

Information and Tools for Program Managers

This toolkit contains administrative tools and suggestions for sexual assault advocate/counselor program managers. The following are included:

- A complete set of sample advocate recruiting and application materials from the Santa Fe Rape Crisis Center.
- A sample suicide assessment form from Hennepin County Medical Center in Minneapolis, MN.
- Strategies for implementing institutionalized change to prevent compassion fatigue and burnout among staff and volunteer advocates/counselors.
- A discussion of the importance of evaluation, whether you are establishing, maintaining, or expanding an advocacy program.
- A summary of the history and development of rape crisis centers, with a brief discussion of the pros and cons of using volunteer advocates.

Sample Advocate Recruiting and Application Materials

Sample Inquiry Letter

Dear Prospective Advocate,

Thank you for your interest in the Santa Fe Rape Crisis Center (SFRCC) Advocacy Program. Enclosed you will find general information about the Advocacy Program, a training schedule, and an application.

The next volunteer training, a 40-hour intensive, will begin on [DATE] (exact dates and times are included on the attached schedule). The training will include presentations on such topics as sexual assault, child sexual abuse, crisis intervention techniques, post-traumatic stress disorder (PTSD), handling suicide calls, crisis call procedures, advocate self-care, grief and healing, domestic violence and domestic violence crisis intervention, role plays, and diversity training. Participants in the training include the Sexual Assault Nurse Examiner's (SANE) Initiative, District Attorney's Office and its Domestic Violence Unit, Esperanza, Victim/Witness Assistance Program, New Mexico State Crime Lab and Child Protective Services, as well as our professional clinical and administrative staff.

Our training is a time-intensive but rewarding experience that will prepare you to effectively assist and advocate for survivors of sexual and domestic violence. Once you have completed the initial training, the time commitment to the Advocacy Program becomes much more manageable, consisting of one monthly meeting (held from 6 to 8 p.m. on the third Tuesday of each month), and four hotline shifts per month, which can be done from home or by digital pager.

Volunteering with the SFRCC Advocacy Program is not only a way to help those in crisis; it is an opportunity to join a helping community of dynamic people. Advocates are invited to participate in regular group activities, from hiking trips to potlucks. The work is hard, but the rewards are many, including the chance to make wonderful friends.

To begin the application process, please complete the enclosed forms; then call me to schedule an interview. Thank you again for your interest in volunteering at the SFRCC. I look forward to welcoming you into our Advocate community.

Sincerely,

Advocacy Supervisor

Sample Job Description

The Role of the Volunteer Advocate

Advocates at the SFRCC staff our 24-hour hotline from their homes, taking a minimum of four shifts per month. In addition, advocates also provide crisis advocacy services at the SANE Unit at St. Vincent's Hospital to assist survivors of recent sexual assault. The overall role of the advocate is to provide information and resources, normalize callers in crisis, and give unbiased emotional support to survivors of sexual assault and their families.

Volunteer advocates are the backbone of our agency and provide a round-the-clock safety net for those in crisis. Through training and ongoing education, our volunteers enhance innate skills and learn new ones to offer professional and compassionate crisis intervention services for the Northern New Mexican community.

Qualifications for Women and Men

1. 21 years of age or older.
2. Resident of Santa Fe County for at least six months.
3. Settled in a job and/or home situation.
4. Has a car in good working condition.
5. Able to respond in person at the hospital.
6. Has a telephone.
7. Has no current personal upheavals to obstruct work with victims.
8. Willing to participate in medical or legal advocacy.

Training

Volunteers for the Advocacy Program are required to attend a 40-hour comprehensive training, which is scheduled on evenings and weekends to accommodate most work schedules. The training thoroughly prepares volunteers to handle crisis calls and assist survivors of recent sexual assault and domestic violence at St. Vincent's Hospital. Moreover, it covers facts and information specific to the diverse and unique population of Northern New Mexico. Required monthly meetings featuring debriefing sessions and educational in-services keep advocates up-to-date on new developments and provide ongoing support for this challenging role.

INFORMATION AND TOOLS FOR PROGRAM MANAGERS
Sexual Assault Advocate/Counselor Training

Sample Written Application

Date _____

Name _____

Address _____

Phone: Home _____ Work _____

Date of Birth _____ Social Security Number _____

How did you hear about our program? _____

Current Employer/School _____

Address _____

Phone: _____

Emergency Contact _____

Address _____

Phone: Home _____ Work _____

References

We will use the employer listed above as a reference. Please list three additional references we may contact, giving COMPLETE and CURRENT addresses and phone numbers since we conduct reference checks by mail.

Name _____

Address _____

Phone: Home _____ Work _____

Relationship _____

Name _____

Address _____

Phone: Home _____ Work _____

Relationship _____

INFORMATION AND TOOLS FOR PROGRAM MANAGERS
Sexual Assault Advocate/Counselor Training

Name _____

Address _____

Phone: Home _____ Work _____

Relationship _____

Please answer the following questions as completely as possible. Feel free to include extra pages if you need additional space.

1. Briefly describe your employment background.
2. Please describe your educational background and training.
3. List any special skills and/or interests you would be willing to share with the center (computer skills, graphic design skills, artistic skills, fundraising, etc.).
4. What are your reasons for wanting to volunteer with SFRCC?
5. What do you think you can offer to SFRCC as an advocate?
6. Please describe your own history with sexual violence, harassment, or domestic violence, if any.
7. Working closely with issues of sexual abuse and domestic violence can be stressful. Describe the types of support available to you.
8. Do you speak Spanish? Any Native American languages? Any other languages?
9. Are you able to commit to attending team meetings and/or in-service meetings on the third Tuesday evening of each month from 6:00 p.m. to 8:00 p.m.?
10. Are you able to commit to this position for a minimum period of 1 year?
11. What do you hope to get for yourself from this experience?
12. Is there anything else you would like us to know about you?

Volunteer Advocate Confidentiality Contract

Responsibilities of the Volunteer Advocate

1. Maintaining strict confidentiality with each case so as to protect the privacy of all clients served.
2. Attending all parts of the initial advocacy training.
3. Attending a monthly advocate team meeting, including in-service presentations, and contacting team leader or program coordinator if unable to attend. Arrangements for scheduling must be made prior to the meeting if absence is inevitable; otherwise, the team leader will schedule the advocate and the advocate will be responsible for filling those shifts.
4. Making a minimum *1-year* commitment to the program.
5. Being on call, from home or by a pager, according to a monthly prearranged schedule.
6. Being completely drug- and alcohol-free while on shift or backing up a shift.
7. Calling the answering service at the beginning of your shift to verify your phone number, updating as needed.
8. Providing information, referrals or emotional support over the phone to any hotline caller, and responding to the SANE Unit or St. Vincent's Hospital to assist survivors of sexual or domestic violence.
9. *Never* entering into a professional relationship with a SFRCC client/hotline caller (e.g., as a massage therapist, dog groomer, business consultant, etc.).
10. *Never* going to a victim's home or the scene of the alleged crime without having a police escort and contacting a team leader or the program supervisor.
11. Reporting a brief description of each case to the office staff *at the beginning of the next working day*.
12. Providing a written report with details of each case *within 48 hours* of the call.
13. Reporting any incident of child sexual abuse (age 17 or under) or alleged/suspected child abuse to the CYFD office and law enforcement *immediately* after receiving a disclosure. By law, this report must be filed.
14. Consulting with office staff before maintaining ongoing involvement in any case.
15. Doing followup on cases when appropriate, and providing information regarding that followup to the program supervisor.

Responsibilities of the Rape Crisis Center Staff

1. Providing an initial, intensive, 40-hour training for advocates as well as followup training and supervision in specific areas to enhance their job performance, as appropriate.
2. Providing debriefing and supervision to advocates in the office and via phone calls during and after the immediate crisis in which they are involved, as appropriate.
3. Providing support services to advocates in the areas of information, referral, backup advocacy, and short-term personal counseling pertaining to their role as an advocate.
4. Providing evaluations pertaining to an advocate's role performance at the request of the advocate or the SFRCC supervisor.
5. Other responsibilities of the SFRCC, as agreed.

I understand and agree to accept the responsibilities outlined above. I understand that *CONFIDENTIALITY* is the primary task of all advocates; therefore, I will use only the office staff and advocate staff for consultation on cases. I understand if I break any part of this contract, my services with the SFRCC will be terminated.

Date _____

Advocate in Training _____

Advocate Supervisor _____

Advocate Interview

Applicant:

Interviewer:

Date of Interview:

Duration of Interview:

Why do you want to volunteer at the SFRCC?

What experience do you have helping others (formally or informally)?

What do you hope to get for yourself from this experience?

Can you identify any issues in your life that might make this work difficult for you (e.g., history of sexual and/or domestic violence, depression, drug/alcohol use, self-harm, trauma, etc.)? If you are a survivor of sexual and/or domestic violence, how have you dealt with your own history of sexual/domestic violence?

If a crisis call triggered personal issues or if you ever felt upset after taking a crisis call, how would you seek support? Would you be willing to utilize counseling?

Tell me about drug and alcohol abuse in your life. Could you commit to remaining drug/alcohol-free while on shift?

Tell me about stress in your life. How do you cope with it? How busy are you?

What is the level of stability in your life? Have you experienced any major changes (i.e., a move, change in career or significant relationship, loss, etc.)?

Are you able to commit to the SFRCC for a minimum period of 1 year and attend a mandatory monthly meeting held on a Tuesday night?

Are you willing to comply with New Mexico state law and report any/all incidences of sexual violence or abuse perpetrated on a minor, if you have identifying information?

Is there anything else about yourself you would like us to know?

Sample Reference Letter

(Date)

(Name) has applied to serve as a volunteer advocate at the Santa Fe Rape Crisis Center. This applicant has given us your name as a reference.

A volunteer advocate at the Santa Fe Rape Crisis Center is someone who donates their time each month to our advocacy program. Advocates staff our 24-hour crisis line on evenings, weekends, and holidays, and assist survivors of recent sexual assault or domestic violence at the local emergency department or at the Sexual Assault Nurse Examiner's Unit. Some of the qualities we look for in our volunteer applicants are honesty, integrity, reliability, balance, compassion and commitment. The contribution our volunteers make to our organization and the services they provide to survivors of violence and their families are both critical and invaluable; therefore, we believe it is essential for us to have an accurate sense of each individual applicant.

Please provide us with any insights that will help us determine the suitability of this applicant for a volunteer position with the Santa Fe Rape Crisis Center Advocacy Program. Your comments would be most helpful in our evaluation process. It is important that you give as honest and complete a summary of your impressions as possible.

Enclosed is a questionnaire to be completed by you. Again, feel free to include any additional comments. A self-addressed stamped envelope has been included for your convenience.

Thank you for your cooperation!

In community spirit,

Advocacy Program Supervisor

Sample Personal Reference Questionnaire

Volunteer Applicant: _____

Please circle the number in the scale ranging from high to low which reflects your opinion of this prospective volunteer. Indicate your general impression in each area. How does this person impress you in each of these areas? Few people will fall in the highest or lowest categories. Use these extremes to indicate a significant impression about this person.

Low Average High

1 2 3 4 5

1. Dependability (follows through with commitments) 1 2 3 4 5
2. Reliability in accepting responsibility 1 2 3 4 5
3. Evidence of good judgment in daily relations 1 2 3 4 5
4. Personal ethics 1 2 3 4 5
5. Flexibility (adapts to changes, accepts people with different values and lifestyles)
1 2 3 4 5
6. Stability in applicant's life 1 2 3 4 5
7. Gets along well with others 1 2 3 4 5
8. How long have you known the applicant and in what capacity?

Do you think this person is suitable to be a volunteer at the Santa Fe Rape Crisis Center?

Additional comments:

Signature _____ Date _____

Sample Critical Item Suicide Potential Assessment

Hennepin County Medical Center, Minneapolis, MN

Primary Risk Factors

Current (obtain consultation from psychiatrist or another staff member if ANY ONE factor is present)

1. Attempt

(+) Present (-) Absent

- Suicide attempt with lethal method (firearms, hanging/strangulation, jumping from high places).
- Suicide attempt resulting in moderate to severe lesions/toxicity.
- Suicide attempt with low rescue-ability (no known communication regarding the attempt, discovery unlikely because of chosen location and timing, no one nearby or in contact, active precaution to prevent discovery).
- Suicide attempt with subsequent expressed regret that it was not completed AND continued expressed desire to commit suicide OR unwillingness to accept treatment.

2. Intent (includes suicidal thoughts, preoccupation, plans, threats and impulses, whether communicated by the client directly or by another person based on observation of the client)

(+) Present (-) Absent

- Suicidal intent to commit suicide imminently.
- Suicidal intent with a lethal method selected and readily available.
- Suicidal intent AND preparations made for death (writing a testament or a suicide note, giving away possessions, making certain business or insurance arrangements).
- Suicidal intent with time and place planned AND foreseeable opportunity to commit suicide.
- Presence of acute command hallucinations to kill self whether or not there expressed suicidal intent.
- Suicidal intent with CURRENT ACTIVE psychosis, especially major affective disorder or schizophrenia.
- Suicidal intent or other objective indicators of elevated suicide risk but mental condition or lack of cooperation preclude adequate assessment.

Secondary Risk Factors

Mediating (obtain consultation from psychiatrist or another staff member if, in addition to some indication of increased risk, seven out of thirteen factors are present)

(+) Present (-) Absent (0) Unknown

- Recent separation or divorce.
- Recent death of significant other.
- Recent loss of job or severe financial setback.
- Other significant loss/stress/life changes interpreted by client as aggravating (victimization, threat of criminal prosecution, unwanted pregnancy, discovery of severe illness, etc.).
- Social isolation.
- Current or past major mental illness.
- Current or past chemical dependency/abuse.
- History of suicide attempt(s).
- History of family suicide (include recent suicide by close friend).
- Current or past difficulties with impulse control or antisocial behavior.
- Significant depression (whether clinically diagnosable or not), especially if accompanied by guilt, worthlessness, or helplessness.
- Expressed hopelessness.
- Rigidity (difficulty with adaptation to life changes).

Major contributing Demographic Characteristics

Not to be included in the ratings, but considered in the overall assessment of suicide risk.

- Male (especially older, white male).
- Living alone.
- Single, divorced, separated, or widowed.
- Unemployed.
- Chronic financial difficulties.

Implementing Institutionalized Change to Prevent Compassion Fatigue

Caregivers and social service agencies have a professional duty to raise overall consciousness and take action to help prevent compassion fatigue. Figley (1995) notes that we know enough to realize that compassion fatigue is an occupational hazard for caregivers, be they family, friends, counselors, or advocates. Recognizing this, Figley stresses that practicing professionals have a special obligation to prepare people in the field for these hazards. What often stands in the way, however, is the work ethic of some social service agencies, which tends to contribute to compassion fatigue. In some agencies, the cultural norm involves regularly working overtime, being on call during time off, not taking lunch breaks and vacations, and not receiving supervision to debrief difficult calls. Employees who complain about symptoms indicative of compassion fatigue may be viewed as a liability, even though such symptoms in no way indicate that the individual is not suited for trauma work. Implicit in this culture is the message that the work of the agency and welfare of survivors is more important than the personal lives and individual needs of the trauma workers. Such a culture needs to become as advocate/counselor-centered as it is client-centered. Doing so results in both a healthier staff and a healthier advocacy field, as experienced advocates are less likely to leave the field or become embittered and less effective in their role.

Research highlighting some of the most effective ways for institutions to reduce the effects of compassion fatigue includes the following:

- **Institute policies that require advocates/counselors to discuss upsetting material and cases.** One helpful measure is for agencies to provide regular staff meetings that include case reviews, debriefing and mutual support, especially for the more distressing cases (Arndt 1988; Alexander, Chesnay, Marshall, Campbell, Johnson and Wright 1989; Eubert 1989; Tobias 1990; Holloway and Swan 1993; Tempelton 1993; Ledray 1998). It may even be necessary to utilize staff support groups (Eubert 1989) or refer staff to a counselor or psychologist for additional emotional support (Holloway and Swan 1993).
- **Ensure that sufficient staff is available to share the workload.** It is essential to keep the number of hours worked and overall stress at a manageable level for each employee (Ledray 1998). It may be necessary to discourage staff from taking back-to-back on-call shifts, especially during busy weekend periods. It may be helpful to have a predetermined number of shifts for which each staff member is responsible each month to ensure that a few are not being overburdened.

Most centers find that advocates are less effective in providing support for the second and especially the third survivor with whom they deal in one on-call period. It is important to closely monitor the number of survivors seen during a typical on-call period. For example, if staff routinely take 24 hours on-call at a time, and more than one survivor is more than rarely seen during that time, it may be necessary to shorten the on-call shifts to 12-hour periods.

- **Experiment with various methods of avoiding compassion fatigue without sacrificing clinical effectiveness.** For example, agencies can put equal emphasis on the rewarding aspects of working with trauma survivors. Figley suggests focusing on how you are helping survivors transform sadness, desperation, and despair into hope, joy, and a new sense of meaning in life. Such transformation also is possible for trauma workers themselves who are suffering from compassion fatigue.

As an organizational model, the Traumatic Stress Institute (TSI) patently recognizes that trauma workers will be affected by their work and has pioneered ways to institutionalize policies to prevent compassion fatigue. TSI sets aside 1 hour each week for the entire clinical staff to express and process feelings raised by exposure to traumatic material, while observing a high level of confidentiality and respect for clients.

Trauma workers who experience traumatic reactions are not shamed or isolated in any way; rather, they are offered support and hope, and their reactions are both validated and normalized. In addition, TSI encourages employees to take adequate vacations and time off for illness and to continue their education. They also are offered health plans with good mental health coverage (Rosenbloom, Pratt, and Pearlman 1995). Moreover, TSI emphasizes the importance of every clinician receiving supervision, regardless of licensure status. This is particularly noteworthy because all too often advocates are not given proper supervision, if any, because they are not formally part of the agency's clinical team. Supervision is imperative, not only for the staff advocate coordinator, but for all paid and volunteer advocates as well. Research conducted by McCann and Pearlman (1990) shows that trauma therapists rated discussing cases with colleagues the most helpful antidote to compassion fatigue, above spending time with family or friends or taking vacations.

What Can Agencies and Organizations Do?

Changing an agency culture that is largely ignorant of compassion fatigue takes time. Administrators need to understand that they have an ethical obligation to protect employees from the occupational hazards of trauma work as much as possible. The prevention of compassion fatigue must be a strategic priority.

Reducing the negative impact of trauma work begins with careful screening of the individuals wanting to do the work. Only staff and volunteers with healthy boundaries and good personal support systems will be able to work directly with this population and remain centered. Others should be discouraged from direct victim contact and steered toward other roles. Program directors who understand the impact of working with sexual assault survivors are better equipped to develop strategies to reduce costly distress and turnover.

The program director should set an example of taking care of oneself and preventing compassion fatigue. Establish personal limits and maintain strong boundaries, such as not giving victims home phone or personal pager numbers and not being available to clients when not in the office or on-call (Ledray 1998). Encourage outside interests for

yourself and your staff, especially activities that provide a physical release and healthy life balance. Hobbies reduce stress, especially those that allow for complete disengagement from work and a sense of completion of a task or goal.

Program directors do well to monitor caregivers who step over appropriate boundaries. An advocate who goes beyond providing information and suggesting options, and begins making decisions for survivors is fostering dependence and becoming a “rescuer.” For example, the advocate should not write or “draft” the victim impact statement to spare the survivor the pain of recalling the trauma (Young 1993). While it may appear emotionally difficult, this is a beneficial part of the victim’s recovery process.

Caregivers require ongoing supervision and debriefing. To meet this requirement, the Santa Fe Rape Crisis Center (SFRCC), for instance, provides clinical supervision to the staff advocacy coordinator and holds mandatory two-hour monthly meetings for all volunteer advocates. The first hour is devoted to small-group debriefings led by an experienced team leader. Group debriefings provide an opportunity to assess the skills and coping strategies of each advocate while educating other advocates on unique ways to handle calls.

Since unstructured debriefing can unnecessarily focus on accounts of sexual violence that can in themselves be traumatizing, Moscinski and Pratt (2000) developed a debriefing protocol that helps advocates process their personal reactions to their trauma exposure while minimizing the amount of traumatic material other group members hear. Guiding volunteers away from details protects clients’ confidentiality as well. Each debriefing takes 3 to 10 minutes and is interrupted only to guide the advocate back to the model. Moscinski and Pratt’s debriefing protocol covers the following:

- Brief overview—two-sentence maximum—of the account. (No details are permitted in order to protect confidentiality, ensure that the group is not retraumatized, and prevent the advocate from hiding behind the account to avoid emotional reactions.)
- What did you feel confident doing?
- What was the hardest part?
- What did you do to take care of yourself during and after the call?
- Do you have any procedural questions or new information to share with the group?
- Do you need anything from the group?

Ten Strategies to Help Prevent Compassion Fatigue

Many agencies are already raising general awareness of compassion fatigue and implementing strategies to prevent it. The following list highlights the most effective strategies.

1. Create an atmosphere in which reactions to traumatic material are considered normal and inevitable, and where employees are supported and validated.
2. Encourage staff to not work overtime. Creating a position that cannot be filled in the number of paid hours is a setup for compassion fatigue. If an employee exhibits satisfactory job performance, it is ultimately the agency's responsibility to ensure that they complete their duties during their paid hours or change the job description to make this possible.
3. Schedule regular, full-staff meetings with periodic facilitated meetings to process reactions resulting from exposure to traumatic material, assess compassion fatigue, brainstorm successful self-care strategies, and discuss the future visions and successes of employees.
4. Enforce a work ethic that encourages staff to take full lunch breaks away from their desks.
5. Provide generous amounts of paid time off to allow for self-care, validate the difficulty of the work, and compensate for the lower pay typically offered at social service agencies.
6. Afford professional development money and time to allow employees to attend conferences, learn new intervention tools, and get "recharged."
7. Emphasize the importance of self-care. Make sure employees regularly have full days off with no on-call duties. Inquire about self-care strategies in all volunteer/ employee interviews.
8. Plan periodic picnics, retreats, nature walks, group lunches, or other agencywide activities.
9. Select a health plan that offers good mental health coverage.
10. Include as part of the agency's mission statement the awareness of and commitment to the prevention of compassion fatigue among employees.

The Importance of Program Evaluation

Why Evaluate?

Evaluation allows for a systematic assessment of program strengths and limitations in order to improve the service delivery process and outcomes. Linking program process or performance with participant outcomes helps staff evaluate their progress and modify the program as appropriate. Information obtained through program evaluation can be used by administrators or funders to make decisions about future program goals, strategies, and options. For example, information such as the average number of “hot calls” made each month or year by advocates can be used to determine whether more volunteers should be trained.

Ongoing program evaluation must be an integral part of every rape crisis center (RCC). Program evaluation helps staff and volunteers learn what they do well, what goals they are accomplishing, and where they could improve to better fulfill other objectives. Evaluation is not effective as a one-time activity completed for “outside” purposes, such as those imposed by a funding source. To be effective, evaluation must be an ongoing tool employed to answer internal questions posed by program staff.

Formal and Informal Evaluation Strategies

Program evaluation may take the shape of formal evaluation or may involve informal data collection strategies. While either approach may accomplish many of the same functions, formal evaluation projects tend to employ more rigorous methods using larger groups and over longer periods of time. Moreover, formal evaluations tend to use standardized tools whose reliability and validity are established, or they establish these prior to the implementation of the formal evaluation.

There are two types of program evaluation relevant to our purposes:

- Process evaluation.
- Outcome evaluation.

Each type of evaluation may be accomplished formally or informally.

Process Evaluation

This type of evaluation focuses on how program services are delivered.

Examples include:

- Sexual assault victims are surveyed and asked if it is helpful to have the advocate come to the emergency department (ED) automatically or if they believe they should be asked if they want her paged.
- Sexual assault victims are asked if it is helpful to bring up the issue of HIV in the ED or if it would be better to wait until a later time.
- Followup telephone surveys are conducted 2 months after the assault to see if the victims took advantage of referral information provided to them by the advocate.
- Calls are placed 2 months after the assault to rape victims who did not come in for counseling. They are assessed for symptoms of PTSD and asked if they are interested in coming in for counseling at this time.
- With counseling visits scheduled, the follow-through rate can then be compiled.
- Victims are surveyed 2 weeks after their ED visit and asked about their satisfaction with the care provided by the police, hospital medical staff, the SANE and the advocate.
- SANEs complete data sheets in the ED on every client seen, providing the following information:
 - The time between the victim's arrival at the ED and the SANE's arrival.
 - If no police report was made prior to the SANE's arrival, whether the SANE was able to resolve the client's fears and if a report was eventually made.

Outcome Evaluation

Outcome evaluation focuses on the results of the service delivered to the targeted individuals or groups. It is important when designing an outcome evaluation to identify the target audience, then to explicitly state what knowledge, attitude, behavior, belief, or symptoms are expected to change as a result of the intervention. With sexual assault, for instance, it may be the reduction of symptoms of PTSD. Results evaluated may be immediate, short-term, or long-term.

The immediate outcome of service may include:

- If victims who did not initially want to report the rape decide to do so after talking with an advocate.
- If victims decide to take STD- and pregnancy-prevention medication.
- Peer review of courtroom testimony.

The short-term outcome of service may include:

- The first few weeks or months after the assault.
- Case presentations and peer reviews.

Evaluations of client outcomes 1 year after the rape and beyond are generally considered long-term. The longer the time period between the initial contact and the evaluation followup, the more difficult it will be to locate former victims; thus, a smaller sample can be expected, which may or may not be representative since rape victims who cannot be located may be better or worse off. Examples include:

- One-year anniversary telephone calls or mailed questionnaires assessing symptoms of PTSD in clients seen for counseling and those not seen.
- Courtroom outcomes of SANE and non-SANE cases in the area; for instance, the proportion of guilty verdicts in the SANE cases versus non-SANE cases.
- Client satisfaction questionnaires completed 1 year after the rape that ask for their feedback after going through the judicial or legal system.
- Yearly meetings with other community agencies to evaluate their satisfaction with the RCC program.
- Community sexual assault felony charge rates and prosecution rates of SANE and non-SANE cases.

Data Collection and Analysis

Evaluation data may be collected using standardized tests with established reliability and validity. It also may be collected using informal questionnaires developed specifically for RCC program evaluation. The data provided may be a simple count, an average or a percentage of cases, or it may involve sophisticated statistical analysis. Often, graphical representation of group or individual values is extremely helpful in understanding results.

Evaluation Utilization

In addition to answering questions raised by RCC staff and volunteers and ultimately improving RCC services, evaluation findings are useful in other ways. Findings may be used to convince funding sources to finance new program components or continue funding effective programs. Community leaders who support the RCC program may want access to the results to justify their ongoing support and to obtain the additional support of their colleagues. The media may be interested in the results. Other programs will likely be interested as they implement programs in their communities. Even if the results are negative or show where the program needs improvement, providing data to community organizations helps build the credibility and trust of the community and of potential clients. When community organizations decide which programs they are going to support, they expect to see documentation of program effectiveness.

Steps of Program Evaluation Planning

1. List the RCC program's primary goals and activities.
2. Identify problem areas, questions or concerns.
3. Identify outcomes of individuals or groups who make use of RCC services.
4. Formulate evaluation question(s).
5. Identify the types of information needed to answer the question(s).
6. Identify where the information is currently available or how to obtain it.
7. Decide who will obtain the information and over what timeframe.
8. Decide how the information obtained will be used.

Evolution of Program Evaluation

As the RCC evolves, the type and intensity of the evaluation will evolve. New programs stand to benefit the most from effective process evaluation. Informal, simple process evaluation of immediate or short-term impact will help staff evaluate program policies and procedures and make early decisions about changes in service delivery.

More established programs may elect to implement a more elaborate victim-and system-outcome evaluation that includes both short-term and long-term components. RCCs may benefit from the expertise often found at nearby universities. Sometimes a graduate student in evaluation or a related field may be able to integrate their thesis with the evaluation of the RCC. Local evaluation consultants also may be solicited to assist the program, at times offering their services pro bono. The RCC director, staff and volunteers may participate in creating the evaluation questions and deciding which outcomes are appropriate for their own program.

History and Development of Rape Crisis Centers

History of Rape Crisis Advocacy

Even though rape has likely occurred for as long as humanity has existed (Brownmiller 1975), only since the early 1970s has there been a concerted effort to better understand the issue and meet the needs of survivors. The women's movement of the 1970s created the first groundswell of information on sexual abuse and brought the extent of the problem to the forefront of public awareness. Feminists across the country organized and sought to make social changes to improve women's individual and collective status, living conditions, opportunities, power and self-esteem (Martin 1990).

Radical feminists in New York organized the first public speak-out on rape in 1971 (Herman 1992). These feminists recognized rape as much more than the result of the uncontrollable sexual drive of oversexed men. Sex was recognized as a weapon that men used against women. The political and control aspects of sexual assault were stressed, they being a way for men to maintain power and control over women by keeping them out of traditional male establishments such as bars, and keeping them dependent upon men for protection (Brownmiller 1975). In her landmark book on sexual assault, *Against Our Will: Men, Women, and Rape* (1975), Susan Brownmiller traced the origins of rape and rape laws as a means for men, not women, to obtain restitution for damage to their property, their women. Tracing the history of rape laws, she found that the term "rape" comes from Raptus, a Latin term which refers to the theft of property.

In the 1960s, definitions of rape became more gender-neutral, recognizing rape as a violent crime, not just a crime of sex. During the 1960s many states' sexual assault laws still contained the marital exception clauses, and the victim's past sexual history was admissible into court under rules of discovery. This was very traumatic to victims, who were forced to defend their sexual pasts while being made to look bad in public courtrooms (Dupre, Hampton, Morrison, and Meeks 1993).

In the mid-1970s the National Organization for Women (NOW) initiated legislative reform in the United States. Within a decade, all 50 states changed laws to facilitate prosecution and encourage women who had been silenced for generations to come forward and report the crime of rape. As Dupre, Hampton, Morrison, and Meeks report, as a result of pressure from feminist organizations, most states had, by 1980, revised their rape laws to:

- Remove the spousal exceptions, dating back to the 17th-century British "doctrine of irreversible consent," where Lord Hale proclaimed a man cannot be guilty of rape committed on his lawful wife because by their mutual matrimonial consent, the wife had given herself to her husband and was thus his possession.

- Restrict, through the implementation of “Rape Shield Laws,” the use of the victim’s previous sexual history to discredit her in court. (While this is indeed a major improvement, one that significantly limits the content of the victim’s sexual history now admissible into court, it has not totally eliminated it. For example, if sperm from another person is present in the medical-forensic exam findings, that is admissible, as is any past consensual sexual contact with the accused.)
- Change the definition of consent to recognize the difference between consent and submission (when the victim did not physically resist due to fear); to recognize the difference between consent and lack of consent (when the victim was asleep or passed out); and to include the use of force or “coercion.”
- Exclude the need for there to be a witness to the rape in order to prove that it was indeed rape.
- Increase the statutory rape age from 10 to 12 years of age in most states. (The 1990s have seen an even more aggressive prosecution of statutory rape as an attempt to reduce teenage pregnancy.)

In 1976, the Pennsylvania Coalition Against Rape (PCAR), founded just 1 year earlier, secured passage of the first recodification of their state rape laws since 1939. In addition to many of the above changes, they eliminated the 90-day statute of limitations and the judicial instructions that the jury bear in mind a victim’s emotional involvement and credibility in a rape trial (Horn 1999).

Also in 1975, the creation of the National Center for the Prevention and Control of Rape at the National Institute of Mental Health resulted in an explosion of research on the previously ignored topic of sexual assault. Millions of dollars were made available to fund not only studies on the impact of sexual assault, but also to research demonstration treatment projects to provide improved medical and psychosocial care to sexual assault survivors. Women were sought out as the agents of inquiry, not just as its objects, and as a result, most of the principal investigators on studies funded by this new center were women (Herman 1992).

History of Rape Crisis Centers

In response to the increased awareness of rape, women worked in small, grassroots feminist collectives to develop the first rape crisis centers (RCCs) (Koss and Harvey 1991). Nearly all of the first RCCs were staffed on a volunteer basis by dedicated individuals who took the lead in developing these centers (Collins and Whalen 1989; Edlis 1993). In the early 1970s, many RCCs were radical feminist organizations, considered such because, as Collins and Whalen recognized, the goal initially was not reform, but total transformation of ideologies, power relationships, and the existing social structure. They were feminist because they were organized by women seeking to change the existing power structure with its “male voices being heard first and more often than female voices” (Fried 1994). They also recognized that their first goal had to be to establish a female-based power structure within their own organizations, because if they

could not effect a power change within the RCCs, they would not be able to stop rape in society (Fried 1994).

In these early years, organizational conflict within RCCs sometimes interfered with their ability to work in a unified way toward social change. This conflict was often the result of group members' differing goals. RCCs needed to learn to help these subgroups negotiate more effectively and with less confrontation in order to establish mutual goals on which they could work cooperatively to achieve. Or, RCCs had to accommodate this diversity by forming subgroups that could work independently on their own goals (Fried 1994).

Some RCCs were formed by both men and women who organized to meet a community need. In 1972, men and women in Boulder, Colorado, founded Humans Against Rape and Molestation. Outrage at a rape/homicide in the community initially brought them together. Their primary goals were to make their community safer by stopping rape and to assist victims. The Boulder RCC is still an active community agency.

As more RCCs developed, representatives came together to form state coalitions. As previously mentioned, 10 RCCs in Pennsylvania joined forces in 1975 to form the PCAR. They immediately began to make dramatic changes in their state's social and legal institutions and laws. PCAR worked collaboratively with local hospitals in 1978 to develop a treatment protocol for rape victims seen at local emergency rooms, and they developed a police training manual in 1981. PCAR continues to serve as a national role model for RCCs and state coalitions. One major contribution was their effort to help establish the National Coalition Against Sexual Assault in 1976. All of this was accomplished by a volunteer staff working out of donated office space. The first paid positions at PCAR were not funded until 1978.

By 1979, there were more than 1,000 RCCs across the United States. As the activities of PCAR demonstrated, RCCs were already beginning to shift from a radical feminist ideology to more liberal, reformism beliefs and cooperative working relationships with established social agencies (Edlis 1993).

Thanks to both organizational evolution and the availability of funding to hire staff, the rape crisis movement has become professionalized and institutionalized. Between 1979 and the mid-1980s, significant change in existing RCCs reinforced this move away from radicalism. This included obtaining state and federal funding to hire professional and paraprofessional staff, some of whom were selected for their expertise in administration or lobbying. These RCCs recognized that, to continue to receive this funding for salaries, the goals of the RCCs would need to appeal to legislators.

Wanting to be recognized for their expertise in providing counseling for sexual assault survivors, RCCs also began to stress credentials and certify volunteers. Traditional funding sources also required RCCs to adopt traditional hierarchical organizational structures with advisory boards who hired executive directors (Collins and Whalen 1989). Most RCCs are now funded by traditional sources such as the state, the U.S. Department of Health and Human Services, and the United Way (Black and DiNitto 1994).

Throughout the 1980s, RCCs gradually changed from a helping model dependent on volunteer staff to a stratified, counselor-client model with paid professional and paraprofessional staff. As state and federal money became available for direct services for other crime victims, RCCs across the country capitalized on this funding by expanding their victim populations to include families of homicide victims and victims of physical assault and robbery. The emphasis moved from reform to service delivery, and the complexion of the staff changed to include more white, middle-class women (Collins and Whalen 1989).

The next step was to better understand the impact of sexual assault and the treatment needs of rape victims. Scientific research on this impact and on evaluation of sexual assault programs began to meet this need (Burgess and Holmstrom 1974; Ledray and Chaignot 1981). While early feminist organizations initially stressed the power, humiliation, and control aspects of rape and minimized the sexual dimension, researchers and women working in RCCs have since recognized that rape also is sexual. While the penis is certainly used as a weapon, and gaining dominance and control over the woman is often a goal (Brownmiller 1985), if a man did not want sex, he could just beat up a woman. Rape is about sex, too (Fried 1994).

RCCs also recognized legislation as a means of dealing with many victim concerns, rectifying the imbalance of power and implementing social change from the top down. During the late 1970s and into the 1980s, RCC staff and volunteers focused on changing the laws pertaining to violence against women. It was RCCs working with legislators to remove the marital exclusion clause that resulted in the ability to prosecute abusive spouses and challenged traditional ideas about the institution of marriage and a woman's role within it (Collins and Whalen 1989). Passage of rape counselor confidentiality statutes in the early 1980s granted privileged communication status to certified rape crisis counselors in their contact with sexual assault victims. They no longer needed to fear being called into court to testify, with their statements possibly used against the victims they were there to serve. This privilege was not easily won, however. In 1980, Anne Pride, then director of Pittsburgh Action Against Rape (PAAR), was held in contempt of court after refusing to give a client's RCC record to the defense attorney in a rape trial. A mistrial was declared, and the issue of the confidentiality of RCC counseling records went to the Pennsylvania Supreme Court. In 1981, the Court ruled on *Commonwealth vs. PAAR* limiting the release of victim-related counseling information to the defense. In 1983, Women Organized Against Rape continued the legal battle against the confidentiality statute and won (Horn 1999).

Sen. Joseph Biden, D-DE, was a strong, effective leader in changing legislation. The Privacy Protection Act of 1978 attempted to focus the attention in the courtroom on the defendant's conduct (the rape) by excluding the victim's past sexual history from the courtroom (Biden 1993). The Violence Prevention Service Act of 1984 created a special restitution fund with criminals paying fines to compensate victims. Rape and domestic abuse victims received priority for compensation (Biden 1993). Sen. Biden first introduced the Violence Against Women Act (VAWA) in 1990, and it was signed into law September 13, 1994, as Title IV of the Violent Crime Control and Law Enforcement Act of 1994. This bill made \$800 million available for training and program development over a six-year period, with \$26 million earmarked for the first year. The aim of VAWA was to deal with violence against women by:

1. Rectifying imbalances.
2. Helping survivors by funding services.
3. Providing resources and grants for education and training for police, prosecutors, judges and victim advocates.
4. Requiring treatment equal to that of men under the law by strengthening old laws and creating new ones (Biden 1993).

The impact of VAWA and other funding sources was widely felt by RCCs across the country. For the first time, funding was readily available for expenses and honorariums, which allowed communities to bring in experts to train paraprofessionals and professionals in their area, improving local victim care. RCCs also used this newly available funding to hire staff and introduce sexual assault advocates into county attorneys' offices and police departments (Fried 1994). Some RCCs remain social-movement organizations dedicated to broad social change from outside the existing social structure; others are working to make change from within. Transforming gender roles is a long-term process, and the institutional development of RCCs is an important part of this social evolution (Fried 1994).

Once RCCs were established to provide support to rape victims, the focus of attention became the injustice and victim blame still present within the criminal justice system and at hospitals. Rape crisis advocates, concerned for how victims were treated by police and hospital personnel, went to police stations to support victims during police interrogations (Edlis 1993) and to hospitals during the rape exam. In many communities this led to an adversarial relationship and conflict between strongly feminist rape crisis advocates and the establishment as represented by the police, medical personnel, and states' attorneys. This was counterproductive to communication and education, and hampered the progress of cases through the criminal justice system. In some communities the situation still has not been rectified, especially in the attitudes and relationship between the police and rape crisis advocates.

The emphasis in most RCCs today is on collaboration and cooperation rather than confrontation with other community agencies (Collins and Whalen 1989). This move to a collegial position within the existing social service structure has made RCCs more accepted and effective in providing training to other community organizations, such as the police, prosecutors, medical facilities, and schools. Most RCC staff today function effectively with these organizations as a member of the Sexual Assault Response Team (SART). Many state RCC coalitions are even taking the lead in obtaining funding to provide training and consultation to medical personnel to develop and implement Sexual Assault Nurse Examiner (SANE) programs (Ledray 1999), much like the RCCs took a leadership role in the 1970s and 1980s in sensitization training and protocol development (Horn 1999). Their motivation comes from the recognition that the SANE model is an effective way to bridge the remaining gap in services for rape victims by providing comprehensive medical care and forensic evidence collection.

When Advocacy Programs Rely on Volunteers

Throughout the nation, advocacy programs have traditionally relied on volunteers to staff crisis lines and ensure round-the-clock service. This has many advantages. In general, using volunteers saves money. In addition, educating civilians about sexual violence and crisis intervention gives communities more individuals who are educated to help friends and family who have been sexually assaulted. They also are in a position to dispel myths and prejudice through their knowledge and understanding of the dynamics of sexual violence. The influence of such individuals persists even when they are no longer advocates, and can help create positive social change long-term.

Arguably, however, volunteer advocacy programs are becoming dinosaurs among the ever-improving crisis response models. As SART teams become increasingly professional, volunteer advocates have become unequal in their training and status. Volunteers cannot be expected to have the same level of reliability and proficiency as paid professionals. Nor can they share the same level of collegiality. Compared to the proficiency, reliability and collegiality shared by SANEs and law enforcement professionals, advocates are in danger of becoming the “weakest link.”

Relying on volunteer advocates also creates a gap in the continuum of care. Volunteers cannot guarantee off-shift availability and may not be able to do thorough followup contact, short-term case management, or legal advocacy. Since volunteer advocates are prohibited from giving out their personal phone numbers, contacting survivors becomes difficult, with most advocates unable to perform the aggressive followup many survivors need in order to receive counseling immediately post-trauma, when the window of opportunity to prevent dysfunctional coping mechanisms and begin healing is most promising. If this responsibility then falls on the program coordinator, survivors have to reconnect all over again with a new person. Not surprisingly, many survivors “fall through the cracks.” This situation could be prevented if advocates were paid and had an expanded job description that included thorough followup for all recent survivors, short-term case management and counseling, ongoing medical and legal advocacy, regular office hours, and frequent on-call shifts to guarantee proficiency and consistent interaction with other first responders.

There is little research on rape crisis advocacy nationwide. For example, what percentage of survivors receive ongoing counseling immediately post-trauma? Is the prognosis of these clients more promising? What factors make it more likely that recent survivors will use support services? How can advocates make such utilization more likely? Which crisis counseling models used by advocates are most effective to prevent PTSD? Do regular check-in calls help survivors feel more supported? What training components are essential for advocates to feel competent in their role?

Since advocacy coordinators are usually busy training and supervising volunteers, and because advocacy does not have the professional cachet and credentials as other disciplines, there is a notable lack of research in the field. This is reflected as well in the lack of a professional journal featuring innovations, research and successes in the rape crisis advocacy movement.

Since their inception, RCCs have relied on volunteers. Such grassroots energy is typically generated and harnessed to effect positive social change. In the rape crisis movement, it is instead used to maintain an institutionalized status quo. This is a systemic problem because many agencies have no choice but to do so for financial reasons. Relying on volunteers, however, may jeopardize the existence of advocacy altogether. And the absence of advocates to provide agenda-free, nonjudgmental emotional support and followup case management for survivors and their families would be a tragic loss.

What You Can Do

The reality is that everything is changing except advocates ourselves. Most SANE programs provide 24-hour coverage with a small number of proficient, paid personnel; advocacy programs are challenged to do the same. Advocates need to compile examples of programs around the country that rely on paid staff and find the funding to do so. Any information evaluating the effectiveness of such programs is invaluable.

If you are involved in an innovative advocacy program, please e-mail Linda Ledray at mistyhillranch@aol.com with a brief program description and contact information, and someone will be in touch for more details. Together, advocates can make systemic changes to ensure that our crucial services remain available for survivors in need of our long-term compassion, presence, assistance, and support.

