

SEXUAL ASSAULT SERVICES IN ALBERTA:

**A Framework of Service Delivery
for Sexual Assault Survivors Living in
Rural, Remote and Northern Communities**

An AASAC
SPECIAL PROJECT

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Introduction

Project Goal

The overall goal of this project was twofold:

- (1) To identify the unique needs of sexual assault survivors and their families who live in rural, remote or northern communities; and
- (2) To recommend a model of sexual assault service delivery in rural, remote or northern communities that best meets the needs of sexual assault survivors and their families.

Project Objectives

The goals of the project were met through the completion of activities to meet the following objectives:

- (1) A documented review of current literature concerning the needs of sexual assault survivors and their families who live in rural, remote or northern communities and relevant models of service delivery designed to meet those needs;
- (2) A documented analysis of any existing rural models of service delivery in Canada and/or the United States.
- (3) Documented recommendations with regards to the development of a rural model of sexual assault service delivery in Alberta.

Research Method

Review of the Literature

A documented review of the current literature was conducted to investigate: (a) the concerns and needs of sexual assault survivors and their families who live in rural, remote or northern communities, and (b) the existence of relevant models of service delivery designed to meet those needs.

As the literature available through refereed journal articles and through academic search engines was initially found to be sparse, the researcher obtained approval from Debra Tomlinson, the Provincial Coordinator of AASAC to extend the research method to include informal telephone interviews of key informants.

Interviews of Key Informants

Key informants were identified as individuals who may have first hand knowledge or other types of knowledge and information about sexual assault service provision in rural, remote and northern communities. The researcher identified key informants to interview in the following ways:

- Individuals who had been recommended to the researcher as key informants by AASAC;
- Individuals who had written key articles or reports (provincial, national, international) about sexual assault in rural and remote areas;
- Individuals who were administrators of sexual assault centres in rural and remote areas (provincial, national, international);
- Individuals who were front line workers of sexual assault centres in rural and remote areas (provincial, national, international);
- Individuals who were recommended by other key informants as possible contacts (provincial, national, international);
- A total of 27 interviews were completed. The interviews resulted in the collection of first-hand information regarding relevant models of service delivery in rural and remote areas.

Organization of Report

The remainder of the report is organized in the following sections:

- Review of the Literature
- Findings from the Interviews of Key Informants
- Synthesis of Findings from the Literature Review and Key Informant Interviews
- Identification of Key Elements of Sexual Assault Provision in Rural and Remote Areas

Review of the Literature

Introduction

Rural Canada occupies approximately 95% of Canada's territory. Almost 9 million people, or about 30% of Canada's population, live in rural and remote areas (Statistics Canada, 2003).

One-quarter of Albertans live in rural and remote areas of the province. Within rural Alberta, there is considerable variation - ranging from the most remote, sparsely populated (and typically most disadvantaged regions) to the more affluent regions that have established economic and social connections with adjacent urban areas (Sorenson & dePeuter, 2005). For survivors of sexual assault in rural and remote areas, opportunities for medical, legal or emotional services are often very limited or even non-existent. Factors specific to rural and remote areas may interfere with or prevent accessibility of services, even if appropriate services (e.g. counselling, medical attention, forensic evidence collection, education, shelters) are available.

Few quantitative studies of rural sexual assault exist. However, there are numerous accounts verifying the needs for sexual assault services and the aspects of rural life that often interfere with the provision and delivery of those services.

Comprehensive rural sexual assault programs and services are required in rural areas for the following reasons:

- Perpetrators of sexual violence rely on the stigma and myths that surround sexual violence to keep survivors silent.
- Sexual assault centres/programs can provide education, prevention strategies, and public awareness in rural and remote communities. This will help rural areas move towards the goal of ending sexual violence by changing public perceptions of, and attitudes toward sexual violence and help break the feelings of isolation that survivors of sexual violence in rural and remote areas often experience.

Due to the scarcity of information on rural sexual assault, some of the literature reviewed in this report originates from the research on domestic violence in rural areas. Intimate partner sexual assault is one of the many types of intimate partner violence. Thus, information about rural sexual assault as one form of intimate partner domestic violence is considered to be applicable when discussing the existence of rural beliefs, attitudes, values and behaviors. In the body of this

report, when references are made to domestic violence, they are done so within the context of intimate partner sexual assault.

Definitions of Rural and Remote

Rural

Numerous definitions of "rural" exist, and there is no standard definition of "rural" used in policy documents, research studies or planning. Pong (2002) suggests that "there appear to be as many definitions of rural as there are researchers" (p. 1). Different definitions of "rural" are based on procedures which make use of different criteria, levels of analysis and methodologies. Furthermore, confusion arises when documents and policies imply but do not explain how the term "rural" is being used (Coward, Miller, & Dwyer, 1990; Statistics Canada, 2003). Not only does this make comparisons between rural areas difficult, but also urban/rural comparisons. Furthermore, there is rarely a breakdown of rural information by gender, age or ethnicity (Mulder et al., 2002).

Generally, the term rural refers to an area, town, county or region that has low population density. Anywhere outside of a city is typically "rural". The highly subjective nature of the definition is reflected by the statement, "rural is what people recognize as rural" (Troughton, cited in Watanabe and Casebeer 1999).

Definitions Used by Statistics Canada

General documents released by Statistics Canada often use the definition of "rural and small town Canada", which refers to people living outside the commuting zones of larger urban centres (Pong, 2002). Another commonly used definition by Statistics Canada is Census Rural Area definition, which indicates that individuals are rural if they are living outside places of 1,000 people or more or outside places with densities of 400 or more people per square kilometre.

Statistics Canada also uses the Organization for Economic Cooperation and Development (OECD) definition of "rural community", which refers to individuals in communities with less than 150 persons per square kilometre. This includes individuals living in the countryside, towns and small cities inside and outside of the commuting zones of urban centres.

Where a more specific definition of rural is essential (such as in policy analysis), Statistics Canada and the Rural Secretariat provide six definitions that are available in the article, *Definitions of Rural* (du Plessis, Beshiri, Bollman, & Clemenson, 2001).

While the building blocks used for classifying an area as rural are based on Census geography (i.e. enumeration areas, census subdivisions, census consolidated subdivisions and census divisions), each definition emphasizes different criteria (population size, density, labour market or settlement context), and each has its limitations and benefits. The specific definition chosen matters for each application, as different numbers of people are generated, different people are classified as rural, and different characteristics of rural people are identified. The Rural Postal Code definition identifies individuals as rural if they have a "0" as the second character in their postal code.

Within Canada, another system which distinguishes between urban and rural populations by commuting areas is described by Sorenson & dePeuter (2005):

Residents of rural Alberta are defined as individuals residing in RST regions that have a population of less than 10,000 and where less than 50% of employed individuals commute to a Census Metropolitan Area (CMA) or Census Agglomeration (CA) (Statistics Canada, 1999a). Residents of urban Alberta are those residing in a CMA or CA. CMAs have an urban core population of at least 100,000 and include all neighbouring municipalities where 50% or more of the labour force commutes into the urban core. CAs have an urban core population between 10,000 and 99,999 and abide by the same commuting rules as CMAs (Statistics Canada, 1999a). (p. 11)

This system was developed by McNiven et al. (2000), and enables rural communities to be further classified using the Census Metropolitan Area and Census Agglomeration Influenced Zones (MIZ). MIZ is designed to measure the degree to which all CMAs/CAs influence the rural community, economically and socially. The four MIZ categories are based on the proportion of the population commuting to CMAs and CAs as follows (Sorenson & dePeuter, 2005, p. 12):

1. Strong MIZ: Between 30% and 49% of the employed workforce commutes to the urban core of any large urban centre, suggesting that this population is strongly integrated with the urban economy.
2. Moderate MIZ: At least 5% but less than 30% of the employed workforce commutes to the urban core of any large urban centre, suggesting that this population is moderately integrated with the urban economy.
3. Weak MIZ: More than 0% but less than 5% of the employed workforce commutes to the urban core of any large urban centre, suggesting that this population is weakly integrated with the urban economy.
4. No MIZ: 0% of the employed workforce commutes to the urban core of any

large urban centre (plus any CSD that has less than 40 people in its employed labour force), suggesting that this population is not at all integrated with the urban economy.

Findings by Sorenson & dePeuter (2005) indicate that of the 25% of Albertans living in rural areas, Weak MIZ zones are the most populated of the rural zones (comprising 12.1% of the total Alberta population), followed by Moderate (6.8%), Strong (4.5%), and finally, No MIZ (1.2%) zones.

Defining Rural by Social Representation

An alternative classification is the social representation of rural as a community of interest, a culture, and a way of life. Some researchers believe that rurality may be more of a concept than a description of particular regions. Sims (1988) has suggested that :

Perhaps rurality exists more as a state of mind and attitude than as an area on a map or a ratio of persons per square mile. Rurality may be best defined subjectively. (p. 21)

Rurality as a Culture

Weisheit, Wells and Falcone (1994) have explained rural areas as a culture; that is, a "rural area is not simply a physical place but a social place as well". This perspective carries implications for service delivery because it suggests the need to adopt approaches that are sensitive to the cultural characteristics of rural populations (Lewis, 2003b).

As discussed in the Rural, Remote and Northern Women's Health Report, rural women consistently describe a rural culture, although its characteristics varied and descriptions made by one woman were contradicted by another. Thus, although rurality has an identifiable culture, the culture varies according to its context. The report emphasizes that:

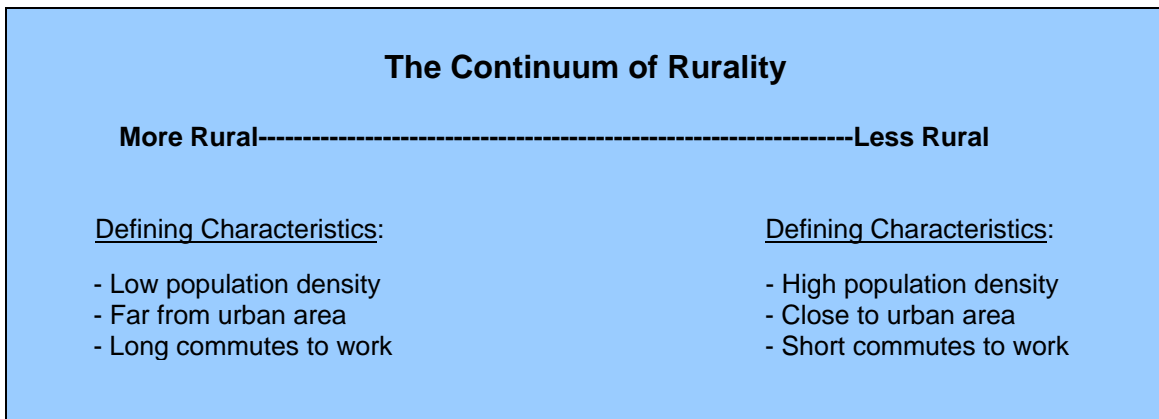
Rural culture must therefore always be taken into account, but at local levels so that its distinctive characteristics can inform appropriate policy"

(Sutherns, McPhedran, & Haworth-Brockman, 2004, p. 5).

Women who participated in the study underscored the need for research to be conducted in ways that take "the whole of women's lives into account, rather than exploring one small dimension in isolation" (p. 8).

Continuum of Rurality

As described by Ciarlo, Wackwitz, Wagenfeld, and Mohatt (1996), rural areas generally share the common characteristics of having comparatively few people living in the area, limited access to large cities (and sometimes to small towns), and considerable traveling distances to "market areas" for either work or every-day living activities. Rural areas exist along a continuum from "more rural" to "less rural". The placement of rural areas on the continuum is difficult to assess, as it may vary widely based upon the consideration of numerous factors such as proximity to a central place that has been identified (e.g. a specific city, an urban area), community size, population density, total population, economic and socioeconomic factors. Since the characteristics that define "more rural" and "less rural" may vary widely, continuums of rurality are highly subjective and are used to depict very general comparisons.



Remote Regions

In some regions, the use of the term "rural" is insufficient in describing the great extent of rurality. Therefore, places beyond a simple description of "more rural" are described in the literature as remote or frontier areas. For instance, some people live in rural frontier villages and towns so remote that there are no roads linking them with other villages, towns, or cities.

Commuting distance might be measured by the duration of an aircraft ride rather than miles driving a car. One definition of "remote" used in the health care literature describes communities as such when they can be reached only by boat, airplane, or snowmobile (Wilcox, Dowrick, & Ward, 2001). The Rural Committee of the Canadian Association of Emergency Physicians defines "rural remote" as

"rural communities about 80-400 km or about one to four hours transport in good weather from a major regional hospital" and "rural isolated" as "communities greater than about 400 km or about four hours transport in good weather from a major regional hospital" (1997, p. 6).

Similarly, the term "frontier rural area" has been used in the mental health literature to describe remote, isolated rural areas with a population density less than 7 persons per square mile (Ciarlo, Wackwitz, Wagenfeld, & Mohatt, 1996).

Northern Communities

The Northern areas of Canada are typically considered to be those communities within the Northwest Territories, Nunavut and the Yukon. Geographically, Northern Alberta covers approximately 60% of the province, yet contains only 9% of the population of Alberta. Northern Alberta consists of over 200 communities spread across 380,000 square kilometers of land. It is made up of 3 cities, 24 towns, 12 villages, 29 First Nations communities, 8 Metis settlements, 130 hamlets and 12 summer villages.

Usage of Rural and Remote in this Report

As this review of the literature examines many articles which use different definitions of rural and remote, the term rural as used in this report will encompass all the geographical areas which are not classified as "urban" (see Troughton, 1999), including very rural (remote) communities.

Sexual Assault Service Needs of Rural Communities

People living in rural and remote areas are not a homogeneous group facing one set of problems in relation to sexual assault. The diversity of rural areas means that some rural individuals may have more options than others. While those living in large regional cities often have access to a range of services and can maintain a sense of anonymity, individuals in rural, isolated and remote areas rarely have the same degree of choice.

Groups of individuals who are often referred to as being underserved, underrepresented or marginalized may experience additional barriers accessing sexual assault services in rural areas. For instance, Aboriginal and Non-English Speaking Background (NESB) women living in rural or remote areas experience additional barriers that include cultural isolation and language barriers (Lovell 1996; cited in Lievore, 2003).

Community-Specific Needs

The need for sexual assault services and programs differs in each rural region and often within each rural community. For this reason, an essential part of providing appropriate and adequate sexual assault services is determining the nature and extent of needs in the community being served. Service needs are as different as the individuals who live within the community, and care must be taken not to make assumptions about the needs of one community based on the needs of another.

The need for sexual assault services of people living within one First Nations in Alberta may be different from the needs of those living in another First Nations in Alberta, even though the individuals may belong to the same tribe. Similarly, the needs of one rural farming community in Southern Alberta may have markedly different needs than another rural farming community in Southern Alberta because of the nature and characteristics of the people who make up the communities and their associated beliefs, attitudes, and behaviors with respect to sexual violence. Societal and cultural attitudes, community history, trends, norms, and the social, economic and political conditions of the community are other factors that affect a community's willingness to acknowledge sexual assault.

The demographic characteristics of individuals living in rural communities may vary widely. For example, some rural communities have large populations of immigrants and refugees from war torn countries who have witnessed or experienced sexual violence in the past. As in large urban areas, micro-communities may exist in rural communities. This is evidenced in a national evaluation of the Rural Domestic Violence and Child Victimization Enforcement

Grant Program (Dutton, Worrell, Terrell, Denaro & Thompson, 2002), which identifies the importance of considering the context of delivering services to a Hmong community living within a small rural town. In addition, some communities may have greater needs for other underserved groups of the population such as gay and lesbian survivors of sexual violence.

A study conducted by the Department of Justice Canada (De Jong, 2003) reported that geography, culture and court structure affect the demand for legal services, the pattern of service delivery, and the quality of services provided in Northern Canada. Difficulties in cross-cultural communication were identified as affecting the quality of legal services delivered, especially in areas with a very high Aboriginal population.

Prevalence of Sexual Assault in Rural Areas

As in most rural areas, the prevalence of sexual assault in rural and remote Alberta remains unknown as many survivors choose not to report sexual violence to law enforcement officials.

In Canada, the victimization least likely to be reported is sexual assault. Only 8% of sexual assaults were reported to police, according to the 2004 General Social Survey (Statistics Canada, 2005b). Similarly, in 1993, the Statistics Canada Violence Against Women Survey found that only 6% of all sexual assaults are reported to police. The 1993 survey also reported that one-half of all Canadian women have experienced at least one incident of sexual or physical violence. Children and youth are over represented as survivors of sexual assaults. According to Statistics Canada, 6 out of every 10 sexual assaults reported to police involved a child or youth (Statistics Canada, 2005a).

Some data collected from national surveys conducted in the United States indicates lower rape and sexual assault rates in rural areas. The credibility of such information has been challenged by more recent and localized studies. In the Adult Sexual Victimization Study conducted in Pennsylvania, data collected from the state's 52 rape crisis centres indicated that sexual assault rates were significantly higher in rural counties compared with urban counties (Ruback & Menard, 2001). The same study found that Uniform Crime Report data collected by the Federal Bureau of Investigation for the same period by the same counties did not show higher sexual assault rates in rural areas.

Rural advocates and some researchers suggest the existence of equal or even greater numbers of sexual assault survivors per capita in rural areas. As justified by Lewis (2003b), "Given the low rate of reporting of non-stranger rape and the high level of familiarity in rural areas, rates of sexual assault may be as high or higher in rural communities than in urban areas". This may be because rural women tend to experience and think about rape perpetrators as non-strangers or an

intimate partner, whereas urban women are more likely to experience and talk about perpetrators as strangers or acquaintances (Ruback & Menard, 2001; Logan, Evans, Stevenson and Jordan, 2004). Identifying perpetrators as intimate partners supports beliefs that rural women's rates of reporting sexual assault may be lower than that of urban women.

A study conducted by the Department of Justice Canada (De Jong, 2003) reported that areas of Northern Canada have a high overall incidence of sexual assault. Nunavut has the highest rate of sexual assault in Canada (788.4 per 100,000 people in 2001, compared with 78.6 per 100,000 people for the country as a whole). This is followed by the Northwest Territories (359.8 per 100,000 people) and the Yukon (254.3 per 100,000 people). A 1989 study sponsored by the Native Women's Association of the Northwest Territories found that eight out of 10 of girls under the age of eight had been survivors of sexual abuse; and one half of boys of the same age had been sexually molested (Child Sexual Abuse in Residential Schools, n.d.; cited in De Jong, 2003).

Given the increased efforts of women's advocacy groups to heighten awareness, education, and interest in sexual assault, the literature reveals a disappointing absence of detailed sexual assault data in Canada since the 1993 Violence Against Women Survey conducted by Statistics Canada. As lamented by Lily Greenan (2004) in her review of the literature on Women and Violence:

Hague et al. note with some surprise a decline in reported sexual assaults over the five years before their report, and with some disappointment the absence of the kind of detailed data that is available on 'family violence' from Statistics Canada (Hague, Kelly and Mullender, 2001). It would seem that in Canada, as in Europe, rape and sexual assault are 'forgotten issues', despite the best efforts of women's advocacy services. (p. 39)

This is echoed by Johnson (2000), who writes, "The paucity of reliable and useful data about the extent of domestic violence experienced by rural women in the United States is remarkable" (p. 3).

Police statistics do not provide a comprehensive picture of the extent or nature of sexual assault, as they count only the incidents that are reported to and recorded by police. For a more detailed discussion of the limitations of data collection on sexual assault statistics, the international literature review conducted by Lievore (2003) is an excellent source of information.

Reasons for Underreporting in Rural Areas

Underreporting of sexual offences has been a chronic problem in Canada and worldwide. In rural and remote areas, underreporting of sexual assaults is considered the norm; underreporting is often exacerbated by factors that are commonly associated with rural life. The collection of national sexual assault data in Canada and the United States has been limited by the definition of sexual assault and survey methodology. There is however, general consensus that sexual assaults are largely underreported.

As with incidents of domestic violence, certain characteristics of rural areas and rural individuals may magnify the extent to which sexual assaults are underreported. These have been identified in the literature as follows:

Reasons for Underreporting of Rural Sexual Assault

- Distrust of outsiders and suspicion of policy solutions "imported" from the city
- Acceptability/Normalization of sexual assault
- Fear of not being supported or believed
- Lack of culturally appropriate responses
- High acquaintance density
- Low anonymity, concern for confidentiality and privacy
- Limited telecommunications
- Issues with police response and court system
- Fear of revictimization by "the system"

Distrust of Outsiders and Suspicion of Policy Solutions

Individuals living in rural communities tend to distrust outsiders and agencies, and be suspicious of policies and practices regarded to be urban in origin. Such distrust may make it less likely that survivors will participate in telephone or other surveys designed to measure rates of sexual victimization (Crocker, 1996; Dietrich & Mason, 1998; Lewis, 2003b).

Acceptability/Normalization of Sexual Assault

The tendency not to report sexual assault may be influenced by informal social codes of behavior that dictate the privacy of family matters and the necessity to maintain family reputation (Jiwani, 1998; Lewis, 2003b; Macklin, 1995; Neame & Heenan, 2004).

Sexual assaults in rural areas are mostly hidden crimes, hidden both intentionally and unintentionally by characteristics of a close-knit culture or an isolated lifestyle.

(Lewis, 2003b)

In some rural areas, people have chosen to ignore sexual assault; such behavior has been enabled by the lack of awareness and knowledge about sexual assault and the lack of sufficient services for survivors of sexual assault. A school survey conducted on Salt Spring Island, British Columbia in 1992 revealed that 44% of boys in Grade 8 thought it acceptable to rape their girlfriends. At that time, there were no sexual assault services, safe houses, victim's services, safe houses, support groups, or crisis lines. Salt Spring Island Women Opposed to Violence and Abuse (SWOVA) was formed in 1992 to address the gaps in services for women survivors of violence. Since its inception, it has experienced backlash, apathy, and denial of the existence of abuse from the community (Jiwani, 1998).

The acceptance or "normalization" of sexual assault is a phenomenon that is increasingly being reported to exist in Australian Indigenous communities and Aboriginal communities within Canada and the United States (Indian and Northern Affairs Canada, 1996; Keel, 2004; Lewis, 2004; Stewart, Huntley & Blaney, 2001). As with all communities, it is important to recognize and respect the wide diversity of peoples within and across Aboriginal and Indigenous communities. Accordingly, rates of sexual assault and the attitudes of individuals towards sexual assault may vary substantially from one community to another.

Normalization contributes to feelings of resignation that things have always been, and will always be this way (Stewart, Huntley & Blaney, 2001). Normalization of child sexual assault and other forms of violence in Aboriginal communities within Canada was identified in a study conducted in British Columbia (Stewart, Huntley & Blaney, 2001).

Because of the extent to which sexual assault is accepted in some Aboriginal and Indigenous communities, survivors who report sexual crimes must often deal with a community response that is largely unsympathetic and sometimes hostile towards the survivor (Neame & Heenan, 2004).

The following statement was made in a 1996 Report of the Royal Commission on Aboriginal Peoples:

When I went into community development and went into northern Alberta, I was amazed. It was like another total world, the way the women were treated; it was normal to be beaten every Saturday night. It was normal to have sexual abuse from young children to older children. And when we looked at it and we studied it, it was the demise of the Native culture that caused that. That never happened before. . .

. . . And when I went up North and I saw women, for survival, had to dress like men, it was a sad, sad state of affairs.... The demise of the Métis and the Indian cultures, a lot of it is the result. Alcoholism and sexual abuse and physical abuse are only symptoms of a much larger problem.

(Senator Thelma Chalifoux, Metis Nation of Alberta, 1992; cited in Indian and Northern Affairs Canada, 1996, p.8)

An Australian study describes sexual assault in Indigenous communities as being widespread and endemic. It indicates that the acceptance of sexual assault in Indigenous communities has escalated to the point that the normalization is intergenerational (Thorpe, Solomon & Dimopoulos, 2004). In the same study, almost all of the Indigenous participants in the focus groups agreed that child sexual assault was either still very much hidden or simply not talked about.

Fear of Not Being Supported or Believed

As cited by Lewis (2003b), members of law enforcement in rural areas are likely to be part of the social network (Sims, 1988; Weisheit, Wells & Falcone, 1994; Weisheit, Wells & Falcone, 1995). This sometimes compounds the problem of reporting non-stranger sexual assaults because survivors are embarrassed and afraid that they will not be supported or believed by an officer that may be acquainted to or related to the perpetrator.

Neame and Heenan (1994) report that for Indigenous workers and those providing services to communities with high Indigenous populations, social and cultural controls resulting from close ties and extended kinship networks can be a serious detriment to reporting sexual assault, seeking help, and prosecution of the perpetrator:

The survivors face community shame. Their families are ashamed and don't believe the survivor. The community talks about the survivor - usually saying that they are nothing but a so-and-so and deserved it. Or there's an

entrenched belief that it couldn't have happened as they are not injured or their clothes torn. Families break down as some families believe and others don't. The survivor is harassed and tormented by the perpetrator's extended family and friends...smaller communities know most people and snicker about it while the survivor is around. This in turn impacts on the survivor and they stop going out socially, become a hermit - and some contemplate suicide.
(Neame and Heenan, 1994, p. 14)

Lack of Culturally Appropriate Responses

There has been increasing recognition of the lack of culturally appropriate services available to support survivors from non-English speaking backgrounds. The inaccessibility or unavailability of culturally appropriate services has been found to be a disincentive to reporting and help-seeking by immigrant survivors (see Neame & Heenan, 2004).

Advocates working in Alaskan Native communities have also reported that cultural barriers are a prominent factor in the decision of survivors to report an assault or seek outside assistance. Such factors may range from fear of retribution by the community's powerful family to belief in ultimate spiritual justice (Lewis, 2003b).

According to Lievore (2003), Aboriginal peoples in Australia, Canada and New Zealand view the Western criminal justice system as part of the problem, rather than a solution to problems of sexual assault and family violence. They reject the criminalization of violence within intimate relationships as the main strategy for dealing with sexual assault. Instead they support community driven strategies, as the diversity of Indigenous communities renders generic models inappropriate. Such strategies are based on customary law and the principles of restorative justice and reconciliation. They are aimed at maintaining family relationships and connectedness, promoting individual and community healing within extended family structures, and ending the violence without offenders being jailed.

A study conducted by the Department of Justice Canada (De Jong, 2003) revealed that in Northern Canada, the impact of culture appears to be related to the composition of the population. Jurisdictions with higher Aboriginal populations experience higher impacts from cultural differences. In Nunavut, the quality of legal service provision was found to be impaired because of significant cultural and linguistic barriers to communication and understanding.

High Acquaintance Density

Rural regions tend to have a close network of familiarity among residents (high acquaintance density). In rural areas, most sexual assaults are by non-strangers (referred to as NSSA or Non-Stranger Sexual Assault) or even more likely, by

closer acquaintances, intimate partners or relatives. The extent of this is believed to be so great that Royse (1999) and other researchers have asserted that the high prevalence of non-stranger sexual assault in rural communities "may be a hidden and unidentified epidemic" (Royse, p. 48).

The survivor-offender relationship has also been identified as important in predicting the reporting of sexual violence. This relationship partly helps identify and define incidents of sexual assault. That is, the survivor-offender relationship is important because it "helps both the victim and others define whether or not an action is rape and whether or not reporting the crime to police would be worthwhile" (Ruback, 1993). Within Aboriginal communities, there may be a high degree of interrelatedness between the survivor and the perpetrator, the survivor and the perpetrator's extended family, and the perpetrator and the community. These relationships are a major barrier to reporting sexual assaults. Generally speaking, the closer the relationship between the survivor and perpetrator, the less likely the survivor is to report the crime (Hunter, Burns-Smith & Walsh, 1996).

Low Anonymity, Concern for Confidentiality and Privacy

A major barrier to reporting sexual assault in rural and remote areas is the lack of anonymity associated with high acquaintance density (Lievore, 2003). Some survivors do not receive the medical attention they need because they are fearful of being seen in a hospital waiting room by others they may know. Rural health care providers such as doctors and nurses may be well-acquainted with the survivor and/or perpetrator, and are sometimes related to patients and their families. This may create a barrier to disclosing abuse because of confidentiality concerns, thus further isolating survivors (Johnson, 2000).

Lower population densities in rural areas increase the likelihood that the survivor may be more "visible" than in urban areas. In *Review and Monitoring of Child Sexual Abuse Cases in Selected Sites in Rural Alberta*, the effects of public scrutiny are discussed:

Small town courtrooms are often seen as a source of entertainment for some community residents. It is very difficult to keep a case like this confidential in a small town.

In one Bassano case, the child victim stated "the most difficult thing about the whole ordeal was trying to keep it secret from friends." In fact, some rural victims needing treatment refused child welfare treatment services or referral because the families feared the "community" would find out. (Phillips & Hornick, 1992, p. 42).

The difficulty in maintaining privacy and anonymity in rural and remote communities is compounded by anxiety related to the increased likelihood that the perpetrator may be regularly encountered. This situation was described by a survivor as follows:

The communities are very close. Everyone knows someone who knows you. Victimization is alive and well from the time the report is made, as it is almost impossible to be anonymous. It is almost impossible not to see the perpetrator out and about on a very regular basis, or their family and friends."
(p. 6, Neame & Heenan, 2004)

Limited Telecommunications

Telephone service in the home is often unaffordable to survivors with low incomes in areas that are very remote. Cellular phone service is often not consistent or unavailable, and is also costly. If survivors live in isolated areas, and are far away from neighbors or pay phones, it requires particular effort to report crimes of sexual violence. A lack of infrastructure such as internet access was identified as a barrier to the provision of legal services in Northern Canada (De Jong, 2003).

Issues with Police Response and Court System

As described by Lievore (2003), the "boys club mentality" is still in existence in some rural communities. That is, networks between members of law enforcement, the perpetrator's families, and the perpetrator coincide, which makes survivors hesitant to report the crime.

In addition, Neame and Heenan (2004) found that in Australia, while there may be formal protocols or arrangements in place to coordinate rural law enforcement response with sexual assault services, there are issues with police consistently complying with such protocols.

Many ethnocultural minority or immigrant women who are survivors of wife assault fear the police and will not report violence due to perceived and experienced discrimination by the police (Roboubi & Bowles, 1995). Some immigrant and refugee women are afraid to involve the police due to their past experiences of violence by police or the military in their country of origin.

Continuing low conviction rates of perpetrators has also been noted as a detriment to survivor reporting. According to an Australian study conducted by Neame and Heenan (2004), jury members were said often to have some knowledge of the parties involved, or to have previously been influenced by the town's "grapevine"

which almost certainly seemed to place blame with the survivor rather than the perpetrator.

Neame and Heenan (2004) also identified the composition of juries to be "highly problematic" in rural areas:

It is very hard to get a conviction, even when the evidence is overwhelming. At the risk of making an un-politically correct statement, we have few professional people to draw on for jury duty and those who are called are usually exempted. This means there is an imbalance in juries... who find it difficult to understand much of the process, let alone the evidence in the way it is presented, and rely on their feelings to guide them. Even if they believe sexual activity took place...they disregard the age of the victim and bring in a verdict of 'not guilty' to all charges. We have had in the last year two occasions when a Judge wanted to berate the jury for getting it wrong and made this fact very clear to the accused. (p. 16)

Fear of Revictimization

Fear of revictimization by "the system" (i.e. police, court system) has been cited as one of the main reasons for the chronic under reporting of sexual offences in Canada (Cameron, 2003). Fassel (1994) estimated that over 80 percent of survivors fail to report do to feelings of shame and humiliation or fear of revictimization through the criminal process.

Challenges to Rural Survivors in Seeking Help

The factors contributing to underreporting of sexual assaults in rural areas (see previous section) create reluctance and are therefore also considered to be challenges or barriers to rural survivors in seeking appropriate types of help. Some of these are listed again in this section and described in further detail.

Barriers or challenges to rural survivors in seeking help that are discussed in this section include:

- Acceptability/normalization of sexual assault
- Dependency on perpetrator
- Geographical isolation
- Emotional distance
- Accessibility to transportation

- Limited telecommunications infrastructure
- Rural values
- Lack of available time
- Culture, racism and religious influences
- Fear of ostracization, retaliation, deportation, and other repercussions
- Denial
- Limited options for legal representation
- Low rates of prosecution
- Privacy and confidentiality issues
- Availability of weapons
- Lack of awareness/information/knowledge
- Service provider incompetence
- Lack of sensitivity and revictimization
- Limited sexual assault service availability
- Lower literacy levels
- Inability to speak English
- Lack of related support services
- Distrust, fear and suspicion of human services
- Work-related issues
- Lack of education, skills and opportunities
- Lack of health insurance
- Perceptions of service affordability

Acceptability/Normalization of Sexual Assault

Particularly when sexual assault occurs within relationships (dating, marriage, common-law relationships), sexual violence in some rural and remote communities may not be viewed as abuse. This tendency to accept or normalize or minimize the crime is captured in a statement made by a rural service provider in British Columbia (Jiwani, 1998):

I find that sexual assault is not recognized as woman abuse unless it's stranger assault or she's physically battered to a pulp. So sexual violence in the context of a date or intimate relationships, I think, is totally unrecognized by most of the community. And nobody talks about sexual violence.

Self-blame and shame are barriers to survivors of sexual assault. According to a study of rape survivors conducted by Logan, Evans, Stevenson and Jordan (2004), women feel ashamed of being a survivor of sexual assault and blame themselves.

Anecdotal reports suggest that child sexual assault in some Aboriginal communities is continuing to increase, yet allegations of child sexual assault are being dismissed, "without investigation, as false and vengeful charges" (Nipshank, 2001).

Dependency on Perpetrator

Survivors who have been sexually assaulted by a family member or someone that they are financially dependent upon may perceive or find services to be inaccessible because of the lack of control they have over their lives. Poverty and financial abuse and control can instill feelings of fear and helplessness in survivors. In some instances, dependency on the perpetrator for alcohol and/or drugs prevents survivors from being able or willing to access help.

The patriarchal, traditionalist attitudes and behaviors found in many rural and remote communities fosters the dependence of women on men, limits help seeking behavior, and "maintains a pathological status quo and restricts individual development while simultaneously lessening the likelihood that an abusive partner will be censured"

(Szikla, 1994; cited in Mulder & Chang, 1997).

Geographical Isolation

Particularly when survivors require immediate help, living in a rural or remote region may be challenging. Police response time to calls for help may be long because of distance to the nearest detachment, and because there may be no specific addresses to help police locate individuals living in rural and remote areas.

Particularly in adverse weather conditions, roads in rural and remote areas may be poor and sometimes too treacherous to drive on due to snow, ice, mud or high water.

The geographical isolation may also create feelings of psychological isolation that may further hamper the ability of survivors to seek and access help (Alston, 1997). Great distances may not only separate rural and remote communities, but survivors' homes as well. Physical characteristics of the land such as rivers, lakes,

mountainous terrain, and gorges may make travel difficult or impossible at certain times of the year.

Both geographical isolation and limited accessibility to transportation are barriers to survivors who want/need to receive a forensic medical examination. This is particularly important if evidence such as blood and "first urine samples" need be collected to support allegations of drug-assisted rape. Strong positive drug test findings are limited to certain drugs and samples that have been taken within 12 and 24 hours of the assault (Kelly & Regan, 2003).

In a study conducted of rural Saskatchewan farm women, distance and traveling were mentioned repeatedly in the interviews as one of the constraints that created an "overarching dimension" in the lives of farm women (Kubik and Moore, 2001). The study did not specifically address the accessibility to sexual assault services; however, the perception of having to travel a considerable distance to access health services was predominant and considered to be a challenge. Approximately 74% of the respondents indicated that they were within 30 minutes of their nearest health care facility and 30% were between 11 and 20 minutes away.

The accessibility of health care and emergency services, participating in community events, having children involved in activities, attending off-farm work, getting supplies, and taking part in recreation all involved time, travel, and other associated costs. When the distance is substantial, farm women and their families must travel and stay overnight - which adds additional costs such as meals and hotel rooms in cities, gas and car upkeep, and childcare costs. Such costs created an additional financial burden for many farm women and their families, many of whom were already experiencing economic difficulties. The major effort often required to access often minimal services is a great barrier in the accessibility of sexual assault services and other related services (Nuffield, 2004).

Emotional Distance

Some women living in rural and remote areas may create an emotional distance from the community as a way of dealing with the lack of anonymity they may experience. Coakes and Kelly (1997) have described these tensions:

[A]s a way of coping with being too close [in small communities], individuals create emotional distance, in turn exacerbating any feelings of isolation. In effect, individuals are simultaneously too close and too distant. (p. 27)

Accessibility to Transportation

Difficulty accessing transportation is a key challenge for survivors who need any type of assistance. Access to a vehicle may be difficult, as well, money to pay for the costs associated with travel (gas, food, lodging) must be available. For survivors with children and/or those who have livestock or summer crops, there are additional expenses to consider before travel, such as childcare and taking care of livestock and crops.

Survivors living in rural and remote areas may not have a valid driver's license. Not having a driver's license makes it particularly difficult for survivors such as those who have physical and/or mental disabilities, the elderly and youth to access sexual assault services. In many rural and remote areas, there is only one vehicle per family, and it is usually used by the husband to get to work (Sutherns, McPhedran & Haworth-Brockman, 2004).

In very remote communities, survivors may need to take an aircraft out, ride by snowmobile, or take a ferry/boat to access law enforcement, healthcare and sexual assault services. Weather conditions and unreliable or infrequent flight/ferry/boat schedules may restrict the ability of survivors to travel when needed. In addition, the cost of traveling is often prohibitive, particularly for repeated trips (e.g. to see counsellors, lawyers).

If available, taxi service is expensive, limited, and often does not provide much confidentiality. Some communities are serviced by a single taxi service and few drivers; using a taxi may trigger community gossip or even be an inappropriate or dangerous action to take. A lack of public transportation (trains, bus services) is common in rural and remote areas.

Lack of close proximity to friends or relatives who can provide transportation are major obstacles to individuals who need to be transported to services such as the nearest hospital, clinic, police station, emergency shelter, court, sexual assault centre, or mental health office. In addition, neighbors and relatives may not wish to "get involved" by transporting sexual assault survivors (The Oregon Story, 2006).

Some emergency shelters and sexual assault centres provide volunteer drivers to assist survivors with transportation; however, there are often insufficient drivers available to accommodate all the needs. In addition, volunteers and/or service provider organizations may not have sufficient insurance coverage to allow volunteers to drive survivors.

In rural and remote areas, the physical distance between survivors and sexual assault services (e.g. hospitals, shelters, counselling, police, lawyers, courts) may also create a psychological barrier:

The distance can create a feeling of disconnect and frustration, especially if coordinating time, transportation and money is difficult. It is an irritation and inconvenience everywhere when lawyers cancel appointments at the last minute and when court dates are changed. However, a rural woman who has spent half a day traveling for the appointment or court appearance, may not be able to come back on the new date and may decide not to seek assistance because the logistics are too complicated and expensive.

(Ontario Women's Justice Network, 2004).

Royse (1999) suggests that survivors who have to travel great distances to access forensic evidence examinations may have to suffer through considerable physical and emotional discomfort if they cannot change their clothes or shower. Traveling great distances may also increase the possibility that important evidence will be lost (e.g. samples of the perpetrator's hair, fibers from perpetrator's clothing).

Limited Telecommunications Infrastructure

Rural women must often work around limited phone service and party lines, poor cell phone reception and unstable Internet service (Ontario Women's Justice Network, 2004). Internet service is usually dial-up in rural and remote areas, as the infrastructure for high-speed internet service is frequently unavailable. Internet access through places in the community other than an individual's home is limited. Not all relevant resources are available online without cost.

Even if computers and internet access are available, many individuals living in rural and remote areas have had limited opportunities to use them, and therefore may not be skilled or may not feel comfortable using the available technology. Opportunities for public education in using computers and the internet are also limited in rural and remote areas. Accessibility to other technologies such as fax machines is also limiting to survivors who need to receive or send sensitive and private information to lawyers or other service providers.

Some homes in rural and remote areas are not equipped with telephones. Party lines are still in existence in many rural areas. Women with party lines face privacy and confidentiality issues when setting up meetings with lawyers and counselors or discussing their situation with friends and family over the phone since other parties can overhear their conversations. Women relying on cell phones for emergency help or for privacy may find them inoperative or unstable in some rural areas (Ontario Women's Justice Network, 2004).

Women researching services on the Internet may have less access due to unstable service providers and to overloaded websites. In addition to unreliable

access, safety and confidentiality when using the web are issues; women may wish to hide their Internet activity to protect their privacy or because of concerns of violence (Ontario Women's Justice Network, 2004).

Accessibility to pay telephones is difficult in rural and remote areas of Canada (International Telecommunication Union, 2002). In one study, rural focus group participants who were survivors of rape mentioned the difficulty in "even finding a public phone to call for help" as a barrier (Logan, Evans, Stevenson & Jordan, 2004, p. 599).

Telehealth refers to a means of sharing health information and providing health care services using interactive video, audio, computer, and advanced telecommunications technologies. While telehealth is currently being used in Alberta to increase the accessibility of health services to rural and remote people, its usage related to sexual assault lies primarily in the provision of telephone crisis lines to survivors of sexual violence. In cases where in-person contact is not possible, telephone counselling is also available for survivors of sexual violence in some communities.

Although there have been tremendous advances to technology within the past decade, access continues to be an issue in the delivery of telehealth service in rural and remote Alberta. Party lines are still in existence in some remote areas of Canada, and public telephone lines are not conducive to confidentiality and anonymity. Pay telephones are scarce, and cellular phone coverage is often limited or non-existent in remote areas. In Wyoming, some sexual assault crisis centres have programs where rural survivors are able to receive free cellular phones and phone service from Verizon Wireless. Unfortunately, many rural areas are still characterized by sparse or no cellular coverage.

Additionally, the protection of survivor privacy and standards of informed consent, liability, and licensing are some additional concerns that must be addressed prior to a survivor's participation in telehealth sexual assault services.

The use of videophones and video teleconferencing is more limited in its most common use in the delivery of sexual assault services to survivors; they are often used to provide further education opportunities for service providers, and is sometimes used by Sexual Assault Nurse Examiners to consult with physicians about specific types of injuries.

Rural Values

Rural and remote communities are often characterized by strong kinship ties, patriarchal beliefs, adherence to traditional gender roles, and beliefs in self-reliance and self-sufficiency (Jiwani, 1998). In a study of sexual assault in rural

areas by Neame and Heenan (1994), service providers noted the rural emphasis on self-reliance in survivors:

There's less help-seeking in rural culture - more acceptance that it is their lot in life. (p. 13)

Lack of Available Time

Particularly for female survivors of sexual assault, studies have shown that rural farm women have little time to seek and obtain help for themselves. Rural farm women play multiple roles that are essential in terms of their unpaid on-farm and household work and their paid off-farm work. A Canadian study of farm women and stress (Sealy-Duquette, 1990) found that, despite their many other activities, farm women carried the primary responsibilities for housework and childcare.

More rural than urban women work a "third shift": As a result of financial need, many farm women participate in a "first work shift" of off-farm employment and then work the "second shift" of housework and child care, often with little participation from their husband and with few community options for child care.

The "third shift" is the farm work, which these women continue to do even while employed off of the farm. These duties may include: keeping financial records, paying taxes and bills, fieldwork and farm chores. This multitude of roles and responsibilities leave rural women little time to attend to their own needs or to seek out social support (Gallagher & Delworth, 1993; cited in Mulder et al., 2002). A survey conducted of Saskatchewan farm women (Davis, 1988) reported that farm women worked, on average, 96 hours a week: 19 hours of farm work, 30 hours at household tasks, 8 hours gardening/canning, 26 hours in active childcare, 9 hours of off-farm work (41% of the cases), and 4 hours of community service.

In addition, rural women often have the responsibility of care giving for aging parents and relatives as large, extended families are more common in rural areas and family members often live in close proximity and rural cultural norms reinforce "taking care of your own" (Bushy, 1993). Care giving is often more difficult and stressful in rural areas because of the lack of available services that can be used to support home care, the distances that must often be traveled to obtain services, and financial difficulties (Mulder et al., 2002).

Approximately one half (48%) of the Saskatchewan farm women in a study by Kubik and Moore (2001) indicated having been involved in the care of someone

with a physical, emotional, or mental health problem (compared to the results of the National Population Health Survey indicating that 14% of Canadian women provide this type of care). Approximately 38% indicated they cared for a parent or parent-in-law, 10% for their husband, and 12% for a son or daughter.

Culture, Racism and Religious Influences

The combination of cultural concerns and the historic lack of culturally appropriate resources in remote areas often discourage survivors from seeking help. In Alaska, advocates report that many Alaskan Native survivors do not think it worthwhile to seek help because they recognize that there are few resources available to help them (Lewis, 2003b).

In an Australian study, Thorpe, Solomon and Dimopoulos (2004) identified the following culturally related issues as gaps and barriers preventing Aboriginal people from accessing sexual assault services:

- The lack of Aboriginal specific services as a main gap limiting sexual assault service options for survivors.
- The lack of Aboriginal staff based at mainstream sexual assault centres.
- Little or no awareness among Aboriginal communities of the existence of sexual assault centres and the nature of support they provide.
- Inappropriate mainstream service responses.
- Inappropriateness of mainstream models such as counselling/appointments, etc.
- Institutional racism.

Racism has also been identified as a barrier to Aboriginal people receiving appropriate services in rural, remote and northern areas of Canada (Hare, 1997; cited in Jiwani, 1998; Sutherns, McPhedran & Haworth-Brockman, 2004). Ethnocultural visible minority women may face racism and sexism in many aspects of their lives.

Religious and moral beliefs and expectations within communities may be a barrier to the education of residents in sexual issues and topics that may be considered taboo (Sutherns, McPhedran & Haworth-Brockman, 2004). Examples of such topics might include rape, incest, sexually transmitted diseases, contraception, abortion.

In many places, religious beliefs and church attendance are important aspects of rural community life. Just as survivors of domestic abuse may not report it to police, survivors of sexual assault may not report because of their religious beliefs.

Fear of Ostracization, Retaliation, Deportation, and other Repercussions

Some communities will ostracize survivors who report sexual assault, or retaliate against them with terror, further abuse, or impose threats upon other family members. As discussed by Jiwani (1998), in small rural communities any challenges to predominating values (such as patriarchy) may be cause for considerable reprisals, backlash and denial. Survivors who report sexual assault and/or want to access sexual assault services sometimes have no other option but to leave the community which often includes their family, relatives and friends.

In one study, focus groups of rural survivors suggested that backlash from the community and family were major barriers to the use of formal services to help them cope with the aftermath of rape (Logan, Evans, Stevenson & Jordan, 2004). This backlash is described by several survivors: "There is always disapproval, especially in this part of the country, for anyone stirring up trouble"; "People will say, 'Why are you trying to hurt that good old boy?'" and "Because of the backlash from other family members that would follow, so those incidents are kept quiet out of fear of the family's reaction and the shame it would bring to the family." (p. 601)

Immigrant women are often threatened into silence by their abusers (e.g. spouses, sponsors, employers) of deportation or of deporting their children. Immigrant or refugee survivors who are not Canadian citizens ("non-status") and are living in the country illegally cannot call the police in an emergency without putting themselves at risk of deportation. Roboubi and Bowles (1995) suggest that ethnocultural minority women (i.e., live-in domestic workers) are particularly vulnerable to sexual abuse and harassment.

Employers' threats of deportation, their economic dependency, and a lack of awareness about their rights, etc., silence these women. Police in Canada do have authority to arrest or detain illegal immigrants on behalf of Immigration Canada.

The fear of reprisals from the survivor's family and community has been identified as a major barrier to the accessibility of sexual assault services to Aboriginal peoples in Canada, the United States and Australia.

(Keel, 2004; Steart, Huntley & Blaney, 2001; Thorpe, Solomon & Dimopoulos)

Denial

Experiencing sexual assault can have a severe impact on immigrant or minority women, especially if their culture places a high value on virginity, chastity and fidelity. They may be stigmatized by their families or communities despite being the victim of unwanted sexual conduct (Roboubi & Bowles, 1995).

Limited Options for Legal Representation

In rural and remote areas, there are often limited options for legal representation. As described by the Ontario Women's Justice Network (2004):

A smaller community means a smaller pool of lawyers. Where no lawyers are available locally, a lawyer may only come into town for specific days each week or month. Traveling to a lawyer's office can be problematic because of limited transportation resources or distance. An additional challenge is the potential of a conflict of interest if the only lawyer in the community knows the abuser or has already worked for him in the past.

Finding a lawyer or having a Crown Attorney with a real and gendered understanding of violence against women is problematic regardless of geography and can be a frustrating and serious barrier to justice. Few lawyers are familiar with First Nations issues, including relevant legislation such as the Indian Act, and its impact on women fleeing an abusive relationship. Women married to military men, too, face unique legal challenges that are often not understood by the law, court processes and lawyers.

In her study of rural women and violence within two communities in British Columbia, Jiwani (1998) elaborates on the problems faced by women living on a military base. Her research found that service providers in one rural area indicated that women living on the military base near their community received inadequate support from the Military Police. As the military base does not fall under the jurisdiction of the RCMP, disclosure of violence does not help to protect the woman or help them to leave the relationship. Jiwani also found that military wives often did not seek help because of the belief that their husbands' careers would be destroyed if violence was disclosed.

Low Rates of Prosecution

Focus groups of rural survivors of rape in one study conveyed the view that there is no justice for survivors of rape (Logan, Evans, Stevenson & Jordan, 2004). One

of the rural women suggested that even when women do press charges, "the perpetrator gets a slap on the wrist" (p.606). Participants believed this to be true especially if the perpetrator knows somebody in the court system or is a prominent figure in the community.

Privacy and Confidentiality Issues

It is often substantially more difficult for survivors in rural and remote areas to maintain anonymity than when in urban areas. In urban areas, the sheer number of people as well as the availability of multiple service providers helps individuals to maintain privacy.

(Ontario Women's Justice Network, 2004)

The possibility of having to sit in a waiting room that may be occupied by neighbors, relatives, or other community members may deter or prevent survivors from seeking or receiving appropriate help.

When service providers are (or are potentially) acquaintances of family members of the survivor or the perpetrator, concerns related to confidentiality are valid (Ontario Women's Justice Network, 2004; Sutherns, McPhedran & Haworth-Brockman, 2004). Some agencies have conflict of interest policies that prohibit them from offering services to family members, which can result in some individuals having no local access to services they require (Ontario Women's Justice Network, 2004).

Survivors are often hesitant to make use of services such as sexual assault centres, hospital emergency rooms, or shelters for fear of having their vehicles recognized and subsequently facing public exposure, social ostracization or retaliation by the perpetrator. Maintaining privacy during a trial may be difficult, and may be a safety issue if the perpetrator knows when the survivor will be at the courthouse.

Survivors may not report sexual assault for fear that their personal history will be "put on trial" through the release of their personal records to the accused (Community Coordination for Women's Safety, 2002b). Focus groups conducted with rural survivors of rape in one study suggested that the fear of the whole town "knowing their business" was a barrier to the utilization of formal services to help survivors cope with the aftermath of rape (Logan, Evans, Stevenson & Jordan, 2004, p. 602). Participants in the study explained that "hospital staff, social workers, and police would gossip about their situations and then the whole community would know what happened to them" (p. 602).

Availability of Weapons

Increased availability of weapons such as firearms and knives common in rural households increases the risks and lethality of attacks upon rural women (Johnson, 2000).

Lack of Awareness/Information/Knowledge

In rural and remote areas, public education about sexual violence and available support services (such as advocacy and court accompaniment) is often inadequate or non-existent. A study of rural and urban survivors and rape indicated that because of the associated stigma, the topic of rape was not openly discussed in their communities, thus resources for coping with rape were not discussed (Logan, Evans, Stevenson & Jordan, 2004). One participant explained:

All my mother ever told me is that women should not be alone in the dark because something will happen that is worse than death...but she never even used the word rape. (p. 598)

In areas where there is resistance to education about sexual violence, non-traditional methods of delivering information and creating awareness have been used. Such methods include: offering information through workshops at community centres or churches, placing informational pamphlets in grocery bags, having informal discussions at events such as craft clubs (knitting, quilting), setting up displays or information booths in non-threatening venues (at the farmer's market, trade/agricultural fairs, libraries, literacy groups, women's centres, winter carnivals, summer festivals), and having fund-raising events for sexual assault service provision (bake sales, fall suppers, community dances, raffles).

In a study of farm women conducted in rural Saskatchewan, Kubik and Moore (2001) reported that a considerable number (41%) of the women indicated that they were not aware of the availability and accessibility of support services in their community for personal, social, or financial problems.

Service Provider Incompetence

Focus groups of rural and urban survivors of rape in one study suggested the incompetence of medical professionals, advocates and crisis line counsellors as being a major problem (Logan, Evans, Stevenson & Jordan, 2004). Participants indicated that hospital staff did not always know the procedures for the rape examination, which makes the experience "even more uncomfortable and negative" (p. 599).

In a study of Rural, Remote and Northern Women's Health (Sutherns, McPhedran & Haworth-Brockman, 2004), the quality of physicians was identified as being problematic.

Rural women identified physicians as having a lack of knowledge of women's health issues, being too insensitive, having stereotypical attitudes towards women, and being patronizing towards rural women. In addition, many found it difficult to discuss sensitive issues with physicians who they were socially familiar with.

Lack of Sensitivity and Revictimization

In rural and remote areas, paying attention to the quality of care may be as important as the type of sexual assault services available. As identified in the literature, people living in rural and remote areas are often suspicious of outside help, and may not seek help if they have had poor experiences previously or believe that the experience and outcomes will be negative.

Rural and urban survivors of rape in a focus group study suggested that professionals in health and mental health service agencies needed to be more sensitive toward survivors of rape (Logan, Evans, Stevenson & Jordan, 2004). Some of the relevant comments included: "They can be cruel," "They don't really focus on what you need," "It's a very uncomfortable feel," "It's difficult for a rape survivor to be treated at a hospital because the wait is extremely long. A women has to sit there for hours and hours, but she can't take a shower, go to the bathroom, smoke, or chew gum because they have to protect any evidence," and "You go to the hospital and it is so stark and clinical, you feel like you are being violated all over again" (p. 601). In the same study, it was mentioned that the court process and procedures of the prosecution (e.g. continually having to recount details of the rape) contribute to women's feelings of being revictimized.

Limited Sexual Assault Service Availability

Focus groups of rural and urban survivors of rape conducted by Logan, Evans, Stevenson and Jordan (2005) found that both rural and urban participants noted the lack of services in their community as a problem. Many of the participants from the rural areas mentioned that some of the specialized victim services had limited hours. One participant commented: "Things like this don't happen from 9 to 5, so women often find themselves with no where to run and no one to call" (p. 595).

Rural participants in the same study mentioned that the immediate availability of the advocate, long wait times to see a mental health counsellor, and the time spent with the counsellor once an appointment was obtained were additional barriers. Rural participants in one group indicated that while police in rural areas will respond, it often takes hours before they arrive. The women attributed the slow response time to the low priority of rape or violence against women to police, and to the shortage of police officers responsible for large geographic areas.

Women in the rural focus group also mentioned that without the availability of other appropriate resources that would enable them to leave a violent relationship (such as transportation and housing), they believed that seeking and using other services to cope with the violence was not likely to be helpful.

Lower Literacy Levels

Rural and remote areas often have lower levels of educational attainment and literacy than urban areas (Sutherns, McPhedran & Haworth-Brockman, 2004). Thus, traditional methods of providing information such as crisis lines, sexual assault information, and other service provider information through pamphlets and posters may not be as effective as in urban areas. Information is only accessible if it is easy to understand and easily applied (Sutherns, McPhedran & Haworth-Brockman).

For survivors with a non-English speaking or reading background, there are particular difficulties in creating awareness of sexual assault and the sexual assault services available.

Inability to Speak English

Sexual assault survivors from non-English speaking backgrounds (often abbreviated as NESB) are particularly disadvantaged in their ability to report sexual violence and access adequate sexual assault services. In a comprehensive document, Lievore (2003) discusses the findings related to non-English speaking women and the barriers to reporting sexual assault. In qualitative studies, non-English speaking women have identified shame and fear as the primary barriers to reporting sexual assault. The information in the remainder of this section is credited to Lievore's findings.

A number of secondary barriers have been identified by researchers in Canada, Britain and Australia. Lievore has organized these into four categories: personal, cultural and religious, informational/language, and institutional/structural.

Personal Barriers

Many non-English speaking women are socially, culturally and linguistically isolated.

- Isolation increases vulnerability to sexual assault and inhibits reporting.
- Disclosure of sexual assault causes personal shame and may bring dishonour to the family. Survivors may believe that disclosure will be viewed as evidence of their failure as wives.
- Reporting is inhibited by fear, which has a number of aspects: fear of reprisal and escalating violence; fear of deportation and loneliness; fear of inadequate social and financial support; fear of victim blaming and disbelief; fear of losing custody of children.
- Lack of self-esteem and confidence, feeling trapped due to family and financial responsibilities, and economic dependence upon abusers also inhibit reporting.

Cultural and Religious Barriers

- Sexual assault is viewed differently by cultural groups and by different members of these groups.
- Some ethnic communities are small and male-dominated. Community leaders may deny that sexual assault is a problem or minimize it.
- Men often hold undisputed authority over household members. The notion of marital rape does not exist in cultures in which women “belong” to their husbands. Sexual assault is sometimes understood as entailing vaginal penetration and/or physical violence. A woman may not regard herself as having been sexually assaulted if neither of these has occurred, or if the aftermath does not fit the perception that the damage is primarily physical.
- The primacy of the family, the permanence of marriage and the privacy of family matters are fundamental cultural and religious values in many ethnic groups. Informal resolution mechanisms within the extended family, the church, or the community are often the preferred way of dealing with sexual assault, and women may be advised to remain in the family.
- Sexual violence is often not disclosed to family or friends, let alone to police or other outsiders. Some cultures believe that women can avoid sexual victimization by not putting themselves in situations where they are at risk.

- In some strongly patriarchal societies, women's sexual reputations are highly prized. Married women who reveal that they have been sexually assaulted may be viewed as criticizing their husbands or betraying community values. Unmarried women may jeopardize their chances of a good marriage.

Informational/Language Barriers

Immigrant women may find it more difficult than other women to access information about sexual assault, family law, their immigration status, their eligibility for assistance or their sponsor relationship.

Women who are sponsored as spouses or fiancées are usually dependent on their sponsors for residency. Perpetrators who are sponsors may deny women access to knowledge about legal rights and options, resources and services, or misinform survivors about their rights and the likelihood of deportation if the relationship breaks down.

Police and lawyers may fail to fully inform survivors of their rights, the legal process, and its outcome. Migrant and refugee women therefore perceive the criminal justice system as discriminatory and insensitive to their needs. The belief that the odds are stacked against them causes some to abandon further action.

Institutional/Structural Barriers

Structural and institutional barriers to reporting include migrant women's prior experiences with authorities, the ethnocentric nature of the criminal justice system. Ethnic, racial and sexist stereotypes are often accepted and perpetuated by the criminal justice system. Police, lawyers and judges often question the intelligence and credibility of women with poor language skills, and these women often fear and lack trust in police and other authorities.

Some women who are of a non-English speaking background are disadvantaged in the courtroom because of lack of cultural understanding. Some cultures have prohibitions against eye contact between men and women, but the complainant's respect for the court and the credibility of her evidence may be questioned if she fails to establish eye contact with prosecutors and judges.

Lack of Related Support Services

Support services related to sexual assault services are often limited or non-existent in rural and remote areas. For example, survivors who do not speak English, or who are not able to read and write in English require the assistance of

translators and interpreters to obtain medical and other appropriate and adequate types of assistance.

Distrust, Fear and Suspicion of Human Services

People living in rural and remote areas tend to have a strong belief in relying on the family for problem-solving, even when the family is dysfunctional. In addition, there is mistrust and suspicion of ideas and/or practices that they view as being urban in nature (Fuller, Edwards, Procter & Moss, 2000). This includes human services, especially services like crisis centres and shelters (Erhart, 2006).

Some survivors living in rural and remote areas are fearful of attempting to access sexual assault services in larger centres. Accessing basic or specialized sexual assault services, social service resources, law enforcement, legal resources, and employment resources can seem and can be complex and confusing for survivors (Erhart, 2006).

Work-Related Issues

Many rural and remote areas are characterized by high rates of seasonal employment. Survivors cannot leave to receive specialized services during the working period, and some put off seeking services until it becomes urgent (Sutherns, McPhedran & Haworth-Brockman, 2004).

In rural and remote areas, there are limited employment opportunities for women; therefore, women are often more dependent on men (i.e. fathers, husbands, partners). Such contexts might increase the likelihood that intimate partner sexual violence and family sexual violence (e.g. rape of children, rape of siblings) may occur. Many rural and remote areas are characterized by high rates of seasonal employment. Survivors living in rural and remote areas who are sexually assaulted by someone to whom they have become acquainted at or through their workplace often face greater challenges than their counterparts living in urban areas:

- Alternative employment opportunities are often scarce or not as available as in urban areas. Consequently, survivors may decide not to report sexual violence for fear of losing their job.
- Survivors who own their own business (or are part of a family business) may not report sexual violence if doing so will jeopardize the reputation and future success of the business.

- For survivors who are assaulted by their spouse or partner, business ownership creates a great dilemma for those who wish to leave. They may have to leave behind their home, community, animals, business assets, and their job. If, as a farm partner, the spouse is not paid a wage, he/she cannot apply to receive unemployment insurance benefits and may be ineligible for welfare (if "the system" determines that he/she has access to business assets).
- For survivors who live on a farm, but wish to access sexual assault services, arrangements must be made to take care of children, farm animals, family pets, crops, and other farm/household obligations.

The educational and occupational choices made by rural women are often a result of the strong socio-cultural emphasis on marriage and motherhood that is commonly observed in rural and remote communities. Their opportunities for employment are therefore limited in comparison to those who live in urban areas (Rowley, 1995).

Lack of Education, Skills and Opportunities

Survivors of sexual assault who live in rural and remote areas have fewer opportunities than urban survivors for advanced education and training. Therefore, they are usually less skilled, have fewer job opportunities, and have less opportunity for advancement within jobs.

Survivors may not be able to take time off of work to receive sexual assault services, and may fear losing their job if the employer is not supportive of the survivor obtaining those services during work hours.

Lack of Health Insurance

Although Canadians enjoy universal coverage for most health services, financial barriers remain important. Many services are only partially insured or not at all, including prescription drugs and fees arising from ambulance transportation, hospital expenses and other services. For survivors requiring psychiatric treatment or private psychological services, there are often fees associated with receiving treatment.

A large percentage of rural residents are employed in small business or are self-employed, and are more likely than urban dwellers to have only "catastrophic" insurance coverage, which lacks behavioral health benefits (Mulder et al., 2002). In addition, some employee assistance programs (EAPs) have restrictions on where employees can access mental health services which are covered under the corresponding insurance plan.

While sexual assault forensic examinations (rape kits) completed in Alberta are covered under Alberta Health Care, there is a charge for survivors who are not landed immigrants or those who do not possess legal documentation of being a resident of Canada.

Perceptions of Service Affordability

In a study examining the barriers to services for rural and urban survivors of rape, survivors in both rural and urban focus groups identified the cost of services (including seeing a psychiatrist for therapy and prescriptions drugs) to be unaffordable (Logan, Evans, Stevenson & Jordan, 2005). Even if it was untrue, the survivors felt that "(t)here aren't many services out there if you don't have insurance" (p. 595).

Challenges to the Provision of Sexual Assault Services

All of the barriers to survivors in reporting and accessing sexual assault services are considered to be barriers to the provision of sexual assault services in rural and remote areas, as most services cannot be provided to adult survivors who do not self-identify and indicate their willingness to receive sexual assault services.

The following have been identified in the literature as possible challenges to the effective planning, operation and delivery of sexual assault services in rural and remote areas:

- Insufficient funding for rural services
- Safety issues and burnout of sexual assault workers
- High staff turnover
- Retractions of sexual assault disclosures
- Lack of access to specialized treatment and diagnostic resources
- Lack of other specialized service providers
- Public scrutiny of service providers
- Geographical isolation
- Limited telecommunications
- Turf wars and service provider resistance to change
- Concentration of authority
- Concerns with law enforcement
- Problems with the criminal justice system
- Delayed court proceedings
- Ideological loneliness of service providers
- Denial of existence of sexual assault by service providers
- Denial of existence of sexual assault by community residents

Insufficient Funding for Rural Services

Setting up and offering sexual assault services in a rural or remote area entails costs that are not generally encountered in urban settings.

Rural and remote areas must frequently compete with urban areas for sexual assault service funding (Lewis, 2003a). Under per capita funding formulas that may work well for urban areas, rural communities can find it difficult to obtain

sufficient funding to maintain a minimum level of services (MLA Steering Committee Report on Rural Development, 2004).

Generally speaking, the time and money required to respond to and process a sexual assault case in a rural or remote area is greater than that for an urban case. Cases in remote areas may require travel (by plane, ferry, boat, bus, car) on the part of survivors, law enforcement, advocates, survivors, and other service providers. Thus, rural service providers (e.g. advocates) are not as likely to process as many cases as their urban counterparts because the number of hours available for face-to-face contact is reduced by the number of hours spent travelling to different locations (Neame & Heenan, 2004). This is a major issue since the amount of funding received is often based on the absolute number of victimizations reported, and not on the per capita rates of sexual assault (Ruback & Maynard, 2001; cited in Lewis, 2003b).

There are also increased costs in sustaining service provider networks; obtaining and maintaining levels of sexual assault training, and for attracting and keeping qualified, experienced staff (Neame & Heenan, 2004). Regular opportunities for professional development through training workshops and conferences for advocates and service providers are typically more costly than in urban areas since transportation, meals and accommodation must be provided.

Attendance by service providers at training and professional development activities is also likely to impact rural areas more. Service providers who are receiving training and education are not able to provide direct service during that time. This may be especially problematic if several service providers in the community wish to attend the same workshop or conference.

Safety Issues and Burnout of Sexual Assault Workers

In rural and remote areas, there may be only one individual who is responsible for delivering sexual assault services such as counselling and court support.

This may pose safety concerns and a great deal of stress and anxiety for the worker. Rural sexual assault workers in the study conducted by Neame and Heenan (2004) described how they were sometimes personally targeted by members of the community and subjected to abuse in the street:

It is also extremely hard for workers in a rural area as it is known where you work so you are constantly asked about matters that happen or you are a more ready target for a perpetrator to access if the perpetrator wants to target someone. (p. 18)

Child welfare workers, police and community mental health personnel in most urban agencies can do their jobs and at the same time, manage to maintain a separate and private, personal life. However, lone sexual assault counsellors living in rural and remote areas may experience burnout from high caseloads, always being "on call" to survivors, having to travel to various rural areas on poor roads and under sometimes poor weather conditions, and having to constantly juggle the boundary between their work and personal lives (Neame & Heenan, 1998).

The separation of work life and personal life can be difficult to maintain in rural locations. As discussed by Trute, Adkins and MacDonald (1994), professional life in farming communities and small town settings can easily overlap with ones social life, participation in community activities, or local shopping excursions. Consequently, clear professional boundaries are more difficult to define and maintain. Being identified as someone who is mandated to investigate crime and uphold the law (such as a child protection worker or a police officer) can also create social isolation from neighbours in a rural community. Serving in a professional role may therefore translate into a lonely existence.

Furthermore, many rural human service workers can find themselves isolated from other professionals for long periods of time. Trute, Adkins and MacDonald (1994) suggest that there can be long periods in which there is little stimulation, access to meaningful practice supervision, or availability of continuing education for rural practitioners. The "social loneliness, paucity of important professional resources, and unrelenting work stress in rural settings can heighten the risk of professional burnout" (p. 19).

In rural and remote communities with limited services and programs, there is also a higher level of social expectation that local women will participate in organizing community services and events. Women know that if they don't get involved (e.g. as a survivor advocate or organizer of services), services often won't be available. The pressure of having to be involved in multiple volunteer activities is stressful and often leads to burnout. This is identified by a participant in the Rural, Remote and Northern Women's Health study conducted by Sutherns, McPhedran and Haworth-Brockman (2004):

It's true. Especially in minority environments, there is a large need for volunteers. And even then, volunteers aren't considered important. And three quarters of the time, it's women that lead these organizations. If I look at the fundraising that they have done to build the nursing home here, three quarters of the people on the committee were women who were working for that.

Many things, networks, all the churches, the well-being committees and many other things, it's all women who are members of these organizations to help these charities. For a community that works a lot on volunteers and their

involvement, it's even harder for the women of these rural regions because they know that if they don't get involved, it means that there won't be any services. And to do fundraising in rural regions, it's much more difficult. (p. F29)

High Staff Turnover

Rural and remote areas are often characterized by high staff turnover. Some of the turnover is related to the very heavy workloads common to human service professionals working in rural and remote areas.

Attracting high-quality, experienced staff to work in rural and remote areas is difficult, and frequent replacements may be costly to the organization (e.g. advertising the position through various media and in multiple places, costs associated with interviewing, training). In addition, high staff turnover sometimes interferes with the quality of services (such as counselling) delivered to clients, as the development of trusting therapeutic relationships occurs over time.

Retractions of Disclosures

In some rural areas, a significant portion of survivors may retract their previous disclosures, thus halting criminal investigations. This may be due to excessive pressure placed upon the survivor by members of the community. Phillips and Hornick (1992) describe an example of this in an Aboriginal community:

The Blackfoot Reserve is a small community composed of a large network of extended families. There is a great deal of gossiping and people are very concerned about how they, and their extended family, are viewed by the rest of the community. Children are thus influenced by nuclear and extended family members' reactions to their disclosures of abuse incidents. If reactions are not supportive of the child's story, the child seemed to feel a considerable amount of pressure to retract the allegation. (p. 39)

Lack of Access to Specialized Treatment and Diagnostic Resources

In rural and remote areas, there is often a shortage or lack of accessible resources such as specialized sexual assault counselling for children, adolescents and adults. They rarely have formal child sexual abuse teams and/or specialized sexual assault crimes units (Phillips & Hornick, 1992). There are often no services for perpetrators who are adults or young offenders (Nuffield, 2003).

There may be limited accessibility to diagnostic instruments, or service providers may not be trained in the proper use of such instruments. There is often a very

limited medical library or availability of specialized medical or psychiatric information, and internet access to specialized databases is not always accessible.

In such cases, service providers such as social workers, mental health counsellors, physicians, and police may have to use a generalist approach and be able to provide a range of assessment and counselling interventions. As described by Phillips and Hornick (1992):

"Victims and their families in Bassano had to drive over 150 kilometres [sic] to Calgary to receive counselling treatment. This, of course, leaves the rural worker with a greater responsibility to provide support and counselling following the initial investigation. In Bassano, the RCMP and child welfare workers work well together preparing child workers for court and keeping victims' families up-to-date on the status of investigations." (p. 36)

Lack of Other Specialized Service Providers

The lack of other specialized service providers to collaborate with in rural and remote areas makes it difficult to form organized groups such as Sexual Assault Response Teams. Some rural and remote communities are fortunate to have a lone sexual assault worker, a police officer, and a public health nurse to form their team.

Alternatively, urban areas may collaborate with numerous organizations including: transition houses, women's shelters, legal aid, substance abuse commissions, mental health, colleges, universities, prosecutors, correctional agencies, forensic examiners, and domestic violence agencies, law enforcement, victims' services hospitals and community and social service providers.

Public Scrutiny of Service Providers

Rural service providers are frequently subjected to tremendous stress regarding decisions that will affect their client. This stress is even greater when service providers must provide services to families they know well or to whom they are related (Phillips & Hornick, 1992). Decisions made by service providers such as child welfare workers are often open to public scrutiny in rural areas - for example, decisions that involve removing children from their family if the perpetrator is a family member.

In rural areas, confidentiality of private personal matters is seen to need special protection. Human service professionals such must often take extreme caution to maintain client confidentiality, for if they are identified in the community as people

who let private matters become known to others, they will quickly lose their credibility and their clients.

Professionals who are sensitive to the privacy elements of 'small town culture', may doubt whether they should release sensitive client information to other professionals (even to an agency that has referred a client directly to them). This can result in interagency distrust and hostility, and can also lead to the hoarding of clients or a hesitancy to make necessary referrals to other appropriate agencies (Trute, Adkins & McDonald, 1994).

Thus, as described by Trute, Adkins and McDonald (1994), "professionals can feel trapped in a service double bind: they either risk leaks in confidentiality, which will cause clients to stay away; or they risk withholding service information, which can alienate allied agencies and weaken collaborative, comprehensive services for their clients" (p. 20).

Geographical Isolation

In some cases, the distance between survivors and the offices of child welfare workers, police and crown prosecutors present problems in enabling survivors (and guardians) to meet prior to scheduled hearings or trials. This may reduce the degree of preparation for cases by the court and survivors (Phillips & Hornick, 1992).

Response time for law enforcement is often longer, as police must often travel to areas with poor roads, and to homes that do not have clear location addresses. In addition, police must travel longer distances to collect DNA evidence such as hair, semen, saliva (from cigarette butts, chewing gum, drinking cups), skin cells, tissue, urine, vomit, etc. from the place the crime was committed. Evidence from the scene of the crime such as fingerprints, presence of "rape" drugs, torn clothing or blood stained clothing can also be used to support a survivor's claim that the crime was non-consensual.

Most drugs used for rape are metabolized out of the blood and urine so quickly that it is rare to obtain a positive blood or urine drug screen (Gotier, 1999). This is a substantial barrier to evidence collection for survivors that have to travel long distances before having a rape kit completed.

In a study conducted for the Department of Justice Canada, geography was identified as a primary cost driver in the provision of legal services to residents of Northern Canada (De Jong, 2003). High costs were associated with travel and accommodation for counsel, for flying in expert witnesses, and for increased costs related to the provision of other legal services.

Limited Telecommunications

Limited telecommunications infrastructure in rural and remote areas can interfere with communication and collaboration of service providers. In Alaska, internet service provision is often offered in the larger centres. De Jong (2003) also reported that a lack of support infrastructure for legal services providers (such as a lack of telephones and internet access) was experienced in Nunuvut, the Northwest Territories and the Yukon.

Turf Wars and Service Provider Resistance to Change

Two related barriers that often prevent agencies from working together to provide a continuum of sexual assault services are turf wars and service provider resistance to change.

In order for collaboration and interagency coordination to be most effective, all participating agencies and their respective service providers (police, victim's services, prosecutors, courts, social service agencies, therapeutic agencies, hospitals, clinics, etc.) must stop turf wars and commit themselves to shared and open collaboration.

Uncertainties and resistances of existing service providers to new ideas and approaches must be overcome. Unlike urban areas that may be able to replace service providers and professionals who are resistant to teamwork, agencies in rural and remote communities must take care and spend time in cultivating and consolidating support at the senior administrative levels (local, regional, and provincial political levels) of all agencies involved (Trute, Adkins, & McDonald, 1994).

Concentration of Authority

In rural and remote areas of Canada, basic human-sector services (e.g. child welfare, community mental health, the courts) do not employ large numbers of people. Rather, they are also usually managed locally by a few individuals in key positions who can hold strategic importance for setting service priorities and policies. This may be beneficial in decision-making and may facilitate easier collaboration between the few actors holding program authority. However, it also makes some communities "prisoners of the idiosyncracies of individual leadership and vulnerable to inflexible decision-making" (Trute, Adkins & McDonald, 1994). Trute, Adkins and McDonald provide the following to exemplify the potential effects of this:

For example, if the area has only one judge who presides in criminal courts, and that judge opposes changes in regular court procedures (such as

alternative sentencing), it can bog down attempts to integrate family treatment with perpetrator sentencing in cases such as those involving father-daughter incest.

Or, if a director of the local mental health service takes a conservative and narrow stance on what services should be delivered by his or her staff (e.g. hold the line on the operating budget), or if he or she only allows travel in the rural area for the provision of direct or face-to-face service to clients, this will effectively block any attempts to have community mental health workers participate in interagency professional meetings (which usually do not involve any direct contact with a client).

This in turn can disable attempts to involve a community mental health program in a coordinated service system. Depending on the intransigence of such people in authority and the scope of the influence in the community-service response to child sexual abuse, their impact on coordinated services can vary greatly. It can be either a blessing or a curse to have decision-making consolidated in the hands of so few key authorities.

Concerns with Law Enforcement

The relationship with rural advocates with local law enforcement has been identified as being critical to service delivery, as in many cases the police are the first to respond to reports of sexual assault. Rural police often work in isolation; small police stations may be understaffed, leading to long delays in responding to survivors' requests for help (Wendt, Taylor & Kennedy, 2002).

In some remote areas of Canada where individuals or families may live in isolation many hours away from a community or RCMP detachment, immediate response is difficult and influenced by factors such as accessibility (by ground, air, water), weather conditions, and availability of officers. This often results in the delayed accessibility to sexual assault services. Few rural areas have female law enforcement officers, yet some research indicates that female officers are preferred when dealing with survivors of sexual offences or domestic violence (Blok & Brown, 2006).

In many rural and remote areas, police play an important community relations role. Rural police often respond to calls for assistance with a more personal, social approach than urban police - which can be beneficial and comforting to members of the community. Such closeness, however, can be uncomfortable and confidentiality may be a genuine concern if the police knows the survivor and/or perpetrator (Lewis, 2003b).

Within the Canadian sexual assault literature, there were few references made to difficulties encountered by providers of sexual assault service with law

enforcement officials. Two issues were identified in Canadian reports regarding possible difficulties that may be encountered with rural law enforcement:

- Some rural police officers may be perpetrators of violence and/or sexual violence themselves (Ontario Women's Justice Network, 2004); their response to survivors' calls for help may be inappropriate or even dangerous.
- Some rural police do not intervene in cases involving violence and women in relationships. Instead, they tend to offer mediation and other alternative dispute resolution strategies (Bell, 1985, 1989; cited in Jiwani, 1998).

Lewis (2003b) indicates that in some rural areas of the United States, "the police have been quite problematic for sexual assault advocates" (p. 17). Some of these issues include:

- Some rural police have been perceived as being very conservative or negative, exhibiting behavior that often serves to revictimize the survivor;
- Some rural police do not exhibit culturally sensitive behaviors; they may not always understand or be respectful of the ways in which people of different cultural backgrounds communicate;
- Some rural police do not take sexual assault seriously, and therefore may not respond in appropriate ways;
- In some rural communities, "police haven't lived up to moral standards". Some police have been involved in embezzlement, drug abuse, domestic violence and sexual assault. "While such complaints may also be true of urban police, the greater level of familiarity within rural communities and the generally smaller size of rural police departments means that community residents would likely know of the improprieties and be concerned about finding sensitivity and fairness";
- In some rural areas with a high turnover of law enforcement officers, it is difficult to maintain having officers who are trained in sexual assault response;
- In some rural areas, there is a lack of sexual assault awareness and experience among law enforcement officers. Some officers have little knowledge of how to process sexual assault cases or the statutes that apply .

Problems with the Criminal Justice System

The majority of sexual assault cases are not reported; only a handful of those reported are ever caught, tried, or imprisoned. This sends a message to communities that sexual assault is not a serious crime. Such a message can

influence how rural communities respond to reports of sexual assault and how they respond to community outreach. The legal process is often so drawn out and complex that survivors do not complete the process. As well, survivors report the legal process often serves to revictimize them (e.g. by making them provide details of the assault over and over again).

In writing about the dynamics of sexual assault and the criminal justice system, Archambault (1999, p. 127) suggests:

Many law enforcement officers, attorneys, prosecutors and even judges have privately stated that if they or a loved one were sexually assaulted, they would not use the criminal justice system.

A system that would not be used by the very people who administer it needs to change its response to the problem it attempts to solve.

There is also a possibility that some individuals within the criminal justice system may be perpetrators themselves. On May 20, 1992, Judge David Lanier was indicted on eleven counts of sexual assault, which he committed in a rural area of western Tennessee. Before federal authorities took over the investigation, local authorities had had difficulty pressing charges, as the District Attorney for the rural area was the brother of Judge Lanier. Lanier received the maximum prison sentence of 25 years and was fined \$25,000 (U.S. Department of Justice, 2006).

Delayed Court Proceedings

The Alberta Victims of Crime Consultation acknowledges that the traditional justice system is often slow, ineffective, and re-victimizes survivors. Survivors are often left out of the justice process and are not heard (Alberta Solicitor General, 2002).

Phillips and Hornick (1992, p. 39) describe the possible effects of delayed court proceedings in rural communities:

In the native communities perpetrators were often sanctioned by the community long before their cases went before the court, and by the time the hearing took place, the situation had lost importance to members of the community. Previously cooperative witnesses often failed to appear, or refused to testify, and victim/witnesses lost their motivation to proceed.

Ideological Loneliness of Sexual Assault Service Providers

When writing of their experiences with the coordination of child sexual assault services in rural Manitoba, researchers Trute, Adkins and McDonald (1994) identified "ideological loneliness" as being a challenge to rural sexual assault workers. As they describe this phenomenon:

It is not uncommon for professionals to find themselves wrestling with the widespread belief that child sexual abuse is a rare phenomenon that involves what is often considered deranged or allegedly deviant perpetrators. It is not uncommon for professionals dealing with allegations of child sexual abuse to find minimization and misinformation operating in such important sectors of the rural community as churches or service clubs. While these practitioners can more easily find and associate with 'kindred spirits' in urban settings, those who work directly with child sexual abuse in rural communities often report a 'wall of denial that pervades community life and that can erode one's energy and convictions.

Most professionals working in child abuse services recognize that inherent in the widespread family violence that pervades our society is an adherence to 'patriarchal belief systems' that perpetuate attacks on the person and bodies of women and children. In rural communities that tend toward political and religious conservatism, there is a heightened presence of such patriarchal attitudes and authoritarianism, particularly as these relate to male domination and sexist values and to family roles and responsibilities. When one works in the child sexual abuse fields, it is essential that there is a heightened awareness of ones' own values and beliefs about patriarchy, gender roles, sexuality and violence. These can create additional work-related stressors for rural practitioners who are attempting to reduce and treat child sexual abuse, particularly those who feel surrounded by a destructive and distorted community ideology and who feel alone in their struggle to cope with it. (p. 20-21)

Denial of Existence of Sexual Assault by Service Providers

The denial of the existence of sexual assault in rural and remote communities is often deep and difficult to change. Alston (1997) suggests that psychological, social, financial, and emotional abuse against women are so embedded in rural cultures that they are often not recognized by many citizens, including professionals.

The denial is sometimes so entrenched that social service providers and healthcare providers have subscribed to the belief that sexual assault is nonexistent or rare in rural areas:

A GP said to me once that he'd worked here for 25 years, and prior to my coming [to the region] there just hadn't been any sexual assault.

(Neane & Heenan, 2004)

Also, as discussed in a previous section, some members of rural law enforcement do not view sexual assault as a serious crime, and therefore do not respond appropriately.

Denial of Existence of Sexual Assault by Community Residents

As discussed previously, the stigma associated with sexual assault is partially responsible for individuals' decisions not to disclose sexual assault. Stigma is also related to the denial of residents living in many rural and remote communities that sexual assault exists.

Widespread denial makes it difficult for clinicians, mental health workers, social workers, parents, and other community members to recognize that sexual assault has occurred or is continuing to take place. The denial and the associated lack of disclosure imposes constraints on the ability of service providers to provide essential treatment. Funding for sexual assault services is often based on user statistics; if demand for sexual assault services is low, the assumption is frequently that services are not required.

Sexual Assault Programs and Services in Rural Areas

The sexual assault programs and services available in rural areas varies widely, but is typically limited or non-existent. The following chart illustrates the types of sexual assault services that might typically be available in large, urban areas compared with those that might typically be available in rural and remote areas within Canada and the United States:

URBAN AREAS	RURAL AREAS	ISOLATED AND REMOTE RURAL AREAS
<ul style="list-style-type: none"> ▪ Advocacy (Information and/or referrals) ▪ Assistance with Compensation Forms ▪ Counseling and Case Management ▪ Criminal Justice Support (court accompaniment) ▪ Crisis Hot Line ▪ Drop-in Centres for Survivor Support ▪ Emergency Financial Assistance ▪ Emergency Housing (Shelters) ▪ Employment Referrals ▪ Family and Community Social Services in Alberta ▪ Family Counselling and Support ▪ Food Pantry/Bank ▪ Hospital Emergency Room ▪ Hospital Accompaniment ▪ Job Skills Training ▪ Law Enforcement ▪ Legal Assistance ▪ Other Assistance (food, clothing, household goods, moving assistance, assistance with establishing or restoring telephone service) ▪ Psychiatric Services ▪ Psychological Services ▪ Prevention and Education Outreach ▪ Services for Perpetrators (e.g. rehabilitation programs, counselling) ▪ Sexual Assault Centres ▪ Survivor Support Groups ▪ Transitional Housing ▪ Transportation Services ▪ Victims Services (through RCMP in Alberta) 	<ul style="list-style-type: none"> ▪ Advocacy ▪ Crisis Hot Line ▪ Family and Community Social Services in Alberta ▪ Hospital Emergency Room ▪ Law Enforcement ▪ Outreach ▪ Prevention and Education ▪ Victims Services (through RCMP in Alberta) 	<ul style="list-style-type: none"> ▪ Family and Community Social Services in Alberta ▪ Law Enforcement ▪ Victims Services (through RCMP in Alberta)

Rural communities that have small populations but are adjacent to urban areas may have partial or almost full accessibility to a wide variety of urban sexual assault services. However, many rural areas of Alberta have minimal services available for survivors of sexual assault, and remote areas may only have access to the R.C.M.P and its associated Victims' Services.

Core (Basic) Sexual Assault Services in Urban Areas

AASAC's Core Services Framework

AASAC has identified seven core service areas that they believe are essential in each region of Alberta in order to provide a comprehensive, coordinated approach to service delivery for survivors of sexual violence and their families. AASAC has determined that this framework of core services constitutes a minimum standard of service response. Currently, these core services do not exist in every region of Alberta.

AASAC believes that it is important to demonstrate the impact of services offered at each sexual assault centre. Thus, the ten sexual assault centres have standardized outcomes for the core services offered at each centre. For each service funded by the provincial government, each sexual assault centre at year end will report on whether or not the service/program made a difference in the lives of service recipients. The following section provides an overview of each of the seven core services, the target population, activities/services provided and anticipated outcomes.

The AASAC Core Services include:

- 1. Coordination & Collaboration/Agency and Community Leadership**
- 2. Crisis**
- 3. Counselling**
- 4. Police and Court response**
- 5. Education**
- 6. Outreach**
- 7. Volunteers**

Core Service 1: Coordination & Collaboration/Agency and Community Leadership

To ensure that communities respond to sexual violence in a manner that represents local autonomy, this service is designed to support and encourage communities to take action on sexual violence as part of family violence. Survivors of sexual violence benefit not only from the supports offered by sexual assault centres but also from the strong networks and alliances between the centres and other agencies that conjointly provide them with comprehensive and coordinated services.

This core service ensures that the needs of sexual violence survivors and their families are always included and considered in the development and on-going operations of all family violence, legal, law enforcement, medical, child protection and survivors' services and programs.

Activities within this core service will include the Executive Director functions within an agency or developing/emerging agency, coordination and collaboration of all sexual and family violence services, leadership and advocacy activities that ensure that sexual violence remains a visible and vocal issue within communities and service development activities in response to needs and gaps in service as identified by each community and/or region.

Core Service 1: Coordination & Collaboration/Agency and Community Leadership

Target Population	Activities	Evidence of Success
<ul style="list-style-type: none"> ▪ Individuals who have been sexually assaulted/sexually abused and their families, significant others ▪ Community members ▪ Professionals and services providers 	<ul style="list-style-type: none"> ▪ Providing a full complement of core services ▪ Establishing a sustainable and diverse funding base ▪ Coordinating and collaborating with other service providers in the region ▪ Participating in leadership and advocacy activities that ensure that sexual violence remains a visible and vocal issue within their region ▪ Pursuing service development activities in response to needs and gaps in service as identified by each community in their region 	<ul style="list-style-type: none"> ▪ Outcome measures for core services including number of individuals served and impact of service ▪ Development of core services as needed ▪ Evidence of a sustainable and diverse funding base ▪ Sexual assault services are coordinated with domestic violence, victims services and Child and Family Service Authorities ▪ Identification of gaps in services and plans to respond to gaps

Core Service 2: Crisis

One of the most critical and essential services provided by sexual assault centres is crisis services, which includes in-office crisis response and access to twenty-four hour crisis lines. Crisis workers provide sexual assault survivors with support, stabilization, risk assessment, information, referrals and hospital accompaniment.

Core Service 2: Crisis

Target Population	Activities	Evidence of Success
<ul style="list-style-type: none"> ▪ People who have been recently sexually assaulted (within 72 hrs) 	<ul style="list-style-type: none"> ▪ Advocate for services ▪ Short term Counseling ▪ Support Groups ▪ Individual Support 	<ul style="list-style-type: none"> ▪ Crisis Stabilization (medical attention) ▪ Increased awareness of services ▪ Increased knowledge about sexual violence
<ul style="list-style-type: none"> ▪ Recent and historical survivors of sexual assault 	<ul style="list-style-type: none"> ▪ Short term Counseling ▪ Support Groups ▪ Individual Support 	<ul style="list-style-type: none"> ▪ Crisis Stabilization ▪ Increased awareness of services ▪ Increased knowledge about sexual violence
<ul style="list-style-type: none"> ▪ Family members of survivors of sexual assault (secondary survivors) 	<ul style="list-style-type: none"> ▪ Short term Counselling ▪ Support Groups ▪ Individual Support 	<ul style="list-style-type: none"> ▪ Crisis Stabilization ▪ Increased awareness of services ▪ Increased knowledge of how to support survivors

Core Service 3: Counselling

Treatment options available through the sexual assault centres include both individual and group counselling for children, women and men.

The counselling focuses on helping female, male, adult and child survivors cope with the effects of the trauma they have experienced. Both short-term (up to 12 sessions) and long-term (up to one year) counselling is provided.

Core Service 3: Counselling

Target Population	Activities	Evidence of Success
<ul style="list-style-type: none"> ▪ Recent 	<ul style="list-style-type: none"> ▪ Individual and Group Counselling 	<ul style="list-style-type: none"> ▪ Reduce Sexual Assault Trauma ▪ Decrease in PTSD symptoms ▪ Increased coping skills
<ul style="list-style-type: none"> ▪ Historical 	<ul style="list-style-type: none"> ▪ Individual and Group Counselling 	<ul style="list-style-type: none"> ▪ Reduce Sexual Assault Trauma ▪ Decrease in PTSD symptoms ▪ Increased knowledge on dynamics of sexual abuse
<ul style="list-style-type: none"> ▪ Secondary Survivors (ie parents, spouses, other family members and significant others) 	<ul style="list-style-type: none"> ▪ Individual and Group Counselling 	<ul style="list-style-type: none"> ▪ Increased knowledge on impact of Sexual Violence ▪ Have knowledge on how to support survivors ▪ Reduce Trauma

Core Service 4: Police & Court Support

Through police and court support programs sexual assault staff and volunteers assist survivors as they navigate their way through the criminal justice process including police investigations, preliminary hearings and trials. It can often take up to two years for a sexual assault trial process to be completed and frequently longer for the symptoms of post-traumatic stress disorder to abate.

With adequate intervention support, survivors of sexual assault can proceed through the criminal justice process and recover from the effects of trauma. Services are offered in the following areas: options counselling, police accompaniment for reporting, court preparation and accompaniment, advocacy for survivors through the court system and follow-up, including de-briefing, information and referral counselling.

Core Service 4: Police & Court Support

Target Population	Activities	Evidence of Success
<ul style="list-style-type: none"> ▪ Individuals who report Sexual Violence to Police 	<ul style="list-style-type: none"> ▪ Advocacy ▪ Provide information ▪ Provide Support ▪ Provide Police and Crown accompaniment ▪ Provide Court preparation sessions 	<ul style="list-style-type: none"> ▪ Increased knowledge of criminal justice system ▪ Increased client knowledge on individual case information
<ul style="list-style-type: none"> ▪ Individuals considering reporting to police 	<ul style="list-style-type: none"> ▪ Advocacy ▪ Provide information ▪ Provide Support 	<ul style="list-style-type: none"> ▪ Increased knowledge of criminal justice system ▪ Increased awareness of options

Core Service 5: Education

Critical to the decrease of the crime of sexual assault in Alberta are the education, prevention and public information services provided by sexual assault centres. Currently, professional educators with the ten sexual assault centres throughout Alberta, deliver interactive and informative presentations to children, teens and adult audiences in their local communities and surrounding areas on issues related to sexual assault prevention and information.

Specialized education and training services are also delivered to key professional groups, such as RCMP, Victims Services, Addiction Counsellors, Child Welfare Workers, Prison Staff, Doctors, Nurses, Shelter Staff etc.

Core Service 5: Education

Target Population	Activities	Evidence of Success
Professionals	<ul style="list-style-type: none"> ▪ Respond to individual inquiries for information ▪ Provide education presentations 	<ul style="list-style-type: none"> ▪ Increased knowledge on Sexual Violence ▪ Increased awareness on relevant services ▪ Increased ability to respond to disclosures
Parents	<ul style="list-style-type: none"> ▪ Respond to individual inquiries for information ▪ Provide education presentations 	<ul style="list-style-type: none"> ▪ Increased knowledge on Sexual Violence ▪ Increased awareness on relevant services ▪ Increased ability to respond to disclosures
Children/Youth	<ul style="list-style-type: none"> ▪ Respond to individual inquiries for information ▪ Provide education presentations 	<ul style="list-style-type: none"> ▪ Increased knowledge on Sexual Violence ▪ Increased awareness on relevant services ▪ Increased ability to respond to disclosures
Adults	<ul style="list-style-type: none"> ▪ Respond to individual inquiries for information ▪ Provide presentations 	<ul style="list-style-type: none"> ▪ Increased knowledge on Sexual Violence ▪ Increased awareness on relevant services ▪ Increased ability to respond to disclosures

Core Service 6: Outreach

Outreach services focus on removing client barriers and ensuring that services are available and accessible to diverse populations, rural communities and previously un-served or under-served areas within the province. This is an essential element for effective delivery of services.

Outreach services work to ensure that partnerships and collaborations are developed with new groups, organizations and communities. These services are based on a community development model that seeks to engage diverse and previously un-served and under-served groups, organizations and communities.

Core Service 6: Outreach

Target Population	Activities	Evidence of Success
<ul style="list-style-type: none">▪ Professionals	<ul style="list-style-type: none">▪ Provide Training▪ Provide Education▪ Workshops	<ul style="list-style-type: none">▪ Increased knowledge of Sexual Violence▪ Increased knowledge of resources available in the community
<ul style="list-style-type: none">▪ Community Members with diverse groups	<ul style="list-style-type: none">▪ Provide educational workshops	<ul style="list-style-type: none">▪ Increased knowledge of Sexual Violence▪ Increased knowledge of resources available in the community▪ Established relationships with diverse populations

Core Service 7: Volunteers

Under the supervision of professionals, community volunteers operate many of the services provided by AASAC members, especially 24-hour crisis intervention services.

Key to the delivery of effective services is the recruitment, training and supervision of these volunteers. To this end, Volunteer Coordinators across the province work to engage new volunteers, ensure effective and on-going training, supervision and recognition.

Core Service 7: Volunteers

Target Population	Activities	Evidence of Success
<ul style="list-style-type: none"> ▪ Direct service volunteers 	<ul style="list-style-type: none"> ▪ Recruit, Train to work on crisis lines, evaluate, reward 	<ul style="list-style-type: none"> ▪ Increased knowledge of issues of sexual violence ▪ Increased skills for service delivery
<ul style="list-style-type: none"> ▪ Governance volunteers 	<ul style="list-style-type: none"> ▪ Recruit, orient, coordinate, reward 	<ul style="list-style-type: none"> ▪ Increased knowledge of issues of sexual violence ▪ Contribution of time, skills and wisdom ▪ Organization has sufficient financial resources ▪ Staff are supported, acknowledge and rewarded ▪ Organization has a strategic plan
<ul style="list-style-type: none"> ▪ Other 	<ul style="list-style-type: none"> ▪ Recruit, orient, coordinate, reward 	<ul style="list-style-type: none"> ▪ Increased knowledge of issues of sexual violence ▪ Contribution of time, skills and wisdom

Models of Rural Sexual Assault Service Provision

There are few descriptions of rural sexual assault models in the literature. Due to the additional challenges faced in providing services to rural and remote areas, sexual assault agencies and teams are often forced to be more resourceful than their urban counterparts.

The majority of models of sexual assault service provision currently described in the literature apply to urban areas, and include specific information about which service providers are to be held accountable for particular types of services. Generally speaking, such models involve multi-disciplinary teams formed through the collaboration of various agencies that provide integrated, collaborative, coordinated service delivery.

The "victim-centered" or "survivor-centered" approach is used in most collaborative models. This approach examines the needs of the survivor at each stage of service provision and recommends various agencies that could provide the needed service or support. The goal of using this approach is to provide competent interdisciplinary services that are sensitive to the needs of survivors. This helps to ensure that survivors are treated with compassion, fairness and respect in the process of reporting the crime to law enforcement and in seeking counselling and medical services. The provision of services in a supportive, empathetic environment is hoped to encourage survivors to report sexual assault crimes and to seek appropriate support services.

Universal screening for domestic violence is a practice that is gaining attention in its potential to offer survivors opportunities for disclosure of violence, enable health care providers to work with survivors in protecting their safety and improving their health. Such screening may help reluctant survivors to disclose information about recent or historical sexual assault, and may help to ensure that they receive appropriate support, information, and other types of assistance without having to approach law enforcement.

The Integrated Delivery Model

The integrated delivery model has been considered an ideal standard of sexual assault service provision for many years. It has also been referred to as a collaborative model and a multi-disciplinary model. Many integrated models for sexual assault services incorporate health services (forensic examinations, mental health and physical services), survivor advocacy, substance abuse services, family services and legal services.

Some integrated models operate on the "one-stop" shopping concept, where all services are available to survivors in one facility. Such models enable service

providers to communicate and collaborate easily, and are believed to minimize the revictimization of survivors.

The advantages of using the integrated delivery model in rural and remote areas include:

- (1) Increased coordination in the planning and development of services.
- (2) Increased flexibility to meet individual survivor needs.
- (3) Increased ability to provide a continuum of service response.
- (4) Increased opportunities for the provision of specialized services to survivors (Olle, 2005)
- (5) Integrating services increases the opportunities for professional support and professional development (Olle, 2005)
- (6) Increased support and resourcing of generalist workers.
- (7) Increased capacity of the services involved to share ideas and practice wisdom.
- (8) Increased capacity of the service providers involved to raise their level of knowledge and skills through mutual exchanges of information and through increased train-the-trainer opportunities.
- (9) Increased capacity of the services involved to raise community awareness about sexual assault and sexual assault services.
- (10) Increased opportunities to reach community members and involve them in early intervention and prevention activities.
- (11) Increased opportunities to identify and address gaps in services.
- (12) Increased opportunities to improve, monitor and evaluate service delivery.
- (13) Increased opportunities to improve the quality and delivery of services and products in the most cost effective manner.
- (14) Increased capacity for service providers to work towards common goals.

The major challenges in using this model effectively in rural and remote areas include:

- (1) Obtaining sufficient financial resources to support key positions,
- (2) Finding ways to collaborate and coordinate services despite the physical distances that may exist between agencies and service providers,
- (3) Finding ways for service providers to keep in regular contact, and
- (4) Encouraging individual service providers to develop meaningful relationships with service providers in other agencies.

SART (Sexual Assault Response Team) Model

Within the past three to five years, the formation of Sexual Assault Response Teams (SART) represents a current trend in collaborative sexual assault service provision. A SART is a multidisciplinary team of individuals (both public and private) that works collaboratively to provide specialized sexual assault intervention services. The sexual assault centres in Edmonton and Calgary have developed and currently operate SARTs.

The relationship between all agencies/members in the team is often formalized through the development of protocols and procedures which create a standard of practice for each agency/member. Generally speaking, collaboration in SARTs is informal with verbal protocols rather than formal written agreements.

The National Sexual Violence Resource Centre (2006) reports that in the United States, of the 258 SARTs that responded to their survey: 47% have informal verbal agreements between member agencies, 31% have written interagency agreements with all of the SART agencies, and 16% have written agreements with some of the SART agencies. With respect to how SART teams conduct their business, the same report indicated that this varies widely. Approximately 37% of SARTs meet monthly, 20% meet quarterly, 5% never meet, 4% no longer meet, 2% meet semi-annually, and 10% meet as needed.

Standards define the responsibilities of each team member and often set guidelines for expected levels of expected training and the specific survivor services to be provided by each team member. In some instances, the rationale, outcome and measurement criteria for each standard may be outlined by the SART.

Additionally, some SARTs require statements of accountability which include contact information (names, phone numbers) for supervisors of team members,

should a team member fail to provide satisfactory services. In theory, each member of the team has an equal voice in establishing the protocols, procedures and standards. A recent study conducted by the National Sexual Violence Resource Centre (2006) revealed that many SART teams in the United States do not have a designated administrator"/coordinator.

Sexual assault response teams are specialized to fit the needs of each community and operate with a survivor-centered approach. The core members of SART teams generally include: prosecutors, forensic examiners, law enforcement officers and survivor advocates. Some teams include dispatchers and/or crime lab specialists (National Sexual Violence Resource Centre, 2006).

While the extent and types of services provided by SARTs vary, they usually include some combination of the following (National Sexual Violence Resource Centre, 2006):

- survivor advocacy
- crisis intervention
- counselling and support for survivor and family members
- forensic exams and medical attention
- law enforcement assistance
- information and safety planning
- assistance from prosecution officials
- notification from probation or parole officials
- community awareness and prevention education programs

Training for SART members is usually offered locally, however, some teams or team members attend regional or national training sessions. Cross training among disciplines is common in SARTs.

SANE (Sexual Assault Nurse Examiner) Program Model

Sexual assault nurse examiners often operate within Sexual Assault Response Team systems or closely with other members of the sexual assault response system in a community. SANEs deliver coordinated, expert forensic and medical care necessary to increase the successful prosecution of sex offenders and to ensure medical intervention for survivors of sexual assault.

SANEs are registered nurses who are specially trained and certified in performing quality forensic medical-legal exams. They provide emotional support for survivors and are qualified to testify in trials as expert witnesses. Most SANE programs are hospital based and housed in emergency rooms. The remainder of

SANES operate in the community at rape crisis centres, sexual assault centres or health clinics.

Most SANE programs use a pool of SANEs who are on call 24 hours a day. The on-call SANE is paged whenever a sexual assault survivor enters the community response system (e.g. police, sexual assault crisis centre or other service provider).

A Regional SANE program is an alternative to each community having its own SANE program. Regional SANEs will see more clients, and each SANE will be able to complete a sufficient number of exams to develop and maintain clinical competence (Littel, 2001). Regional programs are a more cost-effective way to provide SANE services in rural and remote areas where no one medical facility sees large numbers of sexual assault cases. Regional SANEs are sometimes referred to as mobile services, as the SANEs travel to a number of medical facilities to provide their services.

SANEs provide a model of care for sexual assault survivors, however themselves do not provide a complete continuum of sexual assault services for survivors. Successful SANES work closely with other members of the community sexual assault response system (e.g. advocates from sexual assault crisis centres, law enforcement officers, prosecutors, other court personnel, forensic personnel, and other survivor/witness specialists based in justice system offices).

The advantages of having SANEs operate in rural and remote areas include:

- SANEs increase the likelihood that survivors who require forensic examinations and/or medical attention will be treated with compassion, dignity and sensitivity. This may also increase the likelihood that survivors will continue to seek assistance for sexual assaults, and may increase the likelihood that other survivors will seek assistance for sexual assaults within the community.
- SANEs help to ensure that the sexual assault forensic kit is completed proficiently and in a timely manner. Emergency department staff may fail to gather and/or document all available forensic evidence.
- The SANEs help to decrease the long waiting periods that survivors must wait to have a forensic or medical examination completed.
- SANEs help to ensure that survivors are knowledgeable about the services available to them, and help to coordinate the receipt of appropriate services.

The challenges of having SANEs operate in rural and remote areas include:

- There are often not enough sexual assaults reported in rural and remote areas to maintain the specialized skills of the nurses.

- SANE nurses who are not utilized frequently may become bored and dissatisfied with their position.
- SANE nurses still face the barriers of travel and geographical isolation in delivering their services.
- SANES are not a substitute for survivor support provided by advocates.

The Nested Ecological Model

While it has not been used as a model for the delivery of sexual assault services, the nested ecological model was used as a guiding framework by Dutton, Worrell, Terrell, Denaro and Thompson (2002) to evaluate a rural domestic violence and child victimization enforcement program. In their framework, Dutton et al. used the model to organize information about the types of activities used in the rural programs and to identify potential outcome measures and the assumptions associated with the desired outcomes. The nested ecological model has also been used by the World Health Organization (2002) to understand the causal and multi-faceted nature of violence. The model is to be understood in the context of real life, where each level overlaps and interacts with one another.

The nested ecological model was first developed by Urie Bronfenbrenner (1979) to explain human behavior in the context of larger systems in which the individual functions. The nested levels that make up the ecological model are different but interacting. Within each level, factors that make up the complexities of life are identified.

Bronfenbrenner's ecological model consists of five environmental systems that range from close interpersonal reactions to broad-based influences of culture:

- An individual's social networks and interactions within them (Microsystem)
- Collaborations between microsystem components (Mesosystem)
- Institutional practices and policies (Exosystem)
- Societal values, customs and cultural attitudes (Macrosystem)
- Developmental history of all systems within the ecology (Chronosystem)

The Shared Mental Health Care Model

The shared care model is presented in this report as it is well established that sexual assault is often found to impact the mental health and wellness of survivors. In addition, the shared care model embraces the type of community collaboration and flexible service delivery style that appears to be well suited for rural and remote areas.

Underlying Principles and Concept of Shared Care

Shared mental health care is an increasingly successful approach whereby mental health and primary care providers work together as part of a well-coordinated mental health care delivery system that attempts to address problems related to accessibility of mental health services, coordination of care, and continuity of care.

(Canadian Psychiatric Association & College of Family Physicians of Canada, 2003).

The integration of primary health care and specialized mental health services has been identified by Health Canada (2002) as one of the innovative "Best Practices" in mental health reform.

Most of the literature on shared mental health care in Canada applies to the collaboration of psychiatrists and primary care physicians, although other models of shared mental health care exist and are being implemented. Shared mental health care is based on the following principles (Craven et al., 2000, p. i):

- Family physicians and psychiatrists are part of a single mental health care delivery system.
- The family physician has an enduring relationship with a patient that the psychiatrist should aim to support and strengthen.
- No single provider can be expected to have the time and skills to provide all the necessary care a patient may require.
- Professional relationships must be based upon mutual respect and trust.
- Roles and activities of family physicians and psychiatrists should be defined, coordinated, complementary and responsive to the changing needs of patients, their families, and other caregivers, as well as to resource availability.
- The patient must be an active participant in this process, understanding that both the family physician and psychiatrist will remain involved in his or her care, and knowing who to contact when a particular problem arises.
- Shared care should be sensitive to the community context in which such care takes place.

The Canadian Psychiatric Association and The College of Family Physicians of Canada describe the concept of shared mental health care as follows:

Shared care covers a broad spectrum of collaborative treatment possibilities, and no single model or approach will be applicable in every community or situation.

At the very least, it involves clear, helpful, 2-way communication between the family physician and psychiatrist or psychiatric service. At the other end of the spectrum, it may involve psychiatrist and/or other mental health workers providing consultation and treatment in the family physician's office and developing collaborative management plans with the family physician.

Functions that lend themselves well to shared care include early detection and the initiation of treatment, ongoing monitoring, crisis intervention, relapse prevention, and mental health education.

Shared care should lead to improved patient outcomes and quality of life; a more efficient use of resources; optimal use of the time and skills of family physicians, psychiatrists, and other providers; improvement in the ability of family physicians to access timely and appropriate psychiatric consultation and backup; and enhanced morale and reduced frustration on the part of providers.

(Kates et al., 1996, p. 6)

The overall goal of shared mental health care projects is to improve the outcomes for individuals with mental health problems.

Models of Shared Care

The integration of shared mental health services in primary care settings can include the following models (Canadian Psychiatric Association & College of Family Physicians of Canada, 2003):

- (a) Visiting Consultation Model. The mental health specialist visits a primary care practice periodically to see patients, discuss cases with primary care staff and provide education, input and resources.
- (b) Parallel Model. Specialized mental health services are delivered in the primary care setting, although contact between the mental health specialist and primary care physician may be limited and their respective services may function relatively independently.
- (c) Integrated Model. Specialized mental health staff work as a part of a broad multidisciplinary primary care team.

Shared Care in Rural/Isolated Communities

The reports on shared mental health care (Craven et al, 2000; Kates et al., 1996) suggest that collaboration between family physicians and mental health care providers can be adapted to any community, but may be particularly useful in more isolated, underserved communities.

Because of the shortages of psychiatrists and other specialized mental health care providers in rural and isolated communities, alternate models of shared mental health care have been developed. Many such models acknowledge the central role of the primary care physician in delivering mental health services in the community. Thus, such models may include: outreach by psychiatrists who visit communities periodically to deliver clinical and educational services; telephone backup to family physicians; the use of new technologies for video consultations, case conferences and educational sessions; web-based clinical and educational training activities; and specialized training for family physicians as mental health providers (Craven et al, 2000).

Challenges to Implementing Shared Care Models in Rural and Remote Areas

Linking primary care and mental health care remains difficult, particularly in rural areas. One of the primary and persisting problems is a failure to appreciate that primary care and mental health providers differ in terms of their patients, reimbursement, and treatment philosophy. Discussing their review of fifty-three successfully linked primary care and mental health programs operating in rural areas, Lambert and Hartley (1998) cautioned that:

... [T]he lessons from successfully integrated programs are not easily reduced to a how-to list. Organizations cooperate with each other when it is in their interests to do so. They must recognize the benefits of integration and perceive that they will gain more by integrating services than they will lose by sharing clients or staff. Integration involves each organization's losing some autonomy. Motivation to integrated cannot be mandated, nor is the availability of funding alone sufficient to provide this motivation. (p. 966)

Insufficient collaboration can pose a barrier to peoples' receipt of mental health services. Interdisciplinary communication and collaboration can be particularly difficult in rural areas because of the following:

- Different professional groups may be committed to distinct styles of practice. For example, primary care physicians who see many patients for short periods of time may not appreciate the need for psychologists to spend hours with individual patients (Barbopoulos & Clark, 2003).

- In rural settings, paraprofessionals may provide referrals, help in treatment, and participate in joint professional development activities with psychologists. Rural psychologists might not appreciate the different educational and training backgrounds of other mental health professionals such as psychiatric nurses and psychiatrists, and paraprofessionals such as self-help group workers (Barbopoulos & Clark, 2003), other professionals such as social workers and occupational therapists, or alternative health providers such as herbalists and acupuncturists.
- Lack of formal training and experience in collaborative models. Many psychologists in rural practice lack experience and graduate training in community or rural psychology methods (Murray & Keller, 1991; cited in Barbopoulos & Clark, 2003).

In a 1999 survey conducted by the Canadian Psychiatric Association Research Network, time constraints were identified as a barrier to the implementation of shared care by psychiatrists and family physicians. Both felt that it would be difficult to take time from their clinical activities to devote to activities for which there is no remuneration; this was not identified as a major problem for those physicians already involved in shared mental health care projects (Craven et al, 2000). Results of the same survey suggested that psychiatrists would be willing to devote some additional time to joint clinical or educational activities or in the provision of some telephone backup.

Physician remuneration issues, limited funding for collaborative projects, limited personal contact and communication between psychiatrists and family physicians, and attitudinal barriers also create some barriers to the implementation of shared mental health care. These are discussed in more detail in the report by Craven et al, 2000).

An article by Burley (2003) reviews the process of developing a shared mental health care relationship in a community. It discusses important considerations such as identification of goals and objectives of the collaboration, referral processes, frequency of follow-ups, fee structures, working with front-office staff, liaising with other mental health care providers, and exploring opportunities for teaching and learning.

Other Types of Community Team Models

Numerous other types of collaborative models have been developed by rural communities to maximize the use of scarce professional resources and services that are often characterized by rural areas. The Jasper Community Team Model is an example of such a rural initiative within Alberta. Since 1997, health and social service agencies within Jasper have been engaged in a process of intersectoral collaboration and community health development to improve service delivery in

Jasper. The model focuses on linking hard to reach members of the population with resources that are relevant to their health, social, educational and recreational needs. This is accomplished through the collaborative work of their team, which is composed of organizations and community representatives. More information on the Jasper Community Team model may be obtained from the town of Jasper.

Summary of Literature Review Findings

The review of the literature revealed that the information available about sexual assault service provision in rural, remote, and northern areas remains sparse. This may be a result of several factors:

- (1) Few formal research studies concerning the needs of sexual assault survivors and their families have been conducted in rural, remote or northern communities.
- (2) Many rural sexual assault centres appear to be operating on a year-to-year basis, with program renewals dependent upon funding renewal or availability. Limited resources are spent in providing direct services such as advocacy and counselling; there is little time to spend developing a formal structure for the delivery of sexual assault services.
- (3) Much of the available information concerning the needs of sexual assault survivors and their families in rural, remote or northern communities is anecdotal and has not been collected in a consistent manner.
- (4) Formal needs assessments of sexual assault survivors and their families conducted in rural, remote and northern communities are rarely conducted because of the limited resources (money, time) available to conduct such research. Additional financial and other resources are required to conduct needs assessments in rural, remote and northern regions because of accessibility issues. Accessibility to individuals and families is limited by the sparse population and great distances that must be traveled to collect interview data.
- (5) Conducting needs assessments through the use of telephone surveys and interviews are often not feasible because many individuals in such areas do not have a telephone in their homes. Party lines still exist in some remote areas, and do not allow for confidential responses. In addition, it may not be safe for survivors to discuss sexual assault in their own homes.

Responding to online surveys would not provide adequate assessments of needs as many survivors do not own or have access to a computer with internet service.

There are few stand alone sexual assault centres in remote and northern areas. If they do exist, asking participants to travel to the centre to be interviewed for a needs assessment is costly and time-consuming, as some have accessibility only by plane, bus, ferry and train service. In addition, participation in such research would require that survivors be reimbursed for costs associated with being away from their home and/or work. This could include paying for travel, adequate and safe childcare (which is often

unavailable), paying for time taken off of paid work (often 1 day or more including travel time), meals, accommodation, and farm labour to take care of animals, crops and daily chores.

Because the existence of sexual assault is often strongly denied or hidden in rural, remote and northern communities, it may be difficult to get individuals to participate in needs assessments for fear of ostracization and possible repercussions. Individuals that do participate may not provide accurate information.

- (6) The lack of a consistent definition for the terms rural and remote throughout the literature makes it difficult to make generalizations about the service provision characteristics and barriers to service delivery that exist in rural and remote areas.

Moreover, the literature suggests that information about rural and remote communities cannot and more importantly, should not be generalized when planning for and developing sexual assault services.

Results of Key Informant Interviews

A total of 27 interviews of key informants were completed between February, 2006 and April, 2006. Sixteen of the key informants lived in Canada, ten lived in the United States (including Hawaii), and one lived in Australia.

The purpose of the key informant interviews was to gain access to additional information that would not otherwise be available to the researcher. As the interviews were not conducted with the intention of performing a qualitative study, a qualitative analysis of the information was not completed.

The information in this section of the report includes a summary of relevant findings resulting from the interviews of key informants. The findings have been broken down into the following areas:

- Barriers to the reporting of sexual assault by survivors in rural and remote areas.
- Barriers to accessing services by survivors in rural and remote areas.
- Barriers to service providers in delivering sexual assault services in rural and remote areas.
- Identification of strategies for the successful delivery of sexual assault services in rural and remote areas.

Findings within each of the categories identified above are outlined in the remainder of this section.

Barriers to the Reporting of Sexual Assault by Survivors

- Cultural barriers are difficult to overcome.
- Survivors fear potential repercussions of reporting, such as ostracization by the community.

Barriers to Accessing Services by Survivors

- People living in rural and remote areas do not want to be seen in waiting rooms or other public places where they must go to access sexual assault services. It is difficult to maintain privacy and anonymity in rural areas where most people are acquainted with one another.

- There are often no emergency shelters in rural and remote areas where survivors can go to if their home is an unsafe area. Some programs have the funding to enable survivors to stay at a motel, although motels in rural and remote areas are often sparse, and may be an unsafe place for the survivor.
- Survivors often need a range of support services available - especially in the case of intimate partner abuse where the survivor is planning to leave the perpetrator. Food, transportation, shelter, childcare, legal assistance, and financial as well as emotional support are often required. Education and training are often needed by survivors searching for employment.
- Many individuals living in rural and remote areas cannot take enough time off of work or time from their own farming, childcare, and household duties to access sexual assault services. Survivors often have to travel several hours or up to a day (one way) to access specialized sexual assault services.
- Many individuals do not have access to transportation so that they may receive sexual assault services on a regular basis.

Barriers to Delivering Sexual Assault Services

- Rural nurses who are trained in SANE sometimes see too few survivors per year (e.g. between 1 and 5) to maintain their skills and their interest in being a SANE. Some nurses find the minimal activity level too boring, and decide to give up their designation as a SANE.
- Even though some of the SANE programs within the United States have been operating in rural areas for more than ten years, the impact of some of the SANE programs is still largely unknown. The barriers to reporting and accessing services in rural and remote areas still exist, and the number of individuals who access the SANE remains low.
- In some areas of rural Wyoming, Fredericton, and Alberta, there is too little demand for sexual assault services to justify having stand-alone sexual assault centres.
- Many key informants indicated that while they know there is a great need for sexual assault services in rural and remote areas, there is no way of determining what the extent of the need is. Because of the lack of statistics to support the need, it is difficult to receive funding to develop sexual assault services.
- Several key informants indicated that Aboriginal peoples are generally uncomfortable and wary of going to a sexual assault centre. This is often a result of fear, mistrust, and assumptions about the kinds of services that will be

provided. They often assume that the services provided will not be culturally sensitive, relevant, nor appropriate for them and how they wish to deal with and heal from sexual assault.

- There are often no specialized services that are close enough to refer survivors to (e.g. psychiatrist, perpetrator programs, child sexual assault counsellors).
- There are few sexual assault programs that have front line workers who are culturally competent and have the training and ability to provide the types of services that would be accepted and used by Aboriginal peoples.
- There is insufficient training of other rural service providers by the public educators working for sexual assault centres. This creates a barrier because service providers such as physicians, nurses, mental health workers, social workers, and police (among others) often do not feel confident in providing necessary assistance and basic levels of support for survivors.
- Accessibility to high quality, specialized training is expensive, especially if it requires individuals to travel to urban centres to complete the training. Additionally, if scarce professionals such as physicians are to receive training, arrangements must be made to hire a replacement physician.
- There are often limits to the amount of support that can be provided by sexual assault centres. For instance, a centre may have funding to provide a maximum of ten counselling/support sessions for one year for clients, however, sexual assault usually requires long term support over many years.
- There is often a high turnover of service providers in rural areas. This makes it difficult to maintain levels of training, and often interferes with maintaining relationships and regular communication with other service providers. It is often challenging to keep informed about the responsibilities of each service provider and to coordinate services as a result. Some of the key informants indicated that the staff turnover of rural areas is a great barrier in forming and maintaining a sexual assault response team (SART).
- The recruitment and sustainability of high quality, dedicated and specialized professionals is extremely difficult in rural and remote areas.
- Many service providers in rural and remote areas have multiple roles and serve on multiple committees. This makes it difficult to arrange for meetings, especially if service providers must travel long distances to attend meetings.
- It is difficult, if not impossible to run sexual assault support groups and group counselling in some rural and remote areas because of the difficulty in maintaining privacy and confidentiality of information.

- Poverty is often so prevalent that even if sexual assault services are offered, many survivors cannot afford to take time off of work or spend the money to access the services (gas, taxi, accommodations, childcare, etc.).
- Many schools and community groups are resistant; they do not wish to have someone to provide prevention education and information about sexual assault.
- Victim blaming is still a great barrier in rural and remote areas. The survivor is the person who is most blamed and ostracized by the community; the perpetrator often has more support from the community, family and friends than the survivor.
- Several service providers indicated that many survivors arrive at the hospital intoxicated. Many women self-medicate through substance abuse as a way of coping with multiple victimizations that have occurred throughout their lives.

This creates difficulty for the provision of sexual assault services in those communities in which survivors must be sober before a forensic examination and survivor interview can be completed.

- It is difficult to assess how effective community outreach has been. While many rural people seem to be receptive to the ideas and knowledge in an educational setting, it is difficult to know how they will respond to situations involving a family member or a close acquaintance.
- Some service providers indicated that resistance from some physicians in obtaining training to complete forensic examinations is a barrier to assisting survivors. Some physicians do not wish to complete forensic examinations as they do not wish to testify as an expert witness.

Strategies for the Delivery of Sexual Assault Services

- As part of an outreach strategy, sexual assault services are advertised in the bathrooms of gas stations and local bars. This is often accomplished with posters that have tear-off phone numbers that are small enough pieces of paper to be tucked away easily in a pocket or purse.
- Some rural sexual assault programs in the United States have programs in partnership with a telephone company. For example, Verizon wireless has drop off locations for used cellular phones. The used phones are refurbished and given to individuals who do not have telephones in their homes. There is no charge for the use of these telephones to gain access to sexual assault services. One of the drawbacks to the program is that the rural areas are

sometimes so remote that they have sparse, inconsistent, or no cellular coverage.

- Particularly in remote communities where outreach is being conducted, schedule two or three days in the community and provide education and information to a number of different groups (e.g. RCMP, Family and Community Support Services, hospital staff, community service groups).

Instead of spreading educational programs in schools over an entire year (e.g. 5 periods per year), one week might be devoted to providing education to various grade levels in the school (e.g. 1 period per day for 1 week). This will maximize the impact on the community, save resources (time, money) and delivers a message of commitment to the community.

- In communities with a high population of Aboriginal peoples, or on First Nations reserves or Metis settlements, spending two or three days in the community will help to deliver a message of commitment to helping and respect for learning the ways of the Aboriginal peoples.
- In remote communities, scheduling of appointments can be modified to better suit the needs of survivors and to help overcome some of the barriers to accessing and providing sexual assault services. For example, some rural centres schedule longer counselling appointments with shorter frequency rather than shorter appointments with greater frequency.
- Always conduct follow-ups after workshops or educational sessions in communities. Accomplish this with radio advertisements, newspaper articles, and through other means.
- Seek the best quality training that can be afforded for advocates and other front line sexual assault workers.
- Develop ongoing and strong relationships with professionals working in the hospital emergency room, social workers, providers of social services, mental health counsellors, members of law enforcement, and the prosecutors office. Direct partnerships are important; one-to-one meetings and conversations about important issues are often essential to obtaining assistance when it is needed. Big group meetings are frequently not productive in getting things accomplished and relationships built. It is often impractical to schedule large meetings, and it is difficult for all individuals to communicate their thoughts openly.
- Particularly because they must often travel long distances to attend meetings, and because time is valuable to individuals living in rural areas, it is important that the attendance of rural people at meetings is recognized, acknowledged and valued. Once rural provider indicated the importance of providing lunch and refreshments for attendees as a small gesture of thanks and hospitality.

- One rural service provider in Canada indicated that they are able to provide support and information to sexual assault survivors 24 hours a day, 7 days per week. The help line in the area is set up through an answering service that immediately patches the survivor through to volunteer staff who work from their own homes to provide support. The volunteers are extensively trained through the sexual assault centre.
- Several sexual assault centres indicated that they have agreements with their local taxi company to transport survivors to sexual assault shelters or the sexual assault centre. This service is essential for survivors who cannot afford the transportation, or do not have access to money. The taxi is paid by the shelter or centre upon arrival. Unfortunately, many rural and remote areas do not have taxi service.
- Careful screening of all individuals involved with providing services to sexual assault survivors is essential. A service provider indicated one instance in which the taxi driver was an offender himself, and was identified by one of the woman that he had transported to sexual assault centre.
- Even with careful screening, it may not be possible to identify offenders or to prevent them from the provision of other services that survivors may require. Particularly in areas where there are strong extended family ties, political issues, and normalized attitudes towards sexual assault, the provision of as much education and support possible is much preferred over the alternative of doing nothing.
- Especially within large geographical areas, the sexual assault service needs of one community cannot be predicted by the needs of another community in the same area. One service provider indicated that in one community, the SANE sees 120 to 140 survivors per year. There is such a demand for the completion of forensic exams that the SANE cannot keep up with them all. In another community within the same large geographical area, the SANE only sees 4 patients per year, and has difficulty maintaining her skills. It is not practical to have a mobile SANE, since the region is too vast and would require many hours of travel over poor roads. The survivor would not be able to have the forensic examination completed within the window of time required, and would have to suffer from discomfort while waiting for the SANE to arrive.
- In rural and remote areas that cover a relatively small geographical area, mobile SANEs are used to share costs among communities. Most small hospitals cannot afford to keep a SANE on call for 24 hours per day, seven days a week if the number of survivors accessing the services is small (e.g. under ten survivors per year). Hospitals in multiple rural communities share a pool of SANEs that are "mobile" in that they travel from one hospital to another as they are needed. This helps to prevent boredom and also helps to address the issue of SANE nurse turnover; if one SANE leaves the region, there are others available to take over until a new SANE is trained.

- One service provider indicated that the key to the success of their sexual assault services (and high prosecution rates) is that the SANE and law enforcement officer conduct the initial interview of the survivor together at the hospital.

The hospital is the facility where the interviews can be held and recorded. The joint interview allows for the improved collection of evidence. This enables the nurse to testify with greater evidence as an expert witness; for example, the nurse can indicate "he strangled her, she said she felt dizzy".

- Obtain minimum commitments of time and money from key service providers (e.g. law enforcement, hospital), and have funding in place prior to starting a major initiative such as a SART.
- One service provider indicated that telephone counselling is used extensively with survivors. This helps to address barriers related to transportation, distance, childcare, poverty, anonymity, employment, other commitments (taking care of livestock, watering the crops, etc.), and privacy. As well, it enables survivors to access support and information sooner than if they have to wait for an examination, referral and travel to a sexual assault centre for an appointment. Telephone counselling is helpful when the weather conditions are poor, and in-person appointments cannot be kept.
- When establishing relationships with law enforcement, one administrator of a sexual assault centre indicated the importance of providing as much assistance to law enforcement officers as possible. She emphasized the importance of finding out how the sexual assault centre could make things as easy as possible for police. That is, the sexual assault centre is the initial contact for the survivor. They collect the forensic evidence, store it at the centre, and subsequently contact the police if the survivor wishes to report the crime.
- An administrator of a sexual assault treatment centre indicated the importance of making use of key service providers in the most effective manner possible. In their case, a physician is the SART leader. This is effective because "hospitals [and other service providers] respond to doctors", and can be very influential in the promotion of policies and procedures. However, they do not ask that the physician attend all the SART meetings; they respect the other important commitments of the rural physician.
- Another administrator of a sexual assault coalition in the United States expressed the importance of respecting the time of all service providers involved in a SART: "We don't meet monthly or weekly. One person may wear many hats - you have to be respectful of their time."
- An administrator of a sexual assault treatment centre in the United States suggested the value of her success in eliminating "piecemeal" funding. Her organization is now responsible for grant-writing and advocacy to the legislature, and speaks on behalf of all sexual assault programs within the

state. By obtaining the funding for all programs, the skills and experience of individual program administrators can more effectively be used in front-line service provision. It also eliminates the competition for funding among sexual assault programs within the state, and encourages a more collaborative and unified approach to the delivery of sexual assault services.

- An administrator indicated that their SANEs are located in sexual assault centres, college campuses and clinics to improve accessibility for rural and remote survivors.
- An administrator of a sexual assault centre in Canada remarked that they have found it particularly effective to collaborate with the community in promoting awareness of sexual assault. This helps to ensure that various service providers within the community are sending a consistent message to people about sexual assault information, the sexual assault services available, and how to access those services. By pairing with other organizations, it enables the centre to deliver information about sexual assault to the community without being singled out. Residents do not like to hear information about sexual assault on the radio stations, and complain each time there are such broadcasts. The sexual assault centre collaborates with the substance abuse commission, so that when alcohol abuse is discussed, a representative of the sexual assault program presents information on the relationship of sexual assault to alcohol use.
- Rural and remote areas often have difficulty finding funding to conduct needs assessments. One service provider suggested to "start where you know there is a need, then gather the best information you can."

Synthesis of Literature Review Findings and Key Informant Interviews

Best practice models are often based on data-informed, evidence-based approaches. Models and protocols provide a framework within which sexual assault responses may be managed, however do not necessarily lead to good interventions or protect survivors from inappropriate ones. Even those that have been identified as "best practices" in one location may not necessarily work in another.

The notion that urban models of best practice do not necessarily transfer to rural areas was examined by Crocker (1999), who discussed the failure of the case consultation model to work for child protection teams in Newfoundland and Labrador. After attempts to conform to a rigid urban service model continued to result in poor outcomes, the child protection teams began to work on the assumption that community people have the skills and ability to solve their own problems. With the new locally developed model, the community was held responsible for the existence of child abuse and neglect. Teams therefore encouraged community responsibility and participation through public awareness and education projects. Professional development became multi-disciplinary and an important component of the model. Team members also included individuals recruited from the community at large - this factor in itself has been instrumental in changing attitudes and behaviors within the community.

Monsey et al. (1995) also suggested that interventions and models which may be effective in urban areas may not represent the best solutions for rural communities. Some types of service provision that are practical in urban areas may be impractical and unachievable in rural and remote areas. For example, sexual assault counsellors serving survivors in rural and remote areas may provide a 2-hour session once every month instead of the 1-hour sessions twice a week which may be appropriate in an urban setting. This may help to reduce the stress placed on the survivor due to travel costs. If the weather prevents travel, rural sexual assault counsellors/advocates may also provide counselling and support by telephone if it is safe and appropriate to do so.

Trute, Adkins and McDonald (1994) indicated that a lack of discretion often characterized by rural areas may interfere with clients accessing what might be appropriate service alternatives to pursue in the urban setting, such as group therapy or multi-family interventions. The use of such clinical interventions in a rural setting can compromise confidentiality and anonymity when they involve people that closely share other social or community ties.

Models, protocols, procedures and services that have been developed for urban areas, such as a SART with fifty or more multi-disciplinary service providers that

serves hundreds or thousands of survivors a year, may not transfer well to a rural and remote area that may have one or two service providers (e.g. a public health nurse and law enforcement officer) and serve fewer than five survivors per year. Some of the key informants interviewed for this investigation revealed that in their community, it is difficult to justify developing a sexual assault response team when their communities have had one report of a sexual assault in five years or longer.

An issue that became evident in the review of the literature and perhaps more importantly, through the interviews of key informants is that there is very little agreement on what constitutes a model of sexual assault service delivery. When asked, "What model of service delivery are you using in your rural area?," most of the key informants responded by describing different program components that they offered (e.g. we have volunteer victim advocates and we do outreach). A couple of key informants responded that they did not have a model of service delivery, and several indicated that they had a sexual assault response team (SART) in place.

Rural and remote areas seldom have the luxury of having a large and specialized Sexual Assault Response Team, yet many are able to deliver core sexual assault services through collaboration with survivor advocates and several other service providers. The lack of information about what differentiates a SART from a group of service providers working together to deliver sexual assault services has created confusion in the field. Even though some rural areas appear to be operating a SART, the key informant interviews revealed that many rural service providers perceive that SARTs exist in urban areas or larger rural communities that have access to a greater number and variety of specialized resources.

Conclusion

The findings of this investigation lead to the conclusion that it is not possible to develop a model of sexual assault response based on "best practices" in rural and remote areas. This conclusion is based upon the following findings:

- The literature review and interviews of key informants revealed that no comprehensive evaluations of sexual assault service delivery models have been conducted in rural and remote areas.
- There are commonalities in the types of barriers faced by rural and remote survivors with respect to the reporting of sexual assaults and the accessibility of sexual assault services. Knowledge of these commonalities may be very useful in the education of rural advocates and others who will provide rural sexual assault services. However, the coordination and delivery of such services depends largely on other community variables, such as the number and types of other service providers available to collaborate with.

Although rural communities may share service accessibility barriers related to transportation, the nature of these barriers may be very different. For example, one community may require a solution that requires more accessible flight schedules for survivors who need to be flown to hospitals in order to obtain a forensic examination. Another community's transportation barrier may be solved by finding one volunteer to drive an elderly survivor to monthly counselling appointments within the same town (e.g. a ten minute drive).

- The literature review and interviews of key informants revealed that significant consideration must be given to the many challenges encountered by rural service providers that are seldom encountered by urban service providers.
- The literature review and interviews of key informants revealed that significant consideration must be given to the many barriers faced by survivors living in rural and remote areas in reporting sexual assaults and in accessing services. Many of these barriers are unique to individuals living in rural and remote areas; some barriers are community specific. Thus, barriers must be identified locally and solutions for overcoming the barriers must be developed locally.
- Urban models of sexual assault delivery are often developed with data and knowledge obtained through formal needs assessments. In rural, remote and northern communities, formal needs assessments are rarely conducted because of the limited resources (money, time, staff) available to conduct such research. In addition, greater amounts of financial and other types of resources are required to conduct needs assessments in rural, remote and northern regions because of accessibility issues. Accessibility to survivors and other possible research participants is limited by the sparse population, great distances that must be traveled to collect interview data, reluctance of survivors to participate in research methods that may compromise privacy (e.g. focus groups), among other factors.

As the existence of sexual assault is often strongly denied or hidden in rural, remote and northern communities, it is often difficult to get individuals to participate for fear of community ostracization and other possible repercussions.

- There is very little information, data or evidence of what the needs of rural and remote communities are with respect to sexual assault services. Data available in rural and remote areas are often unreliable and outdated. Most of the available information concerning the needs of sexual assault survivors and their families in rural, remote or northern communities is anecdotal and has not been collected in a consistent manner. The review of the literature and interviews of key informants revealed that data from nearby urban areas or data from similar sized rural areas cannot be used to generalize the kinds of services a particular community needs.

Furthermore, findings from the literature review and interviews of key informants indicate that in rural and remote areas, particular attention must be paid to the demographic and social characteristics of the community. Often, assumptions are made about the needs and barriers of the community, survivors, and service providers; these assumptions may be biased and influenced by popular belief.

- Results of the interviews with key informants suggest that best practice in sexual assault service provision in rural and remote areas involves much more reliance on the quality of individual relationships between service providers to work collaboratively and maintain respectful partnerships than the dependence upon on formal structures and written protocols often characterized by SARTs in urban areas.

Key Elements of Rural Sexual Assault Service Delivery

The review of the literature and collection of other data through key informant interviews revealed that the availability of sexual assault services and the delivery of sexual assault services vary widely within Canada and the United States. Sexual assault service provision is generally minimal in provinces and states that are not supported by government grants. Typically, those that do receive partial federal and provincial/state funding must compete with urban areas for funding that does not take into account the additional challenges and expenses faced by rural and remote areas.

The organization of sexual assault services in rural and remote areas is often approached differently than in urban areas. As a result of staff shortages, a lack of specialist professionals, and other characteristics shared by many rural and remote communities, it is neither practical nor economically feasible to operate in the same manner as urban sexual assault centres. Many of the sexual assault services available to rural and remote survivors have developed from grassroots efforts with one or two concerned and highly motivated individuals.

As discussed in the previous section, this investigation revealed that there is no best practice model of sexual assault services and service delivery for rural and remote areas. However, a number of key elements in the successful development and delivery of sexual assault services in rural and remote areas were identified through:

- (1) Information obtained through the review of the literature on rural sexual assault services.
- (2) Information obtained during the interviews of key informants.

These key elements are first outlined, then explained in detail in the section that follows.

Key Elements

It is recommended that the following key elements be considered in the development and implementation of sexual assault services in rural and remote areas.

- 1. Invest in the establishment and maintenance of cooperative, coordinated, collaborative relationships that will support effective sexual assault service delivery.**

Ideally, develop a Sexual Assault Response Team (SART) to ensure that a coordinated response system is in place. Consider using train-the-trainer seminars for professional development (see the Detailed Descriptions of Key Elements section).

- 2. Build and maintain relationships with other key individuals within and outside of the community.**

Identify and gain the assistance of individuals who are "movers and shakers" (including youth) in the community to help create and sustain community interest, involvement, and support in sexual assault service development and provision.

- 3. Initiate or support involvement in a Sexual Assault Nurse Examiner (SANE) program or a Regional SANE program in partnership with other communities.**

Prior to the development of either program, analyze the pros and cons of doing so extensively.

- 4. Support and become involved in the development of a "shared care" model of mental health services.**

The shared care model is another way in which service providers can support the emotional health of survivors.

- 5. Seek and gain knowledge about the community's needs for sexual assault services.**

Conduct initial and ongoing needs assessments to determine the sexual assault service needs of the community. Use members of different groups within the community to assist with obtaining information (e.g. youth, service groups, religious groups, ethno-cultural groups).

6. Develop strategies to confront barriers or challenges specific to the community.

- Consider the three categories of barriers discussed earlier in the literature review and in the results of the key informant interviews: (a) reasons for underreporting of sexual assaults, (b) barriers to accessing sexual assault services, and (c) barriers to the provision of sexual assault services.
- Consider other barriers and the interactions of barriers that may be unique to the community. The Nested Ecological Model (discussed earlier) may be useful in identifying such barriers (e.g. individual barriers, policy related barriers, inter-agency issues).
- Consider the "Strategies for the Delivery of Sexual Assault Services" that were identified by the interviews of key informants.

7. Tailor education and awareness campaigns to the community context.

Consider demographic variables, local knowledge, political issues, cultural issues, community schedules, community concerns, and other relevant information.

Consider developing a "Hot Peach Pages" program (see the Detailed Descriptions of Key Elements section).

8. Strive to deliver services with cultural competence.

If the community has a high population of Aboriginal people, and particularly if there is an Aboriginal settlement(s) within the community, it is essential to being working with Aboriginal people early on to develop culturally relevant and respectful programs and service delivery strategies.

9. Demonstrate commitment to the ongoing recruitment of sexual assault advocates and other volunteers.

Invest in their ongoing training and development.

10. Continually search for and maintain sources of financial support for sexual assault programs.

11. Lobby for the reduction or elimination of piecemeal funding provincially and nationally.

12. Develop long-range plans and evaluation strategies to support the sustainability of sexual assault services.

Ideally, develop long-range plans and evaluation strategies prior to the development and implementation of sexual assault programs and services.

13. Recruit generalist practitioners in the community who are motivated to provide specialized services.

Whenever possible, do not hire professionals who are interested in performing a single, narrow role in the community. Always consider how community capacity may be built.

14. Constantly search for relevant opportunities, and seize those opportunities.

Search for opportunities to network and 'build bridges' within the community. Take initiative in the recognition of opportunities and act upon them. Be informed about current events that may provide windows of opportunity to enhance participation and interest in education and prevention campaigns.

Detailed Descriptions of Key Elements

1. **Invest in the establishment and maintenance of cooperative, coordinated, collaborative relationships that will support effective sexual assault service delivery.**

Coordination, Cooperation, Collaboration are essential in:

- Providing a continuum of sexual assault service delivery
- Providing information and sexual assault service delivery to a wider and more diverse number of people
- Delivering consistent and accurate messages about sexual assault and sexual assault services
- Communicating information about sexual assault in a manner that is non-threatening to the community
- Showing support for and build the strength of other community-based initiatives
- Supporting sustainability of sexual assault programs and services

Sexual assault does not fall neatly into the category of a health issue, counselling issue, criminal justice issue or human rights issue – it is all of these. Therefore, no one system alone can provide an effective response to sexual assault. A consultative, coordinated or collaborative response from the health care, counselling and criminal justice systems will have the best chance of meeting the needs of a survivor of sexual assault.

(Light, 2000; cited in Community Coordination for Women's Safety, 2002a)

Cooperation

Cooperation

Cooperative relationships and agreements among organizations are excellent ways to offset some of the costs of operating sexual assault centres by sharing various types of resources with others in the community.

For example, counselling and temporary housing for survivors of sexual assault may often be found through survivor assistance programs or shelters for abused women. The advantages of cooperative agreements are that many of the

overhead costs of offering sexual assault services can be shared with other helping organizations (e.g. rent, utilities, support staff). In another example, an organization for immigrant women may provide office space for a sexual assault centre. The immigrant serving organization may work with the sexual assault centre to help with language interpretation of women who have limited or no English speaking skills. Likewise, the immigrant serving organization might refer immigrant women requiring sexual assault services to the sexual assault centre. The provision of some services may require a greater development of working relationships than just cooperation.

Coordination

Coordination

Coordination may work to fill gaps in services and to create a more barrier-free and united response to sexual assault.

For example, a hospital may agree to contact the sexual assault centre when a sexual assault survivor enters the emergency department to have an advocate be present at the hospital. The hospital and sexual assault centre may coordinate to create a protocol to support this agreement. The agreement may also include coordination of services by law enforcement, who may have brought the survivor to the hospital, and who may subsequently transport the survivor to a shelter, sexual assault centre, or other place.

Collaboration

Collaboration among service providers and key individuals and groups in the community is an essential part of sexual assault service provision in rural and remote areas. Collaborative service models are important to provide continuum of service delivery (Sheehan, Meurs & Flanagan, 2001). The development of a Sexual Assault Response Team (SART) is a collaborative effort in which sexual assault services are delivered by a team of service providers. In a very remote area, the team may consist of a sexual assault advocate and a law enforcement officer.

Collaboration

The goal of collaboration is to create a safety net with no holes for survivors to fall through. It is an in-depth (often written) working relationship where each discipline has a defined role and responsibility and there is mutual understanding of others' roles and responsibilities.

Collaboration can result in a community-wide protocol for responding to sexual assault. Forming a collaborative sexual assault response is successful when there are sufficient people in the community who are committed to caring about sexual assault service provision and work together to address it on an ongoing basis.

Mason (2001) has emphasized how strategically important it has been for rural services to build collaborative relationships with local networks to better ensure the successful operation of specialist sexual assault services. Mason describes how the expansion of rural sexual assault centre to include a 24-hour crisis care response to survivors of recent sexual assault was dependent on positioning the role of the service within the context of health and other key community service networks. Doing so helped to secure the support and involvement of professionals who might otherwise not have agreed to work in partnership with them. This has allowed those with substantial influence in the community to become better educated of the need for specialist but coordinated service response to sexual assault.

Train-the-Trainer

Train-the-Trainer Workshops and Seminars

Use of Train-the-Trainer workshops and seminars is increasingly used as a way of collaborating with other organizations for professional development. Train-the-Trainer refers to professional development workshops, seminars and other resources (books, videos, manuals) that are designed to provide training to sexual assault and other service providers (e.g. law enforcement, social workers, survivor advocates, physicians, nurses, mental health workers).

The intent of such training is to help anyone who might be a point of access for a survivor to feel comfortable sharing sexual assault information in a sensitive and effective way. When sexual violence materials are given to local agencies to distribute to survivors, it is much more likely that they will incorporate the information into their practice if that information has been mentored into their workplace through training.

Train-the-Trainer is an effective way to deliver consistent education, information, and technical assistance to the target audience. In rural and remote areas where the presence of specialized sexual assault professionals is rare, Train-the-Trainer sessions can help to increase the likelihood that local service providers will feel confident in helping survivors with specialized issues, rather than simply referring them on to urban centres that may be inaccessible to survivors.

The Alaska Network on Domestic Violence and Sexual Assault (ANDVSA) Train-the-Trainer Project in Alaska is a good example of how rural and remote areas can benefit from this approach.

The following are some examples of Train-the-Trainer workshops and seminars that have been offered in the United States and Canada:

- Information Technology Training
- The Dynamics of Sexual Assault - myths and realities, survivor perspectives, barriers to reporting
- How to Interview Survivors of Sexual Assault - overcoming credibility challenges, barriers to effective interviewing, stages of effective interviews, how to handle disclosures
- Drug Facilitated Rape Investigations - types of drugs used, effects of the drugs, investigative strategies
- How to Complete a Forensic Examination - correct procedures for completing a rape kit, how to preserve forensic evidence
- Sexual Assault in Survivors with Disabilities and Elderly Survivors - barriers to reporting, barriers to identification of, prevention strategies
- Sexual Harassment - defining sexual harassment, barriers to reporting sexual harassment, strategies for dealing with sexual harassment, laws about sexual harassment
- Juvenile Sex Offenders - barriers to identification of, strategies for working with, programs available for
- Alcohol and Sexual Assault
- Child Sexual Assault
- Self-Defence Techniques & Creating Self-Protection Plans
- Conducting Background Checks for Volunteer Advocates - procedures, barriers to conducting checks
- Training Survivor Advocates - instruction on how to train advocates, addressing different learning styles, how to conduct presentations, educational materials, handling advocate biases, advocate boundaries
- Conducting Community Needs Assessments
- Emergency Contraception Following Sexual Assault
- Witnesses of Sexual Assault - use of expert witnesses
- Male Advocacy
- Advocacy of Immigrant and Non-English Speaking Survivors
- Sexual Assault Program Sustainability and Funding
- Restorative Justice - what it is and how it works
- Steps for SART Development, Implementation and Sustainability

- Therapeutic and Counselling Techniques for Treating Survivors
- Leadership - developing and funding sexual assault crisis centres, nonprofit management, standards, managing groups

Communication

Communication

Communication is, of course, essential in carrying out the processes of coordination, cooperation and collaboration effectively. In communicating information, personal contact and word of mouth are important processes in rural areas. It is important to look for opportunities to provide outreach in ways that offer direct, face-to-face access for victims/survivors. Informal contact with personal interaction is often more meaningful and less intimidating for rural people seeking information and assistance.

(Doherty, 2002)

Value of Establishing Personal Relationships in Community

Perhaps even more important than in urban areas, taking the time to establish and maintain good personal relationships with service providers is often more effective than simply attending group interagency meetings (although such meetings are often essential in decision-making and organizational processes).

Consult Community for Local Knowledge and Expertise

Tapping into the expertise of local people is important - they may have prior knowledge that can save time, money, and effort. As discussed by Doherty (2002):

People living and working in rural communities know what works and does not work. They know what nights to avoid, like bingo night. They know when men and women are involved in seasonal work and the most appropriate public relations strategies for reaching the target audience. One rural community suggested that information sessions for women should be timed with the departure of the men in the community who work in the woods for several weeks at [a] time. Others tied events to when the boats were away fishing and so on. It is important to know about the "life" of the community and when and how to deliver information. (p. 34)

Rural people should be consulted about the content and relevance of information to be disseminated - and whether they feel that there is any information missing. In addition, it is important to find a variety of appropriate places to display informational materials.

As not all people will be comfortable picking up information about sexual assault when in openly public areas, with permission, information could also be placed in private examination rooms of clinics, restrooms, and change rooms. Messages, brochures, and posters directed at men could be placed in garages, bars, and gyms (Doherty, 2002).

Acknowledge and Express Appreciation for Local Involvement

In rural areas, where people often have to travel fair distances to attend meetings, it is important to acknowledge individuals and show appreciation for their participation. If it is possible, make certain that refreshments are served and provide lunch if the meetings occur over the lunch hour.

Some rural service providers have suggested that in order to reach the people who need information the most, it is better not to hold events that are advertised as "women only" events or "sexual assault information sessions", or some individuals will feel threatened, and will discourage or prevent others from attending (Doherty, 2002).

Communicate Confidence in the Community

It is important not to impose "set" projects on rural communities. Instead, projects which communicate the message of having confidence in the community (i.e. through turning ownership over to local committees) work well because they build community self-confidence in creating and implementing local solutions. Local service providers should always be consulted and asked to act in an advisory capacity when developing programs and products such as informational brochures (Doherty, 2002).

Communicating and Delivering Consistent Messages

Because of the shortage of financial and professional resources in rural and remote areas, sexual assault programs and services for adult survivors are frequently housed within organizations or programs that serve a broader population.

Cooperation, coordination and collaboration with other agencies is essential to communicate a consistent message with respect to sexual assault issues in rural communities. This enables sexual violence and sexual assault services

information to be disseminated through a number of different organizations so that a larger and wider audience can be reached.

Consistency and accuracy of information is essential; conflicting information can create confusion and misinformation - albeit unintentional - that may be detrimental to the creation and delivery of sexual assault programs and services. To help ensure that consistent information is delivered to the community, the following strategies are suggested:

- Regularly provide partnering agencies and organizations with up-to-date information brochures and other materials that have been developed for dissemination by the local sexual assault centre so that such materials can be referred to and handed out when required.
- If partnering agencies and organizations have information/education sessions (e.g. about domestic violence, substance abuse, mental health), ask if a representative of the local sexual assault centre can speak briefly about sexual assault and its relationship to the topic (e.g. domestic violence). The representative can be available later to answer questions and provide informational materials.

Deliver Concise Messages Using Plain Language

Materials and messages aimed at reaching survivors of sexual assault should be simplified, concise, and use plain language. Highlight local contact numbers for service providers, toll-free numbers, or local help lines that can offer greater assistance and detail (Doherty, 2002). Pictures and graphics can also be effective to attract attention.

Communicate with Sensitivity to Rural Social and Cultural Factors

Information about sexual assault and the ways in which sexual assault services are delivered must address obstacles that are often associated with living in rural and remote areas (e.g. transportation, poverty, literacy), as well must be culturally appropriate and relevant.

Findings from a study by Hornosty and Doherty (2001) on family violence in rural areas suggested that materials, programs and information targeted at rural areas should incorporate examples of abuse that are relevant in a farm or rural context.

Similar to urban areas, rural areas are often characterized by the existence of multiple "cultural" groups or settlements. There may be groups within cultural groups, or people may belong to more than one cultural group. The point in identifying these groups is to find as many ways as possible to communicate with members of the rural community. For example, if there is a Hutterite colony in the

community, members of the colony should be asked to assist in the planning and delivery of sexual assault services. If there is a large population of immigrants and/or refugees to the area, representatives of each cultural group should be consulted for input and assistance.

In Canada, the United States and other countries, many sexual assault programs have directed their attention to building relationships across existing services by offering training and support to other professions such as general practitioners, police, and hospital staff. In turn, sexual assault programs may be the recipients of specialized training and support. For instance, a forensic examiner might deliver training to physicians, survivor advocates, police, and nurses on how to correctly complete a rape kit, and discuss the importance of each step in the process. This type of cross training is recognized as being important in encouraging a more coordinated and sensitive response to survivors of sexual assault.

Building and Maintaining Relationships with Key Individuals Within and Outside of the Community

Regular and effective communication can build strong and trusting relationships in the community over time. This may allow service providers to gain access to schools and community forums where sexual assault can be addressed in preventive ways (Lewis, 2003b).

Rural service providers have identified the importance of developing and maintaining relationships with key individuals who may live outside of the community, but who may be instrumental in providing assistance in other ways. For example, maintaining relationships with key individuals such as administrators of foundations or organizations that have previously provided funding or may be a source of future funding.

Many provinces have family violence committees, inter-agency committees, family violence working groups or advisory committees that are consulted by government and others. Connection to and participation in such forums is important. Such connections may ensure that small rural organizations are part of a larger strategy (Doherty, 2002).

2. Build and maintain relationships with other key individuals within and outside of the community.

It is essential to identify key people in the community who are local "movers and shakers" and who have an interest in the provision of sexual assault services. These people might be individuals with no previous affiliations in the community, or might be those who serve in service groups such as the Rotary Clubs, women's groups, family groups or church groups.

Working with schools or churches provides many existing contacts and opportunities for reaching rural residents. Such organizations may have the capability of delivering information and knowledge through radio announcements, local television stations, school and church bulletins, and posters.

3. Initiate or support involvement in a Sexual Assault Nurse Examiner (SANE) program or a Regional SANE program in partnership with other communities.

Prior to the development of either program, analyze the pros and cons of doing so extensively. If there is a low demand for sexual assault services in the community, training a SANE may not be the best use of available resources. If neither an individual SANE or Regional SANE program is feasible or practical, consider alternatives. For example, it may be possible for a physician or public health nurse may receive specialized training to conduct forensic examinations and provide appropriate information and support.

4. Support and become involved in the development of a "shared care" model of mental health services.

It is a well established finding that sexual assault in childhood often has profound and lifelong consequences on both the physical and mental health of survivors. Adult survivors may suffer from post-traumatic stress disorder, psychological reactions, depression, and other mental health related disorders.

Therefore, any strategies and programs that promote the mental health and well being of individuals will complement the delivery of sexual assault services within a community.

5. Seek and gain knowledge about the community's needs for sexual assault services.

Conduct initial and ongoing needs assessments to determine the sexual assault service needs of the community.

If resources are not available to conduct comprehensive needs assessments by an external researcher, other types of information (qualitative and quantitative) may be gathered by service providers to *gain insight* into the types of sexual assault services needed, and the extent of that need.

6. Develop strategies to confront barriers or challenges specific to the community.

A. Consider the three categories of barriers discussed earlier in the literature review and in the results of the key informant interviews:

(a) Reasons for underreporting of sexual assaults:

- Distrust of outsiders and suspicion of policy solutions "imported" from the city
- Acceptability/normalization of sexual assault
- Fear of not being supported or believed
- Lack of culturally appropriate responses
- High acquaintance density
- Low anonymity, concern for confidentiality and privacy
- Limited telecommunications
- Issues with police response and court system
- Fear of revictimization by "the system"

(b) Challenges to accessing sexual assault services:

- Acceptability/normalization of sexual assault
- Dependency on perpetrator
- Geographical isolation
- Emotional distance
- Accessibility to transportation
- Limited telecommunications infrastructure
- Rural values
- Lack of available time
- Culture, racism and religious influences
- Fear of ostracization, retaliation, deportation, and other repercussions
- Denial
- Limited options for legal representation
- Low rates of prosecution
- Privacy and confidentiality issues
- Availability of weapons
- Lack of awareness/information/knowledge
- Service provider incompetence

- Lack of sensitivity and revictimization
- Limited sexual assault service availability
- Lower literacy levels
- Inability to speak English
- Lack of related support services
- Distrust, fear and suspicion of human services
- Work-related issues
- Lack of Education, Skills and Opportunities
- Lack of health insurance
- Perceptions of service affordability

(c) Challenges to the provision of sexual assault services:

- Insufficient funding for rural services
- Safety issues and burnout of sexual assault workers
- High staff turnover
- Retractions of sexual assault disclosures
- Lack of access to specialized treatment and diagnostic resources
- Lack of other specialized service providers
- Public scrutiny of service providers
- Geographical isolation
- Limited telecommunications
- Turf wars and service provider resistance to change
- Concentration of authority
- Concerns with law enforcement
- Problems with the criminal justice system
- Delayed court proceedings
- Ideological loneliness of service providers
- Denial of existence of sexual assault by service providers
- Denial of existence of sexual assault by community residents

B. Consider other barriers and the interactions of barriers that may be unique to the community. The Nested Ecological Model (see page 70) may be useful in identifying such barriers (e.g. individual barriers, policy related barriers, inter-agency issues).

C. Consider the "Strategies for the Delivery of Sexual Assault Services" identified through the interviews of key informants in this study (see page 81). In particular, consider:

- The use of alternative scheduling of counselling appointments to better accommodate the needs of survivors in rural and remote areas.
- Spending three continuous days in remote communities to deliver prevention and education workshops to more than one group of residents rather than making three separate trips at different times of the year.
- Setting up a 24hour/7 days per week sexual assault help line that is shared with other communities. The answering service immediately patches the survivor through to volunteer staff in the survivor's community who work from their homes to provide local advocacy and support.

7. Tailor education and awareness campaigns to the community context.

Knowing the needs of the community and characteristics of the community is essential so that educational materials and awareness campaigns can be tailored to meet the various needs of the community. Often, this will involve making changes to the types of examples that are used in presentations and print materials. In rural areas, the "one size fits all" mentality does not work well.

In order to effectively reach people in rural and remote communities, education and information must be delivered in a manner that is appropriate, sensitive and relevant to the social context in which it is being delivered. Thus, if the target audience consists primarily of farm women, examples should be incorporated that local farm women in the area can identify with.

This strategy is supported by findings of a report on family violence in rural areas, which suggested that family violence materials, programs and information should incorporate concrete examples of abuse that are relevant in a farm or rural context. For instance, printed materials might indicate that emotional abuse may take many forms which sometimes involve blaming the survivor for everything that goes wrong around the farm, including broken equipment or bad weather (Hornosty & Doherty 2001).

Education and awareness campaigns must be delivered in different formats and in a variety of contexts to reach as many people as possible. People have different ways of thinking and reacting to educational opportunities, learning and processing information, and assimilating information. Attention must be paid to these different styles.

It is important for service providers to look for outreach opportunities that offer direct, face-to-face access for women and other rural survivors.

There's always something going on, no matter how tiny the community. We just get in there and become part of it. It works because it's so simple and informal, and it doesn't intimidate people.

(Susan Doyle, Public Legal Information Association of Newfoundland, cited in Doherty, 2002)

Doherty (2002) has suggested the following strategies as they apply to the delivery of violence education information and awareness efforts in rural areas:

- Incorporate family violence information into “non-threatening events” such as health fairs, baby clinics, summer festivals, etc. Take advantage of the crowds gathered at events organized by other agencies and other local community events. Ask permission to do a presentation or set up a booth to distribute information and awareness pamphlets.
- Do not hold events that are advertised as “women only” events or “family sexual assault information sessions”. Turn the event into a social or potluck affair and provide the information along with other materials.

As expressed by one rural service provider:

We were told by our rural advisors, ‘don't make it sound as if the event is only for women or it'll turn the men off and they won't “allow” their women to come.

(Maria Franks, Legal Education Society of Nova Scotia; cited in Doherty, 2002, p. 35)

- Non-threatening events may be associated with places people already frequent, such as church suppers, socials, family and child welfare events and health related events. By incorporating the information into the context of general events, it is easier for women to attend.

Use of Printed Materials

In rural communities, printed materials can facilitate easy and safe access. Printed materials still tend to be one of the most popular ways of sharing information about sexual assault. Printed materials may include some of the following: articles written about sexual assault in locally distributed newsletters or local newspapers, posters, flyers, pamphlets, booklets and handbooks.

The format of printed materials is often an important factor in whether survivors in rural areas will be able to access and store the information easily and safely. In order to address issues of safety and privacy, some organizations have presented sexual assault information in innovative and unusual formats. These have included:

- Creation of wallet-sized cards with contact numbers of police, legal aid, crisis lines, mental health, and other organizations
- Collection and subsequent use of clean, empty lipstick tubes to hold a small piece of paper that has contact information to help survivors. Such information can be kept close at hand, and can be easily hidden in a survivor's pocket or purse.
- Distributing bookmarks (in libraries, at events) that refer people to web site information or other contact information to help survivors
- Creation of posters that describe sexual violence and provide toll-free or contact numbers
- Creation and printing of stickers with short, direct messages about sexual assault

Use of Audio-Visual Materials

- Developing locally produced videotapes/DVDs which educate and inform the community about sexual assault. Different videos could be targeted at different audiences (e.g. youth, the elderly, immigrant groups).
- Developing video games or other multi-media or internet related products targeted at the youth population. Local youth who have an interest in developing multi-media projects may be recruited to assist; involving youth might have the additional benefit of exploring youth-related funding to complete such projects. This would also provide some income for youth, could increase the likelihood that other youth in the community would find the material interesting and useful, and would contribute to the development of community capacity.
- Television, radio advertisements or talk shows on the radio are good ways to reach rural people in education and awareness campaigns. In some rural communities, people listen to satellite radio and Internet radio, although usage is still low. The downfall to using these methods is that few sexual assault programs are able to afford these types of education and awareness campaigns. Partnering with local television, radio stations and businesses that will sponsor the campaigns is a strategy that sometimes works. However,

there is still a fear in rural areas that such sponsorship may lead to community ostracization and a decline in business for the sponsoring agency.

- Advertising campaigns, billboards and poster campaigns.
- Toll-free Information Lines are important means of communication in rural and remote regions where neighbors are separated by distance. A toll-free sexual assault line helps to address the financial constraints of rural people as well as concerns related to privacy and literacy. There must be on-going advertising to promote the purpose of the help lines and create familiarity with where to find the numbers. Advertising should be widespread and in places frequented by rural people. Listing of toll-free information and crisis lines in telephone directories has been found to be effective.

The Government of Saskatchewan, SaskTel, and the Saskatchewan Provincial Association of Transition Homes partnered to produce the "Hot Peach Pages" (whose name is being changed to "Abuse Help Lines"). These are peach-colored pages in the telephone directory which contains a written description of what constitutes abuse, a list of help lines, and information on where an individual can go for help. The Hot Peach Pages concept is also being used in the Yukon Territories. The Hot Peach Pages have been put on the Internet (www.hotpeachpages.net/canada) so that accessibility to information on domestic violence and sexual assault is available to Canadians in all provinces.

Use of the Internet

The Internet and new technologies are being used increasingly by sexual assault organizations to distribute information through the development of their own web sites. The effectiveness of the Internet as a distribution tool for rural and remote areas is growing. For the majority of survivors living in rural and remote areas, however, accessibility to the Internet is still not a viable and safe way to obtain the extent and wide range of support services that are often needed in providing a continuum of care.

With technological advancements, some organizations have been successful using the Internet in delivering education, information, support, and a sense of connectedness to survivors of sexual assault in rural and remote areas (e.g. The Rural Womyn Zone, available at <http://www.ruralwomyn.net>).

Results of an Ipsos Reid study indicated that Canadians are spending an increasing amount of time using the Internet, with the average usage being 12.7 hours per week, compared to television viewing of 14.3 hours per week and radio listening of 11 hours per week (Ipsos-Reid, 2005). Since perpetrators of sexual violence within the same household can track the Internet sites that their survivors have been accessing, it is important to create partnerships with community access

sites, libraries and other places that provide a “safe place” for abused women to gather information on the web and find out about their rights. Accessibility to the internet on a household basis remains a barrier for residents of rural and remote Canada.

A study on Internet usage among rural Canadians conducted by Statistics Canada (2004) found that:

- Internet use is lower among households outside the 15 most populated census metropolitan areas, even after three main factors are taken into account: age and education of household head, income of the household. Thus, rurality was suggested to be an independent constraint on Internet use.
- Households outside the 15 major urban centres in Canada with children aged 18 and under were more likely to access the Internet than their urban counterparts.

A limitation to the above study is that households in the Yukon, Northwest Territories and Nunavut were not included in the survey.

8. Strive to deliver services with cultural competence.

Critical to creating success in the delivery of sexual assault services to rural areas is the identification of the sub-cultures that exist within the community. All service providers involved must strive to deliver services to each individual they encounter with cultural competence. Core activities such as collecting and analyzing data, design and implementation of programs and evaluation of programs need to be guided by and conducted within the context of the unique aspects of various populations within the community.

Within the context of this report, we have viewed the meaning of the word culture with a broad perspective that includes ethno-cultural groups and various types of socially constructed groups. Some of the cultural groups that have been identified in this report include: Aboriginal peoples, farmers, farm women, immigrants, and people of non-English speaking background.

Given the social, cultural and linguistic diversity of cultural groups in Canada, generalizing about the sexual victimization of certain cultural groups runs the risk of reinforcing ethnic stereotypes. Each individual has their own sense of social identity and cultural ties, and their experiences may differ widely according to numerous variables including age, socioeconomic status, political beliefs, religious beliefs, etc. Moreover, individuals often identify with or belong to several cultural groups and sub-cultural groups within a community. The development of cultural competence in individual service providers is a complex and ongoing process, and is beyond the scope of this report.

If the community has a high population of Aboriginal people, and particularly if there is an Aboriginal settlement(s) within the community, it is essential to begin working with Aboriginal people early on in the development of culturally relevant and respectful programs and service delivery strategies.

9. Demonstrate commitment to the ongoing recruitment of sexual assault advocates and other volunteers.

Finding and keeping advocates and other volunteers is often a great challenge in rural and remote communities. Advocates and other volunteers working for sexual assault programs and services must receive specialized rural training. Recognize that ongoing training requires additional time commitments from volunteers. Show genuine appreciation for their work and invest in the best quality training that is within the budget for their professional development.

In order for a coordinated community response approach to be successful, advocates specially trained in immediate intervention can provide timely and effective accessibility of information to survivors and survivors.

Advocates also play another key role in the accessibility and delivery of rural sexual assault services. It is essential that ongoing feedback from advocates regarding survivor needs is obtained and used to inform program development and practice. As described by Thelen (2000),

Finally, for a coordinated community response to be effective, it must institutionalize ongoing feedback from advocates on the effect of any reform on the victim. Though each representative of an agency that comes into contact with the victim can develop a sensitivity to the effects of their individual and agency actions on [the victim], their involvement with [the victim] represents only a fraction of [the victim's] journey through the system.

Advocates are uniquely situated to represent the totality of [the victim's] experience because of their ongoing involvement with [the victim] in a variety of settings for an extended period of time, from arrest through case disposition and beyond. Additionally, because advocates' primary allegiance is to the victim and because, ideally, they are not employed by the system, they can afford greater objectivity to observe and identify problems still existent in the system. Without centralizing ongoing feedback from independent advocates to identify continuing problems in the systematic response, a coordinated community response will not keep victims safe, hold offenders accountable or change the climate in the community (pp. 4-5).

Advocates assist with community collaboration and help to sensitize their communities to sexual assault issues. Depending upon the community, advocates employ different strategies and represent varying degrees of involvement with the system.

In rural and remote areas where populations are sparse, and where 'everybody knows one another', survivors may not feel comfortable speaking to an advocate - even though advocates are held to high standards of confidentiality. Advocates have the responsibility of helping survivors do things for themselves and becoming their own best advocate.

It is therefore important that the training of advocates in rural and remote areas is specialized. Advocates must be knowledgeable about the barriers to disclosure of sexual assault, the barriers to accessing services, and the barriers faced by service providers in delivering sexual assault services in rural and remote areas. Such knowledge will enable advocates to communicate more effectively with survivors and to develop strategies for assisting survivors in ways that best suit their needs and takes into account the logistics of accessing and receiving sexual assault services.

10. Continually search for and maintain sources of financial support for sexual assault programs.

One of the greatest factors affecting the availability of sexual assault services in rural and remote areas is the availability of sufficient funds to organize, create, and sustain sexual assault programs.

Directors of sexual assault programs indicate that funding issues are a large part of their responsibilities as program directors. The former advocacy role, which is still a central part of the director's mission, is becoming secondary to that of fundraising in many organizations. In addition, the value of staff with development/fundraising skills is increasing. This mindset is not changing because directors and staff are less committed to their mission, but out of necessity, because the mission is becoming more difficult to achieve in light of existing financial constraints.

Rural and remote areas often have substantial costs related to the transportation needs of survivors and advocates that are not encountered to the same extent in urban areas. Individuals living in rural and remote areas can seldom afford to pay for the costs of transportation over long distances. Many rural and remote areas do not have long distance bus service, and the cost of taking a taxi, plane, ferry, or train to access a sexual assault centre or hospital may be prohibitive - especially if multiple trips are essential.

Ongoing counselling and follow-up care is often required, yet often not available due to shortages of staff and expenses related to accessing counselling services (travel, accommodations, loss of work time, child care costs and availability, lack of or insufficient health care insurance).

If trained volunteers are unavailable, financial resources are required for the provision of sexual assault services such as court accompaniment, referrals to survivor assistance programs, referrals to medical and psychological services, transportation to criminal justice related appointments, emergency financial assistance or referrals, assistance in preparing victim impact statements, and outreach services.

Dedication to ongoing fundraising efforts is essential for sexual assault centres. Developing, adapting, and sustaining an effective fundraising strategy is fundamental. The provision of sexual assault programs and services is dependent on the receipt of sufficient funds. Ongoing fundraising in the community to support sexual assault programs and services helps to raise and maintain awareness of sexual assault and sexual assault programs and services in the community.

Local fundraisers and community solicitations are common in domestic violence and sexual assault programs. However, for many organizations, these efforts are challenging and have limited returns. Programs often spend many days preparing mailings or organizing events, which can be taxing on a small staff. Additionally, fundraisers often only earn a couple thousand dollars. However, in many cases, well-organized annual fundraisers and individual donor solicitations can provide some of the most consistent sources of long-term funding.

Rural Strategies for Saving Money and Generating Financial Support

- Since 24 hour sexual assault crisis lines are expensive to operate, some sexual assault programs share operational costs with domestic violence programs, creating a sexual assault/domestic violence crisis line. In some communities, local answering services have been asked to donate their time to answering crisis calls during the night. These calls are then forwarded to the home of a volunteer who is "on-call" to take the crisis call.
- Regional or province-wide crisis lines could be developed to eliminate challenges organizations face in staffing and paying for a 24-hour phone line. Instead, volunteer/professional time and program money could be redirected to other services and programs. Critics of this approach suggest that speaking with an advocate that understands local information and issues is invaluable. Alternatively, a regional or provincial crisis line could be used as a complementary service; it could fill in during volunteer shortages and after hours.

- A regional/provincial phone line(s) may garner support from foundations, which are increasingly interested in programs that endeavor to lower program costs and minimize duplication of services.
- Whenever possible, try to recruit advocates and volunteers who have previous experience with fundraising and grant writing.
- Many non-profit agencies are creating social entrepreneurial ventures which can provide them with a greater source of more consistent revenue which is not earmarked (traditional funding streams often require evidence that allocated funds are used in specific ways). Such for-profit ventures can serve multiple purposes.
- Collaborate with other sexual assault centres in other areas of the province in for-profit ventures. For example, thrift stores in rural and remote areas may not have a sufficient population base to provide adequate types and amounts of donated items. Some thrift stores in large cities receive so many donated items that they choose which items to be sold in the stores, and discard the remainder. Such discarded items could be transported to thrift stores in rural and remote communities through a network of volunteer drivers (including transport trucks who could be asked to volunteer their services periodically).

11. Lobby for the reduction or elimination of piecemeal funding provincially and nationally.

Many sexual assault centres and programs rely on funding obtained year to year from a variety of sources. Such an approach may prevent or compromise the ability of communities to provide an essential continuum of sexual assault services to their residents.

With respect to violence prevention programs, Jiwani (1999) indicates that:

The lack of continued funding for prevention programs results in a built-in capacity for failure for many of these programs. This is due primarily to the intermittent implementation of these programs which is contingent on funding; the over-use of voluntary labour, or the reliance of the program on the presence of one core person; the tailoring of programs to capitalize on different but related issues in order to get funding; and, the piecemeal funding afforded to anti-violence programs where a multiplicity of organizations apply on a project basis to one funder and are allocated minimal amounts.

The state of Hawaii has been successful in obtaining stabilized funding for "a more uniform, coordinated system of statewide services for sexual violence victims". The strategy enables core sexual assault services to be delivered through

statewide sexual assault service provider agencies (Sexual Violence Strategic Planning Group, 2005).

Address the "Band-Aid" Approach to Piecemeal Funding

Band-Aid Approach to Piecemeal Funding

Frequently, agencies that provide sexual assault services must compete annually against one another to the same funder(s) for often minimal amounts of money to operate particular programs. Inadequate and piecemeal funding can lead to a "Band-Aid approach" to sexual assault provision, the deterioration of existing services, and the limited ability to deliver reliable, consistent and essential sexual assault services to survivors.

As identified by the Sexual Violence Strategic Planning Group (2005), limited and piecemeal funding may also:

- Erode the infrastructure of sexual violence programs, which may result in high staff turnover.
- Limit the capacity of sexual violence programs to expand their scope of services.
- Discourage the provision of comprehensive outreach approaches to underserved survivors (such as immigrants, elderly, persons with disabilities, survivors of sex trafficking, persons with limited English proficiency, and gays/lesbians).
- Limit the ability of the organization to participate in long-term strategic planning.
- Take a toll on the scope of services delivered. For example, rather than providing needed services of survivors of sexual violence, the service providers have had to divert their personnel resources in order to manage the multiple funding grants (since each grant usually requires specific, written, quarterly reports and data to account for the funds).

12. Develop long-range plans and evaluation strategies to support the sustainability of sexual assault services.

Many sexual assault programs and services in Canada and the United States operate on a year to year basis, and survive on grants and donations obtained through a variety of sources. Sustainability of innovative, exciting, promising practices are often a significant obstacle to the ongoing success of projects. Many

initiatives described as being promising practices that are no longer in existence were funded as one-time projects.

In the area of sexual assault, some practitioners have been involved in highly successful initiatives, however, once the funding is over, the initiative ends, and the "trial" population that was being served by the program is left with no services.

Especially in the field of social service provision, it is very difficult for rural communities to deal with decreases in the types of services available. In 2002, community-based survivor assistance programs and women's sexual assault centres in British Columbia had their provincial funding cut by more than one million dollars. The funding resulted in the permanent closures of some women's centres and reduced accessibility of sexual assault services to survivors.

The following have been identified in the literature as being important to the sustainability of sexual assault services:

- Goal setting and creating indicators of success
- Gathering of qualitative information
- Addressing the "band-aid" approach to funding

Goal Setting and Creating Indicators of Success

A key to developing sustainable services is clear identification of what long-term goals and related objectives need to be accomplished, and how success will be defined (Doherty, 2002):

- Set standards to measure progress and success of objectives. For example, if a new web site is to be developed, a goal should be set for how many hits from visitors are expected each week. If a related objective is to increase the number of weekly hits through a promotional campaign, a way to measure the hits must be put into place in order to measure the outcome. Another way to measure the success of a website is to find out how many sexual assault inquiries received were initiated by people viewing the website.
- Generate proactive and innovative strategies to meet goals and objectives. Find ways of monitoring the effectiveness of informational materials. For example, by monitoring the number of daily inquiries about sexual assault, a baseline statistic can be established (e.g. 3 inquiries per day). With a baseline, it is then possible to measure the impact of an awareness campaign (e.g. inquiries increased to 6 per day after the campaign was launched).

Gathering of Qualitative Information

Doherty (2002) noted that many public legal education and information organizations use anecdotal feedback from front-line service providers who distribute family violence information directly to abuse survivors to determine whether the information is helpful and making a difference.

The feedback from people who have called an agency directly for information also sheds light on whether information has been difficult to understand and how useful it is. Doherty identifies one community initiative used newspaper articles to provide information about family violence; the initiative reported that the local committee received a letter from a woman thanking them for saving her life. That letter became a key indicator of success and a motivation to continue the public awareness effort.

Other types of information can be very useful in measuring progress. For example, keeping track of the number and type of organizations that wish to form mutual partnerships is an indicator that a process to ensure success in the long term is being achieved (Doherty, 2002).

As outlined by Doherty (2002), success can be measured by monitoring growth in requests to deliver information at events:

- Many organizations encourage other community organizations to call when they are organizing events in their area and want a speaker to address a specific topic. By monitoring where, how often, and what topics are requested, it is possible to identify and target gaps in service delivery.

In rural and remote areas, a more proactive and small-community approach is to visit or call other organizations and offer to serve as a speaker on a topic that may be relevant or of interest to them. For example, appropriate topics to approach schools might include: date rape, drug facilitated rape, sexual harassment, child sexual assault.

- If “information requests” are used as an indicator of interest in a topic, then services must be promoted so that people are aware that they can make requests. It may not be a lack of interest that is keeping people from calling and booking a speaker, rather a lack of awareness of what is available.
- In Saskatchewan, calls to help lines were monitored for three months after the Hot Peach Pages had come out to determine if this project made a difference in access. The service agencies reported anywhere from 12% to 100% of the callers having found their number from the new peach pages. Usage of the phone book was highest in rural areas. This kind of evaluative information supports the maintenance and continuation of such services.

We track the number of people who attend our workshops and we judge our success by how often we get asked to do more.

(Kim Winger, Portage College; cited in Doherty, 2002)

New sources of funding must be continually explored, and relationships with previous sources of funds must be maintained. This often involves collecting "evidence" of the need for programs and services, and which usually involves collecting user statistics and conducting evaluations of programs and services on a regular basis.

Sustainable programs:

- Have clear goals and objectives.
- Recognize that the collection of data (qualitative and quantitative) is important in documenting achievement of goals and objectives
- Use a variety of indicators of success, such as getting more people involved in the planning and delivery of programs and services, monitoring requests by other service providers or organizations for information and education.

13. Recruit generalist practitioners in the community who are motivated to provide specialized services.

The rural practitioner must be a generalist who is capable of providing a variety of interventions, since most rural communities cannot afford many specialists or different referral sites. It is difficult to provide effective services in rural areas in which boundaries of professional identity and role must be carefully maintained.

In urban areas, it may be possible to have child protection workers doing only child protection work and not extending themselves into family counselling, or to have family counselling delivered solely by psychologists. In rural settings where professional expertise is at a premium, more flexibility in treatment roles is required if local treatment programs are to be developed and delivered effectively (Trute, Adkins & MacDonald, 1994).

Existing professionals who are asked and supported by rural communities to expand their practice through education and training may find the new experiences to be stimulating, energizing, and an opportunity to expand their therapeutic

abilities and widen their professional contribution to the community (Trute, Adkins & MacDonald, 1994).

14. Constantly search for relevant opportunities, and seize those opportunities.

It is important to take advantage of opportunities to build bridges with other service providers. Partnerships that are strengthened by situational variables are very important in creating awareness in the community, working together for a common cause, and delivering consistent information and messages to residents.

Current events and local issues can also create opportunities for outreach. High profile news reports of sexual offences within the country, province or community provide excellent opportunities to inform the community about myths and facts related to sexual assault. Residents are more likely to read educational material and attend to radio discussions if they are interested in the topic.

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