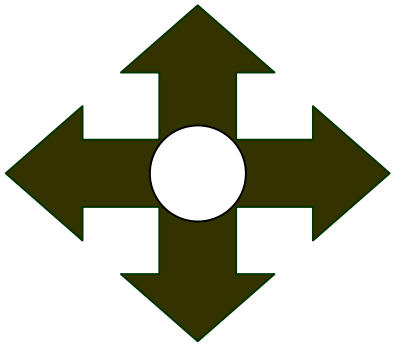
The Feasibility of Creating a Family Advocacy Centre for Calgary

FINAL REPORT

FOR THE ACTION COMMITTEE AGAINST VIOLENCE



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1.0 Executive Summary

1.1 Project Overview

In January 2002, RESOLVE Alberta was contracted to conduct a feasibility study to examine the possibility of establishing an advocacy centre in Calgary. Working closely with the Family Advocacy Planning (FAC) Committee, RESOLVE Alberta mapped existing services, identified gaps in the current service delivery system in Calgary, researched co-ordinated service models throughout North America, conducted interviews with key stakeholders in the community and facilitated several brainstorming sessions with members of the planning committee. The background information was presented at a community consultation in June 2002 with over 75 representatives from the sexual abuse/assault and domestic violence serving community. The proposed model for an advocacy centre for Calgary would provide medical, legal and counselling services for adult victims of sexual assault and child victims of abuse. Services for those affected by domestic violence could be added subsequently.

The FAC committee continued to meet throughout the fall of 2002, confirming the plan to implement the advocacy centre and beginning to formalize the involvement of the stakeholders represented on the committee. This report summarizes the planning process from January to October 2002 and presents background materials that support the feasibility of a Calgary advocacy centre.

1.2 How Serious a Problem is Violence in Calgary?

The sexual assault of adults and sexual and physical abuse of children are significant problems in Canada. In 1993, Statistics Canada's Violence Against Women's survey reported that Alberta had the second highest rate of violence against women in Canada. The same study estimated that 39% of adult women in Canada had experienced at least one incident of sexual assault since age 16. Only 6% of these women reported their assault to the police. In 2001, the Calgary Sexual Assault Response Team (CSART) attended to 243 victims of sexual assault.

With respect to child victims of sexual abuse, in 1998, an estimated 135,573 child maltreatment cases were investigated in Canada. Only 38% of the sexual abuse investigations were substantiated. Of these victims, 69% were girls and 31% were boys. In Calgary, several prevalence studies (Bagley, 1991, *N*=750; Bagley & Young, 1990, *N*=620) estimated that from one-fifth to one-third of Calgary women have been sexually abused at least once during childhood.

The Child Abuse Unit at the Alberta Children's Hospital serves approximately half of the 700 referrals that they receive each year. In 2001, the Calgary Sexual Assault Response Team (CSART) conducted 18 forensic exams on child victims of sexual assault. The Family Advocacy Centre Planning Committee identified serious concerns about the gaps in services provided to sexual assault victims between the ages of 14-18, who are children mandated into an adult system.

Intimate partner violence has been the focus of considerable community collaboration over the past decade to deal with this serious problem. A 1993 Canadian national study, the Violence Against Women Survey, estimated that "three-in-ten women currently or previously married in Canada have experienced at least one incident of physical or sexual violence at the hands of a marital partner."

In 2002, the Calgary Police Service responded to approximately 12,000 domestic violence related calls for service, resulting in more than 4,000 criminal charges being laid. Domestic assaults are the second most frequent call for service by the Calgary police. Children were present, and likely exposed to the violence, in 50% of the police calls.

Adults and children who are disabled or from diverse cultural groups are equally vulnerable to each of the previously described forms of family violence, if not more so than the majority population. As just one example, Aboriginal Canadian women report spousal violence rates three times higher than non-Aboriginal women (LaRocque, 1994).

The costs of violence against Canadian women are enormous, not only in personal costs to well-being, self-esteem and safety, but in monetary terms as well. In 1995, researchers from the London Ontario Centre for Research on Violence Against Women and Children, focusing on just three forms of violence (child sexual assault, sexual assault of women and woman abuse in intimate partnerships), estimated an annual cost of $4.2 billion Canadian dollars for the social services/education, criminal justice, labour/employment and health/medical service systems to address such abuse.

1.3 What are Advocacy Centres?

When an adult or child has been sexually assaulted or abused, s/he often requires medical services and counselling and also needs to decide whether to report the assault to the police. If the victim is a child, representatives from either or both child welfare and the police may be involved. The roles of the health, justice and mental health systems and organizations frequently converge and diverge through the phases of disclosure, investigation, and treatment. This overlap may be at times collaborative and at other times conflicting.

Victims must find their way between services, attending investigative interviews and accessing resources with numerous professionals, often at separate locations. To complicate matters, as victims present for service or interviews, they may work with different professionals within each system. Research has confirmed that such fragmentation can secondarily victimize the victim, as s/he must repeatedly re-tell the events of the assault to police, medical examiners, counsellors and legal representatives. In addition to further exacerbating the victim's trauma symptoms, fragmented systems contribute to an increased probability of inconsistencies in the victim's and professionals' accounts of events, decreasing the rates of successful prosecution.

Coordinated interagency responses to sexual abuse/assault and domestic violence have been recommended for over 20 years. Such responses involve a multi-agency effort to respond in a coordinated and systematic manner to the crisis of sexual assault, child abuse, or domestic violence in meeting the service and support needs of victims and society. Coordinating the service provision for victims of sexual assault decreases the number of interviews for victims, increases successful prosecution and improves communication between agencies involved in the sexual assault/abuse case. The current services in Calgary represent a community coordinated response.

Advocacy centres move a co-ordinated interagency response under one roof, streamlining services to victims. Rather than the victims and their families travelling between agencies at different locations, advocacy centres co-locate some of the essential systems and services into one central location. Whether serving adults or children or both, common features of advocacy centres include: co-ordination of investigation, crisis response, representation from law enforcement, prosecutors, child protection, referral, and therapeutic services. While not all advocacy centres provide on-site medical facilities, they most often have a co-ordinated arrangement with appropriate medical facilities nearby.

While there are over 400 Children's Advocacy Centres in the United States (only two in Canada), primarily focusing on child sexual abuse, advocacy centres that offer services for adults or for both adults and children or that offer services for sexual assault and domestic violence, are rare.

In summary, over the past three decades, the continuum of service delivery has evolved from independent organizations to co-ordination to co-location of services. It has become evident that co-ordination of services to victims is an essential component of service delivery. Co-location of services at one site is a seemingly logical and progressive step in the evolution of victim-centred service delivery.

1.4 Why an Advocacy Center for Calgary?

The Family Advocacy Centre Planning Committee held a visioning meeting in February 2002 to focus its planning for the next several months. In discussing options, the FAC Planning Committee was excited about developing a centre that would incorporate a broad range of services beyond sexual assault and abuse, with the possibility of inviting other domestic violence organizations to co-locate, such as Homefront and the Violence Information and Education Centre (VIEC). This would effectively consolidate a number of agencies that already work in a coordinated fashion, into one centre.

However, the committee decided to initially focus its priority on services for sexual assault/abuse, with the possibility of incorporating services for those affected by domestic violence in the future. This decision was made for several reasons. For the past decade, the city of Calgary has put considerable energy and resources into addressing domestic violence, with a number of innovative projects emerging such as Homefront. A similar collaboration with respect to sexual assault has not occurred and this seemed an appropriate time to address this gap. Secondly, the inclusion of a broad number and focus

of programs seemed ambitious, especially without first collecting information about whether other communities had embarked on similarly comprehensive models. Third, the cost of being more inclusive would result in a more expensive centre, and since funding was a significant question, it seemed preferable to begin by focusing more narrowly on services to address sexual assault and child sexual and physical abuse.

Sexual assault/abuse has occupied an alarmingly low position in the public profile of social issues in our community. Calgary's existing response to sexual assault has consistently been under-resourced, resulting in a desperate need to enhance the existing response to sexual assault victims. Currently in Calgary, both adult and child victims must navigate through a fragmented system as they attend multiple investigative interviews and attempt to access resources and supports, a process that serves only to further traumatize victims and negatively influence chances of successful prosecution. There are limited opportunities for essential follow-up and long waitlists in many agencies that provide specialized counselling services for victims. There is often miscommunication and misunderstanding between professionals within the system. While Calgary has a number of dedicated professionals that provide exceptional service within the confines of the existing response, clearly, we must find ways to provide more consistent, comprehensive and victim-centred services to those affected by sexual assault/abuse.

What would a Family Advocacy Center in Calgary provide for victims? The concept for a centre in Calgary to provide comprehensive, seamless services to adult and child victims of sexual assault/abuse was initially modeled after the Mesa's Centre Against Family Violence, ChildHelp USA and the Family Advocacy Centre in Phoenix Arizona. While investigative and prosecutorial efforts are critical components for ensuring that offenders are help accountable, the immediate and long-term focus for the Calgary Centre is on meeting the needs of individuals and families impacted by sexual assault/abuse and domestic violence. The Calgary Centre will emphasize comprehensive, on-site community-based agency participation for both adult and child victims.

In addition to co-locating the Sex Crimes Unit, Calgary Police Service and visiting offices for Alberta Justice, Phase I of the Calgary Centre will include the medical and nursing components of the Calgary Sexual Assault Response Team (CSART), the Child Sexual Abuse Clinic, Alberta Children's Hospital, and Calgary Communities Against Sexual Abuse (CCASA).

The RESOLVE Alberta Feasibility Study Interim Report in June 2002 identified the potential benefits of creating a centre in Calgary. The centre would:

1. Benefit victims of both child sexual and physical abuse, adult sexual assault and domestic violence.
    - The approach would be victim-centered, operating in a streamlined, coordinated, and comprehensive approach.
    - One location decreases fragmentation of services, thus minimizing system-induced trauma to victims and non-offending family members.
    - Provides support to victims and support persons.

- Provides a venue for enhanced follow-up and access to specialized services.

2. Contribute to successful prosecution in supporting and following the victim through the justice process.
   - Would offer improved facilities for collection of medical evidence and case investigation.
   - Investigations by police and child protection can be more easily coordinated.
   - The process of moving through the investigative and support systems is clearer. This benefits both service providers and victims.
3. Benefit service providers and agencies devoted to assisting victims:
   - Allow a more consistent response from service providers.
   - Support partnerships between agencies, in particular those serving marginalized groups.
   - Extensive connections to agencies means the Centre will be able to better meet diverse community needs related to disability, language, culture, immigration status, sexual orientation or street involvement.
   - Educate service providers and the broad community and offers prevention programs.
   - Provide de-briefing to staff affected by vicarious trauma.
4. Raise the profile of sexual assault/abuse in our community.
   - Provides an opportunity to conduct research on the problem locally.

1.5 Summary and Recommendations

The year-long feasibility study included a community consultation in June 2002 and an in-depth search for models of advocacy centres appropriate for the needs identified by the FAC Planning Committee. The process has culminated in a model that addresses adult victims of sexual assault and children who are victims of all types of abuse, including physical abuse. Services for those affected by domestic violence will also be provided through referral and outreach with integration (including possible co-location) of domestic violence programs and staff.

The FAC Planning Committee was composed of representatives from the major stakeholders that would need to be involved in the advocacy centre as designed. While the committee reviewed other advocacy centre models elsewhere, particularly in the United States, the proposed centre is unique to the needs of the Calgary community. The background information with respect to the impact of sexual assault and child abuse and how victims have been further traumatized by having to deal with fragmented systems that at times work at cross purposes, represents a significant argument for the new centre.

Advocacy centres, particularly those developed to address child sexual abuse, are only in the beginning stages of being evaluated. However, the few studies on the efficacy of several characteristics of advocacy centres, such as videotaping interviews to prevent revictimizing the adult or child by having them repeatedly describe the assault, and facilitating the staff from various systems to work collaboratively and to focus on the needs of the victim rather than the system, also strongly support an advocacy centre model. Given the parallel medical, legal and counselling services necessary to address

each form of assault/abuse, the facilities needed for each are similar and sharing these resources is both practical and cost-efficient.

The proposed Calgary model includes services for both adults and children, for not only sexual assault and child abuse, but intimate partner violence as well. This unique model requires even more collaboration than a centre devoted to either adults or children or to only one form of violence. The plan is both ambitious and innovative.

The Calgary community has at least a decade-long history of working collaboratively to address family violence. The last ten or so years has seen the development of a number of innovative programs. These included the Calgary Domestic Violence Committee protocol project, that consulted with over 60 agencies to develop and implement domestic violence protocols. The Action Committee Against Violence has developed numerous initiatives, for example, the Youth Violence Prevention Project that invited violence prevention personnel and their major consumers, community agencies and schools, to collaborate to improve the quality of and accessibility to prevention programs.

One of the most impressive initiatives has been the development of Homefront, the specialized domestic violence court model in Calgary, that involved collaboration between multiple levels of the justice system (the police, Crown's office, judiciary, probation, Calgary Legal Guidance) and the many community agencies that address domestic violence, (the emergency and second stage women's shelters, specialized programs for those who perpetrate abuse and those who are victimized by it). The community cooperation that resulted in the success of Homefront bodes well for launching a similarly complex advocacy centre project.

The community response and extent to which organizations both support and agree to become partners from this point, will finally answer the question of whether the centre is feasible. While many important questions have yet to be answered and details have yet to be addressed, the extent to which the FAC Planning Committee has worked together thus far in creating a concrete plan and significant community interest speaks to the viability of the plan.

2.0 The Feasibility Study Process

2.1 Introduction

This report documents the work of RESOLVE Alberta and the Family Advocacy Centre (FAC) Planning Committee over the past year. In February 2002, after exploring a number of options, the FAC Planning Committee concluded that the major focus for the project would be exploring the viability of a Calgary advocacy centre for both adult and child victims of sexual assault, with the inclusion of domestic violence related services in future, if so desired.

The report summarizes a literature and website review of the complexities of the systems' response to sexual abuse/assault and what services agencies currently offer to victims, identifying the evolution of service delivery models to becoming more coordinated and victim-focused. Interviews with 21 key stakeholders resulted in a community map of the three phases of service delivery (disclosure, investigation and treatment) to child and adult victims of sexual assault/abuse in Calgary. The map of services assisted us in identifying the strengths, limitations and gaps in the existing model of service delivery, from which developed a rationale for the proposed advocacy centre model.

2.2 Background for the Feasibility Study

In the summer of 2001, a delegation including then Calgary Mayor, Al Duerr and Alderman Bev Longstaff, toured the Mesa Center Against Family Violence and the Phoenix Family Advocacy Center in Arizona. Each offers a streamlined approach to domestic violence and sexual assault, co-locating representatives from key systems and organizations at one site to better coordinate services to victims. Impressed with these models of service delivery, Mayor Duerr and Alderman Longstaff asked Karen Walroth, the Co-ordinator of the Action Committee Against Violence, to explore the viability of developing an advocacy centre in Calgary.

In November 2001, a community consultation in Calgary with a large group of invited professionals from domestic violence and sexual assault serving systems, listened as Ms. Dee Williams, from the City of Phoenix Family Advocacy Center, presented their centre's model. Representatives at that meeting concurred that the next logical step was to examine the feasibility of developing an advocacy centre in Calgary. Ms. Walroth received funding from the Safer Calgary Initiative, City of Calgary, and commissioned RESOLVE Alberta to conduct the Family Advocacy Centre Feasibility Study.

2.3 Feasibility Study Methodology

This feasibility study utilizes a participatory-action model of qualitative research. The goal, to determine the feasibility of developing a family advocacy centre in the city of Calgary, entailed exploring options and consulting with a broad number of informants from the sexual assault and domestic violence-serving community, both locally and

across North America. We looked for other models of advocacy centres and, to document what exists locally, consulted with 21 key stakeholders in Calgary, including members of the FAC Planning Committee that acted as a research advisory team to RESOLVE Alberta. This report documents the work by RESOLVE Alberta and prepared in consultation with the FAC Planning Committee.

RESOLVE Alberta personnel organized and chaired a number of planning meetings and two brainstorming sessions with the FAC Planning Committee in 2002 to identify what services and features a proposed advocacy centre might include. For example, at the February 14, 2002 meeting, the first brainstorming process created a vision of what the advocacy centre could entail, its possible benefits and what agencies might wish to become involved. RESOLVE worked closely with the FAC Planning Committee, keeping in regular contact with members as they provided feedback and guidance from the central systems involved in the potential advocacy centre.

RESOLVE Alberta conducted an extensive literature review using academic databases (PsycINFO, Sociofile, Ingenta, Article First, Social Work Abstracts, and Academic Search Premiere) searching for research evidence of the efficacy of coordinating services to adult and child victims of sexual abuse, sexual assault, and domestic violence. An internet search was conducted to identify models currently utilized to serve victims of domestic violence, sexual assault and child abuse. We also looked for research specific to the advocacy centre concept, however, there has been little published to date. We searched for formal evaluations of advocacy centres and other models of service delivery. The literature gathered was screened for relevancy to the FAC project, thoroughly reviewed, summarized, and integrated into the June 11th Community Consultation document.

We conducted a second widespread Internet search for other models of family advocacy centres across North America, contacting approximately 56 potential centres. These were screened and reviewed to examine their relatedness to the FAC Feasibility Study. Given that many sites appeared to offer more integrated services than they actually did when we asked them to describe their operation, we found relatively few models of advocacy centres that served adult victims of abuse/assault. The most relevant centres, and the ones that we used in constructing our model, were the Mesa Centre, the Phoenix Centre and the Zebra Child Protection Centre in Edmonton.

Laura Cavicchi conducted interviews with 21 key stakeholders in the Calgary community serving domestic violence, sexual assault and child sexual abuse. Stakeholders were asked to describe what was working well in Calgary's response to child sexual abuse and adult sexual assault, what areas most need improvement, and are there any gaps or limitations in the current delivery of services. We analyzed the interviews and identified common themes.

This process assisted us in outlining the strengths and limitations in Calgary's current response to child sexual abuse and adult sexual assault. From this we created two

maps of services that outline the Calgary Community Response to Sexual Abuse Age 18 and over and the Calgary Community Response to Sexual Abuse Under Age 18.

Several members of the FAC Planning Committee and RESOLVE Alberta travelled to Edmonton to visit the Zebra Child Protection Centre and the Stollery Children's Hospital Child and Adolescent Protection Centre. The contacts that we met at these organizations provided valuable insights and information with respect to developing a child abuse protection centre.

We created a summary document and PowerPoint presentation for the June 11th Community Consultation. The document outlined the progress in the feasibility study to that date, and included the key components as outlined above. We summarized and analyzed the feedback gathered from focus groups at the June 11th meeting and sent this back to community members.

We continued working with the FAC Planning Committee in the fall of 2002, chairing a second brainstorming session that resulted in every committee member endorsing the advocacy centre model presented in the June consultation. With that validation, we developed an implementation plan. Since then, the FAC Planning Committee has initiated discussions with the decisions-makers from the involved health, justice and community agencies to begin implementing and further developing the advocacy centre model.

3.0 The Complexity of the System's Response to Sexual Abuse/Assault

This section documents provides an overview of what we know about sexual assault, sexual abuse and intimate partner abuse in Canada. RESOLVE searched for the latest available and best Canadian research on each topic, but because large Canadian studies are not conducted routinely, some of the materials are ten years or older. Given that the dynamics of abuse and assaults change very slowly, this should not be considered a major disadvantage.

This section also provides information about the systems designed to address each problem and the evolution of agencies from isolated responses in the 1970's to community coordination in the 1980's and 90's. Most recently, a new model of providing service, called advocacy centres, combines the goals of being victim-centred and causing the least secondary trauma to clients, with enhancing the collection of forensic evidence and ease of facilitating follow-up counselling and court-preparation services to child and adult assault victims. The major benefits of advocacy centres are presented, in conjunction with the limited research supporting their efficacy.

3.1 Canadian Statistics on Sexual Abuse/Assault and Domestic Violence

Both children and adults are affected by sexual assault and sexual abuse. However there is debate about whether we should use the term "sexual assault" for both. Because children are most often sexually abused by those in a care-giving situation, the sexual acts are repeated and become increasingly intrusive. In contrast, while the sexual assault of adults can also be perpetrated by a familiar individual, it is often a one-time, though still traumatic, incident.

The literatures on treatment and services to address sexual assault and abuse tend to be separate, which submerges the linkages between the two. Yet many would argue that the similarities are so dramatic that the fact that largely different systems address child and adult victims of sexual assault is problematic. Further, women abused by intimate partners are often sexually assaulted by them as well. Both child and adult victims commonly require medical and legal services; both often have serious and long-term reactions to the trauma. What do we currently know of the prevalence of childhood sexual abuse, sexual assault and domestic violence in Canada?

3.1.1 Child Sexual Abuse: Child sexual abuse occurs when an adult or youth uses a child for sexual purposes. Sexual abuse includes fondling, intercourse, incest, sodomy, exhibitionism, and commercial exploitation through prostitution or the production of pornographic materials. Child sexual abuse is a serious social problem that cuts across all income, racial, religious and ethnic groups, as well as rural, suburban and urban communities. Several retrospective studies of the rates of child sexual abuse in Calgary (Bagley, 1991, $N = 750$; Bagley & Young, 1990, $N = 620$) estimated that 21.7% to 32% of Calgary women have been sexually abused at least once during childhood.

Despite high estimates of the prevalence of the sexual abuse of both girls (about 1 in 3 or 4, depending on the study) and boys (about 1 in 5), including very young children, few cases are disclosed, or when disclosed, substantiated. The low rates of identification of abuse may be related to a lack of understanding of how to report abuse and/or to whom to report it

The recently completed Canadian Incidence Study of Reported Child Abuse and Neglect (Trocmé, MacLaurin, & colleagues, 2001) documented 135,573 child maltreatment investigations conducted in 1998 across the country. The study divided child maltreatment investigations into four primary categories: physical abuse (31% of all investigations), sexual abuse (10% of all investigations), neglect (40% of all investigations), and emotional maltreatment (19% of all investigations). Thirty-eight percent of the sexual abuse investigations were substantiated. In substantiated cases of sexual abuse, 69% of the victims were girls and 31% were boys.

The most common child problems related to sexual abuse are depression or anxiety (29%), age-inappropriate sexual behaviour (17%), behaviour problems (14%), negative peer involvement (13%) and irregular school attendance (10%) at the time that the reports of child sexual abuse were substantiated. Such short term negative consequences of childhood sexual abuse, have been documented by numerous researchers (Daignault, Vézina, & Hébert, 2002; Hébert, Parent, Tremblay & Daignault, 2002). Finkelhor and Browne (1985) conceptualize the trauma as not only reflected in sexual distress, but in difficulties with trust, feelings of stigmatization, and powerlessness. Further, however, the negative effects often extend into adulthood (Bagley & Young, 1990; Westbury & Tutty, 1999). Children with a physical or mental disability are especially vulnerable to sexual abuse (Health Canada, 1997).

3.1.2 Adult Sexual Assault: The most recent survey regarding adult women's experience with sexual assault was conducted by Statistics Canada in 1993. This Violence Against Women survey measured the incidence of sexual assault as defined by the Criminal Code of Canada: "an assault committed for a sexual purpose or an assault of a sexual nature that violates the sexual integrity of the victim". There are three levels of charges, based on the degree of force used and the severity of the offence. Included in the charges are: sexual assault; sexual assault with a weapon, threats to a third party or causing bodily harm; and aggravated sexual assault.

The Violence Against Women study estimated that 39% of adult Canadian women have experienced at least one incident of sexual assault since the age of sixteen (1993). Alberta had the second highest rate of violence against women in Canada with 58% of adult Albertan women having experienced at least one incident of physical or sexual violence since the age of sixteen. The report estimated that only 6% of female sexual assault/abuse survivors report to the police.

Although the report is ten years old, this research remains the latest and only national study that examines the life-time prevalence of a broad range of forms of violence against Canadian women. Also the dynamics and the impact of violence and abuse do not change dramatically over such relatively short time periods. The immediate

and long-term effects of sexual assault include rape trauma, depression, anxiety and suicidal thoughts and attempts (Tomlinson, 2000).

3.1.3: Violence in Intimate Partner Relationships: : The abuse of intimate partners, primarily women abused by men, is a serious problem in Canada (Tutty & Rothery, 2002). The prevalence of domestic violence varies according to different studies. The 1999 General Social Survey on Victimization conducted by Statistics Canada (2000) concluded that, "7 percent of people who were married or living in a common-law relationship experienced some type of violence by a partner during the previous 5 years. The 5-year rate of violence was similar for women (8 percent) and men (7 percent). Overall, this amounts to approximately 690,000 women and 549,000 men who had a current or former partner in the past five years and reported experiencing at least one incident of violence" (p. 5).

Although men and women self-report experiencing similar levels of violence, the consequences and nature of the violence perpetrated against women are more severe and long-lasting. In the Statistics Canada report, women were more than twice as likely as men to report being beaten, five times more likely to be choked, and almost twice as likely to have been threatened by or have a gun or knife used against them. Men were more likely than women to report being slapped (57% versus 40%), having something thrown at them (56% versus 44%) and being kicked, bit or hit (51% versus 33%). (p. 5)

The violent acts against women were repeated more often: 65% of women compared to 54% of men were assaulted on more than one occasion, 26% of women as compared to 13% of men were victimized more than 10 times. The results of the abuse more often led to injury for women: 40% of woman compared to13% of men who had reported violence in the past five years were injured. Women were five times more likely than men to require medical attention for these injuries. Perhaps most informative is that women fear their partners' violence to a significantly greater extent, with 38% of women compared to 7% of men fearing for their lives (Statistics Canada, 2000).

In comparison, the previously mentioned 1993 Violence Against Women Survey that focused solely on women, estimated that "three-in-ten women currently or previously married in Canada have experienced at least one incident of physical or sexual violence at the hands of a marital partner" (Rodgers, 1994, p. 1). Such differences in estimates of abuse occur because of the manner that violence is defined, for example, whether it includes forms of abuse other than physical, such as sexual assault or financial abuse. Nevertheless, the conclusion that from 7 to 30 percent of Canadian women have experienced violence from intimate partners is concerning.

Abused women face a number of serious and trauma-inducing stresses while living with or after leaving an assaultive partner (Tutty, 1996), which have been associated with symptoms in both their physical and psychological health (Follingstad, Brennan, Hause, Polek, & Rutledge, 1991). These stressors include significant physical assault, marital rape, murder, being stalked, and threats of kidnapping or taking legal custody of children. Given the severe and chronic stress endured by abused women, it should not be surprising that

many experience symptoms such as depression, anxiety, sleep disorders and suicidal thoughts (Tutty, 1998). These common symptoms are consistent with a trauma response, similar to victims of child abuse and sexual assault.

Women who are abused physically by male intimate partners are often sexually assaulted by them as well, a little acknowledged dynamic (Mahoney & Williams, 1998). In a study of intimate partner violence in two Calgary shelters, approximately half of the residents reported marital rape in addition to their physical and psychological abuse (Tutty & Rothery, 2002). A 1995 Alberta study of high school students (Bagley, Bolitho & Bertrand) found that students with a higher number of unwanted sexual contact in the previous six months suffered greater negative effects, including conduct disorders, somatic complaints, emotional distress and suicidal ideation.

Children who live in violent homes are also commonly exposed to the domestic abuse, either seeing it in person or hearing it indirectly. The consequence of such exposure includes resorting to either physical aggression or passive acceptance as methods of dealing with conflict (Jaffe, Wolfe, & Wilson, 1990 et al, 1990; Moore, Peplar, Mae & Kates, 1989). Canadian research by Jaffe, Wilson, and Wolfe (1986) concluded that children that observe interparental abuse commonly exhibit signs of heightened anxiety, depression, low self-esteem, problems at school, self-abuse, aggressiveness, dependency, somatic difficulties, and poor sleep habits. If children who have witnessed wife abuse have themselves been abused, they are even more likely to suffer emotional and behavioural consequences (Hughes, Parkinson & Vargo, 1989). A recent review of studies that examined linkages between intimate partner violence and physical child abuse found that, of 12 studies, eleven (92%) supported the association (Tutty, 1999).

In 2002, the Calgary Police Service responded to approximately 12,000 domestic violence related calls for service, resulting in more than 4,000 criminal charges being laid. Domestic assaults are the second most frequent call for service by the Calgary Police Service. Children were present in 50% of the calls received by the police.

3.1.4 Domestic Violence in Diverse Groups

Adults and children who are disabled or are from diverse cultural groups are vulnerable to each of the previously described forms of family violence in equal if not increased rates to that of the majority population. According to the Disabled Women's Network (1989), an estimated 42% of women with disabilities have been or are in abusive intimate partner relationships. Individuals with disabilities face the same systems difficulties as other assault victims such as service fragmentation and being forced to reiterate their traumatic experiences. In addition, they must deal with existing myths and stereotypes with respect to their disabilities, and barriers such as communication problems, physical access, and intellectual gaps such as access to information when attempting to disclose their abusive/neglectful situations. Sobsey (1994) estimated that those with disabilities are 1.5 times at greater risk for abuse than their non-disabled peers.

Aboriginal Canadian women report spousal violence rates three times higher than non-Aboriginal women (LaRocque, 1994). Eight in ten Aboriginal women in Ontario

reported having personally experienced violence (Ontario Native Women's Association. 1989; Dumont-Smith and Sioui Labelle, 1991). The spousal homicide rates for Aboriginal women are more than eight times the rate for non-Aboriginal women (Statistics Canada Homicide Survey, cited in Federal-Provincial-Territorial Ministers Responsible for the Status of Women, 2002).

Immigrant and refuge women also report high levels of abusive intimate partner relationships. In a 1993 study of 64 women from four ethno-cultural communities in Montreal, MacLeod and Shin revealed that 69% of respondents had experienced some form of abuse. In a 1990 manual developed jointly for the Calgary Coalition on Family Violence and the Calgary Immigrant Women's Centre, Bhola and Nelson noted that immigrant and refugee women often stay in abusive relationships because of isolation, few economic resources, a lack of employment or underemployment and language barriers. Because they may fear both deportation and the police, they seldom report domestic violence (Brownridge & Halli, 2002).

3.1.5 The Costs of Violence in Canada: The costs of violence against Canadian women are enormous, not only in personal costs to well being, self-esteem and safety, but in monetary terms as well. In 1995, Greaves, Hankivsky and Kingston-Riechers from the London Ontario Centre for Research on Violence Against Women and Children focused on just three forms of violence: incest or child sexual assault, sexual assault or rape of women, and woman abuse in intimate partnerships. In examining the financial impact of such victimization on four selected policy areas: social services/education, criminal justice, labour/employment and health/medical, they concluded that such violence costs the country an estimated annual 4.2 billion Canadian dollars.

The ripple effects of violence against women include poverty and homelessness both for the women who experience violence and any dependents. Directly or indirectly, the immediate and longer-term consequences have enormous social and economic ramifications.

3.2 The System's Response to Sexual Assault/Abuse

Childhood sexual abuse and adult sexual assaults not only result in immediate trauma, but the long-term effects often seriously interfere in victim's lives for years. The actual act of assault is but one element of the trauma that scars the lives of both adult and child victims. Not only are sexual assaults criminal acts, they also attack the victim's psychological well-being and are a violation of physical health and safety.

Given the obvious developmental differences and treatment needs of adults and children, there are variations in the systemic and organizational response to child abuse and adult sexual assault/abuse. Similar to the trauma, anguish, and turbulence that are activated by sexual abuse/assault, coping with the demands of the systemic and organizational response can be equally as harrowing and complicated. The responses to sexual assault/abuse have been implemented to investigate, to seek justice, to advocate, to protect, to support, and to treat medically and psychologically, as each system works to meet their philosophical and legally mandated roles in addressing sexual assault/abuse. It

typically involves counsellors and advocates, law enforcement, medical personnel, the criminal justice system (prosecution and defence), and child protective services in cases of child sexual abuse (Anderson & McMaken, 1990; Berliner & Conte, 1995; Henry, 1997; Jaudes & Martone, 1992).

The response to sexual assault/abuse is complex because of these multiple systems. Martin, DiNitto, Byington and Maxwell (1998) describe the inter-organizational mandates in "rape processing', the activities undertaken by each service as the rape case moves through the various levels of the system. Each system has different priorities. Depending on which system is initially contacted, the response may be quite different.

Medical personnel treat physical injuries and collect forensic evidence that may be used to help prosecute the offender. The role of law enforcement (the police) is to protect the victim and society from the perpetrator, to gather the facts and evidence, to determine if and what charges will be laid, and to establish a strong case to present to the prosecutors. The criminal justice system works to ensure that society is protected from offenders, however, they must also take necessary measures to make certain that a person is not wrongfully accused or that the accused's rights and freedoms are unduly jeopardized. Child protection services are mandated to ensure that children are protected from further abuse in the home. Sexual assault/abuse counsellors and other mental health professionals support, advocate, and engage therapeutically with victims in addressing the trauma of recent and historical sexual assault/abuse. Each professional must understand both the role and process of the other professionals involved in the systemic and organizational response to sexual assault/abuse (Duquesne & Faller, 1988).

Further, the roles of these various systems and organizations converge and diverge through the phases of disclosure, investigation, and treatment. This overlap may at times be collaborative and other times conflicting. Each Canadian system and the linkages between them have been critiqued. Difficulties in the police response (Griffiths, 1998) or expectations that women will not be well-treated by police or in court (Tomlinson, 2000) may lead women to choose not to report. Du Mont and Parnis (2000, 2001) have conducted several studies with respect to problems with the use of forensic medical evidence in resolving adult sexual assault cases. De Jong (1998) and Palusci (2002) report that sexually abused children rarely present with medical conditions or forensic evidence.

Victims must often navigate between services, attending investigative interviews and accessing resources with numerous professionals, often at separate locations (Anderson & McMaken, 1990; Campbell & Ahren, 1998). To complicate matters, as victims present for service, they may work with different professionals within each system (Jaudes & Martone, 1992). Research has confirmed that such fragmentation can secondarily victimize individuals as she/he must repeatedly re-tell the events of the assault to police, medical examiners, counsellors, and legal representatives (Anderson & McMaken, 1990; Campbell, Sefl, Barnes, Ahrens, Wasco & Zaragoza-Diesfeld, 1999; Henry, 1997; Jaudes & Martone, 1992; Seigel, 1999). In addition to further exacerbating the victim's trauma symptoms, fragmented systems may contribute to an increased probability of inconsistencies in the victim's and professionals' accounts of events,

therefore decreased rates of successful prosecution (Henry, 1997; Jaudes & Martone, 1992; Seigel, 1999).

Contact with staff of the various systems impacts the victim, both positively and negatively. Campbell et al.'s 1999 study with 102 rape victims found that the treatment received from staff of legal, medical, and mental health organizations influenced the survivors' levels of distress post-disclosure. Negative experiences with legal and medical personnel contributed to higher post traumatic stress and overall higher secondary victimization.

Importantly though, Campbell et al.'s study also showed that victims who engaged in sustained counselling with mental health professionals had lower levels of post traumatic stress. Similarly, Weisz's 1999 study of the legal advocates who provide essential emotional and informational support to victims of domestic violence, found that more of the women involved with advocates took legal action against offenders such as obtaining protective orders and testifying in court. As such, services that connect with victims supportively, can positively impact both their own mental health and the prosecution of the crimes against them.

3.3 The Evolution of Service Delivery Models for Sexual Abuse/Assault

Over time, a number of different mechanisms have been developed to serve adults and children victimized by sexual assault/abuse: grassroots rape crisis centres; multidisciplinary hospital-based teams; coordinated interagency community response; fee for service forensic consultation teams; one-site children's advocacy centres and family advocacy centres.

During the past three decades, the nature of services for sexual assault and child abuse service delivery models has evolved from independent organizations in the 1970's and 80's, to coordinated interagency responses in the 1990's, and, in the past several years, to advocacy centres that co-locate a number of health, police and counselling services in one site.

3.3.2 Independent Organizations: Originally, sexual assault, child abuse, and domestic violence services functioned in relative isolation. While providing essential counselling services and advocating and accompanying victims to court, they did not often collaborate with other systems such as the police and prosecutors (Anderson & McMaken, 1990; Campbell & Ahren, 1998).

The early rape crisis centres are one example of independent models of service delivery. First developed in the 1970's, rape crisis centres are still perceived by many as the strongest advocates for sexual assault survivors. They both developed and operated from a strong feminist perspective, and were initially opposed to cooperating with justice and mental health organizations, conceptualizing these as patriarchal in nature and inducing further trauma for women (Koss & Harvey, 1987). Over the past 30 years, rape crisis centres have modified their approach and work in cooperation with the other systems. Contemporary sexual assault centres are intrinsically related to the early rape crisis centres in their victim-centred philosophy, as they work to decrease the system

induced trauma to victims and focus on raising the issue of sexual assault in the public consciousness.

3.3.3 Coordinated Interagency Responses: Coordinated responses to dealing with sexual abuse/assault and domestic violence have been recommended for over 20 years. With respect to adult sexual assault victims, for example, as early as 1983, Underwood and Fiedler recommended a timely response to rape, one that involved a well-coordinated effort between agencies to share resources and expertise.

Community coordinated responses involve a multi-agency effort to respond in a coordinated and systematic manner to the crises of sexual assault, child abuse, or domestic violence to better meet the service and support needs of victims and society. Coordinated interagency responses most often involve the police; prosecutors; crisis services; medical; sexual assault/domestic violence counsellors; specialized victim's advocates; legal/court advocates; and child protection workers in sexual abuse/assault cases involving children (Anderson & McMaken, 1990; Campbell & Ahren, 1998; Coulborn Faller & Henry, 2000; Jaudes & Martone, 1992). In most coordinated interagency responses to sexual assault/abuse, agencies continue to maintain their own separate locations, but work together in a systematic manner to address the components of the sexual assault/abuse in order to decrease system trauma to victims.

The three service phases of a coordinated response include the disclosure phase, investigative phase and the treatment phase (Trute, Adkins, & MacDonald, 1994). A coordinated interagency response strives to streamline the victims' progression through each of the three service phases.

Campbell and Ahren (1998) assert that the context of rape for the victim must be a core factor in developing coordinated services. The perspective of the victim, service providers and the overall community/society must be included in the development of effective service delivery models. "When practitioners 'march on' with their work, unconcerned with the rape victim's right to know about and choose among alternative procedures, they reinforce her status as victim, ignore her capacity for survival, and undermine her recovery from the trauma of rape" (Koss & Harvey, 1987, p. 81).

Koss and Harvey further suggest five essential dimensions in assessing the effectiveness of a coordinated interagency rape response: availability; accessibility; quantity; quality; and legitimacy. *Availability* refers to the actual resources that exist in a community and draws light to the community's commitment to the crisis of rape. *Accessibility* means that services can be easily obtained by victims at any time of the day (i.e. 24 hour crisis line or hospital emergency room) with consideration for diversity issues. *Quantity* ensures that the community has an appropriate number of services and staff available to meet the needs of the population. *Quality* infers that the available services are victim-centred and knowledgeable of the factors involved in the trauma of sexual assault. *Legitimacy* refers to the degree of value granted to services by reputable primary systems, as well as the level of promotion of such services in the community.

The Domestic Abuse Intervention Project (DAIP), implemented in 1981 in Duluth, Minnesota, is the most commonly cited example of a coordinated interagency

response. It is primarily focused on women victims of domestic abuse (*Domestic Abuse Intervention Project* (n.d.); retrieved March 12, 2002, from http://www.duluth-model.org/daipmain.htm). The DAIP coordinates the efforts of domestic violence serving agencies in a victim-centred approach to intervention, becoming a model for the development of coordinated interagency responses throughout the U.S. Included in the DAIP are police, 911, prosecutors, sheriff, district bench, probation, public and mental health representation, and the women's shelter. These agencies respond to domestic violence in a coordinated manner according to a set protocol whereby each agency can simultaneously operate in a victim-centred manner and meet its philosophical mandate. As mentioned previously, Weisz' 1999 study of the DAIP found that legal advocates provide essential emotional and informational support to victims of domestic violence and assist more women taking legal action against offenders, including obtaining protective orders and testifying in court. Similar agencies operate in Santa Barbara, California (Domestic Violence Emergency Response Teams for Zero Tolerance) and Ann Arbor, Michigan (Thelen, 2002).

A Sexual Assault Response Team (SART) is another example of a coordinated response, similar to the DAIP described above, but with a focus on sexual assault. A SART is composed of representatives from law enforcement, sexual assault centres and/or legal/court advocates, medical personnel (doctors and/or nurses). Sexual Assault Nurse Examiners (SANE nurses) appear to be used extensively in the U.S. to conduct the medical examinations, but to a lesser extent in Canada.

A Canadian example of a coordinated interagency response is the Manitoba Rural Child Abuse Project (Trute, Adkins, & MacDonald, 1994) response to child sexual abuse. This collaboration involved systems and organizations at the family, agency and community levels in rural Manitoba. The three year project utilized key personnel to assist the coordination of services for victims and their non-offending family members. Each team member operated according to a prescribed role that focused on the victim, the non-offending family, the service providers or the entire coordination process. Such coordination and understanding between agencies resulted in a reduction in the system-induced trauma to children who had been sexually abused and their non-offending family members.

Another Canadian example is the York Region Abuse program (Harper, 1990) that addresses adults, children, families and offenders who have experienced child sexual abuse.

Coordinated approaches that deal with violence have met with considerable approval and been implemented broadly. Berliner and Conte (1995) noted that in cases of child sexual abuse, "coordination of investigations to reduce unnecessary interviews is virtually universally believed to be desirable" (p. 372). Research on coordinating the services for victims of sexual assault confirms that it decreases the number of interviews for victims, increases successful prosecution and improves communication between agencies involved in sexual assault/abuse cases (Anderson & McMaken, 1990; Moriarty & Earle, 1999; Tjaden & Anhault, 1994).

3.3.4 Advocacy Centres: Advocacy centres move a coordinated interagency response under one roof, streamlining services to victims. Rather than victims and their families travelling between agencies at different locations, advocacy centres co-locate some of the essential systems and services in one central location. Whether serving adults or children, or both, the common features of advocacy centres include: coordination of investigation, crisis response, and representation from law enforcement, prosecutors, child protection, referral and therapeutic services (Anderson & McMaken, 1990; Berliner & Conte, 1995; Henry, 1997; Jaudes & Martone, 1992). While not all advocacy centres provide on-site medical investigations, they most often have a coordinated arrangement with medical facilities nearby.

Most of the advocacy centres in North American are for children who have been sexually abused. The first Children's Advocacy Centre (CAC) opened in Huntsville, Alabama in 1985. Since 1987, the National Children's Alliance (NCA) in the United States has served as a membership organization that works in a guidance capacity for Children's Advocacy Centres (CAC) across the US. The NCA identifies the purpose of Children's Advocacy Centres as providing "a comprehensive, culturally competent, multidisciplinary team response to allegations of child abuse in a dedicated, child-friendly setting" (*National Children's Alliance*. Retrieved May 28, 2002, from http://www.nnac.org/network.html). In their endeavours to alleviate trauma to child victims and their non-offending family members, Children's Advocacy Centres strive to coordinate and co-locate services under one roof. Most CAC's co-locate representatives from child protection, police, prosecution, counsellors and advocates. There are now 400 CAC's across the U.S.

A primary goal of CAC's is reducing the number of times that a child victim must re-tell his/her story (Anderson & McMaken, 1990; Henry, 1997; Jenson, Jacobson, Unrau, & Robinson, 1996; Reichard, 1993). In a study of 90 sexually abused children (aged 9 to 19) who had been through the court, Henry (1997) concluded that reducing the number of interviews significantly decreased the level of trauma experienced by the child after disclosure of the abuse.

The major method to reduce the number of investigatory interviews by the various systems involved in a child sexual abuse case is videotaping the initial interview (Coulborn, Faller, & Henry, 2000). Using video can decrease the need for subsequent interviews with the child victim or can assist professionals to strategize a second interview that would be the least trauma-inducing for the victim (Jenson, Jacobson, Unrau & Robinson, 1996). Coulborn et al. (2000) studied 323 child sexual abuse cases extracted from criminal court, finding support for videotaping as an important component of one community's protocol for child sexual abuse cases. In cases in which the offender confessed, 61.9% of the prosecutors possessed videotapes of the child victim interview.

In Canada, the co-location of services to one-site to better serve victims of child abuse, sexual assault or domestic violence is a new phenomenon. Canada has several advocacy/co-location centres that focus on child abuse but none with a focus on sexual assault. Edmonton recently launched the Zebra Child Protection Centre, based upon the CAC model in the U.S. St. Catherine's, Ontario is presently in the business-planning

stage of developing a CAC. Regina and Saskatoon have Children's Justice Centres (focusing on child abuse) that co-locate child protection and law enforcement, and coordinate with prosecutor's office, court preparation, victims' services, counselling and medical services.

As early as 1992, Steele called for more systematic evaluations of children's advocacy centres, yet few have been conducted. In 1996, Jenson, et al. published one of the only evaluations of CAC's, studying three Child Advocacy Centers in Utah, with 294 child participants. Using pre-test and post-test measures immediately following the first investigative interview and at three-months, they evaluated the child's parents and team member's satisfaction with the investigative process and the legal and treatment outcomes. Jenson et al. concluded that the multidisciplinary teams in a hospital-based setting had a positive influence in assisting families and children to acquire needed services. However, they also reported that parental satisfaction decreased between the initial interview and three-month follow-up. Parents reported feeling alone in dealing with their child's sexual abuse. The findings suggest the need for further support/contact for parents to assist them in coping with their child's sexual abuse.

Similarly, Davison (2002) reported on prosecution rates with respect to the Dallas Children's Advocacy Centre. While only a minority of the investigated cases were prosecuted, once charged, the rates for carrying forward cases, guilty pleas and conviction rates were high.

Currently, Dr. Theodore Cross from the University of New Hampshire is conducting a national evaluation examining how CAC's work and in what ways they are effective. It will assess the effects of programs within CAC's, different types of CAC's, and the impact of CAC's on children, families, agencies, the court system, and communities. (National Evaluation of Children's Advocacy Centers, n.d.)

Aside from evaluations, the development of advocacy centres has certainly resulted in debate. Reichard, an American judge, suggested in 1993 that children's advocacy centres that focus only on child sexual abuse may be defining themselves too narrowly. She described a program in Marion County, Indianapolis, Illinois, that changed from being a children's advocacy centre to Family Advocacy Centre. The workers expanded their mandate from solely focusing on child sexual abuse to also addressing domestic abuse.

In response to this suggestion, several authors raised concerns about broadening the mandate of child advocacy centres. Williams (1993) questioned possible conflicts of interest if a children's centre were changed to a family advocacy centre. He was concerned about additional demands on the resources of the centre, and gave an example of a case that could divide a team: issues with respect to children witnessing abuse and whether a mother can be defined as unwilling to protect her children if she continues living with an abusive partner. Similarly, Sorenson (1993) suggested that children's advocacy centres need to first establish that they are conducting their first mandate effectively before expanding to service other constituencies.

Fewer advocacy centres serve adult abuse victims in either Canada or the United States. In our Canadian review, we contacted every provincial association of transition

houses and emergency shelters and sexual assault centres. Because we found no adult FAC's in Canada dealing with sexual assault and/or domestic violence, our review concentrates on several American advocacy centres (see Table 1).

The Phoenix Family Advocacy Center serves adult victims of sexual assault and domestic violence. On-site representatives include the police, prosecutors and county attorney's office, the SANE (Sexual Assault Nurse Examiner) program, probation, counsellors and advocates from sexual assault and domestic violence centres and the City Manager's Office. These professionals work together to streamline services for victims through case management, collaborative investigations, conduct medical and forensic exams, advocate for victims in the criminal justice system, and provide counselling for victims and non-offending family members.

The Marion County FAC, mentioned previously, was initially developed as a CAC in 1990 but changed its focus to include the whole family, given that child abuse and violence between adult family members tend to be linked (Reichard, 1993). The community believed that the CAC could provide better service by addressing the problems of the family as a whole unit, so as not to exclude issues that are interrelated

with child abuse. Since then, the Marion County FAC serves both adult and child victims of domestic violence. Although the centre will address issues of sexual assault, that is not its primary purpose. The police, prosecutor's office, sheriff department, child abuse hotline, IndyCorps (a domestic violence organization), child protective services, and social work interns are all co-located at the FAC. The Marion County FAC provides on-site police investigation, safety planning, videotape of child abuse investigative interviews, domestic violence court advocates.

The Mesa Center Against Family Violence (CAFV) serves both adult and child victims of sexual assault and domestic violence. CAFV on-site representatives include: police units (domestic violence, sex crimes and child abuse, sex offender notification, and victim's services), professional forensic interviewer, child protective services, forensic paediatric services, SANE program, county attorney's office, city prosecutor's office, adult probation, and sexual assault counselling. These agencies and organizations coordinate services to provide on-site video-taped interviews, medical forensic exams, criminal investigation, victim services, crisis intervention, referrals, victim notification and short-term counselling.

Table 1: Advocacy Centre Models

City of Phoenix Family Advocacy Center – Phoenix, AZ	The Zebra Child Protection Centre Edmonton, AB	Mesa Center Against Family Violence (CAFV) – Mesa, AZ	Marion County Family Advocacy Center – Indianapolis, IN
One-site co-location of services; disclosed, central location.	One-site co-location of services – based on National Children's Advocacy Center model in the US; disclosed location with security.	One-site co-location of services; secure location.	One-site co-location of services; disclosed location.
Serving: Adult victims of domestic violence and sexual assault	Serving: Children under age 14 who have been abused & non-offending family members.	Serving: Child & adult victims of sexual assault & domestic violence. Intervention in cases of child neglect or abuse.	Serving: Child & adult victims of domestic violence. Includes sexual abuse, severe physical abuse & neglect, child witness of crime or abuse.
Managing organization: City Manager's Office	Managing organization: Executive Director and Board of Directors.	Managing organization: Mesa Police Department	Managing organization: Non-profit organization
On-site representation from: - City Manager's Office - Police Family Investigations Bureau - Prosecutor's Office – victim services - County Attorney's Office - Adult Probation Office - CASA (Center for Prevention of Abuse and Violence) Counsellor/Therapist - Sojourner Center Domestic Violence Shelter – victim advocate - SANE (Sexual Assault Nurse Examiner) Program - Social Work Interns	On-site representation from: - Edmonton Police Service : Child At Risk Response Team (CARRT); Child Protection - Alberta Child & Family Services (2 Child Protection workers, one Access/Custody Dispute worker) - Crown Prosecutor's Office (part-time) - Victim Services (employee of Zebra) - will be adding other community representatives as centre continues to be developed (i.e. mental health/treatment services)	On-site representation from: - Police - Child Protective Services - Professional child forensic interviewer - Victim's services - Forensic Pediatric services for medical exams 24hrs/day 7 days/week - County Attorney's Office - City Prosecutor's Office - SANE Program (for adult victims) - CASA - Adult probation (domestic violence)	On-site representation from: - Police - Prosecutors Office - Marion County Sheriff Dep't - IndyCorps/Americorps (domestic violence organization) - Child Abuse Hotline
On-site Services: - Criminal investigation - Sexual assault forensic/medical exams - Emergency Protection Orders - Case management & crisis intervention - Crisis & long term individual & group counselling - Emergency & transitional shelter placement - Victim advocates (community, police, & prosecutors staff - Safety planning & victim rights - Court accompaniment - Financial assistance	On-site Services: - Criminal & child protection investigation of child abuse - Videotaping for police and child protection joint interviews - Victim Services provide 24 hr. crisis response & intervention, follow up and referral; assistance with the criminal justice system.; assistance with Victim Impact Statements; Requests for Restitution; Financial Benefits for Victims of Crime - Referral to: Court Preparation Program, & Court Accompaniment Program	On-site Services: - Criminal investigation of sexual assault & domestic violence - Medical examinations/attention for sexual/ physical assault - Crisis intervention - Video interviews with victims - Audiotaped confrontational phone calls (to elicit confessions) - Victim's Services & victim notification - Short-term counselling - City Prosecutor's Victim Rights Program provide legal and emotional	On-site Services: - Criminal investigation of domestic violence and child abuse - Child protection services hotline - Child interviews - videotaping - Safety planning (emergency 911 cell phones) - Domestic violence court advocates - Family research coordinator (information, support & advocacy to victims of child abuse & their non-offending care givers) - Protective order court advocates Outreach advocates

- Referral to appropriate community resources - Resource Library	- Child - & victim - centered environment - Prevention and Education for professionals & the larger community	support for court process - Violence education & referrals	- Project Safe Families (case management & safety planning)
Community Partners: - Assistance League of Phoenix - Fire Department Response Team - Municipal Court - Childhelp USA - Arizona Coalition Against Domestic Violence - Local & Regional Domestic Violence Shelters - Agencies assisting with transportation and accommodation	Community Partners: - Police - Alberta Child & Family Services - Crown Prosecutor's Office - Victim's Services - To be determined	Community Partners: - Local domestic violence shelters - Hotel/motel program for emergency housing - Community service organizations that provide clothing, toys, baby supplies, emergency 911 cell phones, food staples, etc.	Community Partners: - Center of Hope SART - Indiana University School of Medicine (child sexual abuse team) - Domestic Violence Network - Julian Center (women's shelter) - Children's Bureau of Indianapolis - Indiana Advocates for Children - Youth Emergency Services - Center of Hope
Evaluations &/or academic literature:	Evaluations &/or academic literature:	Evaluations &/or academic literature: Seigel, G.C. (1999). *The impact of the Mesa Center Against Family Violence on child abuse investigations.* Uekert, B.K. (1998). *Process evaluation of the Mesa Center Against Family Violence.*	Evaluations &/or academic literature: Reichard, R.D. (1993). *Dysfunctional families in dysfunctional systems? Why child advocacy centers may not be enough.*
Web-site: http://www.ci.phoenix.az.us/CITZASST/fac.html	Web-site: http://www.	Web-site: http://www.ci.mesa.az.us/police/default.htm	Web-site: http://www.familyadvocacycenter.com/

Comparing these four centres, one notices different emphases. Edmonton's Zebra Centre most clearly focuses on child abuse. Marion County, originally a CAC, expanded their mandate to service adult victims of domestic violence. Phoenix serves only adult victims of sexual assault and domestic violence although it works collaboratively with Childhelp USA, Phoenix's advocacy centre for child sexual abuse. In future, the two agencies may co-locate but maintain separate facilities. The Mesa centre is the most comprehensive, serving adults and children who have been either victims of sexual assault, domestic violence, or child abuse.

Who is responsible for managing the centres and which agencies co-locate there also influences the functioning of the organizations. For example, the Mesa and Zebra centres were developed by and have a strong police presence, which impacts how the community perceives the centre and may affect whether some victims will feel comfortable seeking services there. Furthermore, the term, "co-locating", is somewhat imprecise, reflecting a continuum from moving entire agencies/units into a centre, to an agency simply having an office in the centre for their use. Which organizations co-locate more fully and which co-locate to a more limited extent may have a dramatic effect on the climate of the centre.

Published research on family advocacy centres is lacking. Seigel's 1999 unpublished evaluation of one-stop sites reported that compliance with the first response protocol in serious child sexual and physical abuse cases improved after the Center Against Family Violence opened in Mesa, Arizona. Since the opening of the CAFV, there has been greater coordination between agencies such as law enforcement, prosecutors and child protective service (CPS) workers, which may in part be due to the improved proximity of the agencies that are now co-located under the roof of the CAFV. The Seigel evaluation found that there were increased medical forensic exams, which likely influenced the development of stronger legal cases that were submitted to the prosecutor's office. With better and more compelling evidence, more cases were successfully prosecuted.

The continuum of service delivery has evolved from independent organizations to coordination to co-location of services. It has become evident that coordination of services to victims is an essential component of service delivery. Co-location of services at one site is a seemingly logical and progressive step in the evolution of victim-centred service delivery.

In light of the information collected in the literature and website review, RESOLVE Alberta directly contacted 39 agencies across North America for information about their service delivery models. A large proportion of these contacts were made with sexual assault serving organizations across the Canadian provinces and territories, in an effort to discover the presence of advocacy centre models (providing a streamlined, co-location of services) in our own country. Through our internet search, we found approximately 20 potential models on websites; however, the majority of these only appeared to co-locate services. In fact, most were independent organizations that either were part of a coordinated interagency response to domestic violence, sexual assault/abuse, or the organizations provided a number of services independently. With the exception of the 400 CAC's across the US, we uncovered only six existing centres that

offered an advocacy/co-location model of service delivery, or at least presented the most clearly defined example of such a model in our search[1]. Although a thorough search was conducted in Canada, we found that agencies only rarely employed an advocacy/co-location service delivery model.

A wealth of literature documents the efficacy of multidisciplinary teams in investigating child abuse and sexual assault, secondary (or system-induced) trauma, the negative effects of multiple interviews on children, and the difficulties/opportunities in interagency coordination (see for example: Bross, Ballo & Krofmache, 2000; Faller & Henry, 2000; Fargason, Barnes, Scheider & Galloway, 1994; Glisson & Hemelgarn, 1998; Hochstadt & Harwicke, 1985; Kolbo & Strong, 1997). However, we found a paucity of evaluations of advocacy centres in the academic literature. Given the typical delay in researching new approaches and publishing the findings, the lack of available research is not unusual, but represents a serious gap in our understanding of whether the advocacy centre approach would be a significant improvement over a coordinated community response.

3.4 The Benefits of Advocacy Centres

The following section documents the perceived benefits of an advocacy/co-location approach. The information was collected from the literature, representative from existing advocacy centres and interviews with 21 Calgary key informants.

A major conceptual difference between advocacy centres and previous approaches to assisting those affected by sexual assault and abuse is that the services are child and/or victim-centred. The centre clients are provided most of the necessary services on-site, rather than being referred to agencies scattered throughout the community. This streamlining of services in one central location means that investigations by police and child protection are more easily coordinated and service providers can provide more consistent responses. Having a centralized location can also improve the facilities utilized for investigations.

The process of moving through the investigative and support systems is clarified, benefiting both service providers and victims. Advocacy centres are thought to enhance the ability to track and support victims throughout the entire justice process.

One major goal of advocacy centres is reducing trauma to victims and non-offending family members, partially by providing support to both victims and their immediate circle of family and friends. Providing follow-up services to abuse victims is much easier since they can meet with these staff at the centre and then, either be referred to the outside agency having already engaged with the new staff member or continue to meet at the advocacy centre. Further, staff that deal continuously with trauma victims can be more easily de-briefed to prevent or provide early intervention for vicarious

[1] Included in the six centres: Zebra Child Protection Centre in Edmonton, the Children's Justice Centres in Regina & Saskatoon, the Phoenix Family Advocacy Centre, the Mesa Centre Against Family Violence, and the Marion County Family Advocacy Centre in Indianapolis.

traumatization: the trauma reactions that helpers can develop as they work over time with victims of trauma (Pearlman & Saakvitne, 1995).

Advocacy centre staff can address issues beyond assisting victims, by providing training for service providers and education and prevention for the broad community. As such the centre can contribute to raising the profile of sexual assault and child abuse in the community. Within the community, advocacy centres support partnerships between agencies, in particular those serving marginalized groups. Centralized services provide a unique opportunity to conduct research, with enhanced access to information and study participants.

4.0 Calgary's Response to Child Sexual Abuse and Adult Sexual Assault

Calgary has a number of organizations and systems that address sexual assault and child sexual abuse. These systems are often coordinated, though both professionals and victims may find it difficult to understand the specific mandates of the systems and organizations and to navigate the route through the phases of disclosure, investigation, and treatment.

Comparable with most communities in North America, Calgary's response to sexual assault and child abuse involves primary systems such as child protective services, law enforcement, crown prosecution, and medical and treatment services. In Calgary, the central systems and organizations include: the Calgary Police Service street officers and its specialized units (Domestic Conflict; Sex Crimes, Child Abuse, Child At Risk Response Team), the Calgary Health Region and its auspices (Alberta Children's Hospital Child Abuse Unit, & the Rocky View General Hospital Sexual Assault Unit); a sexual assault centre (CCASA); the Crown Prosecutors Office; and Calgary Rocky View Child and Family Services.

Laura Cavicchi from RESOLVE Alberta met with members of all of the above organizations and with additional representatives from several Calgary shelters for abused women, Homefront (the Calgary specialized domestic violence court), Calgary Legal Guidance, Calgary Police Services Victim's Assistance, Safe Haven (a shelter for youth sexually exploited through prostitution). Laura documented the flow of services separately for children and adults, identifying what is working well, what is problematic and whether there are gaps in the system.

As can be seen from Table 2 on the following page, agencies vary with respect to the age of the clients that they are mandated to serve. The following sections detail the roles and responsibilities of Calgary sexual abuse/assault services, describing child-focused and adult-focused services separately. In addition, the section on each agency summarizes the responses gathered from the 21interviews conducted with sexual assault and domestic violence stakeholders in Calgary.

4.1 Calgary's Primary Systems for Child Victims of Sexual Abuse

Calgary Sexual Assault Response Team (CSART)

CSART is a multidisciplinary sexual assault crisis response team. Members of the CSART team include: CCASA Call-Out Workers, CSART physicians, CSART Nurse Co-ordinator, CSART nurses, the Calgary Police Service, and the RCMP. When CSART attends to cases involving children under age 14, child welfare must be notified. In turn, Child Welfare must then notify the Calgary Police Service or the RCMP in order to

Table 2: Calgary Services for Sexual Abuse/Assault Victims by Age

ORGANIZATION NAME	ROLE	AGE OF CLIENT POPULATION
Child & Family Services	Child Welfare Workers are authorized by the Child Welfare Act of Alberta to ensure that children are protected from abuse and neglect.	Age 17 & under.
Child Witness Court Preparation Program	Prepares children to testify in court.	Age 17 & under.
Calgary Police Service - Child Abuse Unit	Criminal investigation of sexual abuse of children under age 14.	Age 13 & under.
Alberta Children's Hospital – Child Abuse Unit	Treatment/counselling of child victim of sexual abuse and non-offending parent.	Age 12 & under.
Calgary Police Service – General Investigative Unit (GIU) or street officers at district level	Criminal investigation of sexual assault & child sexual abuse that does not fall under jurisdiction of other specialized units	All ages.
Calgary Sexual Assault Response Team (CSART)	Crisis/acute response to sexual assault. Conducts forensic exams & medical treatment. Includes CCASA counsellors, nurses, doctors, and police (if requested). Follow-up within 24 hours.	All ages. Age 13 & under attend ACH for forensic examination. Age 14 & over attend RGH for forensic exam.
Calgary Police Service – Victims Assistance Unit	Support, information, & referral to child & adult victims, and non-offending family members.	All ages.
Other: community agencies & private therapists serving victims of sexual abuse	Sexual abuse/sexual assault counselling. i.e. Catholic Family Services, Calgary Psychological Resources, Calgary Counselling, Calgary Family Service Bureau	All ages.
Calgary Community Against Sexual Abuse (CCASA)	CSART call out role. Crisis counselling & 10 sessions for recent or historical victims of sexual abuse/assault. Court preparation & accompaniment. 24 hour crisis line. Prevention & education, & *Who Do You Tell*? school based program.	Age 12 & over for counselling.
Rocky View General Hospital (RGH) – Sexual Assault Unit	Only specialized sexual assault forensic exam site in Calgary. CSART doctors and nurses.	Age 14 & over.
Calgary Police Service – Sex Crimes Unit	Criminal investigation of serious adult sexual assault cases (victims over age 14), i.e. those involving a weapon or serious injury & the victim wants to pursue criminal charges.	Age 14 & over.

Note that numerous other resources that address violence and abuse exist in Calgary. For a complete listing of Calgary domestic violence services, refer to the Community Resource Inventory compiled by ACAV in October 2001.

conduct a joint investigation. CSART statistics from the year 2001 reveal that of the 243 cases that CSART attended, 18 were children seen at the Alberta Children's Hospital.

Alberta Children's Hospital – Child Abuse Unit

ACH Child Abuse Unit sees children who have been sexually and physically abused, both intra- and extra-familial. ACH Child Abuse Unit serves approximately half of the 700 referrals they receive each year. The waitlist may range from 8 to 12 weeks. For those referrals deemed appropriate for brief crisis intervention, ACH Child Abuse Unit offers the Fast Track Clinic (up to 8 sessions), which has a waitlist of only one week, as they deal only with acute abuse issues. Referrals to the Fast Track Clinic originate most often from cases of extra-familial sexual abuse.

Calgary Police Service – Child Abuse Unit

The Child Abuse Unit of the Calgary Police Service may conduct criminal investigation of child sexual abuse cases under age 14. This unit works closely with child protection workers. Child Abuse Unit may be involved at the ACH through CSART or may enter the investigation at the post-crisis phase.

Calgary Communities Against Sexual Abuse (CCASA)

CCASA is the primary specialized agency that provides both crisis and short term counselling with sexual assault victims and sexual abuse survivors in Calgary. CCASA will work with adolescents aged 12 and over, and provides the "Who Do You Tell?" prevention/education program for schools. In addition to the 24 hour crisis line operated by CCASA, the agency is also part of the 24 hour CSART response to child and adult victims. CCASA Call-Out Workers provide 24 hour crisis intervention, accompaniment, and advocacy.

Calgary Rocky View Child and Family Services

Child protection workers in Calgary are authorized by the Child Welfare Act of Alberta to ensure that children under age 18 are protected from all forms of abuse. In cases of child sexual abuse, it may take three to six weeks before child welfare and the police may conduct a joint interview with the child. Child welfare protocol dictates informing the police of cases of child sexual abuse. Child protection workers and police will then conduct joint interviews and complete their respective investigations. In cases of extra-familial sexual abuse, Child Protection would only be involved if the parent persistently failed to protect the child from the offender.

Child At Risk Response Team (CARRT)

CARRT may be called as an immediate response to an "at risk" or acute situation involving a child under age 18. CARRT is a partnership between the Calgary Police Service and Rocky View Child and Family Services. Each team includes a police officer and a child protection worker. CARRT will attend to the crisis and make appropriate referrals.

Figure1: Calgary Community Response to Sexual Abuse Under Age 18

We'll have to add this diagram for the final report. It's too large for this paper size!

The Child Witness Court Preparation Program

The Society for the Investigation of Child Abuse offers the Child Witness Court Preparation Program in an effort to minimize system-induced trauma to children who may testify in court. This program operates in a group format through which children receive information regarding the courtroom court processes.

Figure 1 presents a map of Calgary's interagency response to victims of sexual assault/abuse under age 18.

4.2 Calgary's Primary Systems for Adult Victims of Sexual Assault

This section documents the services and organizations in Calgary that deal with adult victims of sexual assault. Note that there is some overlap with agencies that deal with child victims.

Calgary Sexual Assault Response Team (CSART)

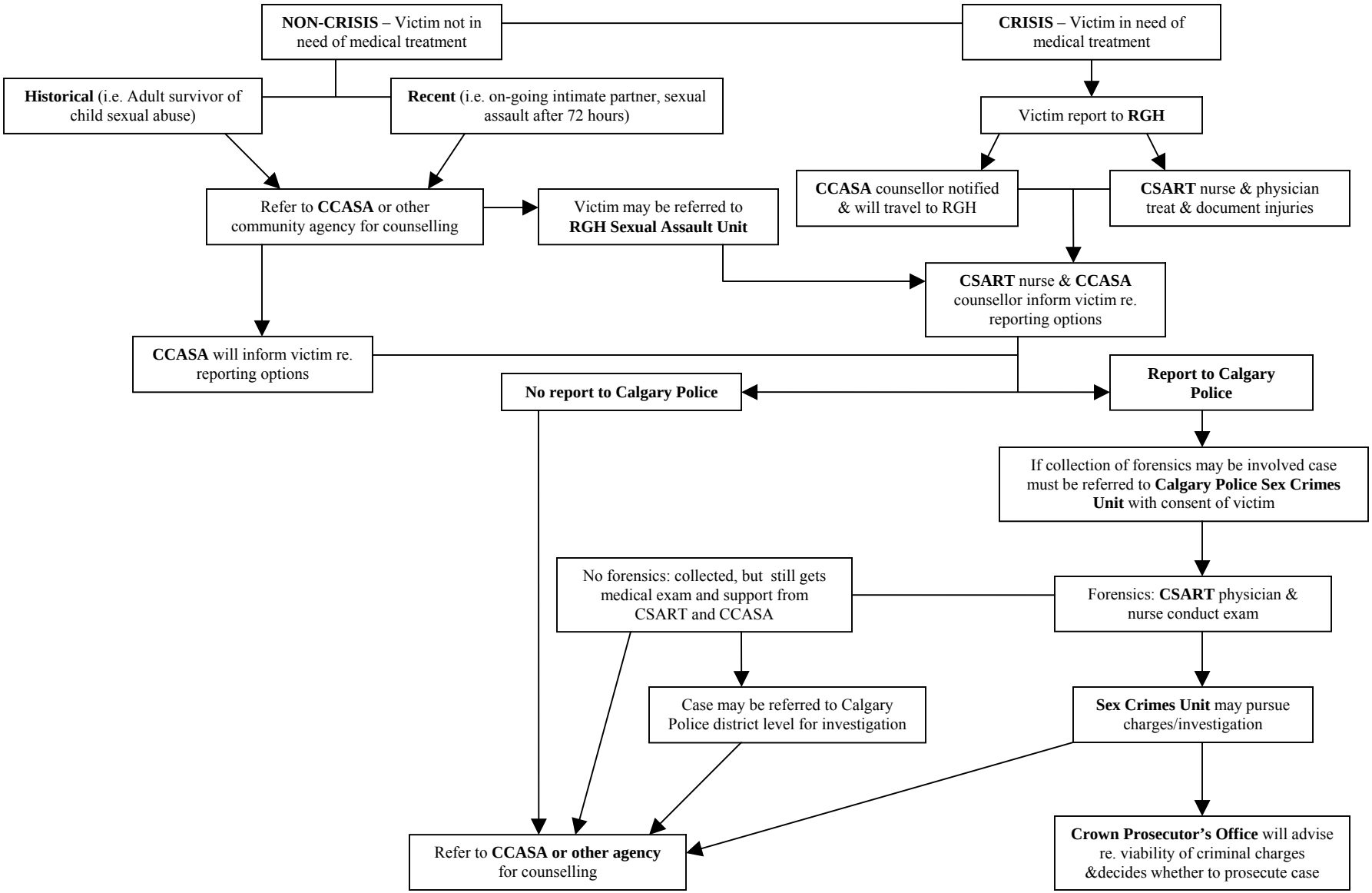
CSART is a multidisciplinary sexual assault crisis response team. Members of the CSART team include: CCASA Call-Out Workers, CSART physicians, CSART Nurse Co-ordinator, CSART nurses, the Calgary Police Service, and the RCMP. CSART provides crisis counselling, advocacy, and accompaniment, follow-up, medical treatment, and conducts forensic exams. Forensic exams are conducted only when the CPS Sex Crimes Unit has approved the collection of evidence. CSART statistics from the year 2001 reveal that of the 243 cases that CSART attended, 123 forensic evidence (rape) kits were completed, handled by Sex Crimes. The Sexual Assault Unit at the Rocky View General Hospital is the only site in Calgary designed and specialized to serve sexual assault victims and conduct forensic exams for victims age 14 and over. The CSART Nursing Co-ordinator works out of the RGH Sexual Assault Unit, and the CSART on-call physicians attend RGH to conduct exams. On occasion, the CSART physicians and RN's will attend other hospital sites (Peter Lougheed Centre and Foothills Medical Centre) if the victim's medical condition is unstable enough to prevent their transfer to RGH.

Calgary Communities Against Sexual Abuse (CCASA) CCASA is the primary agency that provides both crisis and short term counselling with sexual assault victims in Calgary. CCASA also works with adult survivors of child sexual abuse. CCASA provides court preparation and accompaniment with victims. CCASA Call-Out Workers are members of the CSART response, through which they provide 24 hour crisis intervention, accompaniment, and advocacy.

Calgary Police Service – Sex Crimes Unit

The CPS Sex Crimes Unit may conduct criminal investigation of sexual assault cases involving victims age 14 and over. Sex Crimes is involved only in serious cases of sexual assault including, for example, those that go beyond inappropriate touching or fondling or involve weapons or major injury. In order for Sex Crimes to be involved in a case, the victim must consent to filing a police report. In 2001, Sex Crimes investigated 248 cases of the 808 sexual assaults referred to the Calgary Police Service**.**

Figure 2: Calgary Community Response to Sexual Abuse Age 18 & Over



Calgary Legal Guidance (CLG)

Volunteer lawyers donate their time in providing legal assistance and court preparation. CLG will also assist victims in obtaining quick access to restraining orders and emergency protection orders.

Other

Other agencies that may work with either children or adults include Calgary Psychological Resources, Calgary Catholic Family Services, Calgary Counselling, Calgary Family Service Bureau as well as private practitioners in the community who specialize in sexual assault or child abuse issues.

Figure 2 presents a map of Calgary's interagency response to victims of sexual assault/abuse age 18 and over.

4.3 The Strengths of Calgary's Current Community Response

This section documents the responses gathered from 21 interviews with sexual assault and domestic violence stakeholders in Calgary, conducted by Laura Cavicchi for RESOLVE Alberta. The key informants were asked their opinions about what is working well in Calgary's response to child sexual abuse and adult sexual assault, what areas most need improvement, and what, if any, gaps or limitations exist in the current delivery of services. The interviewees identified a number of strengths in Calgary's existing interagency response to child sexual abuse and adult sexual assault/abuse as well as some issues of concern.

Many of the strengths are attributed to the CSART team, which is, in effect, the major component of Calgary's coordinated community approach to dealing with both sexual assault and child sexual abuse. CSART developed a protocol for Calgary's response to the crisis of sexual assault. The specialized sexual assault training of CSART physicians and nurses, including Paediatric Emergency Physicians, has contributed to greater sensitivity to the needs of adult and child victims. The implementation of the CSART Nursing Co-ordinator position has assisted in maintaining a higher level of co-ordination and follow-up to victims, particularly from the physician's and Registered Nurses' perspectives. The CSART team travels to the Alberta Children's Hospital to collect forensic evidence, thereby reducing trauma to child victims

The Rockyview General Hospital Sexual Assault Unit located in the Emergency Room provides immediate access to all health services. Changes in the CSART protocol allow physicians to conduct examinations and collect evidence prior to police interviews. This has decreased the waiting time for victims in the Emergency Department at RGH. The response time for all members of CSART has improved. CSART was described as working well with Calgary Police Child Abuse Unit and as working towards improving the levels of service in general.

The respondents noted that another key strength was the collaboration between the professionals dealing with various aspects of the response to sexual assault/abuse.

Those involved in the response to child sexual abuse (i.e. child protection, police, crown, ACH) have respect for the differing mandates, roles and positive collaborative relationships. There is a positive relationship among the members of the Criminal Justice Committee. The Calgary Police Services Domestic Conflict Unit works well with victims and makes appropriate referrals when there is a disclosure of intimate partner sexual assault.

A final strength identified by the respondents was that the specialized professionals are well-trained and the services useful. For example, the Child Witness Court Preparation program is working well. The Crown Prosecutor's Office attempts to assign cases of sexual assault and child sexual abuse to prosecutors that have experience in this area and to have the same staff follow the case from preliminary to final trial.

4.4 Limitations & Gaps in Calgary's Current Response to Sexual Assault/Abuse

This section summarizes the limitations and gaps in service as identified by the 21 interview participants. They identified six major concerns: 1. children in adult systems; 2. limited reporting and the low public profile of sexual assault and child sexual abuse; 3. some problems with respect to the counselling/treatment services; 4. problems with respect to unique populations of victims and marginalized groups; 5. problems within systems and organizations and: 6. funding.

4.4.1. Children in adult systems The map of services to victims of sexual assault and child sexual abuse highlights several complications with respect to the chronological age of sexual assault/abuse victims. The age of the child sexual abuse victim determines the involvement of the justice system and child protection (i.e. child welfare, police), yet this is not consistent with the mandates of other involved organizations. The age of consent to sexual activity is 14 years (a person aged 12 and 13 can consent to sexual activity between same-age peers). As such, adolescent victims of sexual assault or child abuse from age 14 to under 18 are considered children in Alberta, but fall within the sphere of adult-oriented sexual assault systems and organizations. Respondents also raised concerns with respect to the adolescent population, given that they are at a high risk and few services are directed specifically towards them.

4.4.2. Limited reporting and low public profile of sexual assault/child sexual abuse The general public is perceived as having only a limited awareness about what constitutes child sexual abuse, adult sexual assault, and consent, particularly in intimate relationships. The victims of child sexual abuse and adult sexual assault typically feel shame and stigma and often blame themselves for the assaults. The number of disclosures and reporting is far below the actual occurrence of the violence.

Even when they acknowledge the significance of sexual assault and abuse, members of the general public may not be aware of how to enter the system or where to access services. Further, they may not be accurately or adequately informed as to how the systems work. For example, they may only know what they see on television, which is overwhelmingly American and based on a judicial system that differs substantially from

that in Canada. In fact, however, even system and agency representatives may not know the appropriate pathway for reporting and what support services exist.

4.4.3. Problems with Counselling/Treatment services There are limited specialized resources for sexual assault, child sexual abuse, and non-offending family members or support persons. Not uncommonly, counselling and treatment agencies have waitlists that limit access to services. For example, the Alberta Children's Hospital – Child Abuse Unit can have a waiting list of from 6 to 8 weeks. Community treatment agencies often have limited financial resources to expand services to meet the perceived demand. Further, those who seek services for recent sexual assault have different needs than those who present with historical sexual assault. As well, male victims and survivors, currently a much smaller proportion of disclosures, may need different services.

4.4.4. Problems with unique populations of victims and marginalized groups The stakeholders expressed concerns regarding the lack of specialized service providers for a number of marginalized groups and unique populations of victims. There were additional concerns that such populations may not be accessing resources. The interview participants identified the following groups as under-serviced: ethnocultural groups; adolescents (age 14 to 18); offending/sexualized children; victims with mental health issues/diagnoses or addiction issues; victims with (cognitive/developmental) disabilities; male victims of sexual assault, including adult male survivors of child sexual abuse; those sexually exploited through prostitution – adults involved in the sex trade and children and adolescents exploited through sexual exploitation; victims of intimate partner sexual abuse (i.e. in domestic violence system) and seniors.

4.4.5. Problems with Systems and Organizations Miscommunication and misunderstanding can exist between system representatives with respect to the individual roles, mandates, and protocols for sexual assault and child sexual abuse. This seems most apparent in cases of child sexual abuse, when many first response professionals are unclear about what systems to contact and the age of victims and under which system they fit. A number of interviewees commented on the absence of one central location for victims and their families to access all services that are necessary in both the investigative and treatment aspects of addressing cases of sexual assault and child sexual abuse. The stakeholders highlighted some issues with respect to the following systems and agencies that respond to sexual assault and child sexual abuse: the police, child welfare, CCASA, The Rockyview General Hospital Sexual Assault Unit/Medical, CSART and the legal processes. Each is addressed briefly.

Street level constables with Calgary Police Service are typically the first to respond to sexual assault/abuse, however, they may not be sensitive to the issues and trauma surrounding sexual assault. There is little overlap between the Domestic Conflict Unit, Sex Crimes and other units that may deal with intimate partner sexual assault. Finally, the informants identified the need to improve the response time to sexual assault.

It may take representatives from children's protective services (child welfare) over 6 to 8 weeks to investigate a child's disclosure of sexual abuse because of high

demands for service and coordinating joint interviews by child welfare workers and Calgary Police. Since the decentralization of the child protection system, some inner-city communities with higher needs and an increased demand for services/funding have longer waiting period for investigations.

Child protection workers have no mandatory taping (video or audio) of disclosures, thus resulting in the need to re-interview victims if the case is to proceed to court. Once identified, there are limited resources for families that have been impacted by sexual abuse. Child protection workers and the courts have been mandating their clients to attend CCASA for counselling to address their sexual abuse trauma. CCASA has been continually under-resourced for the volume of service it is asked to provide in the community.

The Rockyview General Hospital Sexual Assault Unit/Medical was the focus of a number of concerns. Situated in the emergency room, the physical environment of the sexual assault unit is medical and sterile, and may not offer the appropriate level of safety for victims. Medical personnel vary in their response time to sexual assault calls. Accessing follow-up services may be difficult, because they are located in a different location and victims may not understand or have difficulty finding the services post-disclosure of abuse/assault. The staff has also noted difficulty tracking victims for follow-up for medical treatment (i.e. STDs, Hepatitis B) and identified the need for a central location for victims to access follow-up sexual assault and child sexual abuse services.

More physicians and nurses need to be recruited to the CSART on-call response, and they need to be compensated for on-call time. As well, a co-ordinator for the CSART physicians is needed. A salaried CSART Co-ordinator position would improve the team's functioning dramatically. A higher profile for CSART and the sexual assault unit at RGH of private practice physicians and the broader community is recommended. Finally, the CSART program needs more space and follow-up services.

Aspects of the legal system response to sexual assault/abuse in Calgary could also be improved. The specialized sexual assault education offered to legal system (i.e. Crown lawyers, judges, defence lawyers) could be improved, as could the cross-training between medical and legal system with respect to the mandates and needs of each system. The lawyers in the Crown Prosecutor's office may not be specially trained; a specialized court process/justice response would more effectively deal with sexual assault/abuse cases.

4.4.6. Funding Issues Alberta Children's Hospital and Child Protection are under two different ministries, which poses funding and responsibility issues. The entire area of sexual assault and child sexual abuse is under-funded (i.e. crisis and long term intervention, prevention, education, etc.). CSART is under-resourced and under-funded, which contributes to timeliness of response. There is a critical need for secure and consistent funding for sexual assault and child sexual abuse services.

4.5 Summary of Calgary's Current Response

In summary, while the Calgary community co-ordinated response to victims of sexual assault and child sexual abuse has many strengths, the interviewees identified a number of problems, not least of which are questions about how to enter the system and a simplified way to offer both health, counselling and legal follow-up to those affected by sexual assault/abuse. Reportedly, these problems have been improved in communities that have developed either children's or family advocacy centres.

The table outlining the best examples of advocacy/co-location models of service delivery found by RESOLVE and the FAC Planning Committee was presented earlier. A table with the *proposed* model for Calgary added for comparison purposes is presented in the following pages. It should be noted that we did not find any models in North America that focused on sexual assault/abuse and child abuse under one roof, as we are proposing for the Calgary advocacy centre. Furthermore, only two FAC Centres serve both adult and child victims under one roof. As such, the concept proposed by the FAC Planning Committee for a Calgary Advocacy Centre is innovative and a potentially ground-breaking model of service delivery centred on sexual assault/abuse and child abuse.

Table 3: Advocacy Centres Including Calgary Model

City of Phoenix Family Advocacy Center – Phoenix, AZ	The Zebra Child Protection Centre Edmonton, AB	Mesa Center Against Family Violence (CAFV) – Mesa, AZ	**PROPOSED** Calgary Family Advocacy Centre
One-site co-location of services; disclosed, central location.	One-site co-location of services – based on National Children's Advocacy Center model in the US; disclosed location with security.	One-site co-location of services; undisclosed, secure location.	One-site co-location of services – integration of advocacy centre models to suit unique needs of Calgary. Disclosed, central location.
Serving: Adult victims of domestic violence and sexual assault	Serving: Children under age 14 who have been abused & non-offending family members.	Serving: Child & adult victims of sexual assault & domestic violence. Intervention in cases of child neglect or abuse.	Serving: Adult victims of sexual assault, child victims of physical and sexual abuse. Further incorporation of domestic violence services in the future.
Managing organization: City Manager's Office	Managing organization: Executive Director and Board of Directors.	Managing organization: Mesa Police Department	Managing organization:
On-site representation from: - City Manager's Office - Police Family Investigations Bureau - Prosecutor's Office – victim services - County Attorney's Office - Adult Probation Office - CASA (Center for Prevention of Abuse and Violence) Counselor/Therapist - Sojourner Center Domestic Violence Shelter – victim advocate - SANE (Sexual Assault Nurse Examiner) Program - Social Work Interns	On-site representation from: - Edmonton Police Service : Child At Risk Response Team (CARRT); Child Protection - Alberta Child & Family Services (2 Child Protection workers, one Access/Custody Dispute worker) - Crown Prosecutor's Office (part-time) - Victim Services (employee of Zebra) - will be adding other community representatives as centre continues to be developed (i.e. mental health/treatment services)	On-site representation from: - Police - Child Protective Services - Professional child forensic interviewer - Victim's services - Forensic Pediatric services for medical exams 24hrs/day 7 days/week - County Attorney's Office - City Prosecutor's Office - SANE Program (for adult victims) - CASA - Adult probation (domestic violence)	On-site representation from: - CCASA - Calgary Police Service: Child Abuse Unit; Sex Crimes; Victim's Assistance Unit - Alberta Children's Hospital – Child Abuse Unit - Calgary Health Region Authority (CHR) - CSART - Calgary Rocky View Child & Family Services - ACAV - Crown Prosecutor's Office - Violence Information & Education Centre (VIEC) - Probation
On-site Services: - Criminal investigation - Sexual assault forensic/medical exams - Emergency Protection Orders - Case management & crisis intervention - Crisis & long term individual & group counseling - Emergency & transitional shelter placement - Victim advocates (community, police, & prosecutors staff	On-site Services: - Criminal & child protection investigation of child abuse - Videotaping for police and child protection joint interviews - Victim Services provide 24 hr. crisis response & intervention, follow up and referral; assistance with the criminal justice system.; assistance with Victim Impact Statements; Requests for Restitution; Financial Benefits for	On-site Services: - Criminal investigation of sexual assault & domestic violence - Medical examinations/attention for sexual/ physical assault - Crisis intervention - Video interviews with victims - Audiotaped confrontational phone calls (to elicit confessions) - Victim's Services & victim notification - Short-term counseling	On-site Services: - 24 hour crisis response - Criminal investigation of child sexual abuse & adult sexual assault - Forensic exams provided in victim – centered and child friendly environment - Videotaping for police and child welfare joint interviews - Access to Restraining Orders, Emergency Protection Orders, and - Follow-up, individual, & group

- Safety planning & victim rights - Court accompaniment - Financial assistance - Referral to appropriate community resources - Resource Library	Victims of Crime - Referral to: Court Preparation Program, & Court Accompaniment Program - Child - & victim - centered environment - Prevention and Education for professionals & the larger community	- City Prosecutor's Victim Rights Program provide legal and emotional support for court process - Violence education & referrals	counselling for victims and non-offending family members - Court preparation & accompaniment - Referral to appropriate community resources - Specialized services for ethno-cultural and marginalized groups - Tracking of offenders - Prevention & education for professionals and the community at large. - Resource library (VIEC)
Community Partners: - Assistance League of Pheonix - Fire Department Response Team - Municipal Court - Childhelp USA - Arizona Coalition Against Domestic Violence - Local & Regional Domestic Violence Shelters - Agencies assisting with transportation and accommodation	Community Partners: - Police - Alberta Child & Family Services - Crown Prosecutor's Office - Victim's Services - To be determined	Community Partners: - Local domestic violence shelters - Hotel/motel program for emergency housing - Community service organizations that provide clothing, toys, baby supplies, emergency 911 cell phones, food staples, etc.	Community Partners: - Action Committee Against Violence - CCASA - Calgary Police Service (Child Abuse, Sex Crimes, Domestic Conflict, Victims Assistance, Child At Risk Response Team) - Calgary Rocky View Child & Family Services - Homefront - Calgary Health Region - CSART - Calgary Legal Guidance - Crown Prosecutor's Office - Child Witness Court Preparation - Calgary Coalition on Family Violence - Calgary & area women's emergency & transition shelters - RESOLVE Alberta
Evaluations &/or academic literature:	Evaluations &/or academic literature:	Evaluations &/or academic literature: Seigel, G.C. (1999). *The impact of the Mesa Center Against Family Violence on child abuse investigations.* Uekert, B.K. (1998). *Process evaluation of the Mesa Center Against Family Violence.*	Evaluations &/or academic literature: Process evaluation after opening of centre. Centre may provide access to information and participants for future research in the area of sexual assault and child sexual abuse.
Web-site: http://www.ci.phoenix.az.us/CITZASST/fac.html	Web-site: http://www.	Web-site: http://www.ci.mesa.az.us/police/default.htm	Web-site: To be determined.

5.0 Developing an Advocacy Centre for Calgary

This section documents the process of the FAC Planning Committee and RESOLVE Alberta in developing an advocacy model that would fit within the Calgary context and reflect the needs, wishes and support of the sexual and domestic violence abuse serving agencies in Calgary and the Calgary community in general. The process covers a year, from November 2001 with the session with Dee Williams to the end of October 2002, when the FAC Planning Committee began deliberations with the key systems involved for issues such as funding and building space and concrete plans with respect to what facilities and materials each partner would need.

5.1 First Steps

As noted in the introduction, this process was initiated by a 2001 visit to the Mesa Center Against Family Violence and the Phoenix Family Advocacy Center in Arizona by a delegation including the then Calgary Mayor Al Duerr and Alderman Bev Longstaff. Each centre offers a streamlined approach to sexual assault and domestic violence, co-locating representatives from key systems (in particular the police) and organizations at one site to better coordinate services to victims. Karen Walroth, the Co-ordinator of the Action Committee Against Violence, was asked to explore the viability of developing a family advocacy centre in Calgary.

In November 2001, Ms. Dee Williams from the City of Phoenix Family Advocacy Center presented the model in Calgary to 54 invited professionals from domestic violence and sexual assault serving systems, including the police and medical personnel. That meeting concluded with the recommendation that the next logical step was examining the feasibility of developing an advocacy centre in Calgary. The FAC Planning Committee was struck to oversee the feasibility study process. The committee included representatives from each of the major systems involved (health, justice, child welfare, counselling/mental health). RESOLVE Alberta was commissioned to conduct the feasibility investigation.

5.2 A Vision of the Advocacy Centre: February 2002

The FAC Planning Committee (members listed previously) convened to plan how to assess the feasibility of an advocacy centre for Calgary. The first step was a "visioning" workshop on February 14th, 2002 to brainstorm about what planning committee members envisioned for a Calgary model. Members were encouraged to think broadly and inclusively, to identify how the Calgary community could benefit from such a centre. These ideas would form a framework that would result in a later community consultation and plan for implementation, if there was support for the model. Note however, that these ideas were meant to assist the planning process, not to describe a final model for a Calgary advocacy centre.

The first visioning task was to identify what needs an advocacy centre could fulfill for both clients and service providers. The committee listed a number of characteristics of an advocacy centre that would meet client's needs. These included a centre that would be designed for needs of victims. It would be confidential and private (i.e. victims not seen going to police station), less intimidating than going to hospital or police station. It would be an entry-point for the large number of sexual assault and domestic abuse victims who have not contacted the

police. There would be no waiting – it would have 24 hour support, and proper medical facilities such as medical staff, the ability to collect forensic evidence, showers, and quiet spaces. It would be at a central location that would offer multiple services that accompany clients through advocacy, and representation from start to treatment, follow-up and to court.

The committee also envisioned the centre being child-focused, with on-site child-care facilities and services for family members of victims. It would provide information on resources, such as available spaces in emergency shelters; help with legal issues, including understanding the legal process, and legal help available 24 hours. Such multiple services should provide better flow for clients between services and make it easy to re-enter for continued services. Other characteristics included having as little bureaucracy as possible, being sensitive to diversity with, for example, access to interpreters and materials in different languages and formats (i.e. Braille). Above all, the centre would offer the victim choices and would respect her wishes.

The committee identified a number of ways that a Family Advocacy Centre could meet the needs of service providers. A key feature was creating a facility that would necessitate collaboration, partnership and mutual respect, and better communication between sexual assault and domestic abuse agencies. Working together in a central building would facilitate cross-functional training to enhance understanding the different disciplines involved in the process; sharing expertise so that, for example, shelter staff could learn more about sexual assault and sexual assault counsellors could learn more about intimate partner violence. Having a central, identifiable location with 24 hour services would assist both victims and service providers in knowing where to find appropriate assistance.

Centralizing and sharing resources (i.e. interpreters), should have additional benefits as well, such as having a fund development coordinator, better opportunities for cross cultural training and conducting research. Having staff to co-manage services should be more cost effective (i.e. social service agencies and police). Finally, an advocacy centre could keep violence issues on public agenda, create linkages within and to the community and would be an appropriate site from which to offer prevention services.

The second major task was to identify what services/agencies might be included in some way in the advocacy centre. Again, the committee members were asked to think broadly, without censoring their ideas at this point. Please note, however, that the fact that agencies are listed below, in no way suggests that they have been approached or have agreed to their inclusion in the centre.

Once the agencies were listed, each committee was asked to identify their current priorities with respect to who should be immediately involved. They were given a restricted number of choices to force their decision-making.

In the following list:
♣ = indicate services that are priorities for when the centre opens
▲= indicate services that should be available 6-18 months after opening
☼ =indicate services that should be available in the long term
The following agencies/services were seen as priorities by at least one committee member:

- CCASA ♣♣♣♣♣♣♣
- Police (possibly including SCU, DCU, VAU, Child Abuse units) ♣♣♣♣▲
- Advocacy for the issues (raising the profile of the issues in the consciousness of the public, funders, public, and private sector players, so that funding cuts are met with a huge public outcry).♣♣♣ ▲▲
- Medical (CSART) ♣♣
- Homefront ♣♣
- Court prep, Counselling, Outreach Services available 24 hours/day ♣♣☼▲
- Helpline ♣▲

The following agencies/services were seen as important to involve within 6 to 18months of opening:

- Co-coordinating/Coalition of organizations ▲▲▲▲
- Services for diverse groups (e.g. persons with disabilities) ☼☼☼☼▲▲
- Periodic visits from intake workers (SFI, housing, Calgary Immigrant Women's Association, etc.) ☼☼▲▲
- Restraining orders and Protection against Family Violence Act (PAFVA), Calgary Legal Guidance ☼▲
- dealing with child abuse issues (Urgent response from CAS, Alberta Children's Hospital). ☼▲
- Cultural sensitivity ☼▲
- Legal services ▲
- Missing persons information (Calgary Police Services)▲

The list of agencies/services that should be involved in the long-term included:

- VIEC ☼☼
- Men's Line ☼☼
- Cross-training ☼
- Family violence training for peripheral agencies ☼
- Services for sexually aggressive children, education about what is abuse ☼

Other agencies that could be involved but were not seen as priorities by the FAC Planning Committee at the February 2002 meeting included:

- AADAC
- Outreach services
- Victim/Crisis Support
- Calgary Coalition for Family Violence
- ACAV (Youth Violence Prevention Coordinator and Turn Off the Violence)
- Child Welfare representatives

The committee members identified characteristics of the centre that they saw as beneficial. These included: access to resources (interpreting, funding, public support, maybe volunteers); representation for victims/children; tracking shelter space/housing; intervention and crisis response & referral facilitation for children & families; connected to the regional intake services (e.g. Alberta Mental Health Board) and group services (parenting, anger management,

child sexual abuse victims). The facilities should include showers and a clothing bank, free meeting space with lots of free parking and child care.

The final question at the February 2002 Visioning meeting was with respect to potential barriers to implementing an advocacy centre in Calgary. The committee raised a number of practical concerns including where we would find/afford a building and how to provide 24 hour accessibility. Funding was a key concern, as was the possibility of funders being confused by being asked to finance agencies that are co-located in the advocacy centre, yet retain their own services in another community location. Another funding issue was the fact that an advocacy centre involves multiple systems such as health and justice. As such, who would pay for facilities and what would be the politics involved? What union issues might be involved?

Another central concern was with respect to the extent of collaboration necessary. Territoriality between organizations, and/or agencies wanting their autonomy could prevent the centre's development. Collaboration is difficult and time-consuming.

Several committee members wondered whether the presence of police and child welfare representatives at the centre might prevent some victims from coming. Others saw the need to investigate the impact of provincial legislation such as the Freedom of Information and Protection of Privacy Act, the Child Welfare Act, and the Health Information Act.

Some committee members raised issues specific to the community of Calgary. Is there family violence fatigue in the community among both those who have worked collaboratively and extensively in the past decade and in the general community in response to fund-raising activities? Another was concerned about the fear of change: "things are good/ok now, will this make it worse?" While sexual assault has not been given the same attention as family violence, how will the public respond to this shift in focus? Further, child protective services are moving to a decentralized model. How will this fit with an advocacy centre that, in contrast, centralizes services?

Finally, the committee members commented on the need to develop a conflict resolution process for the centre and the involved agencies, to create clear boundaries between the agencies and boards, and to clarify roles in the centre to avoid duplication.

In summary, the FAC Planning Committee was excited about developing an advocacy centre that would incorporate the broad ranges of services identified in the brainstorming exercize, effectively consolidating a number of agencies that already work in a coordinated fashion, into one centre. However, the committee members decided to initially focus its priority on services for sexual assault/abuse with the possibility of incorporating services for those affected by domestic violence in the future, if agreed upon by those agencies. This decision was made for several reasons. For the past decade the city of Calgary has put considerable energy and resources into addressing domestic violence, with a number of innovative projects emerging, such as Homefront. A similar collaboration with respect to sexual assault has not occurred and this seemed an appropriate time to address this gap. Secondly, the inclusion of a broad number and focus of programs seemed ambitious, especially without first collecting information about whether other communities had embarked on similarly comprehensive models. Third, the cost of

being more inclusive would result in a more expensive centre, and since funding was a significant question, it seemed preferable to begin by focusing more narrowly, on services to address adult sexual assault and child sexual and physical abuse.

The visioning process created the initial model and a list of questions and concerns to be investigated both by discussions in subsequent meetings, the search for similar models or best practices, and mapping the current Calgary process for victims of sexual assault/abuse. The sum of this information was presented to representatives of the Calgary community domestic violence agencies at a community forum in June of 2002.

5.3 The June 2002 Community Consultation

On June 11th, 2002, the FAC Planning Committee hosted a community consultation meeting partially focused on developing a Calgary advocacy centre. Approximately 75 representatives from the Calgary violence prevention community. With the exception of members of the FAC Planning Committee, this was the first opportunity for many to hear any details about the proposed model.

At the meeting, RESOLVE Alberta presented the background information about advocacy centres in general, and outlined some of the advantages of advocacy centres as identified by the FAC Planning Committee and the literature. The attendees were divided into four groups and asked a series of questions with respect to potential benefits or concerns about the model, implementation issues and how community stakeholders should be involved.

The focus group members identified a number of potential strengths of developing an advocacy centre, but also raised concerns. The concerns included confusion about the terms "family advocacy centre" and "co-location" and dislike of the phrase "one-stop shopping". Several worried that the centre could exclude some populations and agencies, speculated that the cost would be high and wondered how it would be funded. Some felt that a large centre could be bureaucratic and others were concerned that the centre would take over their mandate and clients. Others wondered whether the centre would be driven by the needs of service providers rather than clients. The fear that the centre could exclude certain populations or agencies was the most predominant negative issue associated with the words and phrases of a family advocacy centre.

The small groups also identified a number of benefits of the family advocacy centre model of service delivery, including the centre being a central location for service and referral; a streamlined and coordinated service delivery; a victim centred service; reducing system induced trauma; providing an easier entry point; the potential of enhancing funding resources by bringing services together; on-site crisis intervention; and a method of sustaining current services and bringing them together in an innovative way of delivering services.

The focus group participants made a number of suggestions for the Planning Committee to consider in implementing the FAC. They suggested that the systems must develop clear guidelines around decision making procedures and who would be in charge of making such decisions. Some participants were concerned that the implementation of the centre may be

moving too quickly. Others cautioned against starting too small and/or not including as many agencies as possible from the start. Some of the small group members worried that the focus of the centre and the specific services it could provide was not sufficiently clear. How the centre would be funded was also a major question. Many wanted to ensure that the development of such a centre would not endanger already strained funding resources. Suggestions included:

- running a pilot project first;
- working towards improving coordination of service delivery;
- involving victims in the development of the centre;
- ensuring that the capacity/infrastructure of the sexual assault community is strong enough to support moving ahead with the centre; and
- developing the centre to suit the unique needs of Calgary, not simply copying another model.

The focus group members were also asked how stakeholders should be involved, however, due to the limited time, few answered this question. Once again, the question of how to get stakeholders to "buy in" was raised. Participants suggested that there should be regular consultation with marginalized groups. Funding that follows consumers was one suggestion for how stakeholders could be involved. Several questions were raised with respect to how Homefront would or should be involved with the centre and what role ACAV could play in the development of an advocacy centre.

In summary, the perceived drawbacks to the family advocacy centre model of service delivery centred primarily on concerns that the model lacked clarity with respect to the logistics of creating and operating the centre. Some small group participants worried that the model was overly-focused on sexual assault. They also raised concerns around potential competition for funding if agencies were to co-locate. A final consideration was whether the centre would meet the needs of Calgarians.

In contrast, there was a general positive reaction to the centre as more co-ordinated and victim-focused and to the potential for improved collaboration between agencies. The possibilities to offer improved services to victims and their families, at the same time enhancing the investigation and prosecution of abuse and assault were generally endorsed positively.

Overall, the concerns raised by the members of the discussions groups were well-taken and appropriate. Many of these issues had been raised and discussed at one time or another by the FAC Planning Committee and most still need to be resolved during the more formal planning process. The positive comments mirror the information from the project presentation and indicate at least a certain amount of buy-in of the concept in general.

6.0 Overview of Proposed Advocacy Centre Implementation Plan

In response to the previous half year of planning and to the June 2002 Community Consultation, the planning committee met in late June and early September, clarifying some decisions and raising questions that will need to be answered in future.

The first decision was to consolidate what populations the advocacy centre would initially serve: adult victims of sexual assault and children who are victims of all types of abuse, including physical abuse. Services for those affected by domestic violence could be provided through referral and outreach during the first phase of the centre. Later, there can be more integration (including possible co-location) of domestic violence services. Each of the representatives on the FAC Planning Committee went back to their superiors to clarify whether the system, not just the representative, was prepared to support and become involved with the advocacy plan.

There are, of course, a number of issues to address. How the centre would be funded is a major question. Given the joint jurisdictions between health, the police, the Crown prosecutor's office and mental health, no one system is likely to fund the entire organization.

There will be union issues with respect to the nursing staff, the Calgary Police Service and any smaller organizations that may be unionized. These issues must be clarified and negotiated by members of the working teams who are knowledgeable in this area and can discuss them with their union representatives.

Location will be critical. The centre must be located centrally in the city and be accessible by major transportation routes. If the centre is not attached to a major medical facility, it should be located within a reasonable distance from an Emergency department. In addition, the centre should be fairly close to the court district.

It is recommended that the advocacy centre consider following the National Children's Alliance Centre best practices model and become affiliated with this organization (see Appendix A). With only three other NCAC centres in Canada, this centre could be a ground breaking initiative for western Canada providing a model that other provinces could follow.

6.1 Implementation Plan

The following implementation plan was presented in October 2002 as a working document based on information gathered from the research of RESOLVE Alberta, the FAC Planning Committee, and the Community Consultation held on June 11, 2002. What follows is a *proposed* structure for the potential Calgary Advocacy Centre. Decisions regarding the logistics and levels of involvement must be undertaken by the planning committee (see Figure 3).

6.1.1 Planning Allow 12 to 18 months for planning and negotiating with the core systems, and constructing/renovating the physical site.
Consult with officials from the key services and organizations to present the model and solicit their approval and involvement. A key aspect of this task will be defining the exact extent of the

agency's involvement in the centre and their perception of how they see their agency/service "co-locating".

Planning committee breaks into working teams with each team focusing on a particular aspect of development and implementation. The working teams should be devised into groups respective to their area of expertise. Examples of working teams could include:

Funding Team

- Meet with decision makers in major systems
- Conduct a cost analysis of building or renovating
- Determine which costs will be the responsibility of the centre itself and what costs will be shared with co-located organizations and systems.
- Secure funding for the overall maintenance and operations of the centre
- Organize funding within each organization that will be co-located or provide outreach at the centre.

Organizational/Structural Team

- Decide management structure of centre (example: hire an Executive Director and choose a board of directors)
- Decide whether the centre will have to hire other staff such as an intake coordinator for non-crisis clients, or security personnel.
- Negotiate contracts and union issues within organizations and systems

Treatment Team

- Organize the process for all of the agencies that will provide counselling and follow-up

Diversity Team

- Ensure the centre is accessible to all of the population, arranging interpreters

Facilities Team

- Decide location and size of the centre
- Decide whether to renovate or build
- Decide what security features are necessary

Other tasks include developing protocols with respect to how the groups in the centre will deal with legislation (i.e. reporting to child welfare) and the laws that guide the different professions. A name must be chosen for the centre that reflects its goals and makes it accessible to members of the general public.

The proposed committee framework has already changed dramatically since October 2002, as the Advocacy Centre has negotiated with funders and supporters since the feasibility study process was completed. In late January, for example, an Executive committee was struck to complete the business plan, engage the identified partners, develop a governance structure and develop a fund raising strategy. The FAC Planning Committee has also developed a Fundraising, Building and Land Committee and an Implementation Committee that would include a sexual violence sub-committee, a domestic violence sub-committee, a child abuse subcommittee and a diversity sub-committee.

6.1.2 Involving Primary Services

This victim centred and child friendly facility will facilitate streamlined, coordinated interviews with victims and families with videotape and observation rooms to minimize

secondary trauma to victims. Treatment (counselling) services will be available on-site through co-located services or partnerships with community agencies. The centre will have child, adolescent and adult appropriate rooms for waiting and interviewing.

Given that the term "co-location" can be defined differently, some agencies may see the centre as their home-base of all of their operations. Other agencies may retain their home-base in the community but have a presence at the centre in different capacities such as: working designated hours every week, offering some of their programs through the centre, or to having space available when they go to there as needed.

The primary services of Phase I, as listed below, will likely "co-locate" in the capacity that most suits their involvement in the centre, to be negotiated during the Planning Phase. Note that this model *proposes* what organizations are involved and the services each may offer through the centre.

- CSART – Calgary Sexual Assault Response Team provides a multidisciplinary crisis response to sexual assault. Members of the CSART team include: CCASA Call-Out Workers, CSART physicians, CSART Nurse Co-ordinator, CSART nurses, the Calgary Police Service, and the RCMP. CSART provides crisis counselling, advocacy, and accompaniment, follow-up, medical treatment, and conducts forensic exams. Forensic exams are conducted only when the CPS Sex Crimes Unit has approved the collection of evidence. CSART would likely have designated space at the centre (i.e. medical examination room, interview room, etc.).
- CPS Sex Crimes Unit - Criminal investigation of serious adult sexual assault cases (victims over age 14).
- CPS Child Abuse Unit - Criminal investigation of sexual/physical abuse of children under age 14.
- ACH Child Abuse Unit Fast Track Clinic - Treatment/counselling of child victim of sexual abuse and non-offending parent.
- ACH Sexual Abuse Clinic - One day per week sexual abuse medical clinic for child victims.
- ACAV – Action Committee Against Violence is a city initiative to end violence and abuse in Calgary.
- Crown Prosecutor's Office – Prosecution of sexual assault, child abuse, and domestic violence offenders; and consultation to agencies representing victims.
- CCASA – Some of the following programs *may* be offered through the centre: crisis counselling & 10 sessions for recent or historical victims of sexual abuse/assault; court preparation & accompaniment; 24-hour crisis line; or prevention & education.
- CARRT - Social worker and police officer investigate situations that may involve immediate risk to child. Provides appropriate intervention and referral.
- Women's Shelters – CWES, Awo-Taan and the Sheriff King Home could offer some programs or outreach counselling at the centre. A system of tracking available shelter spaces in Calgary and region could save both women seeking shelter assistance and shelter staff considerable time.

6.1.3 Integrating Services on Domestic Violence

The centre will integrate domestic violence, legal, and violence and abuse serving agencies within 12 to 24 months after opening. The centre has the potential to provide education, prevention, and training initiatives for the larger community and professionals. Having representatives from shelters and other agencies that serve victims of domestic violence makes sense for women who have been seriously physically abused by partners. They can utilize a number of the services and programs already within the advocacy centre, such as videotaping interviews and the court preparation program that supports witnesses. Further, the links and co-occurrence of various forms of abuse means that if a woman were to disclose intimate partner violence as well as sexual assault, the services would be readily available on-site. The centre might provide space for each of the city women's shelters outreach workers, allowing the shelter more needed room for their in-house services.

The centre could house and coordinate access to other Calgary domestic violence services. For example, a computer tracking system of available shelter beds could facilitate not only needed access to shelter space in Calgary and district, but would also significantly decrease the workload of shelter intake staff. The centre might house the joint community domestic crisis telephone line.

Again, the extent to which the following agencies see themselves involved in the centre and/or co-located must be negotiated, but each offers an important aspect of a comprehensive advocacy centre.

- CPS Domestic Conflict Unit - Criminal investigation of domestic violence.
- CLG – Calgary Legal Guidance offers legal advice, court preparation, & restraining order program.
- AASAC – Alberta Association of Sexual Assault Centre is an intermediary association which sets standards, provides education, advocacy, and coordination between sexual assault centres.
- Homefront – Specialized domestic violence court.
- VIEC - Violence Information & Education Centre.

The following agencies may not be co-located, but could have office space available for regular visits or on an "as needed" basis:

- Calgary Immigrant Women's Association
- Child Witness Court Preparation Program
- Independent Living Resources Centre of Calgary
- RESOLVE Alberta
- Kerby Centre
- Calgary Rocky View Child & Family Services
- Alberta Mental Health
- AADAC
- Servants Anonymous

Further, the centre will offer exceptional opportunities to train professional by offering field placements and practica to students in disciplines such as social work, law, nursing, medicine and policing.

6.1.4 Evaluation

Once the centre is operating smoothly, it should be evaluated, especially since the model is unique. The evaluation of the centre could involve interviews with consumers and service providers, a review of client files and following those clients whose cases are prosecuted through the court process to examine outcomes.

6.2 The Feasibility of the Proposed Advocacy Centre Model

The proposed model grew from the work of a planning committee that involved the major stakeholders needed for the advocacy centre as designed; one that addresses both sexual assault and child abuse. While the committee reviewed other advocacy centre models elsewhere, particularly in the United States, the proposed centre is unique to the needs of the Calgary community. The background information with respect to the impact of sexual assault and child abuse and how victims have been further traumatized by having to deal with fragmented systems that at times work at cross purposes, represents a significant argument for the new centre.

Advocacy centres, particularly those developed to address child sexual abuse are only in the beginning stages of being evaluated. However, the few studies on the efficacy of some characteristics of advocacy centres, such as videotaping interviews to prevent revictimizing the adult or child by asking them to repeatedly describe the assault, and having staff from various systems working collaboratively to focus on the needs of the victim rather than the system, also strongly support an advocacy centre model.

The proposed Calgary model, with services for both adults and children, is unique and requires even more collaboration than a centre devoted to either adults or children. Further, keeping available the option to include additional services for victims of domestic violence is also ambitious and innovative.

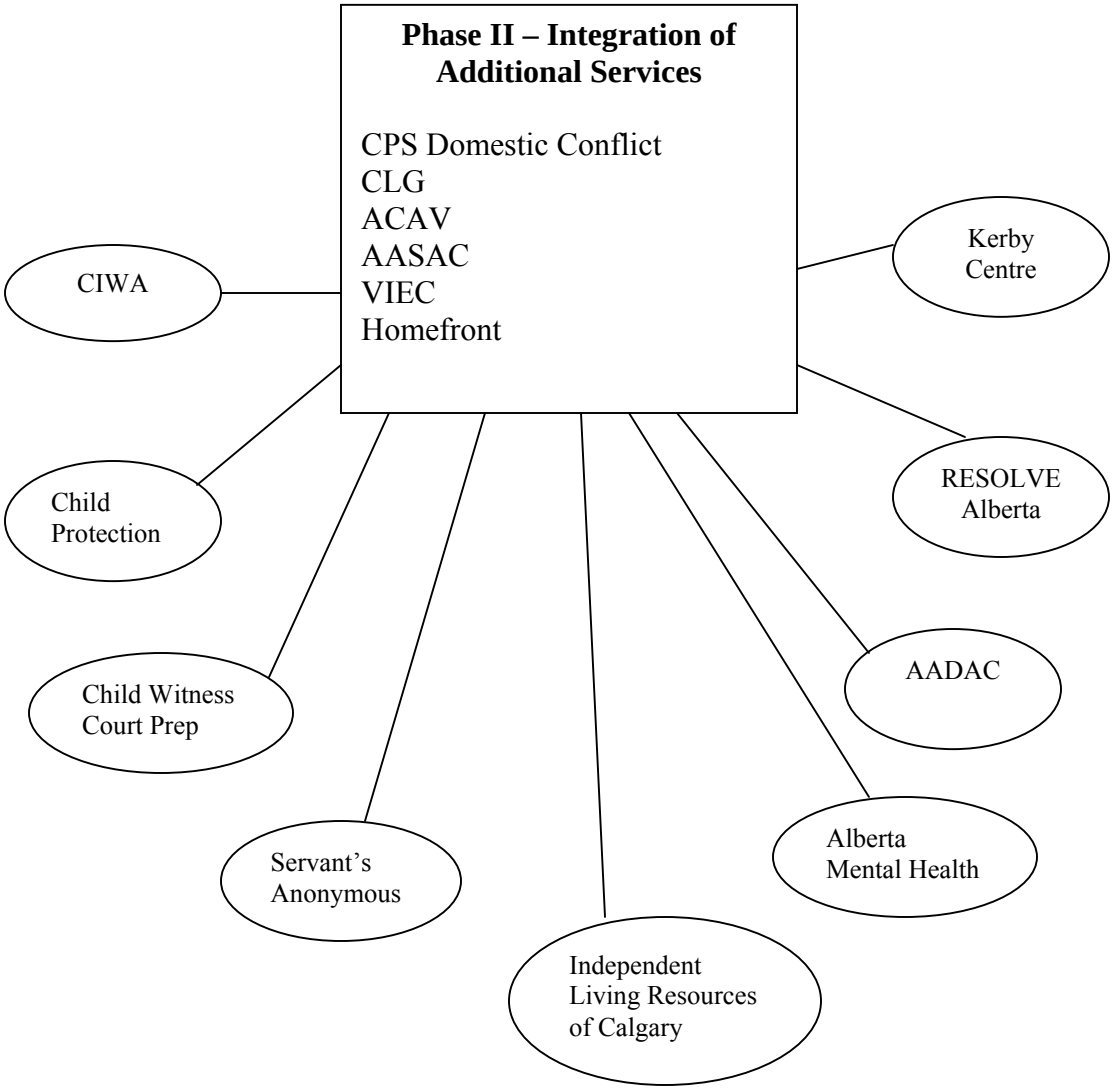
The Calgary community has at least a decade-long history of working collaboratively to address family violence. The last ten or so years has seen the development of a number of innovative programs. These included the Calgary Domestic Violence Committee protocol project, in which Gaye Warthe worked with 64 agencies to develop and implement domestic violence protocols. The Action Committee Against Violence Youth Violence Prevention Project invited violence prevention programs and their major consumers, such as community agencies and schools, to collaborate to improve the quality of and accessibility to prevention initiatives.

One of the most impressive initiatives has been the development of Homefront, the specialized domestic violence court model in Calgary, that involved collaboration between multiple levels of the justice system (the police, Crown's office, judiciary, probation, Calgary Legal Guidance) and the many community agencies that address domestic violence, (the emergency and second stage women's shelters, specialized programs for those who perpetrate abuse and those who are victimized by it). The community cooperation that resulted in the success of Homefront bodes well for launching a similarly complex advocacy centre project.

The community response and extent to which organizations both support and agree to become partners from this point, will finally answer the question of whether the centre is feasible. While many important questions have yet to be answered and details have yet to be addressed, the extent to which the FAC Planning Committee has worked together thus far in creating a concrete plan and significant community interest speaks to the viability of the plan.

Figure 3: Implementing the Calgary Advocacy Centre
Phase I – Primary Services

CSART	ACH Sexual Abuse Clinic
CCASA	CPS Sex Crimes
CARRT	CPS Child Abuse
ACH Fast Track	Crown Prosecutor's Office
Shelters	ACAV



7.0 References

Anderson, A.F. & McMaken, M.E. (1990). Implementing child advocacy: A rationale and basic blueprint. *Juvenile and Family Court Journal, 14*, 1-14.

Bagley, C. (1991). The prevalence and mental health sequels of child sexual abuse in a community sample of women aged 18 to 27. *Canadian Journal of Community Mental Health, 10*(1), 103-116.

Bagley, C. & Young, L. (1990). Depression, self-esteem, and suicidal behaviour as sequels of sexual abuse in childhood: Research and theory. In M. Rothery & G. Cameron (Eds.), *Child maltreatment: Expanded conceptions of helping* (pp. 183-209). Hillsdale, N.J.: Lawrence Erlbaum Associates.

Bagley, C., Bolitho, F., & Bertrand, L. (1995). Mental health profiles, suicidal behaviour, and community sexual assault in 2112 Canadian adolescents. *Crisis: Journal of Crisis Intervention & Suicide, 16*(3), 126-131.

Berliner, L, & Conte, J.R. (1995). The effects of disclosure and intervention on sexually abused children. *Child Abuse and Neglect, 19*(3), 371-384.

Besharov, D. (1990). *Combating child abuse: Guidelines for cooperation between law enforcement and child protective agencies*. Washington, D.C.: AEI Press.

Bhola, S., & Nelson, T. (1990). *Let's work together to stop family violence: Service providers' training manual.* Calgary, AB: The Calgary Coalition on Family Violence & Calgary Immigrant Women's Centre.

Brewer, K.D, Rowe, D.M., & Brewer, D.D. (1997). Factors related to prosecution of child sexual abuse cases. *Journal of Child Sexual Abuse, 6*(1), 71-84.

Bross, D.C., Ballo, N., & Korfmacher, J. (2000). Client evaluation of a consultation team on crimes against children. *Child Abuse and Neglect, 24*(1), 71-84.

Brownridge, D.A., & Halli, S.S. (2002). Double jeopardy?: Violence against immigrant women in Canada. *Violence Against Women, 17*(4), 455-471.

Bulkey, J.A. (1992). The prosecution's use of social science expert testimony in child sexual abuse cases: National trends and recommendations. *Journal of Child Sexual Abuse, 1*(2), 153-180.

Campbell, R. & Ahrens, C.E. (1998). Innovative community services for rape victims: An application of multiple case study methodology. *American Journal of Community Psychology, 26*(4), 537-571.

Campbell, R. Sefl, T., Barnes, H.E., Ahrens, C.E., Wasco, S.M., Zaragoza-Diesfeld, Y. (1999). Community services for rape survivors: enhancing psychological well-being or increasing trauma? *Journal of Consulting and Clinical Psychology, 67*(6), 847-858.

Caputo, R.K. (1991). Police classification of domestic-violence calls: An assessment of program impact. In, Knudsen, D.D. & Miller, J.L. (Eds.) (1991), *Abused and battered: Social and legal responses of family violence. Social institutions and social change,* (17-151). Hawthorne, NY: Aldine de Gruyter.

Cross, T.P., Martell, D., McDonald, E., & Ahl, M. (1999). The criminal justice system and child placement in child sexual abuse cases. *Child Maltreatment, 4*(1), 32-44.

Daignault, I., Vézina, J., & Hébert, M. (August, 2002). The academic performance of sexually abused girls: A preliminary evaluation of potential predictive factors. *Victimization of Children and Youth Conference,* Portsmouth, New Hampshire.

Davison, K. (August, 2002). Child abuse prosecution rate flow from a children's advocacy centre. *Victimization of Children and Youth Conference,* Portsmouth, New Hampshire.

De Jong, A.R. (1998). Impact of child sexual abuse medical examination on the dependency and criminal systems. *Child Abuse and Neglect, 22*(6), 645-652.

Dible, D.A., & Teske, R.H.C. (1993). An analysis of the prosecutory effects of a child sexual abuse victim-witness program. *Journal of Criminal Justice, 21*, 79-85.

Domestic Abuse Intervention Project (n.d.). Retrieved March 12, 2002, from http://www.duluth-model.org/daipmain.htm .

Du Mont, J., & Parnis, D. (2000). Sexual assault and legal resolution: Querying the medical collection of forensic medicine. *Medicine and Law, 19*, 779-792.

Du Mont, J., & Parnis, D. (2001). Constructing bodily evidence through sexual assault evidence kits. *Griffith Law Review, 10*(1), 62-75.

Dumont-Smith, C. and P. Sioui Labelle. 1991 *Dragging wife abuse out of the closet*. cited in the National Family Violence Abuse Study/Evaluation. Aboriginal Nurses of Canada on the METRAC website: http://www.metrac.org/new/stat_vio.htm.

Ells, M. (2000, March). Forming a multidisciplinary team to investigate child abuse (Originally Printed November 1998), [On-Line]. Office of Juvenile Justice and Delinquency Prevention.

Faller, K.C., & Henry, J. (2000). Child sexual abuse: A case study in community collaboration. *Child Abuse and Neglect, 24*, 1215-1225.

Family Advocacy Center (n.d.). Retrieved March 12, 2002, from http://www.familyadvocacycenter.com/Choice%201.htm.

Fargason, C.A., Barnes, D., Schneider, D., & Galloway, B.W. (1994). Enhancing multi-agency collaboration in the management of child sexual abuse. *Child Abuse & Neglect, 18* (10), 859-869.

Federal-Provincial-Territorial Ministers Responsible for the Status of Women (2002), *Assessing violence against women: A statistical profile*. Ottawa, Canada: Status of Women Canada.

Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry*, *55*(4), 530-541.

Follingstad, D.R., Brennan, A.F., Hause, E.S., Polek, D.S., & Rutledge, L.L. (1991). Factors moderating physical and psychological symptoms of battered women. *Journal of Family Violence, 6*(1), 81-95.

Forman, B. D. & Wadsworth, J. C. (1983). Delivery of rape-related services in CMHCs: An initial study. *Journal of Community Psychology, 11*, 236-240.

French Gilson, S. (1997). The YWCA women's advocacy program: A case study of domestic violence and sexual assault services. *Journal of Community Practice, 4*(4), 1-25.

The Gatehouse (n.d.). Retrieved January 29, 2002, from http://www.thegatehouse.rog/main.html.

Glisson, C., & Hemmelgarn, A. (1998). The effects of organizational climate and inter-organizational coordination on the quality and outcomes of children's service systems. *Child Abuse and Neglect, 22*(5), 401-421.

Goldstein, J., & Griffin, E. (1993). The use of a physician-social worker team in the evaluation of sexual abuse. *Journal of Child Sexual Abuse, 2*(2), 85-93.

Greaves, L., Hankivsky, O. & Kingston-Riechers, J. (1995) *Selected estimates of the costs of violence against women.* London, ON: Centre for Research on Violence against Women and Children.

Griffiths, J. (1999). *Review of the investigation of sexual assaults: Toronto Police Services.* Toronto, Canada: Toronto Audit Services.

Hardgrove, G. (1976). An interagency service network to meet needs of rape victims. *Social Casework*, 245-253.

Harper, K. (1990). Child sexual abuse: A coordinated interagency response. *Canada's Mental Health,* June/Sept., 7-9.

Health Canada (1997). *Child sexual abuse.* Available online from the National

Clearinghouse on Family Violence at http://www.hc-sc.gc.ca/hppb/familyviolence/childsa.htm

Hébert, M., Parent, N., Tremblay, C. & Daignault, I. V. (August, 2002). Patterns of behavioral difficulties following disclosures of child sexual abuse. *Victimization of Children and Youth Conference,* Portsmouth, New Hampshire.

Henry, J. (1997). System intervention trauma to child sexual abuse victims following disclosure. *Journal of Interpersonal Violence, 12*, 499-512.

Hochstadt, J. J., & Harwicke, J. J. (1985). How effective is the multidisciplinary approach? A follow up study. *Child Abuse and Neglect, 9*, 365-372.

Hughes, H., Parkinson, D., & Vargo, M. (1989). Witnessing spouse abuse and experiencing physical abuse: A "double whammy"? *Journal of Family Violence, 4*(2), 197-209.

Jaffe, P., Wilson, S., & Wolfe, D. (1986). Promoting changes in attitudes and understanding of conflict resolution among child witnesses of family violence. *Canadian Journal of Behavioural Science, 18*(4), 357-366.

Jaffe, P., Wolfe, D., & Wilson, S. (1990). *Children of battered women.* Newbury Park, CA: Sage.

Jaudes, P.K. & Martone, M. (1992). Interdisciplinary evaluations of alleged sexual abuse cases. *Pediatrics, 89*, 1164-1168.

Jensen, J.M., Jacobson, M., Unrau, Y., & Robinson, R.L. (1996). Intervention for victims of child sexual abuse: An evaluation of the children's advocacy model. *Child and Adolescent Social Work Journal, 13*(2), 139-156.

Kaminer, B.B., Crowe, A.H., & Buddle-Giltner, L. (1990). The prevalence and characteristics of multidisciplinary teams for child abuse and neglect: A national survey. In M.B.W. Sandra M. Stith, & Karen Rosen (Ed.), *Violence hits home: Comprehensive treatment approaches to domestic violence* (pp. l549-567). New York: Springer Publishing.

Kolbo, J.R. & Strong, E. (1997). Multidisciplinary team approaches to the investigation and resolution of child abuse and neglect: A national survey. *Child Maltreatment, 2*(1), 61-72.

Koss, M., & Harvey, M. (1987). *The rape victim: Clinical and community approaches to treatment*. Lexington, MA: The Stephen Greene Press.

LaRocque, E.D. (1994). *Violence in Aboriginal communities*. Ottawa, Canada: National Clearinghouse on Family Violence. Cat. H72-21/100-1994-E.

Martin, P.Y., DiNitto, D., Byington, D, & Maxwell, M.S. (1998). Organizational and community transformation: The case of a rape crisis center. In, Odem, M.E. and Clay-Warner, J.

(Eds.), *Confronting rape and sexual assault* (pp. 231-246). Worlds of Women, No. 3. Wilmington, DE: Books/Scholarly Resources.

The Martin Aronold Kruze Memorial Forum (n.d.). Retrieved January 29, 2002, from http://kidshelp.sympatico.ca/help/abuse/kruze/abuse/gatehouse.htm .

Mahoney, P. & Williams, L. M. (1998). Sexual assault in marriage: Prevalence, consequence and treatment of wife rape. In J.L. Jasinski & L.M. Williams (Eds.), *Partner violence: A comprehensive review of 20 years of research* (pp. 113-162). Thousand Oaks, CA: Sage.

MacLeod, L., & Shin, M.Y. (1993). *"Like a wingless bird": A tribute to the survival and courage of women who are abused and who speak neither English nor French.* Ottawa, Canada: National Clearinghouse on Family Violence.

Moore, T., Peplar, D., Mae, R., & Kates, M. (1989). Effects of family violence on children: new directions for research and intervention. In B. Pressman, G. Cameron, & M. Rothery (Eds.) *Intervening with assaulted women: Current theory, research, and practice* (pp. Hillsdale, NJ: Lawrence Erlbaum.

Moriarty, L.J. & Gates Earle (1999). An analysis of services for victims of marital rape: A case study. *Journal of Offender Rehabilitation, 29*(3/4), 171-181.

National Children's Advocacy Center (n.d.). Retrieved January 29, 2002, from http://www.ncac-hsv.org/main.html.

National Network of Child Advocacy Centers (1994). *Best practices (2nd ed.).* Washington, DC: National Children's Alliance.

Office of Juvenile Justice and Delinquency Prevention (2000). *Forming a multidisciplinary team to investigate child abuse: Portable guides to investigating child abuse.* U.S. Department of Justice.

Ontario Native Women's Association. (1989). *Breaking free: A proposal for change to Aboriginal family violence*. Thunder Bay: Ontario Native Women's Association.

Palusci, V. J. (August, 2002). Are medical exams really needed for young victims of sexual abuse? *Victimization of Children and Youth Conference,* Portsmouth, New Hampshire.

Pearlman, L. A. & Saakvitne, K. W. (1995). Treating traumatized therapists. In C.R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder* (pp. 150-177). New York: Brunner/Mazel.

Peled, E. & Edelson, J.L. (1994). Advocacy for battered women: A national survey. *Journal of Family Violence, 9*(3), 285-296.

Reichard, R.D. (1993). Dysfunctional families in dysfunctional systems? Why child advocacy centers may not be enough. *Journal of Child Sexual Abuse, 2*(4), 103-109.

Rodgers, K. (1994). Wife assault: The findings of a national survey. *Juristat Service Bulletin: Canadian Centre for Justice Statistics, 14*(9), 1-21. Ottawa, ON: Minister of Industry, Science & Technology.

Seigel, G.C. (1999). *The impact of the Mesa Center Against Family Violence on child abuse investigations.* Prepared for the Governor's Division for Children and The Arizona Children's Justice Task Force.

Sobsey, D. (1994). *Violence and abuse in the lives of people with disabilities: The end of silent acceptance?* Baltimore, MD: Paul H. Brookes Publishing.

Sorenson, E. (1993). A rose by any name would smell as sweet: Enhancing the functioning child advocacy center. *Journal of Child Sexual Abuse, 2*(4), 111-113.

Statistics Canada (2000). *Family violence in Canada: A statistical profile 2000*. Ottawa, CA: Minister of Industry.

Steele, P. D. (1992). Evaluating multidisciplinary responses to child sexual abuse. *National Resource Centre on Child Sexual Abuse of the National Centre on Child Abuse and Neglect Newsletter, 1*(3), 1, 4.

Sullivan, C.M. & Bybee, D.I. (1999). Reducing violence using community-based advocacy for women with abusive partners. *Journal of Consulting and Clinical Psychology, 67*(1), 43-53.

Thelen, R. (2002). Advocacy in a coordinated community response: Overview and highlights of three programs. *Violence Against Women Online Resources.* www.vaw.umn.edu/BWJP/communityV.htm.

Tomlinson, D. (1996). An examination of sexual assault victims' experiences with the criminal justice system and related support services in Alberta. Unpublished research report.

Tomlinson, D. (2000). *Sexual assault: An exploration of survivors' decisions not to report to police*. Unpublished MSW thesis, Faculty of Social Work, University of Calgary.

Trocmé, N., MacLaurin, B. & colleagues (2001). Canadian incidence study of reported child abuse and neglect: Final report. Available on-line from the National Clearinghouse of Family Violence at http://www.hc-sc.gc.ca/hppb/familyviolence/

Tutty, L. (1996). Post shelter services: The efficacy of follow-up programs for abused women. *Research on Social Work Practice, 6*(4), 425-441.

Tutty, L. (1998). Mental health issues of abused women: The perceptions of shelter workers. *Canadian Journal of Community Mental Health, 17*(1), 79-102.

Tutty, L. (1999). Considering emotional abuse in the link between spouse and child abuse. *Journal of Emotional Abuse 1(*4) 53-79.

Tutty, L. & Rothery, M. (2002). How well do emergency shelters assist women and their children? In L. Tutty & C. Goard (Eds.). *Reclaiming self: Issues and resources for women abused by intimate partners (pp.25-42)*. Halifax, NS: Fernwood.

Uekert, B.K. (1998). *Process evaluation of the Mesa Center Against Family Violence.*

Underwood, M.M., & Fiedler, N. (1983). The crisis of rape: A community response. *Community Mental Health Journal, 19*(3), 227-230.

Ward, S.K. & Finkelhor, D. (2000). Program evaluation and family violence research. *Journal of Aggression, Maltreatment, and Trauma, 4*(1), 1-6.

Weisz, A. (1999). Legal advocacy for domestic violence survivors: The power of an informative relationship. *Families in Society: The Journal of Contemporary Human Services*, 138-147.

Westbury, E., & Tutty, L. (1999). The efficacy of group treatment for survivors of childhood abuse. *Child Abuse & Neglect*, 23(1), 31-44.

Williams, G. (1993). The expansion of advocacy center's role: Too much? Too soon? *Journal of Child Sexual Abuse, 2*(4), 115-118.

APPENDIX A: The Best Practice Guidelines of the National Children's Alliance

1. Child and family forensic interviews – CPS, Child Welfare, CCASA, ACH, Crown.
1. Investigation – Child Welfare; CPS.
2. Mental health treatment – ACH Child Abuse; CCASA.
3. Medical services – CSART team for acute; ACH Sexual Abuse Clinic, CHR ER department.
4. Prosecution – CPS; Crown; coordinate with Homefront?
5. Victim Advocacy – specialized advocate to follow child through system and justice response.
6. Crisis intervention – CSART; CARRT.
7. Multidisciplinary case review – this would need to become more formalized between key players involved in response to child abuse.
8. Prevention programs – i.e. CCASA "Who Do You Tell?"
9. Case tracking – would need to become more formalized.
10. Training – training facilities/rooms offered on-site.
11. Child fatality reviews – Child welfare, CPS, coroner?
12. Community education – will need to be developed.