The Effectiveness of Sexual Assault Services in Multi-Service Agencies

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Introduction

Sexual assault is a pervasive social problem with 18% of women and 3% of men experiencing a completed or attempted assault during their lifetime. More than half of victimizations occur before the survivor reaches the age of eighteen (Tjaden & Thoennes, 2000). Research also shows that two-thirds of sexual assaults are committed by someone known to the survivor, such as an acquaintance, friend or intimate partner. In fact, approximately 15% of sexual assaults are committed by an intimate partner. Many sexual assault survivors experience multiple negative outcomes such as psychological distress, physical health problems, and difficulties in life functioning (Gutner, Rizvi, Monson, & Resick, 2006; Kilpatrick & Acierno, 2003).

In the early 1970s, rape crisis centers (RCCs) were developed to specifically meet the needs of sexual assault survivors and their significant others by providing hotlines, crisis intervention, support groups, and individualized therapy. In addition, RCCs may accompany survivors post-assault to hospitals, police stations or to court proceedings (Gornick, Burt, & Pittman, 1985). RCCs may also focus on social change initiatives (e.g., eliminating society's tolerance of sexual assault) through community education, protests, speak-outs, lobbying, and training other professional agencies on how to improve responsiveness to survivors (Burt, Zweig, Schlichter, & Andrews, 2000). There have been few studies examining the effectiveness of RCCs but the preliminary findings suggest that they are responsive to the needs of survivors and engaged in social change efforts when compared to mainstream social service organizations (Campbell, 2006; Campbell & Martin, 2001; Martin, 2005).

RCCs began as organizations that were intentionally independent (termed free-standing) from other social service agencies because they feared an affiliation would dilute their political and social change efforts (Gornick et al., 1985). Over time, many RCCs either folded, merged, or were implemented by other organizations such as domestic violence shelters or social service systems. Funding constraints and a desire to better coordinate service delivery for survivors with multiple needs lead to the housing of many RCCs within other social service organizations (Gornick et al., 1985). Currently, there are 1,265 RCCs in the United States, with 26% as freestanding programs and 74% affiliated with organizations that focus on multiple social problems (NSVRC, personal communication, April 30, 2009). While the freestanding programs tend to be autonomous in their operations and functioning, RCCs housed within other organizations vary in their level of autonomy. For example, these RCCs may not have complete decision-making power over budgets or service delivery and implementation. This may be particularly problematic if the host organization views the program's priorities or service delivery substantially different than the hosted RCC. As such, there have been concerns that merging RCCs into other organizations might affect the availability and substance of services. This paper seeks to review the empirical literature to examine if organizational affiliation and structure affect the quantity and quality of sexual assault services. Unfortunately, the

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brevity of this paper precludes a discussion on the history of RCCs and their overall effectiveness as a collective group. This paper will conclude with recommendations for future research evaluating the effectiveness of RCCs within multiple organizational affiliations and structures.

Types of Organizations Affiliated with RCCs

The existing literature identifies three overarching types of organizational affiliation among RCCs. First, free-standing RCCs are independent of other organizations and are not affiliated administratively with these organizations. This independence allows for complete autonomy with decision-making around personnel management, fundraising, program development and delivery, and collaborative initiatives (Gornick et al., 1985; Martin, 2005). These programs tend to have fewer staff members, which provide opportunities for frontline staff to be involved with organizational decision-making. Second, many RCCs are affiliated with domestic violence agencies that provide shelter and counseling services to survivors of intimate partner violence. It is not surprising that many RCCs are affiliated with domestic violence programs given that they share similar missions of ending violence and improving the lives of survivors (Martin, 2005). RCCs may be housed within domestic violence agencies as separate programs with their own staff and budgets or they may be embedded whereby funding and decision-making are inseparable from the overall operations of the agency (Gornick et al., 1985). Third, some RCCs are affiliated with larger organizations that focus on social or health issues beyond sexual and domestic violence, including hospitals, county services, universities, criminal justice organizations, and community mental health (CMH) organizations. These larger organizations typically have different goals and service philosophies than their hosted RCCs. These RCCs may be housed as separate programs or embedded within the organizations.

Accessing Resources

Funding is critical to the sustainability of RCCs and the availability of comprehensive services for survivors. Unfortunately, there has been limited research examining the financial and personnel resources of RCCs. Despite the age of many studies (i.e. mid-1980s), the findings have consistently shown that being affiliated with other organizations may lend financial stability to RCCs because many expenses can be shared, such as office space and support personnel. However, the amount of funding affiliated organizations will allocate to sexual assault services may be limited.

Free-standing RCCs typically have budgets and staff that are moderate in size. For example, Martin (2005) interviewed the directors of the RCCs in Florida during the mid-1980s and found that approximately four full-time employees and seventeen volunteers on average staffed the free-standing RCCs (see also Byington, Martin, DiNitto, & Maxwell, 1991). In addition, the average annual budget was slightly under $100,000. RCCs affiliated with domestic violence programs had more stable diversified funding with only a small amount devoted to sexual assault services. The average annual budget for sexual assault services was approximately $10,000. In addition, these organizations generally dedicated one full-time employee with nineteen volunteers to provide sexual assault services. In regards to RCCs affiliated with larger service systems, the size of budget and staff varied, with hospitals and county services having the largest annual budget on average ($224,000 and $152,000, respectively) and full-time staff (approximately five) and volunteers (twenty-two on average) allocated to sexual assault services. The criminal justice system, community mental health organizations, and universities had the smallest average annual budget ($20,000 or less) and staff (one part-time or full-time employee with approximately fourteen volunteers). Since the mid-1980s, there have been many changes to state and federal funding for sexual assault and domestic violence services. Still, anecdotal literature suggests that sexual assault services

remain more under-funded than domestic violence services (DeDomenico-Payne, 2006; Sloan, 2006).

Overall, RCCs affiliated with hospitals and county services have the largest budgets but are similar in staff size to free-standing RCCs. On the other hand, RCCs associated with domestic violence programs had the least amount of funding allocated to sexual assault services. This raises the question of why domestic violence organizations dedicate less funding to sexual assault services. One possible explanation is that domestic violence shelters are resource intensive, which requires larger amounts of funding to maintain the facility and meet the 24/7 needs of multiple survivors. Another factor that may contribute to this low budget is the lack of available state and federal funding for sexual assault services overall. For example, more grants exist for domestic violence shelter services and issues of poverty (DeDomenico-Payne, 2006). Legislators may not recognize the distinction between domestic violence and sexual assault and assume both issues received funding when allocating state or federal dollars to domestic violence programs. As such, there are many states that do not provide funding for sexual assault services even though every state provides funding for domestic violence services (Sloan, 2006).

Even when funding sources are aimed at both victimizations, dual domestic violence programs typically allocate dollars for domestic violence services. For example, STOP funding may be used for domestic violence or sexual violence services as long as the services increase the interaction among nonprofit victim services, law enforcement, prosecution, the courts, and the medical community to comprehensively address the needs of survivors and hold perpetrators accountable (Zweig & Burt, 2007). However, even with this flexibility in funding allocation, STOP funds domestic violence services at a rate substantially above sexual assault services. Zweig and Burt (2003) confirmed this disproportionality in funding by conducting phone interviews with a nationally representative sample of 200 STOP-funded victim service programs and found that funds were substantially more likely to be allocated to domestic violence than sexual assault services. Although domestic violence services themselves do not receive excessive amounts of funding, this inequality may create tension among the domestic violence and sexual assault programs and staff within or among organizations (Sloan, 2006).

Quantity and Diversity of Clientele

One goal of RCCs is to be accessible and supportive of individuals affected by sexual assault and their significant others. The rate of survivors served by RCCs may be one indicator that these programs are well-known, accessible, and accepted among survivors (O'Sullivan & Carlton, 2001). Martin (2005) found that hospital-based programs served the highest number of survivors followed by free-standing programs. RCCs affiliated with domestic violence programs, CMHs, universities, and the criminal justice system served the lowest number of survivors. O'Sullivan & Carlton (2001) also found that free-standing programs tend to serve a greater number of sexual assault survivors than those RCCs affiliated with domestic violence programs. Overall, RCCs affiliated with domestic violence programs, CMHs, universities, and the criminal justice system seem to under-serve sexual assault survivors in their communities.

RCCs serving a wide range of people affected by sexual assault may also suggest accessibility and acceptability of services (O'Sullivan & Carlton, 2001). This is especially important to examine given that RCCs have a history of under-serving marginalized populations (Scott, 2005). O'Sullivan and Carlton interviewed 16 directors of RCCs in North Carolina and found the race of the clientele of the RCCs was representative of the racial demographics of their communities and thus was unrelated to organizational affiliation. However, RCCs affiliated with domestic violence programs served far fewer teenage survivors than free-standing RCCs (O'Sullivan & Carlton, 2001). In addition, O'Sullivan & Carlton noted that free-standing RCCs were more likely to verbalize concern about responding effectively to, and meeting the needs of, underserved populations. This is important because the needs of survivors can vary by age, ethnicity,

socio-economic status, and gender. Thus, services should be tailored to meet the unique needs of a wider range of survivors. It is also possible that RCCs affiliated with other organizations may have narrower criteria for service eligibility. For example, RCCs affiliated with the criminal justice system may provide services only to survivors who report their assault to the police, which prevents survivors who do not report from receiving needed services (Martin, 2005). Further, RCCs affiliated with domestic violence programs are more likely to view sexual assault within the context of domestic violence such as with intimate partner rapes (O'Sullivan & Carlton, 2001). As such, these RCCs may not advertise to survivors who were victimized by strangers, friends, and acquaintances. On the other hand, free-standing RCCs may have a greater ability to serve sexual assault survivors as a whole because they typically have a more inclusive definition of sexual assault (O'Sullivan & Carlton, 2001).

Finally, receiving referrals from community agencies that serve survivors may also indicate that RCCs are perceived by stakeholders as readily available and beneficial to survivors (O'Sullivan & Carlton, 2001). For example, hospitals may examine survivors immediately after the assault and refer them to a local RCC for counseling. In comparing free-standing RCCs to those affiliated with domestic violence programs, O'Sullivan & Carlton (2001) found that free-standing programs receive more referrals from law enforcement and hospitals than those affiliated with other organizations. It may be possible that stakeholders are confused about or unaware of the types of survivors served by the affiliated programs. For example, stakeholders of RCCs affiliated with domestic violence programs may believe these organizations only serve survivors of intimate partner rape.

Comprehensive Services

Survivors have multiple short- and long-term needs following a sexual assault. For example, survivors may seek immediate medical care from hospital emergency departments for assistance with the prevention of pregnancy and STDs or for forensic evidence collection (Ledray, 1996). Survivors may also report the assault to law enforcement and seek safety or justice. However, research has found that survivors often experience negative reactions such as victim blaming from these service systems, which are associated with higher psychological and physical health distress (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001). Emerging research suggests that advocacy from RCCs may help prevent survivors from being treated poorly by medical and law enforcement personnel (Campbell, 2006). Therefore, advocacy is an important service to offer survivors who are navigating through the medical and legal systems. In addition, survivors may experience intense emotions or feel socially isolated and thus may seek counseling or support groups. Therefore, it is important for RCCs to provide a complete range of services to meet the multiple needs of survivors.

Martin (2005) found free-standing RCCs often provided a wide range of services such as a hotline, counseling, and advocacy at hospitals and police departments. In addition, free-standing RCCs were the only programs that consistently offered follow-up services to survivors after providing medical advocacy (O'Sullivan & Carlton, 2001). Studies have found mixed results regarding service provisions of RCCs affiliated with domestic violence programs. While Martin found that RCCs affiliated with domestic violence programs provided services similar to those offered by free-standing RCCs, more recent studies suggest that the affiliated RCCs offer less services (Macy, 2007; O'Sullivan & Carlton, 2001). Macy interviewed directors of North Carolina RCCs and state-level organizations who explained that domestic violence services are more time and resource intensive due to their crisis nature and thus, likely to be prioritized over sexual assault services.

Some RCCs affiliated with domestic violence programs could be more effective at providing services for survivors of intimate partner rape. It is common for survivors of intimate partner rape to seek help for domestic violence before disclosing their sexual victimization (Zweig & Burt, 2003). Therefore, survivors of intimate partner rape are

most likely to seek assistance from domestic violence organizations before RCCs. However, staff members of domestic violence organizations often are not trained in providing counseling, medical, and legal advocacy for sexual assault survivors (Bergen, 1996). Domestic violence agencies may not have policies and procedures inclusive of sexual assault, even assault within the context of an intimate relationship (Johnson, Crowley, & Sigler, 1992). In addition, many staff of domestic violence organizations feel uncomfortable inquiring about survivors' sexual assault history (Zweig & Burt, 2003). This discomfort may be due to a lack of training, prior victimization, or a greater personal sense of fear and vulnerability regarding sexual assault. Therefore, domestic violence organizations may perceive sexual assault, even within the context of an intimate relationship, as outside the scope of their expertise and refer these survivors to RCCs.

On the other hand, free-standing RCCs, or those affiliated with larger social service organizations, may perceive rape by an intimate partner as domestic violence, and consequently refer women to a domestic violence agency. As a result, survivors of intimate partner rape may feel neglected and choose not to follow-up on the referral, resulting in these survivors not receiving services (Bergen, 1996). The combination of sexual assault and domestic violence services within a single organization provides an opportunity for cross-training and developing services to meet the unique needs of survivors of intimate partner rape as well as domestic violence survivors who experienced other types of sexual victimization (e.g., child sexual abuse). However, there has never been a systematic study to examine if RCCs affiliated with domestic violence organizations are more or less effective at meeting the needs of survivors of intimate partner rape or multiple forms of victimization when compared to other types of RCCs.

The range of services provided by RCCs affiliated with larger social service organizations varies by type of agency. For example, CMH-based RCCs have the capacity to provide expert counseling to survivors with serious emotional problems, but they may not accompany survivors to the hospital, police departments, or court (Gornick et al., 1985; Martin, 2005). Furthermore, their counseling services may only be offered during business hours, and thus are less responsive to the needs of working clientele. On the other hand, hospital-based RCCs may provide 24/7 services but often limit services to crisis-oriented counseling and medical care (Gornick et al., 1985). While hospital-based RCCs serve the most survivors, it appears that these services are limited to meeting the short-term immediate needs of survivors. Furthermore, RCCs that are affiliated with county-level crisis lines may only offer crisis intervention, community information and referral. Overall, it appears that the identity of the larger organization often limits the range of services provided to sexual assault survivors (O'Sullivan & Carlton, 2001).

Social Change Activities

Many RCCs mobilize their efforts for social change by lobbying to change sexual assault laws and increase victim rights, raising awareness of sexual violence among the public and professionals, and improving the response to survivors (Burt et al., 2000). These social change efforts are particularly important given that many professional and community members still believe rape myths and treat survivors in hurtful ways (Ahrens, Campbell, Ternier-Thames, Wasco, & Sefl, 2007). Overall, research suggests that free-standing RCCs are the most active in lobbying efforts and promoting social change on behalf of survivors (Gornick et al., 1985). Free-standing RCCs continually educate their communities about sexual assault and actively develop strategies to improve the responses to sexual assault survivors (Martin, 2005; O'Sullivan & Carlton, 2001). Further, Martin found that the free-standing RCCs were the only programs that routinely offered educational programming designed for adolescents and males. In addition, free-standing RCCs regularly collaborated with other organizations on social change initiatives (Martin, 2005). RCCs affiliated with domestic violence organizations

also engaged in social change efforts but these efforts were moderate compared to free-standing programs (O'Sullivan & Carlton, 2001). For example, Martin found that free-standing RCCs provided three times as many rape prevention/ education activities as RCCs affiliated with domestic violence organizations. In addition, RCCs affiliated with domestic violence organizations engaged in less collaborative social change initiatives (Martin, 2005).

Regarding RCCs affiliated with larger organizations, the amount of social change activities vary depending on the type of organization (Gornick et al., 1985; Martin, 2005). RCCs affiliated with CMH and county services provided the least amount of prevention/education activities while those affiliated with the criminal justice system and universities were highly involved in these activities (Martin, 2005). In addition, all of the RCCs affiliated with larger organizations had minimal involvement in collaborative social change activities. Overall, affiliation with these larger organizations may diminish the time or commitment devoted to social change goals. According to Martin, it is possible that these organizational hosts disapprove of social change activities, particularly those activities that challenge the status quo or require a political stance.

Overall, the literature suggests that free-standing organizations may be more effective at addressing the needs of survivors and the community. If RCCs need to merge, the literature suggests that domestic violence programs hold the most advantages because of their similar organizational missions and goals. However, there are multiple ways that RCCs can be structured within domestic violence organizations, with each structure having benefits and limitations. Next, this paper will review the literature examining the advantages and disadvantages of each organizational structure.

Organizational Structure of RCCs Affiliated with Domestic Violence Organizations

Only one study has compared the organizational structures among RCCs affiliated with domestic violence organizations. Zweig and Burt (2003) interviewed 72 representatives from 21 local RCCs and coalitions within four states and found four patterns of organizational structures among the combined domestic violence and sexual assault services. The first type of structure involves domestic violence organizations that do not have a strong sexual assault service identity. For example, these agencies have minimal, if any, acknowledgment of sexual assault in their agency name, mission statement, or advertisement. As such, the community may be unaware that the organization even provides services to sexual assault survivors. In this arrangement, staff members receive minimal training on addressing the needs of sexual assault survivors. The majority of the staffs' time is devoted to domestic violence services in the form of counseling and advocacy, but staff will respond to survivors' concerns of sexual assault if needed. While staff may respond to survivors' concerns, they are less likely to inquire about sexual assault history. This is problematic because survivors of intimate partner rape are less likely to disclose a sexual assault history when they are not asked (Bergen, 1996). An alternative variation among this organizational structure includes one staff member devoted to providing sexual assault services while other staff members provide domestic violence services. While this allows one person in the organization to specialize in sexual assault services, it raises barriers to providing comprehensive services. For example, being available to provide advocacy and counseling may preclude an advocate from engaging in social change initiatives. In addition, the single sexual assault staff member may have fewer opportunities for professional development if peers feel uncomfortable providing or referring sexual assault services. Overall, this structure contains the most limitations to providing comprehensive sexual assault services.

The second and third structure involves RCCs housed within domestic violence organizations where the RCCs retain separate staff and budgets. Typically the RCC and domestic violence program operate as two separate programs under one organization, allowing the RCCs to have decision-making regarding their programming. It may be

possible that this separate programming helps the RCC develop an identity separate from the domestic violence program within their community (Gornick. et al., 1985). Zweig and Burt (2003**)** found that there were two distinct philosophical differences among RCCs that are housed within domestic violence organizations. In the second type of structure, the RCC staff view the services and need for services among sexual assault and domestic violence survivors differently. Specifically, the staff view the needs of domestic violence survivors as crisis-oriented and the needs of sexual assault survivors as therapy-oriented, even though survivors of both victimizations have immediate and longer-term needs. In this structure, the staff are only affiliated with either the sexual assault or domestic violence program and may only be trained for providing interventions with one client population. When a survivor has experienced sexual assault and domestic violence, services are typically provided separately by two staff members. The survivor will receive services from a domestic violence staff member and a sexual assault staff member either simultaneously or sequentially. For example, a survivor may receive counseling for intimate partner violence from domestic violence staff while receiving counseling for the sexual victimization from sexual assault staff. Although the effects of both crimes will likely be intertwined, this arrangement limits survivors to discussing their sexual assault experience with one staff member and their domestic violence experience with a different staff member. As a result, survivors of intimate partner rape or multiple victimizations may find the services disjointed or compartmentalized.

In the third structure, the RCCs are housed as separate programs within the domestic violence agencies but the RCC staff perceive the services for sexual assault and domestic violence survivors as similar philosophically. Specifically, the staff view the crisis management of the two crimes as different with domestic violence services being crisis-focused and pragmatic (e.g., safety planning, housing assistance) and sexual assault services being more therapeutic-based. However, the staff also believe the healing process involved with both crimes is similar. In these RCCs, staff and volunteers are cross-trained and capable of providing services for both crimes. While the programs are independent in these organizations, the staff of each program collaborate closely with one another to address the comprehensive needs of survivors. In these cases, a survivor may continue to receive case management services from the domestic violence advocate while seeking counseling from the sexual assault program or may stay with her original advocate addressing both victimizations. Therefore, survivors who experience both types of victimization have access to service delivery that meets their specific needs.

The final type of structure involves RCCs that are integrated into domestic violence organizations whereby the sexual assault and domestic violence programs are not separated into different programs but are divided by types of work activities, such as direct service and prevention, rather than crime type. The staff view sexual assault and domestic violence as intertwined social problems and the emotional recovery from both victimizations as similar. Specifically, these advocates believe that survivors of both crimes mourn losses as a result of their victimizations, such as the end of a relationship or the loss of control over their lives. As such, the staff of integrated organizations believe that it is impossible to address one victimization while ignoring the other. These organizations provide fully integrated services where staff members provide services for both forms of victimization. Staff members are cross-trained and provide services on a regular basis to survivors of both types of victimization. While Zweig & Burt (2003) did not examine the effectiveness of services on survivors' emotional well-being, they did find that the integrated organizations were more likely to provide specialized services for survivors with unique needs.

Recommendations for Future Research

The current research on organizational affiliation is sparse, with the majority of studies occurring up to two decades ago. Based on this literature, it

appears that free-standing RCCs are the most effective in providing a wide range of services and being accessible and accepted among survivors and community professionals. However, these conclusions are tentative given the age of previous studies and it is possible that the affiliated RCCs have become more or less successful over time in increasing their accessibility, acceptability, and comprehensiveness of services. However, the current literature can be useful to RCCs in that it provides preliminary evidence of the effectiveness of free-standing RCCs, which may be helpful when making decisions about a merger with another organization.

The literature identifies multiple ways that RCCs can be affiliated or structured. However, studies have not systematically examined the combined effect of organizational affiliation and structure on RCCs effectiveness. For example, studies have not examined the accessibility of services among RCCs that are housed as separate autonomous programs within domestic violence organizations compared to those embedded within domestic violence organizations with limited autonomy. Given the time and resource intensity of domestic violence services, it is likely that RCCs who have autonomy over their budgets and provide integrated services within domestic violence organizations are more effective than those with less budgetary autonomy or integrated services. Further, empirical studies are needed to determine if and how autonomy influences the effectiveness of RCCs affiliated with domestic violence organizations. In addition, some of the RCCs affiliated with domestic violence organizations have more integrated services than others. Organizations with highly integrated services expect all staff to be competent in addressing concerns of sexual assault and domestic violence while less integrated organizations have separate staff agendas. Zweig & Burt (2003) predicted that the integrated programs were more likely to be responsive to survivors of multiple victimizations. However, empirical studies are needed to compare the effectiveness of highly integrated programs to less integrated programs.

In addition, future research needs to move beyond assessing comprehensiveness and accessibility of services to examine survivor and community outcomes. Research studies are needed to examine the effectiveness of organizational affiliations, structures, and levels of integration on the quality of direct services and impact on survivors' well-being. In addition, research is needed to understand how organizational affiliations or structures influence the quality of advocacy services and effectiveness in helping survivors navigate the health care and criminal justice systems. Given that many survivors experience negative reactions from system personnel, it would be useful to understand whether the advocacy services of a particular organizational structure are more effective in preventing these negative reactions from occurring (see Campbell 2006 for emerging research on advocacy effectiveness). Further, studies are needed to determine if organizational structure impacts the effectiveness of social change activities aimed at improving the community response to survivors. If a particular organizational structure is found to have positive effects, it will also be important to understand *why* that structure is beneficial.

Finally, the literature suggests that free-standing RCCs are more likely to express concern about meeting the needs of underserved populations. However, more research is needed to examine how RCCs respond to the needs of diverse populations and if particular organizational affiliations are more responsive to these groups. Specifically, the extant literature does not yet address how organizational structures affect the responsiveness to the needs of People of Color, individuals with a disability, Lesbian, Gay, Bisexual and Transgender survivors, adolescents, elderly, survivors of child sexual abuse, males, and other vulnerable populations (e.g., homeless, incarcerated).

Conclusions

Overall, the literature suggests that free-standing programs are more effective because they are a) perceived to be accessible and accepted by survivors and community stakeholders; b) more inclusive of their eligibility criteria for services; c) provide a

wider range of services to meet the short- and long-term needs of survivors; and d) more engaged in social change initiatives including prevention activities tailored for a male and adolescent audience. Of the affiliated RCCs, the research suggests that those affiliated with domestic violence organizations hold the most advantages given their similar missions of ending violence and improving survivors' lives. Sharing a similar mission provides a unique opportunity for staff to engage in cross-training and co-management of cases involving intimate partner rape. While the research found RCCs affiliated with domestic violence organizations were modest in the number of survivors served, they could become more accessible and accepted by survivors and community professionals with the adoption of a more inclusive definition of sexual assault. In addition, these organizations may be perceived by the community primarily as a domestic violence agency. Therefore, it is important that the inclusion of sexual assault services be integrated throughout the organizations' mission statements, goals, advertising materials, policies and procedures. Further, the literature indicates that domestic violence services are likely to be given higher priority over sexual assault services with substantially fewer dollars being allocated to sexual assault services. As such, the RCCs should have autonomy over budgeting, staffing, and programming as a strategy to increase the balance between sexual assault and domestic violence services (O'Sullivan & Carlton, 2001). Overall, domestic violence organizations are likely to be a viable host for RCCs if they engage in continuous assessment and strategize to equally balance the resources and priorities of sexual assault and domestic violence services.

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In Brief:

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Rape crisis centers began as organizations that were intentionally independent (termed free-standing) from other agencies, but overtime, many RCCs either folded, merged, or were implemented by other organizations such as domestic violence shelters or social service systems. While the freestanding programs tend to be autonomous in their operations and functioning, RCCs housed within other organizations vary in their level of autonomy over budgetary or service delivery decisions. As such, there have been concerns that merging RCCs into other organizations might affect the availability and substance of services. This paper reviews the literature to examine whether organizational affiliation and structure affect the quantity and quality of sexual assault services. This paper concludes with recommendations for future research evaluating the effectiveness of RCCs within multiple organizational affiliations and structures.

The literature suggests that free-standing RCCs had moderate budgets and staff, served a high number of survivors, and were more likely to express concern about meeting the needs of underserved populations than affiliated RCCs. Free-standing programs also received more referrals from law enforcement and hospitals than affiliated RCCs. In addition, free-standing RCCs regularly collaborated with other organizations on social change initiatives and developed strategies to improve the responses to sexual assault survivors.

RCCs affiliated with domestic violence programs had the least amount of funding and staff allocated to sexual assault services and served far fewer survivors. These RCCs engaged in social change efforts, but these efforts were moderate compared to free-standing programs. Further, RCCs affiliated with domestic violence programs were more likely to view sexual assault within the context of domestic violence such as with intimate partner rapes. However, a more recent study found four patterns of organizational structures among these programs that range greatly in their service delivery. Empirical studies are needed to compare the effectiveness of these different structures.

RCCs affiliated with hospitals and county services had the largest budgets with a similar staff size as free-standing programs. These programs served a higher number of survivors but often limit services to crisis-oriented counseling to meet the short-term needs of survivors. These RCCs also had minimal involvement in collaborative social change activities. RCCs associated with the criminal justice system, community mental health organizations, and universities had small budgets and staff and served far fewer survivors. RCCs affiliated with CMH and county services provided the least amount of prevention/education activities while those affiliated with the criminal justice system and universities were highly involved in these activities.

Overall, the literature suggests that free-standing programs provide more accessible and comprehensive services than the affiliated programs. If RCCs need to merge, the literature suggests that domestic violence programs hold the most advantages because of their similar organizational missions and goals. However, these conclusions are tentative because the current research is sparse, with the majority of studies occurring up to two decades ago.

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