itself shows each aspect of the SOLs that the program touches on. It shows the school system how they can cover that piece of their SOLs.

In areas where school officials do not believe that there is a problem, are concerned about parental objections to the subject materials, or are highly focused on SOL testing, prevention efforts have been difficult. Officials from at least one school system have denied the local sexual assault crisis center access for prevention efforts but have allowed center staff to counsel students who have disclosed sexual victimization. Specific comments:

> One prevention person for five school districts, so that's a real stretch. Some schools have had sexual assault and sexual harassment claims in the papers and are still not letting [a] prevention person in. Once into the school system, [the prevention person] was only allowed to speak to those people in anger management because "those are the kids that do it."

> Schools are closed to dealing with issues, because dealing with issues then advertises that the school has had those issues. In our community, again, the denial thing is just so huge.
>
> Family life education has not been required since 1997, but it's been in the schools in a lot of divisions. We're getting more and more school divisions. If they have the program or Family Life Education (FLE), they are lucky to have a week to cover all topics under family life….We're seeing anecdotally more school divisions saying I'm going to do away with it and we'll just put it under health. Which is fine, if it's truly identified as that, and it doesn't get sucked away .. . We actually have standards of learning for FLE, but they're not tested….they don't care to use them because they are not as important.

Needed Services that are Unavailable

Table 19 illustrates those services or activities that were reported as unavailable but needed by at least one-fourth of the sexual assault crisis centers surveyed. Most commonly cited were services for specific groups of victims: partners of sexual assault victims; elder abuse victims; male sexual assault survivors; child victims; and teen victims. Directors affirmed that public awareness campaign strategies, such as billboard, television, and radio ads, were unavailable but needed to promote awareness about the centers' services and educate the public about sexual assault. About half of the centers indicated that sign-language interpreters were unavailable but needed and one-third cited the need but unavailability of foreign language interpreters. The most frequent challenge to being able to provide these services was funding.

Table 19 Services that are Unavailable but Needed to Address Sexual Assault, as Reported by Sexual Assault Crisis Centers (n=26), Virginia, 2004

Services Unavailable but Needed	Number of Centers
Support Group for Partners of Sexual Assault Victims	13
Billboard Ads	15
Elder Abuse Support Groups	15
Male Survivor Support Groups	15
Sign Language Interpreters	11
TV Ads	11
Radio Ads	10
Child Support Groups	8
Foreign Language Interpreters	8
Expert Witness Testimony	8
Phonebook Ads	7
Teen Victims	7
Emergency Financial Assistance	6

Source: Sexual Assault Crisis Center Survey, ODU, 2004

Clients Served by Sexual Assault Crisis Centers

VAData[10] is the data collection tool used by the majority of sexual assault crisis centers since 1999. Thirty-four out of 37 centers participate in the system. According to VAData information for 2002, adult victims ranged in age from 18-83 with an average age of 34 years. Clients came from virtually all counties and cities in Virginia and some of the victims were from other states. Table 19 shows the demographic profile of sexual assault crisis centers' clientele in 2002.

According to staff, child victims are typically referred by school social workers, allied professionals or victim/witness offices. Adolescents typically seek help through a hotline call, or receive a referral from a private therapist, police or emergency room personnel. Victims also learn that services are available through advertisements or advice from family and friends. Adult victims may be referred by emergency room or law enforcement personnel. They also self-refer, using a hotline or walk-in service. Some victims are in immediate crisis while others are dealing with the long-term effects of past assaults. Sometimes the primary reason for seeking the services of a sexual assault crisis center is domestic violence. One service provider noted, "Women come to us with the primary presentation of domestic violence, and then disclose part of that violence suffered was sexual violence".

Table 20 Demographic Profile of Users of Sexual Assault Crisis Centers, Virginia, 2002

Characteristic	Percent
Adults	
Gender	
Female	93
Male	7
Race	
White	71
African-American	21
Latino	4
Other	<1
Unknown	3
Education	
Less than High School	20
High School Graduates or GED	40
Some college or post-high school training	26
College graduates	14
Children	
Gender	
Female	75
Male	25

[10] VAdata is an electronic web-based data collection system for Virginia's domestic violence programs and sexual assault crisis centers that is maintained by Virginia Sexual & Domestic Violence Action Alliance.

Table 20 cont'd

Race	
White	65
African-American	24
Bi- or multi-racial	5
Native American	3

Source: Virginia Sexual & Domestic Violence Action Alliance

Types of Crime Victims Served by Sexual Assault Crisis Centers

According to the survey, certain types of victims are served by most, if not all of the centers (e.g., stranger sexual assault, incest, acquaintance rape, gang rape, child sexual violence, stalking, and intimate partner sexual assault victims). Victims who do not tend to utilize the services of sexual assault crisis centers as frequently include elder sexual abuse victims, victims of ritual abuse, trafficking victims, and prostitutes who are sexually assaulted (Table 21).

Table 21 Types of Victims who Use the Services by Number of Sexual Assault Crisis Centers (n=26), Virginia, 2004

Types of Victims/Services	Number of Centers
Intimate Partner Sexual Assault	26
Acquaintance Rape	26
Incest	26
Sexual Harassment	26
Stalking	25
Stranger Sexual Assault	25
Child Sexual Violence	24
Gang Rape	23
Elder Sexual Abuse	13
Prostitution	10
Ritual Abuse	9
Trafficking	6

Source: Sexual Assault Crisis Center Survey, ODU, 2004

It is clear from the Virginia survey data that there are a significant number of victims of prior sexual assault. Moreover, some victims suffer long-term emotional and physical effects from such assaults. It is not clear where victims of prior sexual assault receive services nor if they seek or receive services. This study suggests a need for more collaboration between local mental health services and sexual assault crisis centers in serving this population.

Sexual assault crisis centers only provide services to a small number of victims as compared to the expected number of sexual assault victims each year. Based on surveys, about 31,000 adults alone are sexually assaulted in Virginia each year; however, only

about 11,800 served by sexual assault crisis centers. Although an analysis of the financial resources of sexual assault crisis centers was not a part of this study, the data strongly suggest a need for additional funding to further promote and expand services.

Concerns of Victims

When receiving services from a sexual assault center, clients are asked to rank a listing of possible problems, concerns, or fears under five categories: basic life, family/relationship, health, legal, and trauma related needs (Table 22). Recovery from victimization and attention to the trauma of victimization ranked highest among expressed concerns. One fifth of clients expressed concern with the impact of the violence on children, finances, mental health concerns, and safety.

Table 22 Most Common Problems, Concerns or Fears Expressed by Clients of Sexual Assault Crisis Centers, Virginia, 2000 – 2003

Most Common Problems, Concerns or Fears	Number of Cases	Percent
Recovery from victimization	4,124	42%
Trauma of victimization	2,984	30%
Impact of violence on children	2,196	22%
Financial Needs	2,187	22%
Ongoing mental health concern	2,135	22%
Safety planning	2,037	21%
Housing	1,580	16%
Employment/training	1,405	14%
Criminal (regarding the assault)	1,351	14%
Impact of violence on extended family	1,288	13%
Access to Transportation	1,193	12%
Immediate mental health concern	1,093	11%
Ongoing physical health concern	1,052	11%
Household security	1,000	10%

Source: Virginia Sexual & Domestic Violence Action Alliance

Underserved Victims

For sexual assault crisis centers, those who are underserved include elder sexual abuse victims, family members of survivors of sexual abuse, children and adolescents, and those with language or cultural barriers. Many sexual assault crisis centers indicated that they simply do not have the resources to serve elder victims or family members of survivors. Several of the crisis center workers indicated problems getting into the schools to provide prevention education programs.

Accessibility

Various measures of accessibility were assessed (Table 23, next page). All centers provide services at no cost to the client. Most centers reported providing handicapped access. Several of the services offered by sexual assault crisis centers are available 24

hours a day. Transportation is provided by about half the centers; another fifth rely on transportation being provided by other community agencies. Few centers have the resources for foreign or sign language interpreters.

Table 23 Number of Sexual Assault Crisis Centers providing Accessible Services, Virginia, 2004

Services to Improve Accessibility	Provided by agency	Provided by other community agency	Unavailable but needed
Handicapped parking	22	1	3
Handicapped accessible entrance	21	1	4
Handicapped accessible bathrooms	20	1	3
TTY/TDD Telecommunication	22	2	4
Sign language interpreters	2	7	11
Foreign language interpreters	4	10	8
Services provided in evening hours	21	0	2
Services provided on weekends	19	0	4
Services provided at no cost to client	26	0	0
Transportation to agency	13	5	4
Cognitive/mental health Issues	0	0	1

Source: Sexual Assault Crisis Center Survey, Old Dominion University, 2004

Areas of Challenge for Sexual Assault Crisis Centers

Sexual assault crisis center directors were also asked to identify the major challenges to doing sexual violence work in their communities. The general challenges cited consistently by the directors were a lack of awareness in the community about sexual violence, need for prevention services, victim-blaming attitudes (blaming the victim for the sexual assault) and a lack of resources.

Lack of Awareness

Lack of awareness about issues related to sexual violence was a common problem cited by many directors. Directors described "denial of a problem," "lack of belief that sexual assault occurs," and "ignorance about sexual violence" as key challenges. As one director pointed out, "People tend to not pay attention to our being out there until they need us. Then they don't know where to go." The result of this lack of awareness is many victims don't seek or receive available helpful services. Some victims may not report because these see challenges in their communities. Those who do report face stigma and a community that may not believe their accusations. Directors suggested this was especially a problem in acquaintance rape, child sexual abuse cases, and in rural areas where residents "face fear in speaking out about the violence."

There seems to be a limited understanding by the community as well as professionals of the problem of sexual assault. The unique experiences of sexual assault victims cannot be understood with general explanations of the experiences of victims; nor can the response

to sexual assault be the same as the response to other kinds of victims. The nature of sexual assault requires a specific understanding of the consequences of the violence and a response that is victim-based rather than offender-based. There is also a need for a better understanding of the characteristics, attitudes and behaviors of perpetrators.

Need for Prevention Services

All members of the focus group agreed that they would like to see some form of sexual assault prevention mandated in the schools. "I'd do a statewide curriculum, so that people are choosing a science-based, evaluation-based curriculum. It could be tweaked based on where they are in the state, but we could then collect data on what's being done, and have some validity in the training and how it's being provided."

Based on focus group responses, it appears there is inconsistent implementation of prevention programs or curricula, with some areas reporting great difficulty and others showing promise. In areas where prevention programs are being implemented, a problem seems to be a lack of a rigorous evaluation. A review of successful sexual assault prevention programs and curricula was beyond the scope of this study but would be helpful.

Victim-blaming Attitudes

Victim-blaming is a challenge directors reported encountering in their efforts to provide services to victims of sexual assault. This refers to attitudes and behaviors expressed by community members which blame the victim for the sexual assault. For example, a family member, teacher, friend, or professional may say to an adolescent who just disclosed being the victim of an acquaintance rape, "why were you alone with this person," implying that because the victim chose to be alone with the perpetrator, the victim is responsible for the rape. One director commented that the "local law enforcement curriculum includes victim blaming," suggesting that "law enforcement officers are learning to blame victims before they even encounter these cases."

In the interviews, some advocates noted concerns about judges' actions in cases involving teenage victims, "Children, they believe until they are about 14, and then it's like they don't believe them anymore." "We have a juvenile/domestic relations judge who hears cases when families are involved. He believes that teenage and preteen girls are seductive and difficult to deal with, and get what they ask for, and he makes statements pretty much like that."

Lack of Resources

Insufficient funding was the most commonly cited obstacle directors faced in serving sexual assault victims and was especially problematic in limiting the centers' ability to promote awareness about sexual assault and provide emergency financial assistance and support groups to victims. Many directors noted a lack of resources as a challenge to carrying out sexual violence work in their communities, mainly to provide a wider range of services, extend services to the underserved, and address community problems. One director described the interrelationships between these challenges as follows

An overall lack of understanding about the dynamics of sexual violence [is a problem]. The silence and stigma make it difficult to dialog about these issues. There still exists a lack of sensitivity to the victimization of women, children, and men. Many still entertain victim-blaming attitudes. These are the last issues many want to talk about and/or fund! Sexual violence survivors have unique immediate and long-term needs that many don't understand.

Collaborative Efforts from the Perspective of Sexual Assault Crisis Centers

Crisis center directors or their representatives were asked to address problems they had collaborating with various groups. While the results present the perspective of key providers in sexual assault, the sexual assault crisis center directors and staff, they do not reflect barriers to collaboration perceived by other providers, such as law enforcement and health professionals. A full analysis should include other providers' points of view. Such a study can be completed with additional resources and time.

Methods

Twenty-six directors and seventeen additional crisis center workers completed written responses to: "Please provide a brief description of any challenges you face in collaborating with the following entities in your community" and "What are the major challenges to doing sexual violence work in your community?" Crisis center directors and staff were specifically asked about the following groups: law enforcement, criminal justice (courts, judges, and prosecutors), health care professions, mental health, victim/witness programs, Department of Social Services.

Responses to these questions were content analyzed using standard rules of manifest and latent content analysis. This analysis revealed several themes that were cited as common barriers faced by many of the crisis centers. These barriers have some overlap between each of the systems involved in responding to sexual violence cases. However, some of the barriers are specific to the kind of agency with which the crisis center is working.

Collaboration with Law Enforcement Agencies

A handful of directors cited positive relationships with law enforcement. One director said, "The local law enforcement agencies have been very helpful in collaborating with our agency." Another director appeared to have a similar relationship with law enforcement. She stated, "In our primary service area, we are fortunate to have a cooperative effort and relationship with our law enforcement. They participate actively on various teams and assist with our training." A third director suggested that the ability to collaborate varied among officers. She indicated that only certain investigators seemed to mishandle sexual assault investigations.

In interviews, several advocates praised the work of police, although they also emphasized that there was much variability. One described the police as, "Very considerate towards the victim, very empathetic, immediately want me in." Another said, "In many cases, when there has been a lot of physical assault, they follow through with the cases; when there is a lot of evidence they do a really good job."

A number of problems were cited suggesting difficulty in the collaboration of sexual assault crisis centers with law enforcement agencies.

Exclusion of Advocates from the Criminal Justice Process: Some directors noted that sexual assault crisis workers felt excluded from the criminal justice process. This was manifest, in some instances, through exclusion from meetings or erratic communication with the advocates on case status. Some felt this was due to a lack of awareness among some law enforcement personnel of the role of sexual assault crisis centers. Others felt it was due to a perception that sexual assault crisis centers might interfere with the investigation. The consequence of this exclusion, stated one director, is that not having the sexual assault advocates involved "can be very traumatizing for victims." In a focus group, a sexual assault worker noted, "When people have an advocate, they are much more likely to continue through the criminal justice process."

Inconsistent Collection of Evidence by Law Enforcement: There is a perception among some directors that some law enforcement officials resist colleting or using evidence in sexual assault cases. According to directors, some prosecutors claim that they don't prosecute these cases because they lack evidence. Yet, from the perspective of sexual assault crisis center directors, evidence is available; it is sometimes not gathered because law enforcement officials believe that their efforts would be futile. Directors also believe that some law enforcement officials do not gather evidence vigorously because they think that victims are not telling the truth.

Directors were asked about the use of Physical Evidence Recovery Kits (PERKs) by law enforcement to see whether or not evidence was gathered similarly in different places. One question asked, "In your primary service area, who has the authority to decide whether or not a PERK examination is provided to a sexual assault victim?" Slightly under half of the directors noted that law enforcement officers made the decision, a handful said that the Commonwealth's Attorney made the decision; the same number said that medical professionals made the decision; other directors said that police officers worked with either SANE nurses or the Commonwealth's Attorney to make the decision. Just one director said that the decision was made by the victim, police officer, and hospital staff. It appears that there is no consistent practice statewide in determining whether to administer a PERK examination.

Questioning the Credibility of Victims by Law Enforcement: Several comments made by the directors indicate that they believed law enforcement to be suspicious of victims of sexual assault. Many expressed concern that law enforcement officers "forced" victims to do polygraphs. For some directors, unwarranted suspicions were the main problem directors encountered when collaborating with law enforcement. Directors believed that law enforcement officers were especially suspicious of acquaintance rape victims.

Ignoring Acquaintance Rape: Some of the directors seemed to generally believe that acquaintance rape gets placed on a back burner by law enforcement agencies. One director commented that law enforcement's "preoccupation with 'real' rape" was a challenge and another said that law enforcement officers "don't believe acquaintance rape [victims], especially when alcohol is involved."

Victim-blaming: According to some directors, even when they believe that the sexual act occurred, some law enforcement officers may blame the victim for the violence. According to one director, such blaming is "especially the case when associated with college students and substance abuse."

Requesting Polygraph Tests of Victims: During interviews with local sexual assault workers, several advocates raised the issue of polygraphing sexual assault victims, saying that this appears to be a trend statewide. Taking a polygraph can emotionally injure the victim, create distrust between law enforcement and the victim, their primary witness, be a disincentive to further cooperation, and ultimately be a barrier to seeking justice. Furthermore, The Code of Virginia (§19.2-9.1) states that "the agreement of the complaining witness to submit thereto shall not be the sole condition for initiating or continuing the criminal investigation." Despite this law, advocates reported having observed the use of victim polygraphs as the sole condition determining if investigations should move forward. As an example, one advocate recalled an officer telling the victim, "We have two options here. You can take the polygraph or I can charge you with false reporting." In some localities, both the victim and alleged perpetrator are asked to submit to a polygraph examination. Since the polygraph is a tool used to detect deception, asking victims to take a polygraph sends a clear message that their report of sexual assault is not believed. Contrasted with victims of other crimes, sexual assault victims must seemingly meet a much higher standard of veracity. For example, rarely are victims of other felony crimes asked to take a polygraph; it is assumed that they are telling the truth in their initial reports to the criminal justice community. Even if there is not enough evidence available to proceed with charges or prosecution, the veracity of victims of other felony crimes are not challenged as often as victims of sexual assault.

Denial of Occurrence of Sexual Abuse in Communities: Some directors suggested that some law enforcement officials deny that sexual assault is a problem in their jurisdictions. One director expressed that law enforcement has a "disbelief that crimes occur (sexual assault doesn't happen in [my] county)." Another said that law enforcement officers fail to "identify sexual assault as a crime."

Misunderstanding the Dynamics and Sensitivity of Sexual Assault: Some directors suggested that some law enforcement officers did not understand the dynamics of sexual assault. Victims may have problems recalling details, yet, some police might rely heavily on victim interviews and view inconsistencies as a false report. Consequently, the director explained, law enforcement will not gather other evidence like PERKs. In other instances, some directors stated that police officers did not utilize principles of sensitivity that would be recommended by sexual assault advocates. This manifests itself as a lack of understanding about the trauma symptoms related to sexual assault victims or in some cases, breaking the victim's confidentiality in the community. Some directors indicated that police need more training about sexual assault and the appropriate responses, including handling sexual assault cases with a greater sensitivity. One director who reported a "good" relationship with law enforcement stipulated her high regard for law enforcement by suggesting "continually refreshing mandatory re-trainings of all officers."

Lack of Clear Policies on Response to Sexual Assault: Some directors also suggested that a lack of clear policies describing how law enforcement agencies should respond to sexual assault inhibited their collaborations. One director said, "Cities in our area deal with sexual assaults in very different manners." Another cited the "lack of protocols that include referral to the local center" as being a barrier to collaboration.

Collaboration with Criminal Justice Agencies

Some directors described strong collaboration with criminal justice agencies. One director said, "I have a great relationship with our city prosecutors. They even do [training] with me." Another director said, "They have been very helpful and open to the needs of survivors." A third director simply described an "overall positive" relationship with these other agencies.

In interviews, some sexual assault workers also offered positive or mixed comments about prosecutors and judges. Some examples:

- "[The local prosecutor] prosecutes stranger assaults and child sexual assaults to the fullest, but if the victim is an adult, there is a lot of doubt and blaming."
- "We have a circuit court judge [who] is absolutely outstanding. He holds perpetrators accountable. He's respectful to victims without appearing to give favoritism."
- "Our prosecutor seems to care about the victim and want to do the best he or she can, but only three or four cases have actually gone to court out of the 100+ in two years."
- "I have seen positive behavior from judges. They listen. They take the time to listen to both sides. I have been very impressed with the way they handle a lot of the cases. They are open-minded and very respectful."

Other crisis center directors cited several different challenges they encountered with criminal justice agencies (e.g., courts, judges, prosecutors):

Resistance to Prosecuting Certain Sexual Abuse Cases: Resistance to prosecuting certain kinds of cases was a common barrier to collaboration noted by sexual assault crisis center directors. Four kinds of cases were cited: child sexual abuse cases, acquaintance rape, those lacking substantial evidence, and general sexual abuse cases. Comments on child sexual abuse cases included that prosecutors "do not take child sexual abuse seriously", that the courthouse was not child friendly, and the representation for children was inadequate. About acquaintance rape, some directors reported that acquaintance rapes are not taken to court. One director hypothesized this was because "[prosecutors] say they don't think they'll win and thus it is their responsibility not to waste the court's time." Another director said, "Most [sexual assault cases] don't get any recognition or are not believed unless [there is] a substantial amount of abuse." Another director's comments, that prosecutors were "unwilling to try difficult cases," illustrate a similar experience or

belief. Yet another director stated that prosecutors were simply "not prosecuting sexual assault cases."

Judicial Understanding of Sexual Assault: Several sexual assault directors suggested that some criminal justice officials were not aware of the dynamics of sexual assault and could benefit from training on the issues to improve awareness of the problem.

Concerns about Interpretation of the Law: Some sexual assault crisis center directors described concerns about interpretation of the law, in particular, citing inconsistent treatment of victims or sentencing of perpetrators.

Re-victimization: Some directors cited concerns about re-victimization, which, in this context, means that victims may experience additional harm simply by participating in the court process. One director said, "Many times the legal process treats the victim as the perpetrator." Another director stated that the process "is re-traumatizing for victims."

Communication Problems: Several of the directors cited communication problems as a barrier to collaboration between criminal justice officials and sexual assault crisis centers. For example, one director lamented, "limited opportunities to converse with judges outside of the courtroom."

On another level, directors also suggested that criminal justice officials don't always communicate well with victims, particularly citing that some criminal justice officials are not adequately educating victims about the process or expectations.

Collaboration with Victim-Witness Professionals

Victim-witness professionals are part of criminal justice agencies, but they may have more contact with sexual victims and sexual assault crisis centers than other criminal justice professionals. Collaboration between sexual assault crisis centers and victim-witness programs can be effective, as evidenced by comments made by some of the sexual assault crisis center directors. One director commented that "[Victim-witness] has been very helpful in referring and taking referrals. The collaborative efforts between victim/witness and our agency have proven to be very beneficial for the survivor." Another cited no problems collaborating with victim-witness. A third director cited more open communication as a result of recent turnover at the center and the local victim-witness offices.

Other challenges in collaborating with Victim-Witness professionals as noted by sexual assault crisis center directors include:

Territorialism and Loyalty to the Criminal Justice System: Several directors suggested that perceptions of "territorialism" hinder effective collaboration between victim-witness programs and sexual assault crisis workers. Referrals are not always made to the crisis centers or if they are, they may be for limited services, such as for counseling but not court advocacy. One director speculated that victim-witness workers may be "afraid they will lose funding if they allow us to provide support to victims." Another director stated

that sexual assault crisis and victim-witness workers "need more training on how we can work together."

Victim-witness professionals are criminal justice employees and by law, must share anything victims tell them with the prosecutor. One director indicated that victim-witness advocates sometimes put the system's interests before the victims. She said, "Victim-witness sometimes work on behalf of the prosecutor and not the victims; pleading cases without victims' complete understanding or consent."

Accessibility/Communication*:* Some sexual assault crisis center directors cited problems with accessibility and communication when working with victim-witness advocates. Reasons cited included the rapport with the center, and victim-witness advocates who are either overworked or work part time.

Awareness of Sexual Assault Issues*:* A few directors indicated a belief that victim-witness advocates had limited knowledge of sexual assault issues or sexual assault services.

Collaboration with Health Care Professionals

Some directors reported positive relationships with local health care providers. One director described current efforts to build a relationship with the health care community:

Our local hospital has been actively working with us (over the past six months) to increase the collaborative efforts between our agency and the hospital. They are actively promoting our organization and the services that we can offer to survivors of sexual assault. We are also working on establishing a SANE program as well.

Some of the challenges are described below.

Distance from Health Care Providers: Distance from health care providers is a problem some of the directors cited in working on sexual abuse cases. This is especially problematic in rural areas where certain hospital services may not be readily available for sexual assault victims. One director said, "PERKS are no longer done at our local hospital. Victims are sent thirty miles away to another facility." Another director indicated that "no specialized services such as SANE [Sexual Assault Nurse Examiner] or FNE [Forensic Nurse Examiner]" were available in her locality. A third director stated that there are "not very many health care professionals in [my] community."

Referrals and Role Definitions*:* Several directors described instances in which they believed health care workers should have referred victims to the sexual assault crisis centers, but did not do so. For example:

- They seldom refer to us.
- They don't [always] contact us when they get someone in that may need our services.
- Not giving referrals to sexual assault victims [is a problem].
- Not contacting the sexual assault advocate when a sexual assault victim has come in [is a problem].

- No referrals for services, no screening for sexual assault, difficult collaboration.
- Referrals...are needed.

As an illustration, one director explained frustration over "SANEs who think they are capable of handling both evidence collection and the emotional needs of the victim and [those of] his/her family and friends."

There may be some systemic barriers to referrals. Consider the following comments from one director:

We've experienced a tremendous reduction in accompaniment requests to the emergency room. Health care professionals seem to be wary of contacting crisis centers since the health insurance portability and accountability act (HIPPA) regulations have been enacted. More often, we've seen emergency room requests be based more on what will be helpful to the emergency room staff and with police versus the needs of the victim.

Awareness of Sexual Assault as a Health Issue: One director noted that "many [health care professionals] do not see sexual assault/domestic violence as a health issue, " while another said that health care professionals "lack...general knowledge about sexual assault." To remedy these problems, one director called for "more participation [by health care providers] on sexual assault committees." This same director stipulated a belief that "referrals, education, and screening are needed across the board."

Collaboration with Mental Health Professionals

Sexual assault crisis center directors were asked about challenges they faced when working with mental health workers. Problems that they encountered included role ambiguity, inappropriate referrals, funding related problems, and misunderstanding of sexual assault. The challenges they cited are:

Role Ambiguity: Role ambiguity refers to instances in which mental health workers offered services that can be provided by sexual assault crisis center workers. For instance, one sexual assault crisis center director said that mental health workers "try to fill the role of advocate and [do] not limit their role to therapy." This director cited instances in which counselors attend "court in a supportive role that should be the sexual assault companion's role."

Conversely, other directors described situations in which mental health cases were referred to the crisis centers when the cases were actually beyond the scope of the kinds of cases handled by sexual assault crisis centers. In the words of one director:

Mental health professionals sometimes inappropriately refer survivors to us because they feel unable to deal with the client's sexual assault. However, we are often unqualified to deal with clients' mental health issues. This same director goes on to explain that "affordable mental health services in our rural area are limited," suggesting that the lack of services potentially explains the inappropriate referrals.

Funding Issues: Many of the directors either directly or indirectly implied that funding-related issues created challenges to working with mental health workers in their communities. One director summarized the problem:

Collaboration isn't the issue. Money is the issue. Public mental health is overworked and underpaid with limited experience in sexual assault. Managed care limits the use of private counselors for many survivors. Long-term therapy by licensed professionals is difficult for many survivors to afford and obtain.

Misunderstanding of Sexual Assault: Some directors suggested that some mental health professionals lack an appropriate understanding of the dynamics of sexual assault. Some of the directors seemed to imply that the lack of knowledge about sexual assault may result in the inappropriate referrals and role ambiguity described above.

Collaboration with Social Services Professionals

Sexual assault crisis center directors were asked about barriers they encountered working with social services workers. Their comments were limited to a few words and there were no clear patterns. Some said that they had "good relationships," "a great relationship," and "good support and collaboration" with social services agencies. A few directors said that they had problems getting referrals from social services and one director suggested that social services, when they do work with the crisis centers, do so "to save face only." A few other directors said that social services workers lacked understanding about sexual assault. In addition, a few directors noted that while they worked well with child protective services, they did not interact very much with adult protective services.

Collaboration as Viewed by Representatives of State-Level Organizations

In the focus group with representatives of state-level organizations, respondents were able to highlight specific instances of collaboration amongst agencies, most mentioning that the Department of Health and the Department of Criminal Justice Services were especially helpful in designing joint trainings or workshops. Others noted difficulties with collaboration with law enforcement and mental health agencies.

When later asked for specific recommendations for improved collaboration at the local level, the participants suggested:

- Find a way to get people to see that there is a common goal and that it's beneficial to have people work together.
- Have localities where collaboration works well serve as a model for other localities.
- Grants should make collaboration a condition of obtaining funding.

Collaboration in Summary

Collaboration at the state level and local levels could be improved through the establishment of an entity with authority to oversee implementation of recommendations of this report. Such an entity does not exist but could be modeled after the Virginia

Commission on Family Violence Prevention that operated in the 1990s.

At the local level, some local crisis center workers reported positive working relationships with all of the respective agencies that come into contact with sexual assault victims. Those crisis center workers that described positive relationships also described the presence of such protocol in their areas. However, collaboration among agencies appears difficult for many localities - in part due to differing missions, values, training, and lack of formal, effective collaborative relationships or protocols. Integrated training programs could help staff gain a common understanding of sexual assault dynamics and better understand how their own agency works with other agencies as well as why other agencies operate as they do.

In some communities, Sexual Assault Response Teams have been established to coordinate and standardize inter-agency response to sexual assault. However, it is not clear how many communities in Virginia have such teams, how effective they are, nor what is the unmet need for such collaborative teams.

Recommendations

- The Virginia Department of Health should review sexual assault prevention programs and identify those that show successful outcomes for implementation, in collaboration with other similar prevention programs, such as teenage pregnancy prevention.

- The Department of Education should consider implementing an age-appropriate curriculum to prevent, recognize, respond and refer sexual assault in all schools (kindergarten through higher education) and incorporate sexual assault prevention education in the Standards of Learning.

- A comprehensive study of law enforcement response to sexual assault should be conducted in cooperation with the Department of Criminal Justice Services, the Virginia Sexual And Domestic Violence Action Alliance, and the Supreme Court. Representation from law enforcement, the Commonwealth's Attorney office, the courts and victim advocates should be included.

- Virginia Sexual & Domestic Violence Action Alliance should conduct a comprehensive needs assessment of sexual assault crisis centers in conjunction with Virginia Department of Health and Virginia Department of Criminal Justice Services and make a funding recommendation to the General Assembly.

- The General Assembly should consider appropriating funds for public education campaigns in all Virginia communities to raise awareness of the problem of sexual assault with the message that individuals and communities will not engage in or support sexual assault. Specific topics may include:
  - Prevention of sexual assault.
  - Perpetrator identification, response, treatment and reporting.
  - Stigma of sexual assault and barriers to reporting.

  - Victim recognition, treatment, and reporting.
  - Resources on sexual assault; sexual assault centers and their role and services.
  - Consequences of sexual assault; effects on past victims of sexual assault.

- The Virginia Department of Health, Virginia Department of Criminal Justice Services, Virginia Sexual & Domestic Violence Action Alliance and local Sexual Assault Crisis Centers will work collaboratively and continue their efforts to:
  - Expand services.
  - Reach out to underserved populations.
  - Promote awareness of the problem of sexual assault.
  - Promote awareness of the sexual assault crisis centers.
  - Increase collaboration with other agencies.

- The General Assembly should consider forming a statewide legislative Commission on Sexual Violence to support implementation of the recommendations. The Commission on Sexual Violence should develop a model protocol for collaboration of local agencies on prevention and response to sexual assault, including model joint training of personnel.

- The General Assembly should consider funding for the development and support of strong regional or local sexual assault coalitions to include sexual assault, health, mental health, law enforcement, criminal justice, education, and social services personnel. The funding would:
  - Require collaboration and the development of collaborative agreements.
  - Require establishment of common goals, joint policies, and resource guides.
  - Require development of a joint response protocol to sexual assault.
  - Require integrated training for sexual assault advocates and medical, social service, mental health, criminal justice and law enforcement personnel.
- The General Assembly should consider requesting a study to assess the emotional and physical health needs of victims of past sexual assault and the ability and requirements of the service system to address these needs.

Sexual Assault at Colleges and Universities

Colleges and universities present a unique aspect of the problem of sexual assault. The unique demographic, social, and cultural makeup of colleges and universities contribute to the risk of sexual assault on college campuses. According to the participants of the college campus sexual assault center focus group, demographic/social factors increasing the risk of sexual assault on campuses are age, sexualized culture, drugs and alcohol, and male roles. These factors need to be understood for a better appreciation of the prevention efforts that are being implemented.

Age is a risk factor for sexual assault on college campuses in a number of ways. First, given that younger females are at a higher risk of sexual assault than older females, a sizeable number of potential victims are present on all college campuses. Also, most research finds that offenders are most likely to offend when they are younger. Here, a sizeable number of potential offenders are also present on college campuses. Finally, since college freshman are experiencing a change in their levels of autonomy, some—males and females—may use their independence in dangerous ways. Comments from the campus representatives such as "people are experimenting" and "people doing things their parents don't know about" suggest that they may be at a place in their life course where risk for assault heightens.

On a similar point, the college campus, according to some of the campus representatives can be characterized as a "sexualized environment" with "blurred boundaries." Lines between experimentation, consent, and assault may be "blurry." With many young students being introduced to sexual issues, and with more autonomy than they had in the past, sexual behavior increases. With increases in sexual behavior come increases in sexual misconduct. One comment:

> Tied into the mix is the role of drugs and alcohol on college campuses. Of course, drugs and alcohol do not cause violence, but their use and abuse create situations in which violence, including sexual assaults, may occur. When young people, who are inexperienced sexually and with alcohol or drugs, mix the too, the possibility for harm escalates.

According to some campus experts, also related to the role of age, the sexualized environment, and drugs and alcohol are stereotypical beliefs held by male college students about their roles. Consider the comment:

> There's a culture where women are targeted, where men will talk with one another about how they are going to go out and score. And actually women are doing it now also. The way they talk about it, it's like getting the target, and so I think then there's this idea that this is okay.

In the focus group with representatives of campus sexual assault centers, participants also identified the following trends in the nature of sexual assault on campuses:

- Increased use of "club drugs" "(i.e., Rohypnol, Ecstacy)
- Internet crimes
- Harassment and stalking through technology
- Multiple victims
- "Identity Theft"

Campus representatives reported that drug use was common in sexual assault cases. Some of these instances include situations where male college students "drug" a female college student, while others seemed to involve recreational use by both parties.

In terms of Internet crimes and technological stalking or harassment, a number of campus representatives cited different ways that college students could fall prey to what can be termed "Internet victimization." For example, some students have had their sexual liaisons taped and placed on websites for public review. Very often,

these cases are so difficult to adjudicate that nothing can be done to remove the videos from the internet. Or, offenders may threaten to post pictures or videos.

A trend that many of the representatives agreed was becoming more common were instances in which multiple victims of one offender were coming forward to the police. The campus representatives explained that with cultural awareness promoting the reporting of sexual assault, more and more cases of "serial rapists" are coming to the attention of campuses.

Another trend that the representatives described was increases in occurrences of what can be coined "sexual identity theft." There are two variations of "sexual identity theft." In the first variation, a type of Internet crime, perpetrators take on the identity of an unsuspecting college student, usually a female, and send e-mails or place announcements on Websites asking for sex. Said one campus representative: "Well I've also had people steal other people's identity, and then pretend to be them and email people and tell them to come over and have sex; the women then has people showing up at her house. As well as cyber-stalking stuff too."

A second variation of "sexual identity theft" occurs when perpetrators mask their identity as if to make the victim, again usually a woman, think she is having sex with one person, probably her boyfriend, when in fact, she is having sex with one of his friends. More often than not, these situations appear to involve drug or alcohol use by both the perpetrators and the victims. One campus police officer described the following scenario: "You'll have a young woman in the room, she'll be having sex with one young man, he will get up, and another young man will come in. She's so intoxicated, and the atmosphere was so dark, she didn't know that by the time she finished she'd truly had sex with seven different men." To be sure, this is an example of rape, but perpetrators are believed to perceive their actions as freshmen or sophomoric pranks.

The transient nature of college students is a factor that separates many campus sexual assaults from those in the community. Many college students, especially freshmen, only temporarily live in the college community. When the semester or school year is over, they return to their home communities. Maintaining contact with these different communities can be difficult for campus representatives. Consider the following comments from one campus official:

> Students who make a disclosure at our office want services closer to their home, rather than on campus, if they don't live on campus, and a majority are commuters. I have a network of sexual assault center providers in the outlying regions that I can call on, or give the students the information about, if they want something closer to home.

At colleges and universities, some campus sexual assault center staff report extensive prevention efforts. Some are able to carry out programs for all incoming freshman and/or offer separate programs for men and women. Others focus on the Greek community and provide awareness training to people who are living in fraternity/sorority houses. At least one campus center reported getting male faculty and staff involved as mentors. Many of the center staff question whether their prevention efforts work or how they can measure if the education is making an impact. Here are some comments from college staff:

> One of the things that we do is, I do all 27 dormitories, I speak to all incoming freshman within the first 2 months of them being on campus, specifically talking to women separate from men…The other thing I have done with them, a lot of times they don't know, is let them see the rape stats, nationally. When I say one out of every four college women has been a victim of rape or attempted rape, it shows they are not by themselves, if this happens you need to report it…We're getting into a lot of man, male issues that are false beliefs by our young men between the age of 17 and 25, so I address that group.
>
> [W]e've taken steps to educate our Greek community, to place someone who is trained with sexual assault prevention information in every fraternity and sorority house on campus. The focus we're trying to take now is more peer-to-peer educators as opposed to having myself or some other adult talking to students.
>
> We've had a peer support program going since 1997 which has 3 levels: peer education, which is information giving; peer companions who are one on one with a client; peer advocate who take the pager…and act as first responders. In addition we have another group that has gained momentum over the last year because of VDH funding which is called Men's Allys group—male students that were hand picked by the athletic department, Greek life advisor, some general guys, also male staff and faculty members we've added to the group and call them male mentors. They've been training over the last year about the effects of sexual violence on women and their goal is to help men. As far as whom we target, every college student is an underserved population.

One of the barriers facing sexual assault campus centers is the institutional support for prevention efforts. Representatives almost unanimously agreed that college and university administrators do not place a great deal of emphasis on actively using educational strategies to prevent sexual assault. A related concern lies at the heart of the reality of official statistics. If more sexual assault cases are reported on campus because of the public awareness campaigns, then it will appear that the campus is unsafe. In fact, fewer reports are not necessarily a sign of prevention, but a sign that college students are not reporting their victimization. In effect, there is conflict between the goals of the sexual assault crisis center and the goals of the college or university. In the words of one campus representative, "The thing about that is that it is just the opposite of what some people in the ivory towers want. We want more and more reports, and other people think that means there's more of a problem, but that's not the case."

Collaboration Issues for College Campus Sexual Assault Centers

Campus representatives talked at length about issues they faced with regard to collaboration. They reported collaborating with other sexual assault crisis centers, law enforcement officials, the college or university administration, and faculty and staff. The campus representatives noted that they work with the police on investigations and train campus police officers about sexual assault and educate students about sexual assault cases. Those who cited positive training relationships with the police described protocol that guided the development and implementation of sexual assault trainings.

Complicating collaborative investigations is the fact the campus police officers and campus sexual abuse advocates have different roles. Campus police officers are there to enforce the law, while campus sexual abuse advocates offer services to the victims. One campus representative described this conflict in the following statement:

> A victim may come forward and she may lie about something that occurred because she thinks she may get in trouble. It's hard to then believe that an assault actually occurred. This is where advocates and police sometimes have trouble, this is where we have tension, because they're investigating cases trying to find out did it happen or not; we're advocates, we basically believe that things occurred. We have to work very hard to recognize we're in different roles; when you are able to do that and acknowledge your different roles, it eases the relationship. If not, you're constantly butting heads.

Most directors described their collaboration with local sexual assault crisis centers in positive ways. However, campus sexual assault workers sometimes have to compete with local sexual assault crisis centers for funding. When two agencies servicing different populations but operating in the same community must apply for grants, tension is possible. Some campus advocates overcome this tension by offering and providing their services in a collaborative way to community sexual assault crisis centers.

Campus advocates work with a number of other groups in their efforts to prevent and respond to sexual assault. Campus faculty and staff have a pivotal role in these cases. In many cases faculty are the first to be told about the sexual assault. When this occurs, it is important that faculty understand the federal requirements about reporting assaults. The *Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act* is a federal law that requires colleges and universities to disclose certain timely and annual information about campus crime and security policies. One representative described the Clery Act in the following way:

> The Clery Act requires certain prevention programming on campus. It also requires universities to keep track of records of reported incidents, and not only to the police department but to the person who is designated on your campus as the significant reporting authority. It doesn't have to be by name, and that is where people get so confused. Like a student who comes to the Resident Assistant and doesn't want their (sic) name out there, their (sic) name never has to go out there, we just need the numbers.

Two problems that that seem to arise with the Clery Act are that faculty and staff are not necessarily aware of it and different interpretations of the act exist across colleges and universities. Consider the following exchange that occurred between the campus representatives:

- The Clery act also talks about the area and everything adjacent to it, and usually that's where your students live. They're living 4 blocks away from the campus, that's part of your off-campus reporting statistics that you are required to contact your local agency.
- But adjacent is defined differently by different people.
- And what the law is that if a student comes to you, as an instructor, tells you about an assault but wants you to keep it to yourself, that

person needs to understand that they can't do that, it's against the law. They are bound by law to report it.

- They have to report the number, and that's where there seems to be misunderstanding.
- I think some people are also confusing sexual assault and sexual harassment. At my school, we have a sexual misconduct policy which blurs the sexual assault and sexual harassment which makes it very difficult to separate.

Gaps in Services

The nature of sexual assaults on college campuses warrants a different response than might be utilized in responding to sexual assaults in the community. College campus sexual assault center representatives called for increased funding for prevention programs and to increase awareness of the problem. While this is a common problem for all sexual assault programs, it is a little different for campus programs in that some of the representatives indicated that their administrators would not support seeking grants that required them to closely monitor and report the number of sexual assault cases occurring on their campuses.

Certain populations, such as international students, may be underserved on college campuses. Focus group participants described a number of factors that placed these groups at a higher risk of assault, yet most response systems are designed for traditional cases involving students from the United States.

The lack of a central coordinator of sexual assault services on campuses throughout the Commonwealth is problematic. Many campuses respond to sexual assault with different practices and strategies, and little consistency in the application of state policies has been forthcoming. As well, campuses are left to interpret laws on their own, resulting in a potential disservice to victims. A final problem is the lack of protocol describing how sexual assault cases should be counted on college campus. While federal guidelines exist, each campus appears to interpret these regulations differently. A central coordinator position existed and the official was able to promote consistency and encourage cooperation, collaboration, and information sharing among the colleges and universities throughout Virginia. This position, however, no longer exists.

Recommendations

- The General Assembly should consider appropriating state funds for a statewide position to promote consistency and encourage cooperation, collaboration, and information sharing on sexual assault among colleges and universities in Virginia.

- The General Assembly should consider appropriating state funds for expansion of services by campus sexual assault centers to prevent sexual assault, increase awareness of the problem and reach underserved students.

Summary of Recommendations

Collaboration

1. 1. The General Assembly should consider funding for the development and support of strong regional or local sexual assault coalitions to include sexual assault, health, mental health, law enforcement, criminal justice, education, and social services personnel.

2. The General Assembly should consider forming a statewide legislative Commission on Sexual Violence; similar to the 1997 Virginia Commission on Family Violence, to review the findings and recommendations of this report and support implementation activities, or alternatively the Crime Commission might be requested to do so. :

Law Enforcement and Criminal Justice

3. The General Assembly should request a review of training for law enforcement and criminal justice personnel and recommend changes and funding to improve the amount and quality of training.

4. The General Assembly should request the Attorney General's Office to conduct a comprehensive review, in cooperation with Action Alliance, of the usage of polygraphs on victims of sexual assault in comparison to other crimes in Virginia and issue an opinion.

5. The General Assembly should require the Department of Criminal Justice Services to provide detailed guidance to law enforcement agencies, Commonwealth's Attorney's offices, victim advocates, and hospitals on the proper authorization and reimbursement for physical evidence recovery kits.

Emergency Departments and Primary Health Care

6. The Virginia Department of Health and the Virginia Sexual and Domestic Violence Action Alliance should work with primary care practices and other health care professionals to assure screening of patients for sexual assault.

7. The Virginia Department of Health should work with the Emergency Departments in the state and the General Assembly to ensure that each victim of sexual assault has access to a forensic nurse examiner in the ED or in SANE programs. Worth examining is the model of care used by some Virginia EDs of centralizing forensic nursing services at one hospital within a system of hospitals. This model may have potential, but its current effectiveness is unknown.

8. The Virginia Department of Health and Action Alliance should work with professional organizations such as the Virginia Hospital and Healthcare Association (VHHA), the Virginia Nurses Association, and the Medical Society of Virginia (MSV) to:

- Raise awareness on sexual assault as a health care issue with health care personnel, in particular those in primary care practice and emergency departments. Awareness raising activities could include distributing findings on sexual assault in Virginia and nationally via conferences, publications, and electronic means and by offering training to staff both at emergency departments and primary care practices.
- Develop model written policies and training materials on the care of victims of sexual assault for hospital emergency departments and primary care practices.

9. Local sexual assault crisis centers should partner with local primary care practices, modeled on the strong partnerships in place with some of the EDs, to provide effective services to current and past victims of sexual assault

Sexual Assault Crisis Centers

10. Virginia Sexual & Domestic Violence Action Alliance to conduct a comprehensive needs assessment in conjunction with Virginia Department of Health and Virginia Department of Criminal Justice Services and make a funding recommendation to the General Assembly.

11. A comprehensive study of law enforcement response to sexual assault should be conducted in cooperation with DCJS, VSDVAA, and the Supreme Court. Representation from law enforcement, the Commonwealth's Attorney office, the courts and victim advocates should be included.

12. The General Assembly to consider allocating funds for public education campaigns in all Virginia communities to raise awareness of the problem of sexual assault with the message that individuals and communities will not engage in or support sexual assault. Specific topics may include:
    - Prevention of sexual assault
    - Perpetrator identification, response, treatment and reporting
    - Stigma of sexual assault and barriers to reporting
    - Victim recognition, treatment, and reporting
    - Resources on sexual assault; sexual assault centers and their role and services
    - Consequences of sexual assault; effects on past victims of sexual assault

13. The Virginia Department of Health, Virginia Department of Criminal Justice Services, Virginia Sexual & Domestic Violence Action Alliance, and local Sexual Assault Crisis Centers will work collaboratively and continue their efforts to:
    - Expand services
    - Reach out to underserved populations
    - Promote awareness of the problem of sexual assault
    - Promote awareness of the sexual assault crisis centers
    - Increase collaboration with other agencies

Colleges and Universities

14. The General Assembly should consider appropriating state funds for a statewide position to promote consistency and encourage cooperation, collaboration, and information sharing on sexual assault among colleges and universities in Virginia.

15. The General Assembly should consider appropriating state funds for expansion of services by campus sexual assault centers to prevent sexual assault, increase awareness of the problem and reach underserved students.

Prevention

16. The General Assembly should consider appropriating funds for public education campaigns in all Virginia communities to raise awareness of the problem of sexual assault with the message that individuals and communities will not engage in or support sexual assault. Specific topics may include:
    - Prevention of sexual assault
    - Perpetrator identification, response, treatment and reporting
    - Stigma of sexual assault and barriers to reporting
    - Victim recognition, treatment, and reporting
    - Resources on sexual assault; sexual assault centers and their role and services
    - Consequences of sexual assault; effects on past victims of sexual assault

17. The Virginia Department of Health should review sexual assault prevention programs and identify those that show successful outcomes for implementation, in collaboration with other similar prevention programs (such as teenage pregnancy prevention), in select localities.

18. The Department of Education should consider implementing an age-appropriate curriculum to prevent, recognize, respond and refer sexual assault in all schools (kindergarten through higher education) and incorporate sexual assault prevention education in the Standards of Learning.

Further Research

19. Future research should include a survey of pediatric health care providers as a significant percentage of sexual assault victims are children and adolescents who may still be receiving care from pediatricians.

20. The General Assembly should consider requesting a study to assess the emotional and physical health needs of victims of past sexual assault and the ability and requirements of the service system to address these needs.

References

American College of Emergency Physicians (June 1999). Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient.

ACOG (American College of Obstetrics and Gynecology), www.acog.org, 2004.

ACOG (American College of Obstetrics and Gynecology). (1997). Sexual Assault. *ACOG Educational Bulletin,* 242: 1-7.

AMA (American Medical Association). Strategies for the Treatment and Prevention of Sexual Assault. http://www.ama-assn.org/ama1/pub/upload/mm/386/sexualassault.pdf. October 1995.

Arndt, S, and Goldstein S (1993). The SART/SANE Orientation Guide. Santa Cruz, CA.

Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD). 2002 national guidelines on the management of adult victims of sexual assault. London: Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD); 2002.

Baumer EP, Felson RB, Messner, SF (2003). Changes in police notification for rape, 1973-2000. *Criminology*, 41(3): 841-872.

Bohn DK, Holz KA. (1996). Sequalae of abuse: health effects of childhood sexual abuse, domestic battering and rape. *Journal of Nurse Midwifery,* 41(6):442-56.

Brenner, ND, McMahon, PM, Warren, CW, Douglas, KA (1999). Forced sexual intercourse and associated health-risk behaviors among female college students in the United States. *Journal of Consulting and Clinical Psychology*, 67: 252-259.

Bureau of Justice Statistices (2003). *Criminal Victimization in the United States, 2002 Statistical Tables.*

Campbell, BJ (1995). Preface to the Department of Justice, Report to Congress: The Confidentiality of Communications between Sexual Assault or Domestic Violence Victims and their Counselors: Findings and Model Legislation.

CDC (Centers for Disease Control). (2002). Sexually Transmitted Disease Guidelines, 2002. *Morbidity and Mortality Weekly Report,* 51 (RR-6).

Durose, MR, Langan PA (2001). *State Court Sentencing of Convicted Felons, 1998 Statistical Tables*. Washington DC. U.S. Department of Justice.

Durose, MR, Langan PA (2003). *State Court Sentencing of Convicted Felons, 2000 Statistical Tables*. Washington DC. U.S. Department of Justice.

Fisher, BS, Cullen, FT, Turner, MG (1999). *Extent and Nature of the Sexual Victimization of College Women: A National-Level Analysis*. Washington DC. US Department of Justice.

Haddix-Hill, K. (1997). The violence of rape. *Critical Care Nursing Clinics of North America,* 9(2): 167-74.

Hart, TC. (2003). *Violent Victimization of College Students*. Washington DC: US Department of Justice.

Hutson LA. Development of sexual assault nurse examiner programs. *Nursing Clinics of North America,* 37(1): 79-88.

Institute for Law and Justice (1998). *Review of State Sexual Assault Laws, 1998 Codes*. http://www.ilj.org/rape-law98.htm

Institute of Medicine (2002). *Reducing Suicide: A National Imperative.* Washington, DC: National Academy Press.

Kneedler, HL (1982). Sexual assault law reform in Virginia—A legislative history. *Virginia Law Review* 68: 459-505.

Ledray, L (1992). The Sexual Assault Nurse Clinician: A fifteen-year experience in Minneapolis. *Journal of Emergency Nursing*, 18: 217-222.

Ledray, L. (2001). *Evidence Collection and Care of the Sexual Assault Survivor: The SANE-SART Response*. Violence Against Women Online Resources.

Ledray, L. (1999). *Sexual Assault Nurse Examiner Development and Operations Guide,* Office for Victims of Crime, U.S. Department of Justice, Washington DC.

Ledray L, Arndt S. (1994). Examining the sexual assault victim: a new model for nursing care. *Journal of Psychosocial Nursing and Mental Health Services,* 32(2): 7-12.
Lewis CM, DiNitto D, Nelson TS, Just MM, Campbell-Ruggaard J. (2003). Evaluation of a rape protocol: a five year follow-up with nurse-managers. *Journal of the American Academy of Nurse Practitioners,* 15(1):34-39.

Masho S., Odor R. (2003). *Prevalence of Sexual Assault in Virginia.* Center for Injury and Violence Prevention, Virginia Department of Health, Richmond, VA.

Moriarty, LJ, Earle, JG (1999). An analysis of services for victims of marital rape: A case study. *Journal of Offender Rehabilitation*, 29: 171-181.

Office for Victims of Crime (nd.). *Privacy of Victims' Counseling Communications* U.S. Department of Justice.
Http://www.ojp.usdoj.gov/ovc/publications/bulletins/legalseries/bulletin8/welcome.html.

Plichta SB, Falik M. (2001). Prevalence of violence and its implications for women's health. *Women's Health Issues,* 11:244-58.

Rentoul L, Appleboom N. (1997). Understanding the psychological impact of rape and serious sexual assault of men: a literature review. *Journal of Psychiatric and Mental Health Nursing,* 4(4): 267-74.

Resnick HS, Holmes MM, Kilpatrick DG, Clum G, Acierno R, Best CL, Saunders BE. (2000). Predictors of post-rape medical care in a national sample of women, *American Journal of Preventive Medicine*, 19(4): 214-219.

Sievers V, Murphy S, Miller JJ. (2003). Sexual assault evidence collection more accurate when completed by sexual assault nurse examiners: Colorado's experience. *Journal of Emergency Nursing,*29(6): 511-514.

Talbert S, White SD, Bowen JD, Stephens LM, Mapstone SJ, Spisso KR, Edlich RF (1980). Improving emergency department care of the sexual assault victim. *Annals of Emergency Medicine,*9(6): 293-297.

Tjaden, P, Thoennes, N (1998). *Prevalence, Incidence, and Consequences of Violence Against Women: Findings From the National Violence Against Women Survey*. Washington, DC: National Institute of Justice Centers for Disease Control Prevention.

U.S. Census 2000. http://factfinder.census.gov

U.S. Department of Justice (2003). *National Crime Victimization Survey, 2002 Statistical Tables.* Washington DC: U.S. Department of Justice.

VAASA (Virginians Aligned Against Sexual Assault). *Sexual Assault Crisis Centers in Virginia, Annual Summary of Services Provided, 2002*.

Virginia Department of State Police (nd). Virginia Uniform Crime Reporting program. Available at (http://www.vsp.state.va.us/crimestatistics.htm).

Virginia Uniform Crime Reporting Program. *Crime in Virginia*, January-December 2003, Department of State Police, Richmond, VA, 2004

Virginia Sentencing Commission (2001). *Annual Report*. Richmond Virginia.

Virginia Sentencing Commission (2002). *Annual Report*. Richmond Virginia.

Virginia Sentencing Commission (2003). *Annual Report*. Richmond Virginia.

APPENDICES

Appendices

A. Senate Joint Resolution No. 131

B. Survey 1: Emergency Department Survey

C. Survey 2: Medical Practice Survey

D. Survey 3: Sexual Assault Crisis Center Director Survey and Checklist

E. Survey 4: Survey of Sexual Assault Crisis Center Staff

F. Survey 5: Focus Group Questions with Service Providers

G. Survey 6: Sweet Briar Interview Guide

H. Survey 7: Focus Group Questions – Campus Representatives

I. Tabulation of Frequencies from Sexual Assault Center Directors Checklist

Appendix A

SENATE JOINT RESOLUTION NO. 131

Requesting the Department of Health to study the statewide response to sexual assault victims and the prevention of sexual assault. Report.

Agreed to by the Senate, February 17, 2004
Agreed to by the House of Delegates, March 9, 2004

WHEREAS, the Virginia Department of Health confirms that sexual assault is a major public health problem in the Commonwealth and a 2003 survey conducted by the Center for Advancement of Women shows that sexual assault and domestic violence are women's top concern; and

WHEREAS, in 1999 Virginia law enforcement switched to incident-based reporting and began counting all sexual assaults, resulting in more accurate counting of sexual assault crimes and revealing a steady increase in reported sexual assaults since 1999, and 37 sexual assault crisis centers in Virginia provided services to 9,617 new victims of sexual assault in 2002; and

WHEREAS, according to a recent survey by the Virginia Department of Health, 78.1 percent of sexual assault incidents involving female victims and 94.4 percent of sexual assault incidents involving male victims occurred when the victims were under 18 years of age; and

WHEREAS, national studies have found that females being treated for sexual assault in emergency departments are not being provided the full range of treatment recommended by the guidelines of the Centers for Disease Control and Prevention and the American Medical Association's Standards for Emergency Care; and

WHEREAS, there have been no recent efforts to collect comprehensive statewide data on the response to and prevention of sexual assault; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Department of Health be requested to study the statewide response to sexual assault victims and the prevention of sexual assault. The Department shall examine the responses and prevention programs and activities of law enforcement, sexual assault crisis centers and other advocacy and support services, medical personnel, and the judicial system and design a plan to provide the General Assembly with recommendations for improvements.

In conducting its study, the Department of Health shall (i) review law enforcement and criminal justice statistics and interactions with victims, identify inconsistencies and determine causes; (ii) determine treatment and services provided to victims by medical personnel throughout the Commonwealth; (iii) examine sexual assault crisis centers delivery of services in each locality to determine availability, accessibility and comprehensiveness; (iv) determine the effectiveness of prevention efforts in communities across the Commonwealth and how such efforts can be enhanced; and (v) survey collaborative efforts between all agencies and organizations that work with victims of sexual assault.

The Department of Criminal Justice Services shall provide primary assistance to the Department of Health. Technical assistance shall be provided by the Office of the Executive Secretary of the Supreme Court of Virginia. All agencies of the Commonwealth shall provide assistance to the Department of Health for this study, upon request.

The Department of Health shall complete its meetings by November 30, 2004, and shall submit to the Governor and the General Assembly an executive summary and a report of its findings and recommendations for publication as a document. The executive summary and report shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports no later than the first day of the 2005 Regular Session of the General Assembly and shall be posted on the General Assembly's website.

Appendix B

Emergency Department Survey

Policies and Procedures for Treating Victims/Survivors of Sexual Assault

The state legislature of Virginia has mandated a study by the Virginia Department of health to examine the statewide response to sexual assault victims and the prevention of sexual assault and to design a plan to provide the General Assembly with recommendations for improvements. As part of this effort, the Virginia Department of Health has contracted with Old Dominion University to survey all emergency departments in the state of Virginia about their policies and procedures for treating victims. Old Dominion University has worked with the support and input of the Virginians Aligned Against Sexual Assault to design and implement this survey. The main purpose of this survey is to examine the training and resource needs that emergency departments might have regarding the treatment of sexual assault victims.

This survey takes about 15 minutes to complete. If your emergency department has a sexual assault nurse examiner (SANE) or forensic nurse on staff, please ask that person to complete the survey. Otherwise, please ask the nurse manager of the Emergency Department to complete this survey.

We have a few questions about your emergency department in general, and then several sets of questions about services available to rape and sexual assault victims. We are interested in both victims of date and marital sexual violence as well as victims of stranger violence. Please answer these questions to the best of your knowledge. If you do not have exact figures, it is acceptable to make an educated estimate.

Your answers to this survey are confidential, and no information that can identify you or your hospital will be reported. We will remove any identifying information from the survey before entering the data and storing it. All of the results will be reported in the aggregate only, so as to provide a snapshot of the quality of care available to victims across the state. If you give us permission, we may contact you later to discuss issues of care for victims further.

We know that your time is valuable, and we do appreciate your efforts to complete this survey. **Please know that the state legislature is taking this issue very seriously, and that the results of the survey will be used to formulate policy.**

We will also be happy to share the results with you when the study is complete. You can e-mail Tancy Vandecar-Burdin at tvandeca@odu.edu in the Fall to receive a copy of the final report to the State legislature. In the meantime, if you have any questions about this survey please feel free to contact Dr. Stacey Plichta at splichta@odu.edu.

Please mail the completed survey back in the enclosed postage-paid envelope by July 30th as the state legislature needs the final report back by the end of the summer.

Thank you again for your time and effort on our behalf,

Tancy Vandecar-Burdin
Associate Director
The Social Science Research Center
Old Dominion University

Stacey B. Plichta, Sc.D.
Associate Professor
College of Health Sciences
Old Dominion University

Sexual Assault and Rape Response Survey for Emergency Departments (ED)

Q1: Approximately how many patient visits does your ED have each year? _________

<table>
<tr><td colspan="2">Q2: Approximately how many victims of rape or sexual assault does your ED serve each year (including date rape and marital rape)?
Estimates are fine if you do not have exact figures.</td></tr>
<tr><td>Females age 12-17:</td><td>Females age 18 and over:</td></tr>
<tr><td>Males age 12-17:</td><td>Males age 18 and over:</td></tr>
</table>

Q3: Please tell us about how your ED screens patients for sexual assault and rape.
(check all that apply)

_____ All females are asked about sexual assault and rape
_____ All males are asked about sexual assault and rape
_____ All females are asked about sexual assault and rape when presenting with injuries of unknown origin
_____ All males are asked about sexual assault and rape when presenting with injuries of unknown origin
_____ All females are asked about sexual assault and rape when it is suspected
_____ All males are asked about sexual assault and rape when it is suspected
_____ All females are asked about sexual assault and rape when they disclose it to the health care provider
_____ All males are asked about sexual assault and rape when they disclose it to the health care provider
_____ Other (specify:)

Q4: Does your ED use a standardized instrument to screen patients for rape and sexual assault?

_____ No
_____ Yes

If yes is this instrument (choose one)

___ Included as a separate form in the clinical record
___ Incorporated as a question in the clinical record for all charts in the ED
___ Not on a form but asked verbally and included in the patient notes?
___ Other (specify:)

Q5: Does your ED participate on a SART (Sexual Assault Response Team)?

_____ No
_____ Yes

If yes, please list the types of professionals that are on the team:

Q6: Is there someone at the hospital who is trained to assist victims of sexual violence?

_____ No

_____ Yes
If yes, what is the professional training of this person?

Q7: Do you have a relationship with any sexual assault or rape crisis centers?
_____ No
_____ Yes
If yes, which center(s) do you regularly work with?

If yes, what is your relationship with this center like?

Q8: Are the rape crisis advocate/companion services of a local rape crisis center available to your ED?
_____ No
_____ Yes
If yes, how often do you employ these services
___ Almost never
___ For less than 50% of sexual assault and rape victims
___ For 50%-75% of sexual assault and rape victims
___ For over 75% of sexual assault and rape victims

Q9. What shifts is a rape crisis advocate available to the hospital (either on site or called in)? (check all that apply)
_____ None
_____ Daytime (8AM-4PM)
_____ Evening (4PM-12AM)
_____ Night (12AM-8AM)
_____ 24 hours/7 days a week
_____ Other (specify:)

Q10: How many trained FNE's (Forensic Nurse Examiner) and/or SANE's (Sexual Assault Nurse Examiners) does your ED have on staff (either full-time or part-time)?_______
If FNE and/or SANE nurses are on staff, what shifts are they available? (check all that apply):
_____ Daytime (8AM-4PM)
_____ Evening (4PM-12AM)
_____ Night (12AM-8AM)
_____ Available 24 hours/7 days per week
_____ Other (specify)

Q11: Which of the following services do you routinely offer, or plan to offer in the next year, to victims of rape or sexual assault?				
Service	Do not offer at all	Plan to offer	Offered by outside agency	Offered by hospital
A. FNE/SANE (Forensic Nurse Examiner/Sexual Assault Nurse Examiner) to all victims of sexual violence				
B. Rape crisis advocate/companion available to meet with victim.				
C. Rape crisis advocate/companion in the room with victim during examination				
D. Referral to local rape/sexual assault crisis center				
E. Pregnancy test				
F. Emergency contraception				
G. STD testing				
H. HIV testing				
I. Prophylactic HIV treatment				
J. Prophylactic STD treatment				
K. Blood and urine screening for 'date rape drugs' such as Rohypnol or Gamma Hydroxybutyrate				
L. Screening for presence of alcohol or drugs				
M. Referral to domestic violence shelter				
N. Mental health assessment				
O. Referral for follow-up counseling				
P. Allow victim to choose gender of health care provider				
Q. A place for the victim to shower after the exam				
R. Fresh clothing for the victim				

S. Referrals for alternative safe housing				
T. Follow-up phone calls within 48 hours				

Q12: Does your ED have a written protocol regarding the care of victims of sexual assault or rape in place?

______ No
______ Yes

Q13: Which of the following are currently a part of your routine sexual assault exam?			
Protocol Item	Not a part	Plan to make it a part	Currently a part
A. Obtaining a written consent			
B. Getting an assault history of current assault			
C. Obtaining pertinent medical information about current pregnancy status			
D. Examine orifices involved for trauma and to collect sperm and seminal fluid			
E. Combing pubic hair for foreign hair and matter			
F. Complete fingernail scrapings			
G. Collect the survivor’s blood for type and DNA screen			
H. Collect torn or stained clothing			
I. Take photographs of injuries			
J. Create a body map of injuries			

Q14: Is there a formal training plan for your ED on sexual assault and rape?

______ No
______ Yes

Q15: During the past 12 months, has the ED provided training on sexual assault and rape as part of the mandatory orientation for new staff?

______ No
______ Yes

Q16: During the past 12 months, has the ED provided training to members of the medical staff via grand rounds or other sessions?

______ No
______ Yes

Q17: How would you rate the following training needs (regarding sexual assault and rape) for your staff in terms of importance for the patients that you serve?			
Training Need	Not important	Somewhat Important	Very Important
A. How to collect evidence			
B. How to testify in court			
C. How to help special populations (e.g. male victims, persons with disabilities, persons with mental health issues, lesbian and gay victims, etc.)			
D. Cultural awareness			
E. How to talk with victims and their families			
F. Sexual Assault/Rape Crisis Center services			
G. How to work with the police			

Q18: On average, how would you rate the job your ED does on each of the following?	Poor	Fair	Good	Very Good	Excellent
A. Providing training to the staff on how to assist sexual assault and rape victims					
B. Making sexual assault and rape victims feel as comfortable as possible					
C. Assisting the families of sexual assault and rape victims					
D. Screening patients for sexual assault and rape					
E. Collecting evidence from sexual assault and rape victims					
F. Storing evidence from sexual assault and rape victims					
G. Working with the police on sexual assault and rape cases					

H. Working with the local rape crisis center to help sexual assault and rape victims					
I. Working with patients who have been sexually assaulted or raped by intimate partners					
J. Preserving the confidentiality of the victim					

Q19: What is your position in the hospital?

Q20: May we contact you for more information?

_____ No

_____ Yes

If yes, please provide us with contact information

Name:

Phone:

E-mail:

Q21: What do you think that survivors of sexual assault and rape need from the emergency department?

Q22: What would help your emergency department to better serve victims of sexual assault and

rape?

Thank you for your time and thoughts. We really appreciate your efforts, and will be happy to provide you with a copy of the final report. Please contact Tancy Vandecar-Burdin at tvandeca@odu.edu to request a copy this fall.

Appendix C

Medical Practice Survey
Policies and Procedures for Treating Victims/Survivors of Sexual Assault

The state legislature of Virginia has mandated the Virginia Department of Health (VDH) to examine the statewide response to sexual assault victims and the prevention of sexual assault. This survey will be used to help VDH fulfill that mandate and to provide the General Assembly with recommendations for improvements.

Old Dominion University is conducting the survey for VDH. We are asking a random sample of all primary care practices in the state of Virginia about their experiences in treating victims of sexual assault. We are doing this with the support and input of the Virginians Aligned Against Sexual Assault (VAASA).

This survey takes about 15 minutes to complete. Its purpose is to find out about the training and resource needs that your practice may have about sexual assault victims. We are interested in both victims of date and marital sexual violence as well as victims of stranger violence. Please answer these questions to the best of your knowledge. If you don't have an exact figure, it is ok to give an estimate.

Your answers are confidential, and no information that can identify you or your practice will be reported. We will remove any identifying information from the survey before entering the data and storing it. All the results will be reported in the aggregate only.

We know that your time is valuable, and want to show our appreciation to those who complete the survey. **Upon receiving the completed survey, we will send you a $10.00 gift card to Walmart or Starbucks (your choice) to thank you for your time.**

We will be happy to share the results with you when the study is complete. You can e-mail Tancy Vandecar-Burdin at tvandeca@odu.edu in the Fall to receive a copy of the final report to the State legislature. In the meantime, if you have any questions about this survey please feel free to contact Dr. Stacey Plichta at splichta@odu.edu.

Please mail the completed survey back in the enclosed postage-paid envelope by July 30th. Also, please fill out the attached card with your name and address, and mail it separately. We will send the gift-card to you at that address.

Thank you again for your time and effort on our behalf,

Tancy Vandecar-Burdin
Associate Director
The Social Science Research Center
Old Dominion University

Stacey B. Plichta
Associate Professor
College of Health Sciences
Old Dominion University

Sexual Assault and Rape Response Survey for Physician Practices

Q1: How many physicians (full-time equivalents) work in your practice? _______

Q2: How many nurses (full-time equivalents) work in your practice? _______

Q3: Approximately how many victims of recent rape or sexual assault (including date rape and marital rape) does your practice serve each year? Your best estimate is fine here if you do not have exact figures.	
Females age 12-17:	Females age 18 and over:
Males age 12-17:	Males age 18 and over:

Q4: Please tell us about how your practice screens patients for sexual assault and/or rape. (check all that apply)

_____ We do not screen patients for sexual assault and/or rape.
_____ All women are asked about experiences of sexual assault and rape as part of their health history.
_____ All men are asked about sexual assault and rape as part of their health history.
_____ All women are asked about sexual assault and rape when presenting with injuries of unknown origin.
_____ All men are asked about sexual assault and rape when presenting with injuries of unknown origin.
_____ Women are asked about sexual assault and rape when it is suspected.
_____ Men are asked about sexual assault and rape when it is suspected.
_____ Women are asked about sexual assault and rape when they disclose it to the health care provider.
_____ Men are asked about sexual assault and rape when they disclose it to the health care provider
_____ Other (specify:)

Q5: Does your practice use a standard question to screen patients for rape and sexual assault?

_____ No
_____ Yes

If yes is this instrument (choose one)

___ Included as a separate form in the clinical record
___ Incorporated as a question in the health history for all charts
___ Not on a form but asked verbally and included in the patient notes?
___ Other (specify:)

Q6: Does your practice have any clinical staff who are trained in assisting victims of sexual assault and rape?

_____ No
_____ Yes

If yes, please check the types of training they have received:
___ Forensic Nurse Examiner (FNE)
___ Sexual Assault Nurse Examiner (SANE)
___ Training during a continuing education session
___ Training from a local rape crisis center
___ Other (Specify:)

Q7: Do you have a relationship with any sexual assault or rape crisis centers?
_____ No
_____ Yes
If yes, which center(s) do you regularly work with?

If yes, what is your relationship with the center(s) like?

Q8: Is there an advocate from a rape crisis center that can be called to your practice when needed?
_____ No
_____ Yes

Q9: Does your practice have a written protocol regarding the care of victims of sexual assault or rape in place?
_____ No
_____ Yes

Q10: Which of the following services do you routinely offer, or plan to offer in the next year, to victims of rape or sexual assault?				
Service	Do not offer at all	Plan to offer	Offer referral to outside agency	Offered by practice
A. Advocate from local rape crisis center called in to meet with victim				
B. Advocate from local rape crisis center allowed in the room with victim during examination				
C. Pregnancy test				
D. Emergency contraception				
E. STD testing				

F. HIV testing				
G. Prophylactic HIV treatment				
H. Prophylactic STD treatment				
I. Mental health assessment				
J. Referral for follow-up counseling				
K. Referral to a rape crisis center				
L. Referrals for alternative safe housing				
M. Follow-up phone calls within 48 hours				
N. Referrals to a domestic violence shelter				

Q11: Is there a formal training plan for your practice on sexual assault and rape?
_____ No
_____ Yes

Q12: During the past 12 months, has your practice provided training to members of the medical staff via continuing education, orientation, or other means?
_____ No
_____ Yes (Specify:)

Q13: How would you rate the following training needs (regarding sexual assault and rape) for your staff in terms of importance for the patients that you serve?			
Training Need	Not important	Somewhat Important	Very Important
A. How to collect evidence			
B. How to testify in court			
C. How to help special populations (e.g. male victims, persons with disabilities, persons with mental health issues, lesbian or gay victims, etc.)			
D. Cultural awareness			
E. How to talk with victims and their families			
F. How to work with local Rape Crisis Centers			

Q14: On average, how would you rate the job your practice does on each of the following?	Poor	Fair	Good	Very Good	Excellent
A. Providing training to the staff on how to assist sexual assault and rape victims					
B. Making sexual assault and rape victims feel as comfortable as possible					
C. Assisting the families of sexual assault and rape victims					
D. Screening patients for sexual assault and rape					
E. Working with the local rape crisis center to help sexual assault and rape victims					
F. Working with patients who have been sexually assaulted or raped by intimate partners					
G. Preserving the confidentiality of the victim					

Q15: What would help your practice to better serve victims of sexual assault and rape?

Thank you for your time and thoughts. We really appreciate your efforts, and will be happy to provide you with a copy of the final report. Please email Tancy Vandecar-Burdin at tvandeca@odu.edu to request a copy in the fall.

Appendix D

Sexual Assault Crisis Center Director Survey and Checklist

1. **Name of Agency:____**

2. **Contact Person: ___________________________________ Telephone: __________________**

   Position Title: _____________________________________ E-mail: _____________________

3. **Agency's primary service area?____**

   Secondary service area (if any)?____

4. **How would you classify your agency?**
☐ Independent Sexual Assault Center ☐ Dual SA/DV Agency
☐ Military ☐ Campus ☐Umbrella Agency (CAA, CSB, YWCA, etc.)

5. **How many years has your sexual assault center/program been in existence?_____**

6. By whom is your sexual assault work completed?

PAID STAFF (# of full time employees)	VOLUNTEERS (Average cumulative hours per month)
______Direct Services	**______Direct Services**
______Administration	**______Administration**
______Prevention/Education/Outreach	**______Prevention/Education/Outreach**

7. During fiscal year 2003, we served ______ primary and _____ secondary victims of sexual assault.

8. **Which type of victims use your services? (check all that apply)**
☐ Stranger sexual violence ☐ Acquaintance sexual violence ☐ Child sexual violence
☐ Incest ☐ Adults sexually assaulted as children ☐ Trafficking
☐ Prostitution ☐ Sexual harassment ☐ Stalking
☐ Ritual abuse ☐ Gang rape ☐ Intimate partner sexual violence
☐ Caretaker sexual assault of dependent adults ☐ Other ________________________________

9. In addition to primary victims of sexual violence, we also provide services to: (check all that apply)

☐ Friends & family members ☐ Community members/concerned citizens
☐ Allied professionals ☐ Other ___________________________

10. The agency provides educational presentations on the following topics:

☐ Definitions of sexual assault/abuse ☐ Safety issues—What to do
☐ Options (medical, legal, emotional, etc.) ☐ Short-term/long-term effects
☐ How to respond/support someone ☐ Teen dating violence
☐ Sexual assault risk reduction ☐ Sexual harassment
☐ Child sexual assault ☐ Child assault prevention
☐ Self-defense for women ☐ Self defense for children

- [ ] Criminal justice system & sexual assault
- [ ] Various forms of sexual violence (i.e. stranger, intimate partner, child, etc.)
- [ ] Male survivors
- [ ] Health issues & sexual assault
- [ ] Rape trauma syndrome/ post traumatic stress
- [ ] Other:_______________________________________
____
____

11. The agency provides educational presentations to the following audiences:

- [ ] General community
- [ ] School-aged children
- [ ] Health care professionals
- [ ] Educators
- [ ] Other _______________
- [ ] Faith communities
- [ ] Social service agencies
- [ ] Criminal justice professionals
- [ ] Sexual assault/Domestic violence agencies
- [ ] Volunteers
- [ ] Mental health professionals
- [ ] Law enforcement

12. In your primary service area, who has the authority to decide whether or not a PERK examination is provided to a sexual assault victim?

13. In your primary service area, who determines which PERK examination bills will be forwarded to the Supreme Court of Virginia for payment?

14. In your primary service area, do law enforcement officers stay in the treatment room while any evidence collection or physical examination occurs? ☐ Yes ☐ No

15. In your primary service area, how many sexual assault victims have been asked to submit to a polygraph examination in the past year? _________

16. In your primary service area, will law enforcement agencies accept reports from sexual assault victims who wish to remain anonymous (i.e. blind reports)? ☐ Yes ☐ No

17. In your primary service area, how often does your hospital screen victims for the presence of drugs associated with facilitating sexual assault?
☐ Always ☐ Never ☐ Only when drug-facilitated sexual assault is suspected)

18. Please provide a brief description of any challenges you face in collaborating with the following entities in your community:

Law Enforcement:

Health Care Professionals:

Mental Health:

Criminal Justice (i.e. courts, judges, prosecutors):

Victim/Witness:

Dept. of Social Services

19. Briefly, what do you think are the major challenges to doing sexual violence work in your community?

20. Please check whether the following sexual are provided by your agency (now and in the past three months), whether these services are provided by another agency, or whether they are unavailable. Also indicate what challenges (if any) your agency faces in delivery of these services.

Hotline Services:	Provided by my	Provided by my agency in past 3	Provided by other community agency	Unavailable but	Funding	Lack of Staff Training	Lack of Paid Staff	Lack of Volunteers	Lack of Public Awareness	Resistance to or lack of collaboration or	Other: Please specify
Hotline answered 24 hours by trained staff or volunteers at your agency											
Hotline answered 24 hours by volunteers, staff, and/or answering service that pages staff/volunteer on call											
Hotline answered by statewide hotline with volunteers/staff on-call.											

Emergency Assistance Services:	Provided by my	Provided by my agency in past 3	Provided by other community agency	Unavailable but	Funding	Lack of Staff Training	Lack of Paid Staff	Lack of Volunteers	Lack of Public Awareness	Resistance to or lack of collaboration or	Other: Please specify
Emergency On-site Shelter											
Emergency Hotel Accommodations											
Emergency Financial Assistance											

Emergency Clothing											
Emergency Food											
Emergency Transportation											
Other:											

Counseling/ Support Services:	Provided by my agency	Provided by my agency, in past 3	Provided by other community agency	Unavailable but needed	Funding	Lack of Staff Training	Lack of Paid Staff	Lack of Volunteers	Lack of Public Awareness	Resistance to or lack of collaboration or	Other: Please specify
24 hour crisis counseling											
Individual (face to face) support/ counseling											
Individual Therapy											
Follow-up support/counseling											
Adult Support Groups—Recent Assault											

Counseling/ Support Services Continued:	Provided by my agency	Provided by my agency in past 2	Provided by other community agency	Unavailable but needed	Funding	Lack of Staff Training	Lack of Paid Staff	Lack of Volunteers	Lack of Public Awareness	Resistance to or lack of collaboration or	Other: Please specify
Adult Support Group—Adults sexually assaulted as children											
Adult Support Group—Partners of Victims of Sexual Violence											
Teen Support Groups (for teen victims/survivors)											
Child Support Groups											
Parent/Family Support Groups											
Male Survivor Group											
Information/Written Resources											
Elder Abuse Support Groups											
Other Groups:											

Accompaniment/ Advocacy Services:	Provided by my agency	Provided by my agency, in past 3	Provided by other community agency	Unavailable but needed	Funding	Lack of Staff Training	Lack of Paid Staff	Lack of Volunteers	Lack of Public Awareness	Resistance to or lack of collaboration or	Other: Please specify
Assistance filing victim compensation claims											
Court Accompaniment											
Medical Accompaniment											

Accompaniment/ Advocacy Services Continued:	Provided by my agency	Provided by my agency, in past 3	Provided by other community agency	Unavailable but needed	Funding	Lack of Staff Training	Lack of Paid Staff	Lack of Volunteers	Lack of Public Awareness	Resistance to or lack of collaboration or	Other: Please specify
Law Enforcement Interview Accompaniment											
Assistance with Victim Impact Statements											
Expert Witness Testimony											
Personal Advocacy											
Other:											

Education/ Prevention/ Training Services:	**Provided by my agency**	**Provided by my agency in past 3**	**Provided by other community agency**	**Unavailable but needed**	**Funding**	**Lack of Staff Training**	**Lack of Paid Staff**	**Lack of Volunteers**	**Lack of Public Awareness**	**Resistance to or lack of collaboration or**	**Other: Please specify**
General Community Education											
Prevention Initiatives											
Teen Peer Education Groups											
Training to Allied professionals											
Sexual Harassment in the Workplace Training											
Volunteer Training											
Agency Library											

Accessibility of Services:	**Provided by my agency**	**Provided by my agency in past 3**	**Provided by other community agency**	**Unavailable but needed**	**Funding**	**Lack of Staff Training**	**Lack of Paid Staff**	**Lack of Volunteers**	**Lack of Public Awareness**	**Resistance to or lack of collaboration or cooperation**	**Other: Please specify**
Handicapped parking											
Handicapped accessible entrance to agency											
Handicapped											

accessible bathrooms											
TTY/TDD Telecommunication											
Sign language interpreters											
Foreign language interpreters											
Services provided in evening hours											
Services provided on weekends											
Services provided at no cost to client											
Transportation to agency											
Other:											

Public Awareness/ Outreach	**Provided by my agency**	**Provided by my agency in past 3**	**Provided by other community agency**	**Unavailable but needed**	**Funding**	**Lack of Staff Training**	**Lack of Paid Staff**	**Lack of Volunteers**	**Lack of Public Awareness**	**Resistance to or lack of collaboration or cooperation**	**Other: Please specify**
Agency Brochures											
Sexual Assault Specific Brochures											
Sexual Assault Posters											
Radio Advertisements											
Television Advertisements											
Billboard Advertisements											
Yellow Page Advertisement/Telephone Book											
Other Public Awareness/Outreach Efforts:											

Referral Services:	**Provided by my agency**	**Provided by my agency in past 3**	**Provided by other community agency**	**Unavailable but needed**	**Funding**	**Lack of Staff Training**	**Lack of Paid Staff**	**Lack of Volunteers**	**Lack of Public Awareness**	**Resistance to or lack of collaboration or cooperation**	**Other: Please specify**
Referrals to Mental Health Providers											
Referrals to Medical Treatment											
Referrals to Commonwealth's Atty											
Referrals to Legal Representation											
Referrals to Victim/Witness											
Referrals to Substance Abuse Counseling											
Referrals for Financial											

Assistance										
Referrals for Food/Clothing										
Referrals for Transportation Assistance										
Referrals for Expert Witness Testimony										

Thank you for completing the survey. We hope that you will be available for follow-up communications if they are needed.

Appendix E

Survey of Sexual Assault Crisis Center Staff

June 22, 2004

Dear Conference Participant:

In response to Senate Joint Resolution #131, the Virginia Department of Health has partnered with Old Dominion University to study the statewide response to sexual assault victims and the prevention of sexual assault. As part of this initiative, two weeks ago, we surveyed about half of the directors of sexual assault crisis centers in Virginia and they shared with us some common barriers that arise in these cases. We have done some preliminary analysis on their comments and hope to build on what we have learned from them.

Attached is a survey that was created based on what these directors have shared with us to date. We are hoping that you will be willing to provide further information about your agency and the services that you provide. We hope that if you provide services to sexual assault and/or domestic violence victims, you will fill out this survey.

While your participation is voluntary, this information is critical to the findings of the study. It will allow us to provide information about what services are available in Virginia, where there are gaps, and what resources are needed to provide these services. Please know that because we are not asking for your names, the survey is anonymous. The information you provide will remain confidential. No report or other written summary will ever disclose individual or individual agency responses. Data will be summarized in aggregate and regional form ONLY.

If you are able to help us in this important endeavor, please complete the survey and place it in the secure box marked "ODU Surveys" near the registration desk by noon Wednesday. If you have any questions, please feel free to ask while we are at the conference or contact Tancy Vandecar-Burdin, tvandeca@odu.edu, 757-683-3802. Thank you so much for your help and input!

Sincerely,

The Old Dominion University Research Team
Dianne Carmody
Randy Gainey
Brian Payne
Tancy Vandecar-Burdin

Section 1. Please answer the following questions about your agency and yourself.

1. How would you classify your agency?
☐ Independent Sexual Assault Center ☐ Independent DV Center ☐ Dual SA/DV Agency
☐ Military ☐ Campus ☐Umbrella Agency (CAA, CSB, YWCA, etc.)

2. How many years has your center or program been in existence?_________________________

3. What is your job title? ____________________________

4. How are you classified? ☐ Full-Time ☐ Part-Time ☐ Volunteer

5. How long have you been in your current position? __________________________

6. How long have you been working with victims? ____________________________

7. What town or city do you work in? ____________________________

8. What is your primary service area? _______________ Secondary service area ______________

Section 2. Please read each statement and rate each occupational group accordingly.

On a scale from 1-5 with 1 being not at all helpful, 2 being not very helpful, 3 being somewhat helpful but needs some work, 4 being helpful enough, and 5 being very helpful, indicate how helpful the following groups are in responding to the kinds of cases you encounter.

9. Social services providers __________
10. Hospital social workers __________
11. SANE nurses ________
12. Emergency room staff _________
13. Police _________
14. Prosecutors __________
15. Judges _________
16. Victim-Witness Staff ________
17. Clergy _______
18. Mental health workers _______

On a scale from 1-5 indicate how much of a problem your agency has collaborating with the following occupational groups using the following scale: 1—Many problems collaborating, we don't collaborate at all; 2—Many problems collaborating, we try to collaborate; 3—Some collaboration problems; 4—Few collaboration problems; 5—No collaboration problems.

19. Social services providers __________
20. Hospital social workers __________
21. SANE nurses ________

22. Emergency room staff _________
23. Police _________
24. Prosecutors __________
25. Judges _________
26. Victim-Witness Staff ________
27. Clergy _______
28. Mental health workers ________

On a scale from 1-5 how significant are these problems when working with criminal justice agencies? Use the following scale: 1—not a problem at all; 2—a minor problem; 3—somewhat of a problem; 4—a big problem, but it is getting better; 5—a major problem.

29. Communication with victims _________
30. Communication with my agency ________
31. Resistance to prosecution ________
32. Lack of training _________
33. Revictimization _________
34. Inconsistent decision making _________

On a scale from 1-5 how significant are these problems when working with health care providers? Use the following scale: 1—not a problem at all; 2—a minor problem; 3—somewhat of a problem; 4—a big problem, but it is getting better; 5—a major problem.

35. Isolation makes it difficult to access health care providers _________
36. They don't make referrals _________
37. Health care providers are more concerned about criminal justice system's needs than victim's _______
38. Health care providers sometimes overstep their boundaries with victims __________
39. Communication with victims _________
40. Communication with my agency ________

On a scale from 1-5 how significant are these problems when working with mental health workers? Use the following scale: 1—not a problem at all; 2—a minor problem; 3—somewhat of a problem; 4—a big problem, but it is getting better; 5—a major problem.

41. Not enough mental health services available ___________
42. They try to do our job ___________
43. They don't always understand the kinds of cases I handle __________

44. Inappropriate referrals __________

On a scale from 1-5 how significant are these problems when working with social service professionals. Use the following scale: 1—not a problem at all; 2—a minor problem; 3—somewhat of a problem; 4—a big problem, but it is getting better; 5—a major problem.

45. They don't make referrals _________

46. They lack understanding about the kinds of cases I handle ________

47. Communication with victims ________

48. Communication with my agency ________

On a scale from 1-5 how significant are these problems when working with victim witness advocates? Use the following scale: 1—not a problem at all; 2—a minor problem; 3—somewhat of a problem; 4—a big problem, but it is getting better; 5—a major problem.

49. Territorialism ___________

50. Lack of awareness about sexual assault _________

51. Accessibility ___________

52. Communication problems with victims __________

53. Communication problems with my agency ________

54. Over-concerned with pleasing the court __________

On a scale from 1-5 how significant are these problems when working with law enforcement agencies? Use the following scale: 1—not a problem at all; 2—a minor problem; 3—somewhat of a problem; 4—a big problem, but it is getting better; 5—a major problem.

55. Victim blaming ________

56. Lack of training ________

57. Revictimization ________

58. Police don't believe victim _________

59. Police don't believe the kinds of cases I handle are crimes _________

60. The police aren't sensitive to victims' needs. _______

61. Polygraphs of victims _________

62. Overly suspicious of victims _______

63. They ignore acquaintance rape _______

64. They ignore marital rape _______

65. They lack clear policies on how to respond to the kinds of cases I handle ________

Please provide a brief description of any challenges you face in collaborating with the following entities in your community.

Law Enforcement:

Criminal Justice (courts, prosecutors, judges):

Victim-Witness Advocates:

Mental Health:

Social Services:

Health Care Professionals:

Appendix F

FOCUS Group Questions with Service Providers

Ground rules, introductions and ice-breaker:
What is the one of the major challenges that you face in providing services to victims?

1. How does your role fit in with the criminal justice process?
   (FOLLOW-UP: Many advocates have told us that they feel excluded from the justice process. Has it been your experience that this happens? Why do you think you're excluded?)

2. Does your role sometimes seem to "bother" other professionals? Why does this happen? What do you do to adjust?

3. What do you think can be done to improve the criminal justice response to sexual assault?

4. Please describe your agency's prevention efforts. How do you know if your efforts are working? What else would you like to be able to do regarding prevention? What are the barriers?

5. What kinds of special populations do you serve? (esl, physically handicapped, mentally handicapped/severe mental health issues, elderly,) What special needs do they have? Are you able to meet them? If not, what resources would you need in order to better serve these victims/survivors?

6. What is the policy regarding PERK exams in your locality?

7. What is the policy regarding polygraphs in your locality? Why do you think the police do polygraphs?

8. Are there any regional issues to serving sexual assault victims that the General Assembly should know about?

9. Is there something that we haven't covered that we should have? What else should we know about your work? What other information should we include in our report?

Appendix G

Sweet Briar Interview Guide

Interviewer's Initials _______________
Tape Number ____________________
Does your agency assist sexual assault victims, domestic violence victims, or both?

____________ Sexual Assault

____________ Domestic Violence

____________ Sexual Assault and Domestic Violence

Could you briefly describe a "typical" case from your work?

Now, I'm going to ask you about some of the barriers others have mentioned to us.

(For those working with sexual assault victims only): Could you describe your thoughts about confidentiality and sexual assault work? (specific issues concerning privileged information).

In your work, are advocates excluded from police interviews? If so, why do you think this happens?

What type of training do the staff and volunteers at your agency receive? Would you like to see any changes in the amount or type of training? What about training for those outside of your agency (such as police, prosecutors, etc.)?

Do you feel that your agency has good cooperation and communication with other agencies in the community (like law enforcement, hospitals, social services)? If not, what do you think could be done to improve it?

What legislative changes would you like to see in Virginia?

What are the police doing right?

What are the prosecutors doing right?

What are the judges doing right?

What practices are you aware of in other states that you'd like to see in Virginia?

If you could tell the Virginia General Assembly one thing about your work, what would it be?

Is there anything that I haven't asked about that you think we should consider in our research?

Thank-you for your participation.

Appendix H

Focus Group Questions – Campus Representatives

Introduction—Tell us what you do, where you are from, how many students attend your college or university?

1. How does your office fit in with the broader sexual assault crisis center network?

2. How are your experiences different from other sexual assault crisis centers?

3. What trends have you seen in sexual assault on college campuses?

4. What practices have you found to be successful in preventing sexual assault? Which students are targeted for these programs?

5. Why do you think sexual assault is so prevalent on college campuses?

6. Describe your relationship with campus police. What about your relationship with local police and other crjs officials?

7. Are there certain types of students that are underserved by sexual assault crisis centers? (minority, international, nontraditional distance ed.)

8. What would you tell the legislature?

9. What should we have asked you?

Appendix I

Tabulation of Frequencies from Sexual Assault Center Directors Checklist

Hotline Services:	Provided by my agency	Provided by my agency in past 3 months	Provided by other community agency	Unavailable but needed	Funding	Lack of Staff Training	Lack of Paid Staff	Lack of Volunteers	Lack of Public Awareness	Resistance to or lack of collaboration or cooperation	Other: Please specify
Hotline answered 24 hours by trained staff or volunteers at your agency	16	9	4	2	6	2	3	9	3	2	
Hotline answered 24 hours by volunteers, staff, and/or answering service that pages staff/volunteer on call	14	9	2	1	4	1	3	7	2	1	
Hotline answered by statewide hotline with volunteers/staff on-call.	7	5	5	0	1	0	0	1	0	0	

Emergency Assistance Services:	Provided by my agency	Provided by my agency in past 3 months	Provided by other community agency	Unavailable but needed	Funding	Lack of Staff Training	Lack of Paid Staff	Lack of Volunteers	Lack of Public Awareness	Resistance to or lack of collaboration or cooperation	Other: Please specify
Emergency On-site Shelter	16	9	9	3	3	0	0	2	4	3	
Emergency Hotel Accommodations	14	9	3	3	11	0	0	2	1	1	
Emergency Financial Assistance	12	9	8	6	12	0	0	1	1	1	
Emergency Clothing	17	7	9	1	5	0	0	1	0	0	
Emergency Food	16	9	11	1	5	0	0	1	0	0	
Emergency	15	10	8	1	9	0	0	1	0	1	

Transportation											
Other:	1	0	0	0	0	0	1	1	1	1	

Counseling/ Support Services:	Provided by my agency	Provided by my agency in past 3 months	Provided by other community agency	Unavailable but needed	Funding	Lack of Staff Training	Lack of Paid Staff	Lack of Volunteers	Lack of Public Awareness	Resistance to or lack of collaboration or cooperation	Other: Please specify
24 hour crisis counseling	24	16	7	1	5	1	2	2	3	2	
Individual (face to face) support/ counseling	26	15	6	0	4	2	1	2	3	2	
Individual Therapy	10	6	10	4	6	3	3	1	2	2	
Follow-up support/counseling	26	15	4	0	3	1	1	1	3	2	
Adult Support Groups—Recent Assault	21	12	4	3	7	2	4	3	5	4	
Adult Support Group—Adults sexually assaulted as children	18	7	5	3	9	3	4	4	4	5	
Adult Support Group—Partners of Victims of Sexual Violence	5	0	3	13	12	3	7	5	3	4	
Teen Support Groups (for teen victims/survivors)	11	3	2	7	9	2	3	2	4	4	
Child Support Groups	9	5	3	9	10	3	5	2	2	3	
Parent/Family Support Groups	10	2	2	8	8	2	5	3	4	4	
Male Survivor Group	5	0	4	12	11	4	6	2	4	6	
Information/Written Resources	25	11	2	0	5	1	1	1	1	2	
Elder Abuse Support Groups	2	0	2	13	9	3	4	2	3	5	
Mixed Group	1	1	0	0	1	0	0	0	0	0	
Healthy Relationships Group	1	0	0	0	0	0	0	0	0	0	
Military Group	1	0	0	0	0	0	0	0	0	0	
Survivor Group	1	0	0	0	0	0	0	0	0	0	

Creative Expression Group	1	0	0	0	0	0	0	0	0	0	
Mother/Daughter Group	1	1	0	0	0	0	0	0	0	0	

Accompaniment/ Advocacy Services:	Provided by my agency	Provided by my agency in past 3 months	Provided by other community agency	Unavailable but needed	Funding	Lack of Staff Training	Lack of Paid Staff	Lack of Volunteers	Lack of Public Awareness	Resistance to or lack of collaboration or cooperation	Other: Please specify
Assistance filing victim compensation claims	18	8	16	1	2	3	1	1	3	4	
Court Accompaniment	24	13	9	1	2	1	2	2	2	3	
Medical Accompaniment	22	13	8	1	2	1	2	3	3	6	
Law Enforcement Interview Accompaniment	19	10	5	3	3	1	2	1	2	8	
Assistance with Victim Impact Statements	17	6	11	0	2	1	1	1	2	2	
Expert Witness Testimony	2	1	6	8	5	2	3	1	3	2	
Personal Advocacy	25	15	3	0	2	2	1	1	1	1	
Academic Advocacy	1	1	0	0	0	0	0	0	0	0	

Education/ Prevention/ Training Services:	Provided by my agency	Provided by my agency in past 3 months	Provided by other community agency	Unavailable but needed	Funding	Lack of Staff Training	Lack of Paid Staff	Lack of Volunteers	Lack of Public Awareness	Resistance to or lack of collaboration or cooperation	Other: Please specify
General Community Education	26	14	1	0	2	0	2	2	1	1	
Prevention Initiatives	20	12	2	3	5	1	1	2	1	1	
Teen Peer Education Groups	14	7	2	3	3	1	3	2	1	1	
Training to Allied professionals	25	13	1	1	2	1	2	2	1	2	
Sexual Harassment in the Workplace Training	18	5	1	3	4	2	1	1	2	1	
Volunteer Training	26	13	1	0	1	1	1	1	1	1	

Accessibility of Services:	Provided by my agency	Provided by my agency in past 3 months	Provided by other community agency	Unavailable but needed	Funding	Lack of Staff Training	Lack of Paid Staff	Lack of Volunteers	Lack of Public Awareness	Resistance to or lack of collaboration or cooperation	Other: Please specify
Handicapped parking	22	6	1	3	2	0	0	0	1	1	
Handicapped accessible entrance to agency	21	6	1	4	3	0	0	0	1	1	
Handicapped accessible bathrooms	20	7	1	3	4	0	0	0	1	0	
TTY/TDD Telecommunication	22	7	2	4	4	1	0	0	1	0	
Sign language interpreters	2	0	7	11	12	4	1	1	2	0	
Foreign language interpreters	4	2	10	8	9	5	1	1	2	0	
Services provided in evening hours	21	12	0	2	4	1	3	3	1	1	
Services provided on weekends	19	10	0	4	7	1	4	3	1	1	
Services provided at no cost to client	26	14	0	0	3	1	1	1	1	1	
Transportation to agency	13	7	5	4	13	1	1	2	2	1	
Cognitive/MH Issues	0	0	0	1	1	1	0	0	0	0	

Public Awareness/ Outreach	Provided by my agency	Provided by my agency in past 3 months	Provided by other community agency	Unavailable but needed	Funding	Lack of Staff Training	Lack of Paid Staff	Lack of Volunteers	Lack of Public Awareness	Resistance to or lack of collaboration or cooperation	Other: Please specify
Agency Brochures	26	14	1	0	4	0	1	0	3	0	
Sexual Assault Specific Brochures	24	13	4	1	4	0	0	0	1	0	
Sexual Assault Posters	19	9	5	1	4	0	0	0	0	0	
Radio Advertisements	11	6	2	10	12	0	0	0	0	1	
Television Advertisements	3	0	2	11	15	0	0	0	0	1	

Billboard Advertisements	2	0	2	12	16	0	0	0	0	1	
Yellow Page Advertisement/Telephone Book	12	5	3	7	9	0	0	0	0	0	
Other Public Awareness/Outreach Efforts:	15	10	1	2	4	0	0	0	0	1	

Referral Services:	Provided by my agency	Provided by my agency in past 3 months	Provided by other	Unavailable but needed	Funding	Lack of Staff Training	Lack of Paid Staff	Lack of Volunteers	Lack of Public Awareness	Resistance to or lack of collaboration or cooperation	Other: Please specify
Referrals to Mental Health Providers	26	15	3	0	1	1	0	0	1	0	
Referrals to Medical Treatment	26	15	3	0	0	0	0	0	0	0	
Referrals to Commonwealth's Atty	26	15	4	0	0	0	0	0	0	1	
Referrals to Legal Representation	25	13	4	1	0	0	0	0	0	0	
Referrals to Victim/Witness	26	14	2	0	0	0	0	0	0	0	
Referrals to Substance Abuse Counseling	26	11	3	0	0	0	0	0	0	0	
Referrals for Financial Assistance	25	12	4	0	0	0	0	0	0	1	
Referrals for Food/Clothing	25	12	3	0	0	0	0	0	0	0	
Referrals for Transportation Assistance	24	11	2	1	1	0	0	0	0	0	
Referrals for Expert Witness Testimony	17	5	1	3	1	2	0	0	0	0	