

# SUFFERING IN SILENCE:

An Assessment of the Need for a Comprehensive Response to Sexual Assault in Nova Scotia



Nova Scotia Sexual Assault Services Planning Group

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## Acknowledgements

As primary author of this report, first thanks are given to the survivors of sexual violence who shared their devastating experiences of assault and its aftermath for this research. It is impossible for a written document to fully reflect the urgency and sadness heard in the voices of survivors, their families and their community members. It is my sincere hope that their experience is conveyed in a way that will fulfill survivors' main reason for participating – to help prevent others from experiencing the same harms.

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With sincere gratitude and respect,

Pamela Rubin



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## Executive Summary

This report details the outcomes of the Sexual Assault Needs Assessment, undertaken from April 2006 to September 2008 by the Sexual Assault Services Planning Group (the Planning Group) and provides recommendations for preventing and addressing the harms of sexual violence in Nova Scotia.

Along with the Advisory Council, the Planning Group is made up of Nova Scotia leaders in addressing sexual violence from a survivor-centred perspective. Organizations and agencies comprising the Planning Group are:

- ♦ Antigonish Women's Resource Centre
- ♦ Avalon Sexual Assault Centre
- ♦ Colchester Sexual Assault Centre
- ♦ Nova Scotia Advisory Council on the Status of Women
- ♦ Cape Breton Interagency on Family Violence
- ♦ Transition House Association of Nova Scotia
- ♦ Women's Centres CONNECT!

The purpose of the needs assessment was: (1) to expand the information and understanding available with respect to whether and where survivors access the help they need; (2) to determine how communities across the province are responding to the challenge of sexual violence; and (3) to identify what is needed to prevent and undo the harms of sexual violence in Nova Scotia.

### 1. Sexual Violence in Nova Scotia – Prevalence and Impact

The 2004 General Social Survey on Victimization (GSS 2004) reported the incidence of sexual assault at 40 per 1000 or 4% of those 15 and older. Nova Scotia was one of only two provinces in which the victimization rate increased over 1999 levels (33 per 1000 in 1999). The Canadian average in 2004 was 35 per 1000 or 3.5% of those 15 and older.

In 2006, the population of Nova Scotia of those aged 15 and over was approximately 756,595. Using this figure and the GSS 2004 victimization data, it is estimated that sexual violence has been experienced by at least 30,000 Nova Scotians age 15 and over, the large majority of whom are female.

In 2004, 820 sexual assaults were reported to police in Nova Scotia as described in the Nova Scotia Advisory Council's report, *Sexual Assault in Nova Scotia: A Statistical Profile (December 2005)*. With the level of reporting for 2004 at 8% (GSS 2004), this could indicate the presence of close to 9000 unreported sexual assaults for the year 2004. Data is not readily available with respect to how many reports relate to historical and to recent assaults.

In 2006-2007 Avalon Sexual Assault Centre in Halifax and Colchester Sexual Assault Centre in Truro received over 1000 requests for information, support and services. Service

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providers from non-specialized agencies reported that 30-75% of clients had issues arising from sexual violence that they were seeking help for.

Much data of the last thirty years establishes that there are severe short and long term impacts associated with sexual violence. These include:

- ◆ Greatly increased suicide behaviours and suicide risk
- ◆ Self-harming and self-mutilation
- ◆ Dissociation
- ◆ Sense of isolation and stigma
- ◆ Anxiety
- ◆ Sexual dysfunction
- ◆ Sleep disorders
- ◆ Physical health effects
- ◆ Criminalization
- ◆ Substance abuse
- ◆ Revictimization
- ◆ Reduced earning power
- ◆ Low self-esteem and self-concept impairment;
- ◆ Depression
- ◆ Self-blame, guilt, and helplessness
- ◆ Posttraumatic stress responses
- ◆ Obsessions and compulsions
- ◆ Increased risk of homelessness
- ◆ Diminished later life functioning (over age 60)

Nova Scotia survivors participating in this research and in four previous reports identified many of the above serious, long-term effects in their lives and a lack of services to deal with them. Additionally, sexual violence has the potential to indirectly affect those who are important in the lives of survivors— partners, children, and friends. It can also tear apart the fabric of communities.

In the absence of a comprehensive response, sexual violence will continue to generate high psychological, social and financial costs to communities and survivors.

## 2. Components of a Comprehensive Response & Services Currently Available in Nova Scotia

It is recognized that the best response to sexual violence is a comprehensive one based on the uniform provision of basic core services that encompass personal healing, education, prevention, and advocacy work, working synergistically in communities to address root causes and harms of sexual violence.



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Components of blueprints for comprehensive sexual violence response commonly include:

- ◆ Dedicated sexual assault centre
- ◆ Access to information/options
- ◆ Public education
- ◆ Professional Education
- ◆ Prevention programming
- ◆ Specialized basic support
- ◆ Specialized therapeutic counselling
- ◆ Specialized support for vicarious trauma of service providers
- ◆ Coordination among responders (SART team or other protocols)
- ◆ 24-hour crisis line for sexual violence
- ◆ On-call advocates
- ◆ Accompaniment in justice, medical and other systems
- ◆ SANE program
- ◆ Updated online program directory
- ◆ Policy development
- ◆ Social change advocacy
- ◆ Cultural competency programming
- ◆ Data collection

Nova Scotia lacks a planned strategy to address sexual assault, and lacks nearly all the components that typically comprise a comprehensive response in other jurisdictions. Communities struggle in isolation to address this major problem. This has resulted in an ad hoc patchwork of attempts to meet Nova Scotians' needs without planning or resources. Most core services are not available in Nova Scotia. While some services are available in some areas, these are not congruent with the level of population need, are often not accessible, and are not stably funded.

A review of services by county reveals that only the provision of general information is uniformly present at an adequate level. Even the most fully serviced area, Halifax, provides only several of the principle services and several of these are not permanently or publicly funded (e.g. survivor accompaniment services, professional education services).

- ◆ For basic survivor support and therapy, where available, staffing is not adequate for the size of victimized population. This includes the Avalon Sexual Assault Centre, the only full time sexual assault centre in the province, and the only source of no-cost specialized therapy for survivors. Avalon is facing staff loss and service reductions due to inadequate funding for specialized therapy.

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- ◆ With respect to accompaniment for survivors, this is available on an ad hoc basis only in most areas and on a trial basis only, in Halifax, ending in 2009.
  - ◆ Public education projects are only occasionally delivered due to lack of resources. Professional education is limited by funding as well, with requests for specialized training going unfulfilled.
  - ◆ A crisis line response, on-call response and advocacy for survivors, targeted data collection and other specialized services are virtually absent in the province.

Addressing sexual violence is essential to the goals of the Nova Scotia Advisory Council on the Status of Women, in particular that of *Women's Personal Safety and Freedom from Violence*, one of four key programs in the Council's mandate.

Addressing sexual violence is also essential to the goals of *A New Nova Scotia: A Path to 2020*, and specifically to the priority area of safer, healthier communities. In *Time to Fight Crime Together: Our Strategy to Prevent and Reduce Crime*, of five stated goals, four require a comprehensive community-based response to sexual violence as follows:

- ◆ People are and feel safe and secure in their homes and communities.
- ◆ Those in conflict with the law are held accountable.
- ◆ The frequency and severity of offending and victimization are reduced.
- ◆ Communities and individuals are actively involved in creating a safer Nova Scotia.

Desired outcomes of the *Time to Fight Crime Together* strategy include “more support for victims” through specific interventions including a “stronger response to family violence and violence against women.”

Stated goals of the Health, Health Promotion and Protection, Education, and Justice departments also require addressing the lack of a comprehensive, community-based response to sexual violence in the province.

### 3. The Need for Prevention Programs

Participants in this research were asked to identify what would prevent sexual violence in their community:

- a) *Education* was the nearly universal response, including public, professional, and school-based programming.
- b) *Advocacy* was emphasized by women's organizations and survivors who noted the importance of challenging community and institutional norms that assume and condone male power over women and girls. This was seen as key to eliminating the root causes of violence. This encompasses work addressing gender power imbalances connected to poverty, and the multiple forms of discrimination that make women and girls the main targets of sexual violence.
- c) *An effective justice system response* was mentioned by a minority of participants, including some survivors who emphasized it was important to prevention.

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## 4. The Need for Core Services

Eight core services that are required to ensure a comprehensive approach to addressing sexual violence are: specialized therapeutic counselling; basic survivor support; crisis lines; on-call community-based advocates; justice system accompaniment; sexual assault nurse examiners (SANEs); services for men, and professional education.

### 4.1 Specialized Therapeutic Counselling

The wide-ranging and intensely harmful effects of sexual violence can seldom be overcome without specialized therapy. The therapeutic needs of sexual violence survivors are unique and require a specialized expert response. The current mental health services delivery model is ill-matched to the needs of sexual assault survivors. Best outcomes are achieved through delivery of specialized, holistic, survivor-centred therapy by community-based agencies. The Avalon Centre model of this care is associated with positive outcomes for survivors, has received provincial and national recognition, and provides guidance as to best practices. However, with only 3.7 positions serving the entire province with its 30,000+ survivors, specialized therapy needed for recovery from sexual assault is inaccessible to most Nova Scotians. Further, salaries at community organizations such as Avalon Centre have been extremely low compared to what comparably specialized therapists earn in the governmental and private sectors: this has fuelled a staff retention crisis for Avalon Centre, which is losing a staff position this year, when Avalon Centre will be able to afford to fill only one of two vacated counselling positions.

### 4.1 Basic Survivor Support

One strength of Nova Scotia's overall inadequate response to sexual violence is the quality of non-therapeutic, basic survivor support delivered by women's centres and the transition houses, as well as the two sexual assault centres. However, these organizations generally do not publicize these services for fear of being overwhelmed by population need as they are not adequately resourced to meet population need in this service area.

Basic survivor support can include listening, provision of information and options, and in limited ways at certain organizations, the provision of general ongoing emotional support and some advocacy. These services, however, do not replace therapy and do not address the root causes of symptoms in survivor's lives.

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## 4.2 Crisis Lines

A gap in services affecting the entire province is the absence of a 24-hour sexual assault crisis line.

## 4.3 On-Call Community-Based Advocates

Sexual assault survivors' advocates available for immediate response provide numerous benefits and can prevent serious negative consequences for survivors. There is strong evidence that advocacy is the primary need in the immediate and short-term aftermath of sexual assault, especially where there has been an official report to the police.

It is inappropriate to rely on police-based victim services to fulfill this role. It is important that survivors have an advocate immediately available whom they can fully direct, and who is responding to the situation with no other responsibility than to the survivor. An independent community-based advocate is needed in these circumstances. Community-based on-call advocates bring their understanding of sexual violence as a social issue to immediate response, and are able to support survivors immediately to prevent self-blame, and dispel myths and stereotypes about sexual violence. If the on-call advocate is also connected to an organization providing supportive or therapeutic counselling, services to survivors are more seamless, and referrals and follow up by the survivor for counselling are more likely.

In Nova Scotia, the Avalon Centre does not offer advocates' services at the hospital, due to fiscal constraints. The Antigonish Women's Resource Centre (AWRC) offers volunteer on-call advocates associated with their SANE programming, but this is not a funded part of the first-year SANE program there. Other women's organizations reported occasionally being able to provide an on-call advocate from among staff, but this was not a formal part of response, nor were they resourced to do so consistently or even frequently.

## 4.4 Justice System Accompaniment

No organization in Nova Scotia has ongoing funding to provide consistent justice system accompaniment to adult sexual assault survivors involved in the investigation and trial of their assailant(s).

Department of Justice Victim Services often refer adult Halifax clients to Avalon for justice system support and advocacy because they identify (to Avalon) that they lack the specialized knowledge to address sexual violence issues as well as being limited by the demands of their caseloads.

Currently, Department of Justice Victim Services outside Halifax will usually turn to women's organizations to arrange accompaniment. They express a preference for staff rather than volunteers to do this work, so that the information provided about the court process will be accurate, and so that trauma can be better prevented and identified. Women's centres and transition houses respond on an ad hoc basis to requests for accompaniment depending on the availability of staff.

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The provision of justice system accompaniment by women's organizations is not recognized or remunerated in their core funding. For transition houses, unless the accused is an intimate partner, the services are outside their funded mandate completely. Despite the justice system's urging of survivors to report, this minimal level of emotional support is not being consistently provided.

#### 4.5 Sexual Assault Nurse Examiners

Expert medical response is crucial to the health and well-being of survivors and to the prevention of secondary wounding and long-term negative impacts. Currently only the Halifax area and the Guysborough-Antigonish-Strait Health Authority region offer sexual assault nurse examiner (SANE) services to survivors of recent assaults.

Implementation recommendations for province-wide SANE services were developed by Avalon Centre at the request of the Nova Scotia Department of Health in 2007. Community-based SANE programming, modeled on the successful (Mahon 2003) Avalon Centre program was recommended for the entire province, with immediate implementation beginning in the Cape Breton Regional Municipality area.

#### 4.6 Services for Men

Although social responses to male and female victimization are distinct (Doherty and Anderson, 2004), specialized sexual assault services for men or transgender persons are rare across Canada, and are nearly absent in Nova Scotia. Both community organizations and health system managers recognize this gap and believe it needs to be addressed by the community and the province, in the context of developing a plan for province-wide comprehensive sexual assault services. Possible short term approaches include increased funding for specialized counseling for men, and partnerships with agencies that will or already do provide such counseling, such as various projects or services targeting LGBTI clients. It is the consensus of most survivor-centred service providers that a gender-specific, rather than a gender neutral approach to services is the approach most likely to address male survivors' distinct needs, and least likely to compromise the needs of the majority of survivors who are female.

#### 4.7 Professional Education to Eliminate Secondary Wounding

Survivors' interactions with professionals after an assault may be traumatizing in their own right, causing what is called "secondary wounding": the re-traumatization of the sexual assault, abuse or rape survivor. It is an indirect result of assault which occurs through the responses of individuals and institutions to the survivor. Secondary wounding has severe impacts and is highly prevalent.

Professional education was identified in previous Nova Scotia research as critical in preventing secondary wounding and serving survivors appropriately. This needs assessment found that there has been no coordinated response to the identified needs for specialized training throughout the province.

Avalon Centre, Colchester Sexual Assault Centre, and to a lesser extent, Antigonish Women's Resource Centre have delivered specialized training to professionals serving sexual

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violence survivors. This professional training is limited by the budgets of the respective agencies receiving it, and the resources of the delivering agencies. There is no regular schedule of ongoing training in sexual violence response, at any agency.

The custom designed training programs provided by Avalon Centre focus on sexual assault awareness, response, support, investigation, and advocacy. Which aspects of this training that participants receive depends on their profession, their previous knowledge, experience, and skill level, and the nature of the training workshop. It may provide a broader understanding of the issues pertaining to sexual violence and survivors and a feminist analysis of sexual violence as a social issue. It may be skills-based, providing participants with the knowledge, skills, and techniques to respond to and provide support to victims of sexual assault within the context of their day to day work. They are not trained to be therapeutic counselors but rather to prevent secondary wounding, provide first response to disclosures, inform survivors of options, have a broader analysis of sexual violence as a social issue and to provide basic emotional support.

## 5. The Need to Eliminate Barriers to Access

In addition to inadequate services, survivors and service providers identified barriers to accessing what services do exist. Highlighted barriers included transportation, cultural competence, access for persons with disabilities, and rural challenges.

### 5.1 Lack of Transportation

Transportation for sexual assault survivors is generally not provided by community organizations due to resource, safety and liability issues. If the survivor involves police in the immediate aftermath of an assault, police will usually provide transportation to hospital, or to transition houses in the case of partner violence. This is a less than ideal arrangement, as it can often mean a long car ride with police officers who may or may not have had training in survivors' post-assault needs, and the preventing of secondary wounding.

### 5.2 Cultural Competence

The ability to serve diverse populations in an environment that is safe and sensitive is critical to providing survivor-centred sexual assault services, at the core of which is trust. Cultural competence is expected and supported in many U.S. jurisdictions. Nova Scotia organizations serving survivors partner with diverse community groups and educate staff with respect to diversity issues. The Pictou County Women's Centre has provided leadership with innovative programming in this area. However, there is no resourced support for long-term development of cultural competencies in delivering sexual assault services. This would include improving the representation of diverse populations, especially racialized women, among service providers, for which there is no government incentive or support.

This is a serious gap particularly considering the overrepresentation of non-dominant populations among survivors.

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### 5.3 Access for Persons with Disabilities

Accessibility and special competencies for serving sexual assault survivors with disabilities is not funded in Nova Scotia. The lack of resources to ensure accessibility for persons with disabilities to survivor services is a serious gap, particularly considering their great overrepresentation among survivors.

### 5.4 Rural Challenges

Many rural barriers to access have been identified in literature that reviews sexual assault services in North America. Sexual assault service providers report that sexual assault in rural areas is highly acquaintance-perpetrated and very underreported. Lack of anonymity and an insular rural culture can limit healing and justice. In general, the following challenges have been identified with respect to the delivery of sexual assault services in rural areas in Canada:

- ◆ Insufficient funding for rural services
- ◆ Safety issues and “burnout” of sexual assault workers
- ◆ □High staff turnover
- ◆ Public scrutiny/lack of anonymity (survivor’s service use)
- ◆ Retractions of sexual assault disclosures
- ◆ Lack of access to specialized treatment and diagnostic resources
- ◆ □Lack of other specialized service providers
- ◆ □Geographical isolation
- ◆ □Limited telecommunications
- ◆ Turf wars and service provider resistance to change
- ◆ Problems with the criminal justice system
- ◆ □Delayed court proceedings
- ◆ □Ideological loneliness of some service providers
- ◆ Denial of existence of sexual assault by some service providers
- ◆ Denial of existence of sexual assault by community residents

(here, “service provider” refers to any person or organization providing any services to sexual assault victims, whether these are specialized or not.)

Recent research on the experience of rural Maritime women and girls and their anti-violence service providers affirms that these circumstances are the experience in rural areas of Nova Scotia as well.

## 6. The Need to Create Local Service Structure

There is a need to create and strengthen the local service structure in key areas of Nova Scotia and to develop coordinated approaches in order for sexual assault services to be delivered effectively and efficiently throughout the province.

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## 6.1 New Brunswick Efforts

Creating provincial and local service structures to respond to the severe gaps in sexual assault services must be undertaken carefully. Proper implementation will require coordinated developmental efforts. Such an effort is underway in New Brunswick at this time, with government support for the Fredericton Sexual Assault Centre's leadership.

## 6.2 Halifax, Avalon Centre and the Avalon Model

The province's flagship sexual assault centre (and only full-time centre) is currently not funded adequately to provide core components of a comprehensive sexual assault response.

Avalon Centre's excellent survivor-centred support, therapy and advocacy is recognized and highly valued by survivors, and by the many different agencies with whom they are connected. Avalon's service standards and leadership are recognized nationally and internationally by other sexual assault services and by multi-agency organizations addressing sexual assault.

To summarize the combination of high-value aspects in the Avalon model:

- ◆ Survivor-centred approach: empowering survivors as decision makers in their recovery; always responsive to their needs and lead.
- ◆ Social analysis of sexual violence: putting the violence in context and addressing root causes; avoiding a narrow practice approach only based in psychopathology; demonstrating to survivors that they are not alone societally and are not to blame
- ◆ Specialized therapeutic counselling that recognizes and addresses the special needs of sexual assault survivors, including expertise in PTSD, secondary wounding, child abuse, gendered impacts of sexual assault, therapist/client power balance and trust, and feminist counselling.
- ◆ Prevention and education emphasis to address root causes of violence and secondary wounding. Prevention and education is informed by survivor-centred expertise. High quality customization of professional education.
- ◆ Community-based and independent: as a non-profit community-based organization, Avalon can be responsive to community needs and partners, and choose direction based on survivors' and community priorities.

Their model and leadership is highly attractive to other Nova Scotia communities wanting sexual violence services, and many service providers participating in this research expressed their wish for their community to "have an Avalon," or follow the "Avalon model."

However, this enthusiasm should not obscure that Halifax is underserved based on population, and that Avalon, due to financial constraints, cannot offer a full range of services, nor serve clients optimally in terms of frequency and duration of counselling.

Further, Avalon has had problems with retention of specialized counsellors due to the non-competitive salary that must be offered at their budget level. Avalon's sexual assault



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counsellors are among the most highly specialized of counsellors in the province, and among the lowest paid. The current funding approach by government to these community-based counsellors is not sustainable. Avalon Centre will cut back staff and services this year in order to offer more competitive salaries and retain highly specialized staff (who can easily find more remunerative positions in government or the private sector.) Of two counselling positions vacated this year, only one will be filled. As described earlier, due to staff size, the Avalon Centre's case load of therapeutic clients is limited to just over two hundred per year, very far short of the estimate of Halifax area survivors. Further cuts to staff will exacerbate this problem. The unsustainable nature of Avalon Centre's funding has led the organization's board and treasurer to begin discussing closure of the Centre.

### 6.3 Cape Breton Regional Municipality

Many Cape Breton Regional Municipality (CBRM) service providers expressed having long desired "an Avalon." CBRM agencies and professionals have organized collaborative efforts to move toward coordinated response and improved services, as described earlier in this report. There was growing frustration reported among the CBRM professionals making these efforts, at the lack of government action to establish and support a sexual assault centre serving Cape Breton. Population and identified needs demonstrate that a sexual assault centre is long overdue for this area.

### 6.4 Truro Area

Truro has the unique asset of the Colchester Sexual Assault Centre, the only other sexual assault centre in Nova Scotia besides Avalon. This has resulted in higher visibility of sexual violence issues, and a higher level of awareness and specialized service for this area. However, having only a single permanent part-time staff person is not a sustainable approach for all of the support and education needed for the area, as higher community awareness and visibility turn into a higher demand for information and counselling services for individuals.

### 6.5 Antigonish Area

Antigonish Women's Resource Centre has long provided leadership in sexual violence response in this region: It is the *de facto* sexual assault centre serving its area. Collaborative community action involving justice, health, education and other professionals is significantly formalized in Antigonish, under the leadership of AWRC.

AWRC administers and leads a constellation of community services presently, including a Women's Centre, a Sexual Assault Nurse Examiner (SANE) program; Lindsay's Health Clinic, as well as sexual assault services and education. However, its function as the region's *de facto* sexual assault centre is not officially recognized and is not specifically funded. Service provision, as in all areas, does not meet population need since funding for services to survivors is not tied to the size of the victimized population. Compared to other rural areas, Antigonish also has a higher-than-average presence of university-age population, an age group with higher sexual assault services needs.

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## 6.6 Other Geographic Areas

Leadership in sexual assault response has been provided mainly by the transition houses and women's centres serving other areas of Nova Scotia. These organizations in areas of the province other than the above are supportive of immediate enhancement of staff and services at existing women's centres and/or transition houses in an interim way that did not preclude establishing a sexual assault centre as part of a community-developed response.

A major concern for all regional discussion participants was that the regions be included in developing any implementation plans for their area. It was their strong message that a provincial plan be rolled out only with their ongoing participation in its development and implementation. On-the-ground development work based in their community was strongly preferred, in contrast to using one provincial Halifax-based employee to develop all regional responses.

## 6.7 The Need for a Coordinated Response

Many U.S. and several Canadian communities and have created multidisciplinary bodies, such as sexual assault response teams (SARTs) to oversee coordination and collaboration related to immediate response to sexual assault, ensure a survivor-centred approach to service delivery, and prevent future victimization.

This coordination potentially offers benefits to Nova Scotia:

- ◆ It helps victims receive more comprehensive services in the initial setting.
- ◆ Following the initial response, SART members can make more effective efforts to link victims with resources in the community
- ◆ Improvement in overall service delivery to sexual assault survivors.
- ◆ Survivors and community receive consistent messages about sexual violence.

Many see a coordinated sexual assault response as highly important in their community, and see multidisciplinary collaboration as crucial. They identify however, that it is impossible for these efforts to be moved forward, "off the side of someone's desk"; i.e. without additional resources and staffing.

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# Recommendations for a Comprehensive Response to Sexual Violence

*Nova Scotia should follow other proactive jurisdictions in creating a comprehensive response to sexual violence, with a barrier-free model of coordinated prevention and core services to survivors, with community-based independent service delivery based on the Avalon Centre model.*

## 1. The Need for Prevention Programs

### 1.1 Public Education

- 1.1.1 A comprehensive sexual violence education program for all teachers and students should be developed, for delivery beginning in the elementary grades.
- 1.1.2 Women's organizations and others with expertise in gendered violence should be resourced to participate in the development and delivery of ongoing comprehensive school programming.
- 1.1.3 Women's organizations and others with expertise in gendered violence should be resourced to develop and provide ongoing public education on sexual violence in venues other than schools.
- 1.1.4 The appropriate model for educational programming should focus on changing discriminatory beliefs and conditions that give rise to sexual violence and skills building to challenge gender dominance in relationships. It should not rely on rape-avoidance approaches.
- 1.1.5 Programming should not over-emphasize stranger assaults. It should primarily address assaults by friends, relatives and other persons in positions of trust.
- 1.1.6 Programming should be inclusive and relevant to vulnerable populations, such as persons with disabilities, prostituted persons, women who are subject to racism, elder and immigrant women, and others.
- 1.1.7 Sexual violence as part of partner violence should be emphasized in public education.
- 1.1.8 Provision of public education should be proactive, not only in response to requests, through permanent outreach positions based in community organizations with expertise in gendered violence.
- 1.1.9 The sexual violence component of school-based anti-violence and bullying programming should be increased.
- 1.1.10 A focused program regarding the new age of consent law is needed to make the public aware of these changes. Materials referencing the former provisions should be updated.

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## 1.2 Research, Policy Development/Advocacy

- 1.2.1 Research, policy development and advocacy related to increasing the economic and social status and power of women and other vulnerable populations should be valued and funded as sexual assault prevention. The relationship between this work and sexual violence prevention should be explicitly acknowledged by the government of Nova Scotia.

## 1.3 Justice System

- 1.3.1 Action should be taken to ensure more consistent justice system outcomes across Nova Scotia with respect to sexual violence. Regional variations in sexual assault case outcomes in Nova Scotia should be examined further. Reasons for, and practices leading to, these variations should be identified.
- 1.3.2 The Minister of Justice should convene a round table with all stakeholders to review the recommendations of “Justice Innovations and Women’s Safety” and create a plan to increase the effectiveness of the justice system in preventing sexual violence.

## 2. The Need for Core Services

### 2.1 Specialized Therapeutic Counselling

- 2.1.1 Specialized therapeutic counselling must be made available to survivors regardless of their location in the province.
- 2.1.2 Specialized therapeutic services for survivors are best delivered through community-based specialized centres that accommodate counselling models and service delivery mechanisms geared to survivors’ specialized needs. The Avalon Centre’s holistic, survivor-centred activities and philosophy of service embody these qualities and should be adopted as the model for new sexual assault centres and services in Nova Scotia.
- 2.1.3 The most effective counselling model for sexual violence survivors is not highly compatible with the operation of the general mental health care system. For reasons related to optimal recovery, survivors require specialized structuring of therapy, including:
  - ◆ Very short or no wait time
  - ◆ Specialists who can recognize the need for intervention and assess accurately
  - ◆ Open-ended duration
  - ◆ Weekly frequency
  - ◆ Empowering, non-intrusive methods
  - ◆ Limited caseloads, vicarious trauma support for specialized counsellors
- 2.1.4 Peer support and group work can also be beneficial but also present challenges related to secondary wounding, and should not be used as an inexpensive approach to services for survivors. These options should be viewed as an adjunct to individual therapeutic counselling, and stably funded and subject to standards within that context.

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## 2.2 Basic Survivor Support

- 2.2.1 The unique role of women's centres and THANS members in providing basic survivor support to sexual violence survivors needs to be recognized and resourced properly.

## 2.3 Crisis Lines

- 2.3.1 A 24-hour specialized crisis line for sexual assault survivors should be accessible throughout the province, in the same way that partner violence emergency lines are.
- 2.3.2 Crisis lines should be developed simultaneously with the development of therapeutic counselling resources for communities. Crisis lines are not sustainable as substitutes for therapeutic counselling.

## 2.4 On-Call Community Based Advocates

- 2.4.1 The provision of on-call advocates' services should be viewed as an integral part of comprehensive community response to sexual assault. Core funding for the provision of these services should be allocated to community-based survivor-centered organizations providing other survivor services.

## 2.5 Justice System Accompaniment

- 2.5.1 Justice system accompaniment should be made consistently available to all sexual assault survivors attending the justice system proceedings. Core funding for women's organizations to establish permanent positions is essential. Accompaniment should include all meetings with the police and Crown, preliminary inquiries and waiting time at the courthouse, not just time testifying at trial.

## 2.6 Sexual Assault Nurse Examiners

- 2.6.1 SANE services should be available to all Nova Scotians. The recommendations with respect to SANE programming previously provided to the Nova Scotia Department of Health should be implemented.

## 2.7 Services for Men

- 2.7.1 The gap in men's services needs to be addressed through separate, community-based counsellors and resources, with expertise in the unique needs of male survivors which are distinct. Forcing sexual assault centres or women's organizations to adopt a gender-neutral approach would adversely affect services to most survivors who are female and require an environment that is perceived as safe and staff expertise in female service needs that reflect the gendered experience of sexual assault. Separate services for men staffed by specialized counsellors should be developed, which will respect the majority of survivors' needs for a trusted, woman-centred environment and approach.

## 2.8 Professional Education

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- 2.8.1 A planned approach to the training of justice, medical, mental health, child protection, and other staff should be developed by the province as part of an overall strategy to address sexual violence. Current organizations (Avalon, CSAC, and AWRC) delivering training should be provided additional core funding to continue doing so in an organized and long term manner that reaches all areas of the province. Training should be scheduled to be repeated at intervals and be custom designed, based on previous training to advance particular agencies' goals.

### 3. The Need to Eliminate Barriers to Access

#### 3.1 Transportation

- 3.1.1 Transportation for Nova Scotians to access sexual assault services must be resourced.

#### 3.2 Cultural Competency

- 3.2.1 Groups accorded lower power and status by the dominant culture are disproportionately vulnerable to sexual violence. Increased cultural competencies at organizations serving survivors should be made an explicit and resourced priority now, and for future expansion of sexual assault services. This should include support for training, recruitment and retention of staff from diverse populations. The outreach and programming developed by Pictou County Women's Centre should serve as a template for other organizations.

#### 3.3 Persons with Disabilities

- 3.3.1 This group of the population is enormously overrepresented among survivors of sexual violence. Accessibility and competency in sexual assault services for persons with disabilities should be funded now, and in any future expansion of services.

#### 3.4 Rural Barriers

- 3.4.1 Many barriers unique to rural areas and culture can interfere with access to sexual assault services. Specific rural solutions to access must be developed as part of a comprehensive provincial response to sexual violence.

#### 3.5 Child Care

- 3.5.1 Child care so that survivors with children can access sexual assault services should be resourced.

### 4. The Need to Create Local Service Structure

#### 4.1 Overall

- 4.1.1 Resources are needed for Avalon Centre to continue to lead development efforts to establish a model and standards for sexual assault centres in Nova Scotia, and develop an implementation strategy for a comprehensive response to preventing and addressing the harms of sexual violence in Nova Scotia.

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## 4.2 Halifax

4.2.1 Addressing the gaps in sexual violence services must include ensuring that Avalon Centre, the organization that is looked to as a provincial model, can offer all core services at a level that reflects survivor population needs.

4.2.2 Permanent financial support is needed to:

- ◆ Establish more specialized therapeutic positions and stabilize existing positions, reflecting more accurately the prevalence of sexual violence and the population need (Based on serving a population of approximately 400,000, with 16,000 estimated survivors based on 2004 General Social Survey data.)
- ◆ Bring the compensation of Avalon staff in line with professional norms, to stop the current threat to Avalon services due to inability to retain specialized staff at current sub-par levels of compensation.
- ◆ Stabilize and maintain the provision of justice system accompaniment to survivors;
- ◆ Establish and maintain on-call advocates who can respond in person to survivors of recent assault
- ◆ Establish regular professional education for all government actors who are serving survivors in the course of their work: this would include police, public prosecutors, the judiciary, corrections, drug and alcohol dependency staff, mental health services, and others.
- ◆ Do prevention and public education work on a strategic ongoing basis

## 4.3 Cape Breton Regional Municipality

4.3.1 A sexual assault centre should be established to serve the Cape Breton Regional Municipality. It should be modeled on the Avalon Centre's philosophy and standards of service, work closely with the women's centre and transition house serving the area, and set a precedent for service expansion elsewhere. It should provide services comparable to those of the enhanced Avalon model as recommended above.

## 4.4 Truro

4.4.1 Colchester Sexual Assault Centre should be supported with permanent full-time staff positions and other enhanced support and funding, to bring it closer to the enhanced Avalon model.

## 4.5 Antigonish Area

4.5.1 A sexual assault centre, functioning as one of the family of service centres administered by AWRC, should be recognized and funded to provide core sexual assault centre services in line with those of an enhanced Avalon model.

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## 4.6 Other Geographic Areas

- 4.6.1 The establishment of core sexual violence services and resources is needed in all other areas of the province as well. The particular form and implementation of a strengthened response should be based on community-developed approaches. The provincial government should explicitly support community organizations currently serving survivors, in all planning and implementation processes through government's explicit commitment to local community development funding for this purpose. The current New Brunswick approach to provincial leadership but community-based development should be followed, with resources provided, so that Avalon Centre can share models and standards with regional service providers considering the development of their own sexual assault centre.

## 4.7 The Need for a Coordinated Response

- 4.7.1 Community development funding should be allocated to a staff position based in the community organizations currently leading the response to sexual violence in each region, in order to drive forward the establishment of coordinated response in all areas of the province. This should include Halifax. The Antigonish SART team protocol should be used as a reference point by other communities. Under no circumstances should emphasis be placed on achieving coordinated protocols without adequate support for this work.



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# 1. Introduction

This report details the outcomes of the Sexual Assault Needs Assessment, undertaken from April 2006 to September 2008 by the Sexual Assault Services Planning Group (the Planning Group) and provides recommendations for preventing and addressing the harms of sexual violence in Nova Scotia.

The purpose of this report is to assess the need for sexual assault services for adults using a survivor-centred approach. To accomplish this, the needs assessment was designed to include survivor perspectives in addition to service providers from various community agencies providing both specialized services (sexual assault centres) and non-specialized services.

The report includes seven sections as follows:

1. *Introduction*: the introduction provides background information on the composition of the Planning Group and an overview of the needs assessment purpose, framework and methodology.
2. *Sexual Violence in Nova Scotia – Prevalence and Impact* provides an overview of the prevalence of sexual violence in Canada and Nova Scotia and of the various impacts of sexual violence from the literature review and interviews with survivors.
3. *Components of a Comprehensive Response and Services Currently Available in Nova Scotia* examines the components of a comprehensive response to sexual violence and provides an overview of current services available in Nova Scotia.
4. *The Need for Prevention Programs* outlines the need for public and school-based education programs; for research, policy and advocacy; and a role for the justice system in prevention as identified by research participants. The section concludes with recommendations for prevention programs.
5. *The Need for Core Services* outlines eight core services that are required to ensure a comprehensive approach to sexual violence. The section concludes with recommendations for core services.
6. *The Need to Eliminate Barriers to Access* highlights the barriers to access identified by survivors and service providers in Nova Scotia and through Nova Scotia research. The section concludes with recommendations for eliminating barriers to access.
7. *The Need to Create Local Service Structure* outlines what is required in various areas of the province and the need for a coordinated approach to ensure services can be provided efficiently and effectively. This section concludes with recommendations for creating local service structure.

## 1.1 The Sexual Assault Services Planning Group

The Needs Assessment was coordinated through the Sexual Assault Services Planning Group (the Planning Group). This group was brought together in 2006 by Avalon Sexual Assault Centre, with support from the Nova Scotia Advisory Council on the Status of Women. The

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Planning Group's goal was to address the level of services, strategies and resources available to respond to sexual violence in the province.

Along with the Advisory Council, this group is made up of Nova Scotia leaders in addressing sexual violence from a survivor-centred perspective. Organizations and agencies comprising the Planning Group are:

- ♦ Antigonish Women's Resource Centre
- ♦ Avalon Sexual Assault Centre
- ♦ Colchester Sexual Assault Centre
- ♦ Nova Scotia Advisory Council on the Status of Women
- ♦ Cape Breton Interagency on Family Violence
- ♦ Transition House Association of Nova Scotia
- ♦ Women's Centres CONNECT!

## 1.2 The Needs Assessment Purpose and Framework

Over the course of 2006, the Planning Group uniformly identified concerns across all regions of the province. Two key concerns were the ability of individuals and communities to access adequate services related to sexual violence and the need to prevent and undo the harms associated with sexual violence. The group decided to conduct a needs assessment and, in 2007, accessed funding from the Nova Scotia Advisory Council and the Law Foundation of Nova Scotia, in addition to in-kind contributions from all participating organizations.

The purpose of the needs assessment was: (1) to expand the information and understanding available with respect to whether and where survivors access the help they need; (2) to determine how communities across the province are responding to the challenge of sexual violence; and (3) to identify what is needed to prevent and undo the harms of sexual violence in Nova Scotia.

The needs assessment framework includes:

- ♦ An environmental scan of the current provision of sexual assault service in all regions of Nova Scotia, focusing on who is delivering services to adults (over 16) and what type and level of services are being provided;
- ♦ A literature review identifying prevalence and impacts of sexual violence, core service components in other jurisdictions, and best practices in sexual assault services;
- ♦ Identification of adult Nova Scotia sexual assault survivors' key needs and issues, with respect to specialized services and particular regional needs;
- ♦ Identification of regional service providers' key issues with respect to the impact of specialized sexual assault services' (or their lack) on individuals, communities and systemic outcomes;

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- ♦ Recommendations for preventing and addressing the harms of sexual violence, based on the assets and gaps identified through the research.

## 1.3 Methodology

This section provides an overview of the needs assessment methodology. Methods used to gather information include: (1) a literature review of the prevalence of sexual violence in Nova Scotia; (2) an environmental scan of current sexual assault services; (3) interviews and surveys to gather information from service providers; and (4) interviews and a literature review of Nova Scotia research to identify survivors' needs and issues. Recommendations are based on the findings of the needs assessment and were reviewed and approved by the needs assessment planning group.

### 1.3.1 Literature Review

Review of the prevalence of sexual violence in Nova Scotia relied on government statistics compiled both federally and provincially, as well as the Annual Reports of the Avalon Sexual Assault Centre and the Colchester Sexual Assault Centre. Additional statistics were provided by regional Department of Justice Victims Services' managers and the Antigonish Women's Resource Centre. Review of the periodical literature on core service components and best practices in sexual assault services was conducted using social science databases available through the Novanet system.

### 1.3.2 The Environmental Scan

The environmental scan of the current provision of sexual assault services in the province was undertaken by identifying a network of service providers expanding out from the Planning Group. The first circle of participants included the two provincial organizations whose specific mandate is sexual assault services, Avalon Sexual Assault Centre and Colchester Sexual Assault Centre, and agencies that were members or branches of provincial or regional entities explicitly serving victims of gendered violence which were: transition houses, women's centres, the Sydney Interagency on Family Violence, and Department of Justice Victim Services. These initial participants were interviewed for information about their services and community.

The second circle of identification and participation included mental health professionals, other medical professionals, police, addictions service providers, sexual health centres, counsellors in educational settings, and others. These were identified by the first circle of participants as known to possess relevant expertise and to be helpful to sexual assault survivors.

A third circle of identification and participation included agencies that were not directly identified by previous participants as survivor-centred or necessarily even sexual assault service providers, but were regarded as influential in individuals' and communities' experience of sexual violence, or as partners in community leadership in addressing sexual violence. These included Crown attorneys, provincial service managers, child welfare professionals, police and others.

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### 1.3.3 Identification of Survivors' Key Needs and Issues

The identification of survivor's key needs and issues was made on a "first voice" basis – in the words of Nova Scotia survivors themselves. Six client survivors were referred by members of the Planning Group for interviews, of whom four participated in an interview. Limited participation by survivors is likely caused by the stigma experienced in the role of "survivor," the stress of recounting experiences in interviews, and the burden placed on referring agencies to provide emotional support to survivors' participating in interviews. These factors hinder referrals and participation in research with sexual assault survivors.

In addition, survivors' voices in prior Nova Scotian research were carefully reviewed. More than 170 survivors participated in the following four reports:

- ♦ *Beginning With Us: A Community Response to sexual Assault and Sexual Abuse in Antigonish County* (1994) (Sponsored by the Antigonish Women's Association; project staff Lucille Harper, Ellen King, funded by Nova Scotia Department of Justice, Victim Services)
- ♦ *Can No One Hear My Cry? Sexual Assault in Cape Breton* (1997) (Cape Breton Sexual Assault Coalition)
- ♦ *Kings/Annapolis Women's Project: Survivors of Sexual Abuse/Assault* (1994) (sponsored by Valley Health Service Association, funding by Victim Services)
- ♦ *Survivors Speak Out: Women Who Have Experienced Sexual Violence Share Their Ideas, Opinions and Perspectives about Agencies and Services in Pictou County* (1996) (Pictou County Women's Centre, funded by Women's Program, Dept. of HR)

### 1.3.4 Identification of Regional Service Providers' Key Issues

Regional service providers were identified through the environmental scan and an invitation was extended to participate in the needs assessment. Their key issues were identified through interviews and/or emailed questionnaires.

Multi-agency discussion groups were conducted for service providers with a commitment to survivor services. The discussion groups were held in rural areas to ensure their voice was included in the report recommendations for provincial planning for services. These areas included: Bridgetown (for Annapolis/Kings); Sheet Harbour (for eastern HRM/Guysborough); Port Hawkesbury (for Richmond/Inverness); Truro; and Yarmouth.

Individuals participated from the following offices and organizations<sup>1</sup> in individual interviews, questionnaires and/or discussions (one participant per organization unless otherwise indicated):

- ♦ Antigonish Women's Resource Centre (4 participants including women's centre staff, physician, Lindsay's Health Centre for Women and Nurse Manager, SANE program);
- ♦ Autumn House

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<sup>1</sup> Individuals' opinions do not necessarily reflect the official position or policies of their organization.

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- ♦ Avalon Sexual Assault Centre (7 participants)
  - ♦ Cape Breton Centre for Sexual Health
  - ♦ Cape Breton Interagency on Family Violence
  - ♦ Cape Breton Regional Municipality Police Department
  - ♦ Cape Breton Transition House
  - ♦ Central Nova Women's Centre (2 participants)
  - ♦ Children's Aid Society of Inverness Richmond
  - ♦ Chrysalis House
  - ♦ Colchester Sexual Assault Centre
  - ♦ Eastern Shore Memorial Hospital (2 participants)
  - ♦ Every Woman's Centre
  - ♦ Harbour House
  - ♦ Juniper House (Yarmouth)(2 participants)
  - ♦ Juniper House (Digby outreach office)
  - ♦ Lea Place (2 participants)
  - ♦ Leaside Transition House (2 participants)
  - ♦ Mental Health<sup>2</sup>, Sydney
  - ♦ Mental Health, Port Hawkesbury
  - ♦ Mi'kmaw Family and Children's Services
  - ♦ Naomi Society
  - ♦ Pictou County Women's Centre
  - ♦ Public Prosecution Service<sup>3</sup>
  - ♦ Second Story Women's Centre
  - ♦ Sexual Health Centre for Cumberland County
  - ♦ Sexual Health Centre Lunenburg County
  - ♦ Sheet Harbour High School (counsellor)
  - ♦ Survivors of Abuse Recovering Society (SOAR) (Annapolis/Kings)
  - ♦ The Women's Place (2 participants)
  - ♦ Tricounty Women's Centre
  - ♦ Truro Police, Victim Services
  - ♦ Victim Services, Department of Justice, provincial manager
  - ♦ Victim Services, Department of Justice, regional managers (5 participants)

### 1.3.5 Developing Recommendations

Once all the information was gathered, the researcher drafted recommendations for the review of the Planning Group, consistent with input from the Planning Group given in a series of meetings held in Antigonish over the course of the research. These recommendations were reviewed and unanimously approved by the Planning Group.

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<sup>2</sup> Service providers from Nova Scotia Department of Health Mental Health services participated in their personal capacities. No service providers identified any specialized services offered to sexual violence survivors through Mental Health services. Requested identification of any specialized mental health services to survivors for this report had not been received from the Department of Health as of August 2008.

<sup>3</sup> The Public Prosecution Service participated as an organization in this needs assessment, submitting a response on behalf of all members.

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## 2. Sexual Violence in Nova Scotia – Prevalence and Impact

This section provides a definition of sexual violence used for this research, an overview of the prevalence of sexual violence in Canada and Nova Scotia based on survey reports and data from specialized services (sexual assault centres) and non-specialized services, and an overview of the various impacts of sexual violence from the literature review and interviews with Nova Scotians.

### 2.1 Definition of Sexual Violence

The definition of sexual violence used in the Federal-Provincial-Territorial Ministers Responsible for the Status of Women's 2002 report *Assessing Violence Against Women: A Statistical Profile* is:

“Any form of non-consensual or forced sexual activity or touching, including rape...”

This is the definition of sexual violence used throughout this report. It should be noted that this report purposefully refrains from discussing classes of sexual violence, or categorizing sexual violence according to “seriousness.” This is because survivors’ needs and experience do not necessarily correlate with (particularly justice system) professionals’ estimations of what are “high-end” or “low-end” offences. Survivors may experience a high degree of trauma from non-penetrative sexual touching, for example, depending on the circumstances, yet these offences are typically categorized as less serious by justice professionals.

This report assesses the need for sexual assault services using a survivor-centred approach, which is a different orientation than that which gives rise to the high or low-end categorizations that the justice or other systems may find useful in addressing offences and perpetrators.

### 2.2 The Prevalence of Sexual Violence

Information on the prevalence of sexual violence was gathered from surveys and reports, reports to police in Nova Scotia; estimates of the percentage of all sexual violence that is reported to police; figures and estimates from general service providers regarding the portion of their clients addressing a sexual violence issue; and figures from specialized sexual assault service providers.

#### 2.2.1 Surveys and Reports

The following surveys and reports were reviewed to estimate the extent of sexual violence: the 1993 Violence Against Women Survey and the 1999 and 2004 General Social Surveys.

The Violence Against Women Survey (VAWS) (1993) estimated sexual assault (other than sexual violence as part of partner assault) as having been experienced by 35% of Nova Scotia

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women over age 18. The number of (non-partner) sexual assaults that have been experienced by Nova Scotia women over 18 was estimated at 122,000. The VAWS provided detailed national data on all forms of sexual and physical violence perpetrated by men against women. Provincial data was generated, based on random selection, with 1012 Nova Scotia women participating.

The 1999 General Social Survey on Victimization (GSS 1999) and the 2004 General Social Survey on Victimization (GSS 2004) used a different methodology to assess individuals' experiences of different crimes, and can't be used to identify trends in comparison with VAWS 1993. The GSS 1999 reported that 33 of every 1000 or 3.3% of those 15 and over reported being a victim of sexual assault. Among men, 8 of every 1000 or .8% reported sexual assault victimization.

In the GSS 2004, the incidence increased to 40 per 1000 or 4% of those 15 and older. Nova Scotia was one of only two provinces in which the victimization rate increased over 1999 levels. The Canadian average in 2004 was 35 per 1000 or 3.5% of those 15 and older.

The GSS 1999 reported that nearly 20% of women in relationships, who experienced spousal violence in the previous five years, had experienced sexual violence by a partner. In the same report, the incidence was 33 of every 1000 or 3.3% for men in relationships who experienced sexual violence by a partner. A similar level of victimization continued in the GSS 2004 data<sup>4</sup>.

In 2006, the population of Nova Scotia of those aged 15 and over was approximately 756,595. Using these numbers and the GSS 2004 victimization data, it can be conservatively estimated that sexual violence has been experienced by at least 30,000 Nova Scotians age 15 and over, the large majority of whom are female. (It should be noted that this estimate is conservative and significantly lower than the VAWS 1993 estimates due to differing methodologies.)

Because victimization surveys ask a sample of the population about their personal crime experiences, they capture unreported crimes as well as those reported to the police. The number of unreported crimes can be substantial. In the GSS 1999, 78% of those who reported sexual assault, confirmed that their victimization was not reported to police. An additional 14% did not indicate or did not know whether their sexual assault was reported. The percentage who said they reported their sexual assault to police was listed as "too small to be expressed." This pattern continued in the GSS 2004, with only 8% indicating they reported the sexual assault to police

Rural and urban sexual violence was unique among victimizations in GSS 1999. Rural females did not report a lower rate of victimization with respect to sexual assault compared to urban females as compared to other crimes; for example, rural females reported lower

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<sup>4</sup> The low level of charging of violent partners for sexual violence instead of common assault may be leading to erroneous assumptions and planning with respect to the prevalence of sexual violence in Nova Scotia. According to the *Nova Scotia Family Violence Tracking Project Phase 3: 2000 to 2003*, (December 2006) less than 1% of charges for partner violence were for sex offences. In contrast the General Social Surveys indicate sexual violence by violent partners affecting close to 20% of domestic violence victims, so it is likely that sexually violent partners and their victims are not now being identified through justice system responses to domestic violence.



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rates of robbery and common assault as compared to urban females. This makes it easier to estimate sexual violence survivors per capita across Nova Scotia's urban and rural jurisdictions. However, it is important to plan for higher than average needs in areas with a higher-than-average university-age population, such as Antigonish.

In 2004, 820 sexual assaults were reported to police in Nova Scotia as described in the Nova Scotia Advisory Council's report, *Sexual Assault in Nova Scotia: A Statistical Profile (December 2005)*. With the level of reporting for 2004 at 8% (GSS 2004), this could indicate the presence of close to 9000 unreported sexual assaults for the year 2004. Data is not readily available with respect to how many reports relate to historical and recent assaults.

### 2.2.3 Specialized Sexual Assault Service Providers – Sexual Assault Centres

In 2006-2007 Avalon Sexual Assault Centre in Halifax and Colchester Sexual Assault Centre in Truro received over 1000 requests for information, support and services.

Avalon Centre fielded 728 office calls<sup>5</sup>, primarily from survivors seeking information or services. Slightly over 15% of calls were from non-offending parents or partners of survivors. Therapeutic counselling was provided to 226 clients by Avalon. Colchester Sexual Assault Centre in Truro, while not able to provide therapy, did provide other support to 325 clients in 2006-7.

In 2007, Avalon Centre's statistics show that the great majority of requests for counselling services related to historical assault, with 76% of intake calls related to childhood sexual abuse.<sup>6</sup> In the same year, 15% of all calls were related to recent adult sexual assault and only 6% of requests for counselling services were related to recent assaults.

Another indicator of the prevalence of new adult assaults each year is the number of individuals seen by Avalon's Sexual Assault Nurse Examiner (SANE) program. Individuals access the SANE program only for recent assault (72 hours). They numbered 101 and 98 for 2005-6 and 2006-7 respectively. It is unknown what percentage of recent survivors this represents as, based on the GSS data, those survivors reporting are only a small fraction of the overall number of survivors. It is unknown what percentage of recent survivors in serviced areas (HRM and GASHA) are accessing SANE programming.

### 2.2.3 Non-Specialized Agencies

Another way of estimating the magnitude of sexual assault prevalence is to estimate what percentage of help-seeking clients at a variety of non-specialized agencies have experienced sexual violence.

According to these agencies, many survivors initially present with other issues such as anxiety, depression, substance dependency, other interpersonal violence or are coming in for generalized programs (e.g. self-esteem, anger management). They find that, only after trust is established with the service provider, will the survivor disclose sexual violence as their issue

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<sup>5</sup> This number does not include calls for intake, or with existing therapy clients.

<sup>6</sup> Some of these callers also had experienced sexual violence as an adult.

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of greatest concern. In this research, service providers from non-specialized agencies reported that 30-75% of clients followed this pattern. For example, Every Woman's Centre in Sydney supported approximately 2500 clients in 2006-7, and estimates that 30% or more have disclosed experiencing sexual violence. Furthermore, the centre reports that 50% of those, who directly disclose sexual assault to the centre, are dealing with a childhood sexual abuse issue.

There is generally a lack of hard statistics regarding those directly seeking services to address sexual violence outside the sexual assault centres, although informal counts for 2007 were provided by the Antigonish Women's Resource Centre and Victim Services. The Antigonish Women's Resource Centre reported 41 clients identifying a sexual assault as an adult, with 17 of these also identifying childhood sexual abuse. The New Glasgow Victim Services office reported 65 sexual offense files opened in the year.<sup>7</sup>

As we know from the GSS surveys, these counts are not indicative of existing need. Victim Services files represent a fraction of a fraction of survivors – only those cases where the justice system is proceeding with charges and seeking a conviction, a smaller subsection of the already small 8% of survivors who report according to the GSS 2004 survey.

Furthermore, the Antigonish Women's Resource Centre's client count is part of a service that self-limits by not aggressively promoting survivors' services due to fear of being unable to handle the response as well as lack of promotional resources. The issue of adequate resources was found to be the case for all women's organizations currently providing services to sexual assault survivors. It is unknown what responses would arise from the population if there were well-resourced comprehensive publicity for sexual assault services.

## 2.3 The Impact of Sexual Assault in Nova Scotia

Why tackle sexual assault? What makes addressing the needs of sexual assault survivors so key to individual and community well being? Much data of the last thirty years establishes that there are severe short and long term impacts associated with sexual violence<sup>8</sup>.

Meta-analysis of the many studies respecting sexual violence definitively confirms severe negative impacts on emotions, self-perceptions, interpersonal relating and social functioning, physiological well-being, safety, and self-care for many survivors<sup>9</sup>.

Specific impacts noted in these reviews and elsewhere include:

- ♦ Greatly increased suicide behaviours and suicide risk (Wurr & Partridge 1996; Martin *et al* 2004; Wagner 1997);<sup>10</sup>

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<sup>7</sup> Among new cases opened Sept 01/06 to August 31/07, 65 sexual offense files were opened through the New Glasgow Victim Services office (serving Pictou, Guysborough, Antigonish, Colchester and Cumberland counties). Out of the 65 cases, 14 cases were older offense dates and 51 were more recent. 45 were clients 16 years of age or older (at the time of referral). (Source: Regional Manager)

<sup>8</sup> Several empirical reviews have established that sexual violence is associated with a host of immediate (Kendall-Tackett, Williams, & Finkelhor, 1993) and long-term negative effects (Jumper, 1995; Neumann, Houskamp, Pollock, & Briere, 1996; Briere, Runtz (1993); Romito *et al* (2005). See also Davis & Petretic-Jackson (2000) and Beitchman *et al.*, 1992).

<sup>9</sup> Dagang (1997; Davis & Petretic Jackson (2000a); Brown & Finkelhor (1986)

<sup>10</sup> As reported in Warne & McAndrew (2005), the odds of suicide attempt for sexually abused women is 2-4 times that of non-abused women and for men it is 4-11 times more. A study carried out by Martin *et al.* (2004) found that adolescent girls who reported current high levels of distress about sexual abuse have a threefold increased risk of suicidal thoughts and plans compared with non-abused girls. Adolescent boys who

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- ♦ Self-harming and self-mutilation (Harris 2000; Hawton 2000);<sup>11</sup>
  - ♦ Dissociation;
  - ♦ Sense of isolation and stigma;
  - ♦ Anxiety;
  - ♦ Sexual dysfunction (Meston Rellin Heiman 2006; Finkelhor & Browne 1985);
  - ♦ Sleep disorders (Westerlund 1992);
  - ♦ Physical health effects (Cambre et al 1998; Chartier et al 2007; Leserman et al 2007);
  - ♦ Criminalization (Cernkovich et al 2008; Silbert & Pines 1981);
  - ♦ Substance abuse (Pearce et al 2008 ; Ducci et al 2008; Liebschutz et al 2002; Westerlund 1992);
  - ♦ Revictimization (Krahe et al 1999; Finkelhor & Browne, 1985);
  - ♦ Reduced earning power (Hyman 2000);
  - ♦ Low self-esteem and self-concept impairment;
  - ♦ Depression (Alexander 2007);
  - ♦ Self-blame, guilt, and helplessness;
  - ♦ Posttraumatic stress responses (Alexander, 1993; Finkelhor, 1988; Rowan, Foy, Rodriguez, & Ryan, 1994);
  - ♦ Obsessions and compulsions;
  - ♦ Increased risk of homelessness (Browne 1993);
  - ♦ Diminished later life functioning (over age 60) (Higgins 2000).

Nova Scotia survivors participating in this research and in the four previous reports<sup>12</sup> identified many of the above serious, long-term effects in their lives and a lack of services to deal with them. The following are quotes from the interviews and the reports:

*I wasn't sleeping. I was having terrible...effects from [the assault]. I found it did take a lot out of me. I keep a watch out. I do feel sometimes I am a prisoner in my own home. I still have flashbacks of it. (Sexual Assault Needs Assessment interviews, 2007)*

*People can't understand the repercussions – it's not just an isolated act but affects the rest of your life, your whole life, your family life, every part of your life. The way you look at things – it affects everything. One day you just crash and it hit me to the point where I couldn't function. I didn't deal with it. I didn't know what it was. I thought it would just go away. But one day it just attacked and said I am not going away, so you better deal*

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had been sexually abused and who report current high levels of distress had a 10-fold increased risk of suicidal plans and threats and a 15-fold increased risk of suicide attempts compared with non-abused boys.

<sup>11</sup> As reported by Warne and McAndrew (2005): when those who self-harm, especially women, come into contact with mental health services they are diagnosed as having a Borderline Personality Disorder (BPD), are often labelled by professionals as difficult and demanding, are viewed pejoratively and seen as beyond help. The medical and nursing response to this group of clients is often one of impatience, frustration and hostile care. (Harris 2000)

<sup>12</sup> The four reports are: *Beginning With Us: A Community Response to sexual Assault and Sexual Abuse in Antigonish County* (1994) (Sponsored by the Antigonish Women's Association; project staff Lucille Harper, Ellen King, funded by NSDoJ, Victim Services); *Can No One Hear My Cry? Sexual Assault in Cape Breton* (1997) (Cape Breton Sexual Assault Coalition); *Kings/Annapolis Women's Project: Survivors of Sexual Abuse/Assault* (1994) (sponsored by Valley health Service Association, funding by Victim Services); *Survivors Speak Out: Women Who Have Experienced Sexual Violence Share Their Ideas, Opinions and Perspectives about Agencies and Services in Pictou County* (1996) (Pictou County Women's Centre, funded by Women's Program, Dept. of HR)

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*with this because I am going to take you down. I was a mess, I didn't know where to turn; I was having flashbacks. Numbing [myself with] more alcohol, more drugs, more pills. It doesn't go away by itself. You don't have the resources yourself.* (Sexual Assault Needs Assessment interviews, 2007)

*I can't explain it but it did something to my mind. I was a top student till then. That year I dropped out of school.* (Cape Breton Sexual Assault Coalition report, 1997).

*I thought I was taking on a split personality. I couldn't function in groups. I couldn't look people in the eye. I thought I was losing it.* (Pictou County Women's Centre report, 1996)

*My body isn't mine – it's not valuable. So how about I just go have sex with this one, that one, how about I just go do whatever...it doesn't matter. And if they do something to me, that's normal, that's what I saw growing up... I feel I had so much potential, I feel like they stole something from me, stole a lot from me.* (Sexual Assault Needs Assessment interviews, 2007)

*I wanted to kill myself...I can't function. I can't even leave the house, what's the sense in living?* (Pictou County Women's Centre report, 1996)

*I would get really paranoid and the last thing I would want is food. It's almost as if the mind wants to harm the body by not eating. I still get this way when I am stressed out, having a lot of flashbacks.* (Cape Breton Sexual Assault Coalition report, 1997)

*I couldn't look at anyone in the face. I never felt so isolated. How empty I felt. No one knew. I was sore. I was alone. To tell was mortifying let alone to have them blame me.* (Cape Breton Sexual Assault Coalition report, 1997)

*It's been two years since I left my job and been diagnosed [with PTSD]. It is no better today than that very day.* (Sexual Assault Needs Assessment interviews, 2007)

*I've been severely depressed lately. Not wanting to shower. I've never seen myself like this before. Binge [drinking] and throwing up. I'm so frozen inside, I can't do anything. I don't want nobody near me.* (Sexual Assault Needs Assessment interviews, 2007)

*It takes a toll on you physically, mentally. I've had enough. If my children were older I would give up [commit suicide]...I have those days [where I can take care of myself but] there is no constant support and I can't do it myself* (Sexual Assault Needs Assessment interviews, 2007)

Additionally, sexual violence has the potential to indirectly affect those who are important in the lives of survivors— partners, children, and friends. (Fisher & Lazarus 2006; Polusny & Follette, 1995). The trust required to form interpersonal bonds can elude survivors, hindering intimate relationship with others. (Finkelhor & Browne, 1985). Those who surround the survivor may also be vicariously traumatized by the sexual violence experienced by someone they care for, and/or by their inability to prevent it or heal the survivor.

Survivors' disclosures of sexual violence committed by family members, or trusted community members, can tear apart those same families and communities. It results in secondary wounding and lack of support for survivors. A Nova Scotia example is that of the

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impact on the Sheet Harbour area of the assaults and conviction of a doctor (and former educator) there, as described by a local service provider:

*There are bigger repercussions of what's happening. It creates and manifests its own issues. His wife was one of my best friends. His daughter is one of my daughter's best friends. He [attended the] birth of both of my children. He was my doctor. There are those that believe he is guilty and those that can't even fathom that he was found guilty and lost his license.*

*Those who came forward are all young men, [some] are drug addicts and having addiction issues; they all made bad choices in their lives. Some of [our young adults] are in jail and then that age group, you can see... When it was published in the paper, you picture those who were probably his patients and those that haven't come forward and have made the same kind of lifestyle choices or [have] addictions issues...you just look at the age group and think "Isn't that interesting he has been a patient of his" and so it doesn't take long to recognize probably why he is so messed up in the head or has addiction issues. Probably he is a victim but he would have to come forward [to try to get help].*

*And sometimes it is just hard to see [hidden impacts from the outside] but actually, [you see it in the] parents. I would see the mother [of a victim] and I would support the mother a couple of times.*

*One of the RCMP officers gave a character reference for the doctor. But yet [the RCMP officer] knew what he had done. Ahhh...it is a big spider web and gets all entangled, I think because of the small community dynamics. There are wonderful things about small communities but when you get something like sexual assault...whoa! And I think for a lot of people, they are sad because it didn't go all the way through. So why [would more people] come forward if you know nothing happens. Or he gets a conditional sentence...he got an 18 month conditional sentence, to stay in his home.*

Researcher: So did the Province ever respond in a specialized way considering the number of victims in one location? Response: *No*

Researcher: How many victims do you think that one person had? Response: *30 victims plus. I just look at the all the young kids here that are messed in the head – I'm not saying they're all his victims, but I tell you – a might some are.*

Researcher: What is the population of this community? Response: *Three thousand.*

In the absence of a comprehensive response, sexual violence will continue to generate high psychological, social and financial costs to communities and survivors.



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## 3. Components of a Comprehensive Response & Services Currently Available in Nova Scotia

This section examines the components of a comprehensive response based on a review of core services in Europe, Ireland, England and Wales, the United States and Australia and provides an overview of the services available in Nova Scotia identified through the needs assessment.

### 3.1 Components of a Comprehensive Response to Sexual Violence

It is recognized that the best response to sexual violence is a comprehensive one based on the uniform provision of basic core services that encompass personal healing, education, prevention, and advocacy work working synergistically in communities to address root causes and harms of sexual violence.

Response was recently reviewed and enhanced in Ireland. There, while services may vary between centres, principal services always include the following:<sup>13</sup>

- ◆ Telephone helpline (24hrs a day 365 day per year at the Dublin Centre);
- ◆ Counselling, advice and advocacy services;
- ◆ Medical accompaniment;
- ◆ Justice system accompaniment;
- ◆ Training for other professionals;
- ◆ Research and awareness raising campaigns.

Ireland's best practice model for the delivery of services to survivors starts with a dedicated sexual assault centre to house the comprehensive services in one place, staffed with<sup>14</sup>:

- ◆ Director/ Coordinator/ Manager;
- ◆ Education/ Outreach worker;
- ◆ Advocacy worker, to meet the non-counselling needs of survivors;
- ◆ Administrator;
- ◆ 5 full time counsellors to support each 100,000 -150,000 population.

The services provided by sexual assault centres in England and Wales are similar to those in other European countries and include<sup>15</sup>:

- ◆ Telephone Helpline
- ◆ Counselling
- ◆ Hospital advocacy

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<sup>13</sup> Development of Funding Model for Rape Crisis Centres in Scotland: Final Report to Rape Crisis Scotland; April 2008

<sup>14</sup> Ibid.

<sup>15</sup> Ibid.

- ♦ Justice system advocacy
- ♦ Support groups

The presence of core services in sexual violence responses is similar across comparably developed nations in Europe. Three EU examples include Germany, Poland and Finland, and non-EU Switzerland, whose service models were recently reviewed in the development of improved service models in the United Kingdom. Table 1 shows these examples.

In the United States and Australia, jurisdictions have developed blueprints for sexual violence response which typically include core elements provided through sexual assault

**Table 1: Core Sexual Assault Services: EU and Switzerland examples**

Country	Germany	Switzerland	Poland	Finland
<b>National Organization</b>	Bundesvernetzungsstelle autonomer Frauennotrufe	Viol- secours – Geneva	Poland Women's Rights Centre Centrum Praw Kobiet	Tukinainen
<b>Established</b>	1999	1985		1993
<b>Principle activities of local and national organizations</b>	<ul style="list-style-type: none"> <li>- Information/ advice from qualified staff</li> <li>- Support / encouragement in coping with the experience</li> <li>- Therapies</li> <li>- Self help groups</li> <li>- Stand-by advice and support at court</li> <li>- Publicity</li> <li>- Education</li> <li>- Networking</li> </ul>	<p><b>Support</b></p> <ul style="list-style-type: none"> <li>- Telephone helpline</li> <li>- Individual/ group counselling</li> <li>- Art therapy</li> <li>- Accompaniment (where necessary including legal, medical, social and personal steps)</li> </ul> <p><b>Prevention</b></p> <ul style="list-style-type: none"> <li>- Self Defense</li> <li>- Interactive internet site aimed at adolescents &amp; dealing with date rape</li> <li>- Talking to schools</li> <li>- Research</li> <li>- Lobbying</li> </ul>	<ul style="list-style-type: none"> <li>- Telephone Helpline</li> <li>- Telephone Counselling</li> <li>- Face to face counselling</li> <li>- Refuge</li> <li>- Legal support</li> <li>- Advocacy</li> <li>- Information</li> </ul>	<ul style="list-style-type: none"> <li>- Crisis Telephone Helpline</li> <li>- Legal consultation Telephone Helpline</li> <li>- Open/ fixed therapeutic groups</li> <li>- Individual therapy (with opportunity to write/ tell their story)</li> </ul>
<b>Major Funders</b>		<ul style="list-style-type: none"> <li>- State of Geneva,</li> <li>- Geneva City Council,</li> <li>- Municipalities,</li> <li>- Private Donors and Members</li> </ul>		Finish Slot Machine Association

(Source: Rape Crisis Europe and Rape Crisis Scotland (2006) The Newsletter of Rape Crisis Scotland: International Issue, autumn 2006)



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centres directly or through their community leadership<sup>16</sup>. Components of blueprints for comprehensive sexual violence response commonly include:

- ◆ Dedicated sexual assault centre
- ◆ Access to information/options
- ◆ Public education
- ◆ Professional Education
- ◆ Prevention programming
- ◆ Specialized supportive counselling
- ◆ Specialized therapeutic counselling
- ◆ Specialized support for vicarious trauma of service providers
- ◆ Coordination among responders (SART team or other protocols)
- ◆ 24-hour crisis line for sexual violence
- ◆ On-call advocates
- ◆ Accompaniment in justice, medical and other systems
- ◆ SANE program
- ◆ Updated online program directory
- ◆ Policy development
- ◆ Social change advocacy
- ◆ Cultural competency programming
- ◆ Data collection

### 3.2 Specialized Sexual Assault Services – What is Currently Available in Nova Scotia

Nova Scotia lacks a planned strategy to address sexual assault, and lacks nearly all the components that typically comprise a comprehensive response in other jurisdictions. Communities struggle in isolation to address this major problem. This has resulted in an ad hoc patchwork of attempts to meet Nova Scotians' needs without planning or resources. Most core services are not available in Nova Scotia. While some services are available in some areas, these are not congruent with the level of population need, are often not accessible, and are not stably funded.

Tables 2A and 2B show an overview of available services by county. The services in the left hand column were identified through the environmental scan as core components of a

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<sup>16</sup> See for example, Oregon, *Sexual Assault Task Force Oregon: A Collaborative Approach to Address Adult and Adolescent Sexual Assault in Oregon*, 2006 [http://www.oregonsatf.org/documents/Campus\\_SA\\_Guidelines\\_Final.pdf](http://www.oregonsatf.org/documents/Campus_SA_Guidelines_Final.pdf) ; Michigan, *The Response to Sexual Assault: Removing Barriers to Services and Justice: The Report of the Michigan Sexual Assault Systems Response Task Force*, 2001 <http://www.mcadsv.org/products/sa/TASKFORCE.pdf> ; Queensland, *Response to sexual assault: Interagency guidelines for responding to adult victims of sexual assault* 2001, <http://www.health.qld.gov.au/violence/sexual/16005.pdf>

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comprehensive response. A “Y” indicator on the chart represents “yes” which means there is a stable service available that is adequate for the population. Where there is a “blank” in the table, the service is not available at all. The “P” indicator represents “partial,” which means the service is either tenuous due to lack of stable resources or not adequate for the population, or both.

A review of services by county reveals that only the provision of general information is uniformly present at an adequate level. Even the most fully serviced area, Halifax, provides only several of the principle services identified in the previous section (Section 3.1) and several of these are not permanently or publicly funded (e.g. survivor accompaniment services, professional education services). For basic survivor support and therapy, where available, staffing is not adequate for the size of victimized population. This includes the Avalon Sexual Assault Centre, the only full time sexual assault centre in the province, and the only source of no-cost specialized therapy for survivors. Avalon is facing staff loss and service reductions due to inadequate funding for specialized therapy. With respect to accompaniment for survivors, this is available on an ad hoc basis only in most areas and on a trial basis only in Halifax, ending in 2009. Public education projects are only occasionally delivered due to lack of resources. Professional education is limited by funding as well, with requests for specialized training going unfulfilled. A crisis line response, on-call response and advocacy for survivors, targeted data collection, and other specialized services are virtually unavailable in the province.

The details of the current need for these various aspects of a comprehensive response to sexual violence in Nova Scotia are discussed in subsequent chapters of this report.

### 3.3 Comprehensive Response to Sexual Violence and Achieving Government Goals

A comprehensive response to sexual violence is necessary to meet stated government goals across various sectors.

Addressing sexual violence is essential to the goals of the Nova Scotia Advisory Council on the Status of Women, in particular that of *Women’s Personal Safety and Freedom from Violence*, one of four key programs in the Council’s mandate<sup>17</sup>.

Addressing sexual violence is also essential to the goals of *A New Nova Scotia: A Path to 2020*, and specifically to the priority area of safer, healthier communities as expressed in *Time to Fight Crime Together: Our Strategy to Prevent and Reduce Crime*. Of its five goals, four require a comprehensive community-based response to sexual violence as follows:

- ◆ People are and feel safe and secure in their homes and communities.
- ◆ Those in conflict with the law are held accountable.
- ◆ The frequency and severity of offending and victimization are reduced.
- ◆ Communities and individuals are actively involved in creating a safer Nova Scotia.

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<sup>17</sup> *Nova Scotia Advisory Council on the Status of Women, Business Plan 2008-2009.*

**Table 2A - Overview of Specialized Sexual Assault Service Provision in Nova Scotia by County**

Specialized Sexual Violence Service:	County								
	Cape Breton	Victoria	Inverness	Richmond	Antigonish	Guysborough	Pictou	Cumberland	Colchester
Public Education	P	P			P	P			P
Professional Education				P	P	P			P
SA Crisis Line									
On-call Advocates					P				
SANE				Y	Y	Y			
Publicity Programs for specialized services									
Information	Y	Y	Y	Y	Y	Y	Y	Y	Y
Accompaniment	P	P	P	P	P	P	P	P	P
Basic survivor support	P	P	P	P	P	P	P	P	P
Specialized therapy									
SA Policy development									
Social change work geared specifically to SA	P				P				
Dedicated SA Centre									Y
Intersectoral data collection system									
Sexual Assault Response Team					Y				

**Table 2B- Overview of Specialized Sexual Assault Service Provision in Nova Scotia by County**

Specialized Sexual Violence Service:	County								
	Hants	Kings	Annapolis	Digby	Yarmouth	Shelburne	Queens	Lunenburg	Halifax
Public Education									P
Professional Education									P
SA Crisis Line									
On-call Advocates									
SANE									Y
Publicity Programs for specialized services									
Information	Y	Y	Y	Y	Y	Y	Y	Y	Y
Accompaniment	P	P	P	P	P	P	P	P	P
Basic survivor support	P	P	P	P	P	P	P	P	P
Specialized therapy							P	P	P
SA Policy development									P
Social change work geared specifically to SA									P
Dedicated SA Centre									Y
Intersectoral data collection system									
Sexual Assault Response Team									P

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Desired outcomes of the *Time to Fight Crime Together* strategy include “more support for victims” through specific interventions including a “stronger response to family violence and violence against women.”

Stated goals of the Health, Health Promotion and Protection, Education, and Justice departments also require addressing the lack of a comprehensive, community-based response to sexual violence in the province:

- ♦ *Health*: A comprehensive community-based response to sexual violence accessible to all Nova Scotians is congruent with the government’s commitment, expressed in its *Response to the Provincial Health Services Review 2006-2007* to “offer a range of community-based services to enable children, youth, adults, and seniors to maintain their mental and physical health and receive care close to home, in their own communities.”
- ♦ *Health Promotion and Protection*: The Youth Framework for Actions on Sexual Health provides that “in order to make a successful and sexually healthy transition from childhood to adulthood, young people need supports and resources to help them learn about...gender roles and expectations [and] **sexual assault, sexual coercion, and sexual exploitation.**”
- ♦ *Education*: Goals of the Nova Scotia Department of Education 2007-2008 Business Plan include “promoting healthy active learning communities” and fostering “access, equity and diversity through education...” Sexual violence disproportionately affects the school-aged population. A comprehensive response to sexual violence, including an education-based prevention strategy, will be needed to achieve this goal
- ♦ *Justice*: The 2007-2008 Business Plan for the Nova Scotia Department of Justice includes within its planning context the increase of “support services for victims of family violence, intimate partner violence and **sexual assault** through a **comprehensive approach based on partnerships within government and with community agencies**” and states: “We will develop information and approaches to change societal attitudes and misconceptions about family violence and **violence against women.**”



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## 4. The Need for Prevention Programs

Participants in this research were asked to identify what would prevent sexual violence in their community. The following themes emerged through their responses:

- d) *Education* was the nearly universal response, including public, professional, and school-based programming.
- e) *Advocacy* was emphasized by women's organizations and survivors who noted the importance of challenging community and institutional norms that assume and condone male power over women and girls. This was seen as key to eliminating the root causes of violence. This encompasses work addressing gender power imbalances connected to poverty, and the multiple forms of discrimination that make women and girls the main targets of sexual violence.
- f) *An effective justice system* was mentioned by a minority of participants, including some survivors who emphasized it was important to prevention.

This section reports on what was said in each of the above areas by research participants and through previous studies.

### 4.1 Education and Prevention

This section focuses on what survivors and service providers, participating in this needs assessment, said about the need for public education and school-based programs. It also summarizes the issues raised by survivors and service providers in four previous Nova Scotia studies and the recommendations made in those studies related to education as a tool for prevention.

#### 4.1.1 The Need for Public Education

Service providers in this research strongly emphasized the need for public education to prevent sexual violence. They described ongoing community denial, victim-blaming, trivialization, and normalization of sexual violence. They pointed out that there is no provincial public education strategy with respect to sexual violence and, in the gap, lacking access to quality education, the public is receiving a lot of its information on sexual assault from the media, which may not be reliable, and may perpetuate myths and stereotypes. They emphasized that community knowledge about what constituted sexual assault was limited as follows:

*A lot of people don't understand that any unwanted sex is an assault. If it is a husband or a partner they don't understand they have been sexually assaulted. - Yarmouth*

*Barriers? Part of it, is not even knowing what is a crime. - victim services manager*

*There is a huge amount of room for the public to be made aware of what is going on and to be made aware that any form of sexual assault or abuse is illegal. Especially where the husband or boyfriend gets drunk and comes home and...he rapes his partner. She says,*

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*“What am I going to do? He was drunk.” So I don’t think there is an awareness of that [as sexual violence] in Cape Breton in general. - Sydney*

*I see the younger women really being confused on what sexual violence is, and what they are doing because they want to and what they are doing because of pressure or because of force. - Annapolis Valley*

*We always let them know that just because they’re together or married that doesn’t give their partner the right [to force sex.] That it is rape, depending on what they are telling us. - Cumberland County*

*Women with mental disabilities may end up forced into...sex, and they are saying to us, “That’s OK, right?” And I say “No it is not OK, unless you want it.” Sometimes I am talking to a woman and I definitely see it is a sexual assault, but [she] doesn’t define it the same way. She feels it’s “expected” or it’s something “everyone else does” and so it is not defined as sexual assault. - Sydney*

Transition houses and women’s centres identified a need for an outreach worker specifically to deliver sexual violence education. Most organizations said they could not afford to be proactive in building educational opportunities. As one women’s organization described it:

*I think a few years ago we did sexual harassment and violence. We haven’t done it in a little while. If someone requests a presentation, we will offer it.*

Currently, public education on sexual violence is provided by Avalon Sexual Assault Centre and Colchester Sexual Assault Centre, but it is limited by available resources. Avalon employed one full time educator in 2007-8; however, the position is not permanent and has been primarily supported by non-governmental resources on a year-to-year basis. Other women’s organizations sporadically deliver public education programs. None are permanently funded and are most often funded on a project basis only.

#### 4.1.2 The Need for School-Based Education

In North America, including Nova Scotia, student education on sexual violence prevention has tended to focus on college students. Service providers emphasized that school-based education should start much earlier, in the elementary grades. Some justice system participants emphasized that children need early education in the language of sexuality, such as proper names for body parts, in order to be effective witnesses in sexual assault trials. This can be viewed as prevention education to the extent that convictions are seen as an effective means of preventing sexual violence. Other justice system service providers supported “good touch, bad touch” programming for elementary schools, as these were sources of immediate disclosures whenever they were conducted with an available officer present in the experience of one sergeant:

*It was a great program, the only drawback being that they haven’t come back with it. A couple of years later there is a whole new group of kids in the school. It is very important that there be funding from the province to do this every couple of years. I think we missed the boat in letting it slip. - Sydney*



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Still other service providers, including Victim Services management who see clients regarding a spectrum of violent crimes, felt that sexual violence should be a more prominent part of school-based anti-violence education, such as bullying programs. Law enforcement lamented the fact that high-quality sexual violence educational programs were not a regular part of school programming. Some programs do exist in Nova Scotia, but have been primarily project funded. For example, the Antigonish Women's Resource Centre (AWRC) delivers a healthy relationship curriculum to all Grade 9 students and anticipates an expansion to Grade 10 in September 2009. The program focuses on analysis of gender and power, empowerment, and assertiveness for girls; and non-violence and non-coercion as part of healthy relationships for boys.<sup>18</sup> Another example is the Cape Breton Transition House's dating violence program delivered in the schools.

Recent changes to the Criminal Code raise the age of consent to 16 years (from 14) and introduce new age-proximity exemptions. Public education is necessary to spread this new message about the age of consent, and how adolescents close in age are affected.

Service providers expressed frustration with some current education programs and resources that they felt stressed rape-avoidance by women and girls. Some service providers were concerned about an over-emphasis on school and parent programming that highlighted "stranger-danger" since stranger assaults are a small minority of all assaults, particularly for children. Others noted that the current educational resource for healthy sexuality approved for Nova Scotia schools is *Sex? A Healthy Sexuality Resource* does a good job of defining sexual assault and consent; however, its prevention message stresses girls' behaviour, rather than stressing healthy, gender-equitable relationships and challenging sexually aggressive gender roles for boys. Although this resource has a paragraph assuring students that the survivor is not to blame, the subsequent emphasis on warnings about rape avoidance (including avoiding rape drugs) carries the implication that survivors' can control sexual violence. In addition, the treatment of sexual violence is cursory, especially considering the proportionally higher rate of victimization of youth (as opposed to the population as a whole) and that "safe sexual experiences, free of coercion, discrimination and violence" is part of the essential definition of youth sexual health adopted in the Nova Scotia Roundtable on Youth Sexual Health's Framework for Action (2005).

Avalon Sexual Assault Centre's educational model is that of promoting social change, where the conditions giving rise to sexual violence are challenged through community awareness. Other women's organizations and survivors supported this model as more effective than rape-avoidance education as a prevention model for women and girls. It avoids emphasis on survivors' behaviour as causal to sexual violence and avoids victim-blaming implications. Instead, it highlights the gender myths, expectations and power imbalances that make sexual violence prevalent. Effective education involves age- and gender- appropriate skill-building, and work at the community level to change concepts of gender roles and promote the value of equitable gender relations. Some of their comments follow:

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<sup>18</sup> AWRC is working to get the program integrated into the high school curriculum so it is not AWRC-dependent.

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*Women have been sexually assaulted for years...as part of normal social behaviour...I don't think it's helpful to say, "if only people didn't go party" or "if only" women didn't make themselves attractive...M.D.*

Youth health centres were identified and valued by several service providers as a source of general education and information on sexual violence. One doctor associated with one of the youth health centres commented:

*Young people are not very clear...They have grown up in a community where talking about sexuality is a no-no. [So,] talking about sexual assault and "no means no" and boundaries (is important)...I think people are increasingly vulnerable because they are unable to assess the risk (of sexual violence)... Northern Region*

#### 4.1.3 Public Education and School-Based Education in Previous Studies

The need for public education and school-based education on sexual violence was identified in all four previous Nova Scotia studies.<sup>19</sup> For example, in the *King's/Annapolis Women's Project: Survivors of Sexual Abuse/Assault*, the majority of survivors prioritized education among their service requests, and two-thirds felt that government should pay for these services. Education was the largest proposed branch of sexual violence response in the project's response plan, and one of only four goals chosen for implementation planning.

Some of the themes and recommendations that emerged from a review of these studies are very similar to the issues identified by survivors and service providers in this research. This reinforces that there is clearly a need to move forward with a prevention plan that has public and school-based education as a key component. The following is a composite of the educational issues identified in the four studies:

- ♦ Survivors and service providers believe that an informed community was key to prevention.
- ♦ Survivors identified that the lack of visible, public communication on sexual violence contributes to survivors' fear of disclosing.
- ♦ Survivors reported that public education can counter backlash against survivors.
- ♦ Service providers saw education as the essential first step in increasing community motivation to acknowledge and prevent sexual violence.
- ♦ Public education can address root causes of sexual violence such as the contributing cultural factors related to gender stereotypes and discrimination.

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<sup>19</sup> The four reports are: *Beginning With Us: A Community Response to sexual Assault and Sexual Abuse in Antigonish County* (1994) (Sponsored by the Antigonish Women's Association; project staff Lucille Harper, Ellen King, funded by NSDoJ, Victim Services); *Can No One Hear My Cry? Sexual Assault in Cape Breton* (1997) (Cape Breton Sexual Assault Coalition); *Kings/Annapolis Women's Project: Survivors of Sexual Abuse/Assault* (1994) (sponsored by Valley health Service Association, funding by Victim Services); *Survivors Speak Out: Women Who Have Experienced Sexual Violence Share Their Ideas, Opinions and Perspectives about Agencies and Services in Pictou County* (1996) (Pictou County Women's Centre, funded by Women's Program, Dept. of HR)

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- ◆ Prevention and education should be made a priority by government for mental health services.
  - ◆ Survivors and service providers agreed sexual abuse education should be part of the core curriculum in all schools.
  - ◆ Educators saw the benefits of involving adult survivors of sexual violence with educational skills to talk to school audiences.

The following summarizes the education-related recommendations made in the four studies:

- ◆ That there be a comprehensive sexual violence education program for all teachers and students, beginning in elementary school;
- ◆ That schools make better use of community organizations knowledgeable about sexual violence when planning and presenting sexual violence education;
- ◆ That there be a provincial mandate directing schools to implement sexual violence and harassment information programs;
- ◆ That schools develop an effective sexual harassment policy;
- ◆ That there be specialized training on sexual violence for teachers delivering sexuality curricula; and implementation of professional education that would ensure intervention upon children's first (and often only) disclosure;
- ◆ That there be more public education to increase general community awareness and to increase awareness of need for family and community support for survivors, with emphasis on inclusion of vulnerable populations;
- ◆ That there be training and promotion of public health staff as sexual violence educators;
- ◆ That a prevention education model be chosen that challenges rape-prone beliefs and sexism;
- ◆ That specialized sexual violence prevention outreach educators be permanent full-time positions at women's organizations serving survivors.

## 4.2 Research, Policy Development, Advocacy and Prevention

Contemporary analyses of sexual violence understand it as a problem of power and control, emerging from circumstances of power imbalance. This has largely replaced notions of sexual violence as mental illness, or a poorly controlled biological imperative.

The disproportionate targeting of less-powerful populations (e.g. women, children, economically disadvantaged people, First Nations people, and people with disabilities) by sexually violent men is consistent with this analysis. A relationship between Nova Scotia women's poverty and vulnerability to sexual violence was illustrated in the 2006 report, *Struggling to Survive*.<sup>20</sup>

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<sup>20</sup> Ross (2006)

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Organizations that are working to economically empower women and other targeted groups, as well as to raise social status and power are also operating by these means to prevent sexual assault. As one service provider said:

*How can she leave a relationship with a partner who is raping her, if there is no housing, no money, for her and her children in the community? Dealing with the sexual assaults is going to be third or fourth on her list if the main problem is poverty - Eastern Shore*

Funding for research, policy development and advocacy with respect to preventing and addressing the harms of sexual violence has become increasingly unavailable nationally. While a part of Avalon Centre's commitment to the community, this activity is increasingly tenuous. Other women's equality-seeking organizations have limited access to resources for research, policy development and advocacy, and these may not be focused on sexual violence specifically.

### 4.3 The Justice System and Prevention

Justice system participants and some other service providers felt that the justice system could and should play an important role in the prevention of sexual violence. Some survivors have indicated that the reason they reported their assailant to the justice system was to prevent the victimization of others. Others suggested that prevention may be achieved by police officers being involved in education programs, by deterrence if crimes are treated seriously, and by fewer delays in the court process as noted by these research participants:

*When the (educational) program was on, if a child made a disclosure there was an officer right there to deal with it...they came up and told us what happened to them. - Police officer*

*Let's face it, if the justice system dealt with it in a serious way then men would learn. They need to be punished for their crimes. [Sexual violence needs to be increasingly criminalized] just like domestic violence was. - Cape Breton*

*I would like to see some changes in (delays in the justice system). (A perpetrator) can commit a (sex) crime today and not even think about facing those charges for a year or two...By the time it gets to court it is sanitized by distance from the appalling shock of it (in the community) - Yarmouth*

Other survivors and service providers had relinquished prevention expectations, based on their negative experience of the justice system's effectiveness in addressing sexual violence. Some analyzed the justice system's failures as allowing perpetrators to make the calculation that they had little chance of arrest, conviction, or custodial sentence, and thus actually encouraging sexual violence.

Nevertheless, the justice system is the only process by which perpetrators of sexual violence can be forced out of the general population, forced to participate in treatment, and be monitored by those with the power to intervene if there are breaches of conditions. It also could have an important symbolic role through judges' public decisions, in rejecting the myths and stereotypes about sexual violence that perpetrators rely on to self-justify and escape responsibility. The general public has not yet abandoned hope that the justice system

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can help prevent sexual violence, and continues to call for accountability for these violent crimes.

It is beyond the scope of this needs assessment to closely examine the justice system's effectiveness and potential role in preventing sexual violence in our communities. The lower effectiveness of the Nova Scotia justice system in dealing with sex crimes relative to other crimes and relative to other sections of Canada was apparent most recently in the 2005 report, *Sexual Assault In Nova Scotia: A Statistical Profile*. Interestingly, within Nova Scotia, wide variations were seen by region, with respect to outcomes of reported cases.

Proposed changes to the justice system to promote women's safety were developed in "Justice Innovations and Women's Safety", a project led by Women's Innovative Justice Initiative (WIJI) and whose 2006 recommendations were unanimously supported by participating women's organizations, including Avalon Centre, THANS and Women's Centres CONNECT, who are all members of the Sexual Assault Services Planning Group. Key recommendations from its final report which can be related to sexual assault prevention are attached to this report as Appendix A.

## 4.4 Recommendations for Prevention Programs

Based on the above findings, the following are recommendations for prevention programs for: public education; research, policy development and advocacy; and justice system.

### 4.4.1 Public Education

- ◆ A comprehensive sexual violence education program for all teachers and students should be developed, for delivery beginning in the elementary grades.
- ◆ Women's organizations and others with expertise in gendered violence should be resourced to participate in the development and delivery of ongoing comprehensive school programming.
- ◆ Women's organizations and others with expertise in gendered violence should be resourced to develop and provide ongoing public education on sexual violence in venues other than schools.
- ◆ The appropriate model for educational programming should focus on changing discriminatory beliefs and conditions that give rise to sexual violence and skills building to challenge gender dominance in relationships. It should not rely on rape-avoidance approaches.
- ◆ Programming should not over-emphasize stranger assaults. It should primarily address assaults by friends, relatives and other persons in positions of trust.
- ◆ Programming should be inclusive and relevant to vulnerable populations, such as persons with disabilities, prostituted persons, women who are subject to racism, elder and immigrant women, and others.
- ◆ Sexual violence as part of partner violence should be emphasized in public education.

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- ◆ Provision of public education should be proactive, not only in response to requests, through permanent outreach positions based in community organizations with expertise in gendered violence.
  - ◆ The sexual violence component of school-based anti-violence and bullying programming should be increased.
  - ◆ A focused program regarding the new age of consent law is needed to make the public aware of these changes. Materials referencing the former provisions should be updated.

#### 4.4.2 Research, Policy Development and Advocacy

- ◆ Research, policy development and advocacy related to increasing the economic and social status and power of women and other vulnerable populations should be valued and funded as sexual assault prevention. The relationship between this work and sexual violence prevention should be explicitly acknowledged by the government of Nova Scotia.

#### 4.4.3 Justice System

- ◆ Action should be taken to ensure more consistent justice system outcomes across Nova Scotia with respect to sexual violence. Regional variations in sexual assault case outcomes in Nova Scotia should be examined further. Reasons for, and practices leading to, these variations should be identified.
- ◆ The Minister of Justice should convene a round table with all stakeholders to review the recommendations of “Justice Innovations and Women’s Safety” and create a plan to increase the effectiveness of the justice system in preventing sexual violence.

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## 5. The Need for Core Services

This section outlines eight core services that are required to ensure a comprehensive approach to addressing sexual violence. These are: specialized therapeutic counselling; basic survivor support; crisis lines; on-call community-based advocates; justice system accompaniment; sexual assault nurse examiners (SANEs); services for men, and professional education.

### 5.1 Specialized Therapeutic Counselling

The wide-ranging and intensely harmful effects of sexual violence, described earlier (Section 2.3), can seldom be overcome without specialized therapy. The therapeutic needs of sexual violence survivors are unique and require a specialized expert response. The current mental health services delivery model is ill-matched to the needs of sexual assault survivors. Best outcomes are achieved through delivery of specialized, holistic, survivor-centred therapy by community-based agencies. The Avalon Centre model of this care is associated with positive outcomes for survivors, has received provincial and national recognition, and provides guidance as to best practices. However, with only 3.7 positions serving the entire province with its 30,000+ survivors, specialized therapy needed for recovery from sexual assault is inaccessible to most Nova Scotians. Further, salaries at community organizations such as Avalon Centre have been extremely low compared to what comparably specialized therapists earn in the governmental and private sectors: this has fuelled a staff retention crisis for Avalon Centre, which is losing a staff position this year, when Avalon Centre will be able to afford to fill only one of two vacated counselling positions.

#### 5.1.1 Specialized, Holistic, Survivor-Centred Approaches

In Nova Scotia, participants (service providers and survivors) in Antigonish's 1994 *Beginning With Us* research identified the following components of a positive specialized counselling approach for sexual violence survivors: client-centred, client-directed, flexible; holistic approach addressing physical, psychological and emotional needs of the survivor; address all life issues rather than focus solely on the abuse; recognize the social context in which sexual violence occurs; and use a developmental, life-span perspective.

In the 1994 Kings/Annapolis Women's Project, three themes in a proposed sexual assault response were: (1) an understanding of sexual violence as a manifestation of unequal power relationships among men, women and children; (2) a recognition that sexual violence is one of the variety of expressions of male violence sometimes condoned by social patterns and structures; and (3) a belief that survivors can identify their own needs and can be active and meaningful partners in the meeting of these needs.

The components identified in these two proposals from the 1990's remain important to service providers participating in the current research:

*I think you have to understand clearly the pervasive nature of violence against women in general. That comes from a feminist analysis. You have to look at this crime through a*

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*gender lens because it is overwhelmingly gender-based. That informs the work as a whole, and provides better understanding of what women's experiences are like, and helps us figure out how to best meet their needs. - women's centre staff*

*Something that Avalon offers in terms of being a specialized centre...is the approach of having in mind that it is most often women who suffer from sexual crimes, and how the other systems sometimes don't adequately address that. - specialized therapeutic counselor*

*When I say a feminist analysis [is needed], I mean having an understanding of what the impact is on women, of the various systems we live in. - women's centre staff*

*I think some [professionals] can be very confrontational and demand that [survivors] have to do something in a certain way. Here how we work is we work with women, we accompany women, rather than directing women with things like "Go here, do this or that."... [Instead we] are walking alongside. - women's centre staff*

The importance of specialized survivor-centred care after sexual assault is clear in the (scant) literature. One Canadian study involving women who had been given care two months prior in a specialized sexual assault service concluded that “holistic woman-centred care is of great importance to service users.” Emphasized aspects of such care included: “being respected as human beings with multi-faceted needs, feeling safe, feeling believed, and being given options and information. They also felt cared for beyond the immediate incident, through follow-up” (Ericksen, et al, 2002).

A 2004 study concluded that most significant for survivors' psychological well-being (as rated by survivors) was respectful listening in the context of being given options and not pushed into choices. (Campbell 2004). In recent years, evidence-based research has produced the specialized “interpersonal protection” model of therapy for child sexual abuse survivors, which has multiple strengths, including the proven effectiveness of specialized approaches to the client-therapist relationship as partnership without power imbalance, and specialized approaches to internal criticism and traumatic memories (Thomas, 2003).

Avalon Sexual Assault Centre therapists employ these approaches which are valued by survivors as illustrated by these comments:

*With her what was different was that she told me what could happen, what I could do about it, and how I could do something. She gave me the options, not telling me I have to do anything. I just find it comforting...when I leave from her, it is a quiet day. - survivor*

Special issues for sexual violence survivors are myriad and complex. These can include the following:

- ♦ Seeing those who challenge their boundaries as aggressors, particular where there is a power imbalance (e.g., male, employer or psychotherapist) which can make non-specialized re-enactive trauma approaches inappropriate (Thomas, 2005; Trippany, et al 2006);
- ♦ The need to establish trust in absence of prior models when clients have been subject to sexual violence by those in positions of trust, especially in childhood (Chu, 1998);



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- ♦ Harsh criticism from an inner critic which inhibits from responding to boundary challenges, which can lead to passive acquiescence in therapy (Thomas, 2005);
  - ♦ Physical changes to the hippocampus and other neocortex structures due to prolonged trauma, that reduce the ability to respond to short-term therapies that rely on changing thoughts and actions to change emotional states (Atkinson, 1999);
  - ♦ Secondary wounding and the social/cultural context in which sexual violence occurs.

Community-based women's organizations, due to their relationships of trust with survivors, as well as their expertise, structure and philosophies of service, are well suited to provide survivor-centred care. Research with survivors indicates that, among all responders, such community organizations have been correlated most strongly with healing and least with hurting in post-sexual assault care. Survivors strongly rated their contact with community rape crisis centers as healing (75%) (Campbell et al., 2001). There were no significant associations between perceived secondary victimization and service delivery outcomes for rape crisis centers. In contrast, only 47% of survivors reported contact with the health care system as healing; and nearly a third considered it hurtful. Contact with the legal system was perceived as hurtful by 52% of responders.

Nova Scotia research suggests that this perception is shared by Nova Scotians experiencing sexual assault: Community organizations in Nova Scotia, including community mental health professionals, sexual assault centres, women's centres and transition houses, and organizations serving criminalized women have been identified as enjoying a level of trust by abused, sexually assaulted and marginalized women, that is not associated with either the conventional health or justice systems (Rubin, 2003). Avalon counsellors in this research affirmed that clients continue to experience significant secondary wounding from the justice and other institutional systems.

Avalon Centre's specialty of addressing relational trauma using a woman-centred model has made its service effective for clients, as indicated in evaluation of their programming (Mahon, 2003). The organization is a provincial and national leader. Their counselling model combines a variety of specialized best-practice approaches to relational trauma with a gendered analysis of the causes and experience of sexual violence.

It is valuable to survivors to participate in counselling in the environment of women's equality-seeking organizations, such as Avalon Centre, because their gender-sensitive approach incorporates an understanding of sexual violence as a social phenomenon, rather than a strictly individual issue. Avalon Centre and other organizations using this analysis to address sexual violence hold significant expertise in the specific details of the social patterns affecting their clients. This supports survivors' healing and understanding of themselves as blameless for the violence, and as far from unique as survivors. In the absence of this, sexual assault response is limited by government services that criminalize, medicalize and individualize the issue, in the sense that the "victim" owns the "problem" in a way that implicitly exacerbates isolation and self-blame. This tendency in Nova Scotia was described, for example, in Cape Breton's 1996 report, *Can No One Hear My Cry?*

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In contrast, pioneering feminists and feminist organizations in the 1970's and 80's developed an understanding of sexual assault that saw such violence not as a problem of individuals alone, but as rooted in social phenomena connected to gender inequality, as well as subordination on the basis of race, class, ability and other characteristics. Research revealed (and continues to show) that those with the least status and power in society were those most likely to be sexually assaulted (Canadian Panel on Violence Against Women). Feminist analysis views sexual violence not as a biological imperative which manifests when provoked by victims, nor as largely due to the psychopathology of a few individual deviants, but rather as the predictable outcome of societal beliefs about power, the use of force, and gender roles. Sexual assault is viewed not as a sexual act, but rather one of humiliation and oppression that expresses privilege and dominance.

This analysis, once radical, is now the most widely accepted approach to understanding and preventing sexual violence in Canada:

*Much qualitative evidence and analysis indicates that violence is linked to inequalities and power imbalances in society. As a rule, women's experiences of violence will vary depending on the impacts of gender and other factors such as the woman's race, her ability, her sexual orientation, her age, her cultural, educational and economic status, as well as her experiences of dislocation or colonization. Women who face discrimination on various grounds are more vulnerable to violence and abuse and face greater barriers when seeking services.* - Federal-Provincial-Territorial Ministers Responsible for the Status of Women<sup>21</sup>.

*There are many complicated reasons why boys and men commit sexual assault. For example, boys and men constantly receive sexist and violent messages about how they should act and how they should treat girls and women. These harmful messages might lead them to think that a sexual assault is no big deal or even to think about committing one...Some of these harmful ideas include:*

- *Considering it okay for males to use violence and other threatening behaviours to get what they want.*
- *Thinking that males are allowed to act in sexual ways toward girls and women without first getting their consent.*
- *Believing that females always like sexual attention, even when they say they don't.*
- *Believing that females always should be available and willing to fulfill males' sexual desires.*
- *Considering males as more important than females and that females' ideas, opinions and work are not as valuable as males'.*
- *Thinking that females don't deserve the same respect and opportunities as males.*
- *Believing that males have a right to control the girls and women in their lives – if they don't they aren't "real men" and should feel ashamed.*

- Ontario Women's Directorate<sup>22</sup>

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<sup>21</sup> *Assessing violence against women [electronic resource] : a statistical profile.* Issued also in French under title : Évaluation de la violence contre les femmes, un profil statistique. Status of Women Canada. (2002)

<sup>22</sup> <http://www.citizenship.gov.on.ca/owd/english/youth/sexualassault-stop.htm>

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Once sexual violence is understood as a crime of power and control, stereotypical notions that victims are to blame because of their personal characteristics or provocative sexuality are undermined. For survivors to participate in counselling in an environment that provides consistent messages on this social context is extremely valuable.

Women's organizations are also expert in the special challenges faced by women who are sexually assaulted, by virtue of gender roles and myths applied to women. Female survivors experience sexual assault in unique ways in the context of gender-specific socialization and beliefs. Female gender roles may generate expectations for female sexuality that are very different from those for male sexuality. In addition to beliefs about women's gender roles and sexuality in general, female-specific rape myths abound. These include that sexual violence is caused by females' (including young girls') manner of dress, movement, or speech; that only "bad" women get raped; that women say "no" to sexual advances, but do not mean it; that women commonly lie about sexual violence; that women enjoy sexual violence; that rape "ruins" a female - and there are many more. A subordinate gender role, hostility to female sexual autonomy, and holding women responsible for sexual violence will cause the aftermath of sexual assault to unfold socially and culturally for females in gender-specific ways. Lesbians who are sexual assault survivors also face specific challenges.<sup>23</sup>

A lack of expertise in the social and cultural meaning of sexual assault for women can have negative implications for delivering counselling. One survivor participating in this research described how after her disclosure, her mental health service provider suggested they have their next meeting at Tim Horton's. The survivor felt this was a highly inappropriate setting for discussion of her experience with sexual violence, and specialized counsellors participating in this research confirm this. They also offer that such a suggestion may be the result of a non-specialized service providers' lack of comfort with addressing the profoundly troubling issues associated with sexual violence. Other survivors describe a lack of understanding of partner sexual violence in "couples counselling." Survivors and their service providers also describe non-specialized mental health service providers in Nova Scotia as taking a "boot-strap" approach to increasing survivors' self-esteem which is inappropriate in early counselling and can increase self-blame and attendant risks.

Nova Scotia women in this and previous research strongly affirm the value of woman-centred organizations' post-assault care:

*It was one of the best agencies I went to, because I got the consoling and comfort I needed at the time. I was made to feel it wasn't my fault. - survivor*

*The first thing was that she listened to everything I had to say. I felt that what I had to say was important, that I was important and that I wasn't really losing my mind. - survivor*

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<sup>23</sup> Woman to woman sexual violence may be disbelieved or trivialized. Lesbians' circumstances also change some of the challenges for immediate response: Pregnancy is a factor which many lesbians have deliberately excluded from their lives and may be unsure when they had their last period, or when they are at greatest risk to become pregnant. Since lesbians are the lowest risk group in the adult sexually active population for sexually transmitted infections, many lesbians are less familiar with these diseases. For lesbians who have never had sexual relations with a man, the act of penetration itself may be particularly traumatic, medically and emotionally. A woman may come out of an assault unconsciously blaming her lesbianism for the attack, or, especially when women have been rejected by their families or religious communities because of their lesbianism, feeling that the assault was just punishment. While all women may have internalized myths about how their appearance may provoke rape, lesbians may have the added concern of wondering if the assailant picked them because they looked "gay." Sexual violence is, in fact, often a component of violent anti-lesbian hate crime (Tallmer).

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*Most therapy people quote from a book...They tell you what's wrong with you. My therapist guides me to learn about myself, to discover myself. No drugs, the cure is within myself. There are no words I can ever express - it's like a rebirth. - survivor*

*One of the women there told me when you're sexually abused...the perpetrator is actually doing it to take your power away, and I remember that I was just astonished at that...so I learned that abusers take your power when they hurt you, often before you know you have any. Then I started to learn about feelings - that it was OK to feel sad, to feel anger. - survivor*

*The women there were the first to tell me I had the right to expect better things, that I didn't deserve the bad things that happened to me. - survivor*

*I thought it would be refreshing to speak with a woman and it was. When I talked with her about what happened she actually heard me, she listened, she knew what I was talking about. It shouldn't have taken that long. She was not the first person I talked to but it wasn't until then that I realized how poor all the other counsellors had been. - survivor*

### 5.1.2 Peer support and Therapy Groups

Support groups and therapy groups are available from time to time in a few locations in the province. SOAR is a volunteer group that provides one-to-one peer support for Annapolis Valley survivors. This group has reported survivor approval and success, particularly including peer support services for male survivors. The organization has been hampered by a lack of stable funding, causing services to appear and disappear, and location and contact information to frequently change.

Avalon moved away from volunteer one-to-one peer support and toward professional one-to-one therapy for several reasons. One was the administrative burden of constantly recruiting and training volunteers. Another was volunteers' lack of ability to deal properly with disclosures and triggering emerging for survivors in the course of peer support. Also, these issues emerged for volunteer peer supporters themselves that hindered their ability to provide support to clients.

Avalon Centre and Antigonish Women's Resource Centre periodically run professionally supervised groups. Both organizations are cautious in their approach to groups for sexual assault survivors, and take steps to ensure participants are ready and not experiencing secondary wounding through group work.

### 5.1.3 Issues with the Mental Health System

Survivors and service providers participating in this research and in the four previous Nova Scotia studies identified systemic issues in the mental health care system that created a mismatch between what those services can provide and the needs of survivors and community in response to sexual assault. This was the case notwithstanding the fact that dedicated individuals within these systems did want to provide more specialized, holistic, survivor-centred care. Because of systemic issues, individuals were limited in their ability to do so, despite extensive self-education for greater specialization in a few cases.

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Service providers and survivors emphasized a number of systemic shortcomings in mental health systems' abilities to meet survivors' and community needs: (a) over-reliance on medication; (b) lack of available therapists and programming; (c) lack of specialization; (d) disempowerment that repeats abuse dynamics; and (e) stigma associated with using mental health services. These five shortcomings are further described next.

**(a) Over-reliance on medication**

Women described doctors failing to respond when they were informed that the medications were making them feel further numbed, were not "fixing me", were "making me worse." Survivors in all previous research identified over-reliance on medication, which did not meet their recovery needs. They also described being infantilized through refusals to explain the medications' exact purpose and effects: "I was talked to like a child, 'C'mon, be a good girl and take your pills.'"

Service providers in the current research also identified over-reliance on medication as a problem for women in their area:

*Getting a prescription and then seeing a psychiatrist for 15 minutes every six weeks is not treatment. - family services staff member*

*The...systems don't address...historically how women [were] treated by mental health, for instance called "hysterical" [and presently] put on medications to deal with the effects of PTSD which are relational not just physiological [issues]. But treating [these issues] as physiological only addresses a small piece of what it is they are experiencing. - specialized therapeutic counsellor*

*It's giving them a tool to cope a little better but without dealing with what is causing it in the first place. - specialized therapeutic counsellor*

Recent Canadian research shows that substance abuse is closely connected with past sexual violence (The Cedar Project 2008). In attempts to numb themselves and escape the painful symptoms associated with intrusive memories, survivors sometimes become addicts. In this context, it can be risky to rely on medication for sexual abuse survivors without considering substance abuse. One survivor described her situation for this research:

*I was a mess, I didn't know where to go, who to turn to. I was having flashbacks. Eventually diagnosed me with post-traumatic stress. Now I am on pills that are just numbing me, taking more and more of those pills. More alcohol, more pills, more drugs...There were a few mornings last week when I was surprised I woke up, because I drank so much alcohol and took so many pills...So they put you on the pills? Then what? Am I supposed to numb it all the rest of my life. Because 1 pill doesn't do it, 2, 3, 5 doesn't do it. - survivor*

**(b) Lack of available therapists and programming**

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A lack of available therapists, public or private was identified in all four previous Nova Scotia reports. Survivors and service providers participating in this research confirmed that the situation remains largely unchanged from the 1990's.

*There's something missing...I don't think there are enough therapists dealing with these issues for women. I think they have a good children's team but I don't think there's enough therapists who are dealing with violence against women in this area. When a woman has to go outside of the area, that's a drastic thing. That should never be. - survivor, Survivors Speak Out: Pictou County.*

*More therapists [are needed]... [with] better training. I was suicidal and I needed to be around people...I think they need a day-care program - survivor, Survivors Speak Out: Pictou County.*

*There is a lack of therapists, especially female therapists. - service provider, Can No One Hear My Cry: Sexual Assault in Cape Breton*

*I would have more counsellors available...I wouldn't have such long waiting lists. If a person came and said they wanted to kill themselves, I wouldn't leave them to walk back out. - survivor, Survivors Speak Out: Pictou County.*

*There needs to be more female counselors. They [have] a strong sense of what it is like to be a woman, and they can build a bond, because the therapy is so long. - survivor, Can No One Hear My Cry: Sexual Assault in Cape Breton*

Antigonish's 1994 study identified not only the lack of therapists, but the lack of choice, the reassignment of government-based (as opposed to community-based) therapists and the lack of continuity as problematic. One survivor described the pain of being reassigned to *seven* therapists over the course of her counselling relationship in the public system. The sixteen survivors participating in the 1996 research, leading to the "Can No One Hear My Cry" report, all considered that the fact that none had received immediate counselling may have contributed to a slower than necessary recovery. Research supports earliest intervention to prevent the worst long-term harms of sexual violence (see section 5.1.4).

The lack of therapists (especially female therapists), high caseloads and delays continue to create barriers for survivors seeking counselling, as emphasized by nearly all service providers participating in this research.

**(c) Lack of specialization**

All four previous reports described the negative impact of a lack of specialization in counselling and programming:

*I remember starting to tell a counsellor about it [the assault]. He seemed uncomfortable and I got the message I was to blame. - survivor, Can No One Hear My Cry: Sexual Assault in Cape Breton*

*I was involved with mental health services for behaviour problems way before the incest stuff started coming back, and I think it would be better if part of the assessment looked into whether you've been sexually abused. I think that could have*

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*prevented a lot of my suicide attempts. - survivor, Survivors Speak Out: Pictou County.*

Negative impacts associated with a lack of specialization were described in the current research:

*I don't think [generalist therapists] get the message that it's not something within [survivors] that's the issue [that makes therapy difficult]. It is that the [therapist] doesn't know how to be with that [sexual abuse survivor]. Which ends up with [Avalon] getting a lot more referrals than we can handle - specialized therapist*

*As soon as they disclose childhood sexual abuse, [the therapist] refers to Avalon because they just don't feel comfortable working with it for several reasons - specialized therapist.*

*No one wants to talk about sexual violence - it is painful and ugly. So hearing about it can be traumatic sometimes. Therapists aren't created equal, not at all...some people have different expertise...so that can be a challenge that not everyone at mental health has that expertise that is required. - women's counsellor*

*I had gone to a few sessions at mental health...and she [therapist] mentioned one day if I would like to join the group [ed. note: a non-specialized group for women with depression]...I was set back by it because any of the discussions in the group never discussed my issues...You just went around the room and asked everyone what bothered them that week. I told what bothered me and [they sat] there and told me I was being childish. [The therapist] said, "Yes, I think you are." I wasn't comprehending, she blew me out of the water...The next week rolled around and I didn't bother going. - survivor*

*I broke down and I didn't know where to turn. The best idea I came up with was to sign myself in and get some help but it was a joke. Because they just don't know, or they don't care or they're not educated on it. They don't understand. I had some that rolled their eyes at me, like, "What do we do with this nut-case?" Not outright, but I can read people's tones, body language...They stuck me in the psych ward for about a week and when I came out I was worse. They put me on [medication] which I am trying to get off of now, because I am abusing, using it to cope. - survivor who experienced flashbacks and other PTSD symptoms*

*I found the Department of Mental Health absolutely so awful, the worker that was assigned to me, [I] didn't find she was helpful at all...All she wanted to do was talk about herself...[she suggested] we meet [next time] at Tim Horton's. I was very uncomfortable with that because I am from a small town and how do you talk at Tim Horton's? - survivor* A specialized therapist commented on the above: *That can be a sign that the therapist is not comfortable with the issue, to suggest an environment where it is not suitable to talk about sexual abuse.*

*I didn't feel like I should have to be sitting in this group [ed. note: non-specific therapy group for women] and be one of the people who has to stand up and say, "I am Jane Doe and I am an alcoholic" ...I am not an alcoholic and I have had situations in my life and things that happened and [I said] I thought this was going to help me, but this*

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*group is not helping me...and I got from [the therapist], "Well if you're not happy with this group and if you're not happy with the services you can leave."...I said, "Where am I going to go?" and [the therapist] said, "I don't know, but you should really talk to your family doctor" [ed. note: family doctor's office was a scene of loss of control related to the abuser in this survivor's history] - survivor*

As discussed in the section on secondary wounding, a lack of specialization can lead to professionals who take therapeutic actions that worsen survivors' situations, or who fail to uncover or consider the relevance of sexual violence at all.

**(d) Disempowerment that repeats abuse dynamics**

Antigonish County's 1994 report, *Beginning With Us* notes that some service providers face frustration when trying to provide a more client-directed type of service and the mandate of their service does not meet the needs of survivors for self-direction and empowerment. It identifies a healthy survivor/service provider relationship as a partnership model which acknowledges and respects the autonomy of survivors and does not recreate a power imbalance reminiscent of the abuse. Such partnerships were not readily available through the existing mental health services, in the words of survivors, but were available through women's organizations. Survivors experienced the directive attitude of traditional therapists as authoritarian and patronizing. The same issues were identified in other regions:

*I think there needs to be an improvement [in] keeping the client involved in their own care. I found that a lot of meetings were held with my counselor and my family doctor that I didn't know about...I was told after they happened...I should have been allowed to participate more in my own...care. - survivor in Survivors Speak Out: Pictou County.*

*Most of the women reported that the majority of "treatment" decisions were made for them...Although these women felt uncomfortable with the approach used by these professionals, some continued their sessions because...these men were professionals, "they were the experts." - Kings/Annapolis Women's Project: Survivors of Sexual Assault.*

*There is wrong therapy...the right therapy shoots from the hip. It didn't keep me in the victim role...Some of the things I had used kept me in the victim role. - survivor, Can No One Hear My Cry: Sexual Assault in Cape Breton.*

As described in *Beginning With Us*, traditionally-trained therapists have been taught to define the client's "problem" and direct the client's healing, and it can be difficult for them to transition to a partnership relationship where their role is that of an enabler following the lead of the client.

The failure of the conventional mental health model to provide control for survivors continues currently:

*Some practitioners don't have a background or that training about power differential, and things like that, that are such a huge part of secondary wounding. That happens*



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*to survivors when [therapists] are not aware that they can be using power dynamics in a way that can cause further damage. - Avalon specialized therapist*

*If the therapist has an agenda for that person, that is just intrusive... because it really needs to be client-centred. - Avalon specialized therapist*

*What we try to do here is not just the content of what you're talking about with somebody...but the actual process itself so that women do have a say on how this process unfolds - they do have some control. Because, ultimately, that is what was lost during the assault or abuse. - Avalon specialized therapist*

Mandated therapy by other agencies such as child protection or corrections is also a problem in recreating abuse dynamics and obstructing healing:

*As a policy, we don't do mandated counselling...we have told them [child protection] numerous times over the years and it will stop for a while and then you will get a new batch of child welfare workers. - Avalon specialized therapist*

*They see a woman with a trauma history and they see it is affecting her life, affecting her family...so I think a lot of the time [mandated counselling] is well-intentioned...but you can't force somebody to do this work and have it mean anything which is why we don't do mandated counselling. And even though child welfare doesn't send the referral to us directly, the woman is calling herself but it is under the direct coercion: she is not motivated to get help for herself; she is motivated by not having her children taken away. - Avalon specialized therapist*

#### **(e) Stigma of using Mental Health Services**

Many survivors and service providers are concerned that the use of counselling through the mental health system creates inappropriate stigma for survivors that may already be experiencing intense self-blame.

The focus of the system also tends to be on individuals, and on pathology and not on social conditions and prevention. This can add to survivors' sense of being isolated, stigmatized and unalterably "ruined" by the assault(s). This is frustrating to mental health service providers in the public system, as indicated by their self-reporting of these problems in the 1994 *Beginning With Us* report. There, mental health service providers expressed frustration that they cannot work more closely with the community in a social rather than a purely individual response to sexual violence. Caseloads as well as a sense of "otherness" to a hospital-based service prevented them from engaging in community development. Survivors echoed these perceptions. In Cape Breton's Transition House's 1996 report, *Can No One Hear My Cry*, a response based primarily in the mental health system was explicitly rejected due to stigmatization of survivors.

The current research confirms that neither survivors nor service providers believe the stigma has gone away, as illustrated by these comments:

*I feel sometimes the women feel so soiled that they can't access support...the shame and blame game happens on a much more intensive level. - specialized supportive counsellor*

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#### 5.1.4 Access to Specialized Therapeutic Counselling for Sexual Violence in Nova Scotia

Specialized, holistic, survivor-centred therapy is available in Nova Scotia on a no-cost-to-survivors basis only through Avalon Centre, which has 3.5 therapist positions, and through a 0.2 position at Second Story Women’s Centre. Although the Avalon Centre delivers high-quality holistic, survivor-centred care, its services are severely limited by funding, which also diminishes their ability to apply best practices in the delivery structure of survivors’ therapy.

#### 5.1.5 Current Staffing Levels for Specialized Therapy

With only 3.7 positions serving the entire province with its 30,000+ survivors, specialized therapy needed for recovery from sexual assault is inaccessible to most Nova Scotians. Further, salaries at community organizations such as Avalon Centre have been extremely low compared to what comparably specialized therapists earn in the governmental and private sectors: this has fuelled a staff retention crisis for Avalon Centre, which will be cutting therapeutic services this year, as the organization is only able to afford to fill one of two vacated counselling positions. The result will be the existence of only 2.7 specialized counsellors for the entirety of Nova Scotia for next year.

With the exception of Newfoundland, Nova Scotia fares worst in a comparison of Atlantic and other selected Canadian jurisdictions as shown in Table 3: Availability of Specialized, No-Cost, Therapeutic Counsellors: Atlantic Canada and Selected Jurisdictions

**Table 3: Availability of Specialized, No-Cost, Therapeutic Counsellors: Atlantic Canada and Selected Jurisdictions**

Jurisdiction	Population served	Specialized therapeutic counsellors, no-cost	Ratio
NS	935,000	3.7	1: 253,000
Fredericton, NB	55,000	1	1:55,000
PEI	138,519	3.2	1: 43,287
NL		0	n/a
Niagara region	428,000	2	1: 214,000
Edmonton	1,076,000	8-10 (fluctuates w/ university year)	highest: 1:134,000

#### 5.1.6 Compromised Delivery Structure

Therapeutic counselling for survivors through the existing Nova Scotia mental health care system is a mismatch due to the practice model factors described previously (section 5.1.3) and also in terms of the mechanics of the specialized therapy delivery approaches. These approaches are: (a) very short or no wait times; (b) ability to recognize the need for

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intervention and assess accurately; (c) weekly sessions; (d) open-ended duration; (e) non-intrusive methods; and (f) limited caseloads, vicarious trauma support.

Even when specialized therapy is available in Nova Scotia, through Avalon, these best practice approaches are compromised due to inadequate funding.

**(a) Very short or no wait times**

Research shows that there is a window of time after an assault in which specialized therapy can help prevent some of the long term adverse consequences of sexual violence (Resnick et al 2007). For example, in a 2001 study involving 171 recent female assault survivors, positive changes at 2 weeks post-assault were correlated with the lowest levels of distress at 12 months post-assault among all participating survivors (Frazier, Conlon & Glaser 2001). The ordinary wait times ( 6 weeks - 3 months) reported around the province for mental health services cause survivors to lose this opportunity.

It is also important for survivors to receive services close to the time they disclose and seek help. This is because avoidance may have caused them to wait many years to seek assistance, and they are pushed towards seeking help by the extreme intensity of PTSD symptoms. These may subside for some survivors in the wait time for ordinary mental health services, and survivors may avoid help-seeking until symptoms become unbearable again, and remain caught in a cycle of crisis (Chu, 1998), never embarking on a therapeutic journey which they find too intimidating except at extreme points in suffering.

**(b) Ability to recognize need for intervention and assess accurately**

In addition to generalized assessment skills, counsellors dealing with sexual violence must be able to assess the following factors in survivors (Hensley 2002):

- ◆ How socio-cultural factors will influence the survivor's reaction to the rape;
- ◆ The survivor's history of prior victimization (Ullman & Brecklin 2002);
- ◆ Details of the assault shared by the survivor;
- ◆ How victim-blaming and other secondary wounding may affect the survivor's recovery (Ullman et al 2007).

Lack of experience and specialization will prevent accurate assessment of the above and may create barriers to accessing appropriate supports, and higher risks for survivors. Sexual assault survivors may not have the urgency of their situation recognized by mental health managers who are unused to dealing with these factors or with high-level trauma cases and PTSD. Survivors' symptoms and needs are most like those of combat vets with PTSD, exacerbated by internal and external victim-blaming. This profile is not within the purview or experience of most mental health care practitioners. Additionally, survivors may not present comfortably for non-specialized service providers and managers, and service providers may find themselves avoiding relevant details.

Avalon Centre counsellors also described how some survivors in order to assess whether the situation is trustworthy or just another potential source of secondary wounding, will

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address counsellors in provoking ways, and how counsellors need to have worked through their own triggers, if they are to meet the client's high need for demonstration of trustworthiness. One survivor (a client at a women's centre) described:

*When I came here I was so angry, I attacked K. [I said] "You don't give a f--- about me!" She just took it in, God love her heart...The only people who would embrace me and work with me were at the women's center and if it weren't for them I would be dead today. Because the hospital, they were not equipped to deal with it. - survivor*

Survivors may be misdiagnosed or become stigmatized or targets of discrimination as a result. Presentation and affect of sexual violence survivors may coincide with what non-specialized mental health practitioners typically view as resistance, aggression, or lack of responsibility and effort for therapeutic success. Survivors at high risk for suicide may be disbelieved, pathologized as manipulative, or have their needs dismissed as part of borderline personality disorder pathology<sup>24</sup>. This puts them at greater risk for suicide and other harms, when they are excluded from accessing appropriate care, such as intensive therapy or in-patient treatment. These impacts have been described by Avalon's counsellors in respect to their clients' experiences with assessment and intervention by non-specialists in the general mental health system. In addition to not getting needed care, this can have a stigmatizing effect on survivors which intensifies self-blame and other painful symptoms for survivors, thereby raising suicide and other risks.

**(c) Weekly sessions**

Therapy for survivors can be an extremely intense process, stirring up feelings that are hard to deal with. Part of therapy is not to shut down these feelings but to experience and change one's relationship with them. Sessions of less than weekly frequency cuts the momentum created as experiences and emotions come to the surface, and also does not allow for intensive support when they do.

Avalon counsellors participating in this research indicated that the re-experiencing of traumatic memories and emotions should occur in the context of a high level of support in order to sustain momentum and to build levels of trust that the counselor can "be there" when appropriate. Frequency of sessions at Avalon is sub-optimal due to funding limitations, with sessions offered every two weeks instead of the best practice of weekly sessions.

**(d) Open-ended duration**

Specialized treatment models for sexual violence survivors are based on the clinical experience that many survivors require an initial, sometimes lengthy, period of "developing fundamental skills in maintaining supportive relationships, developing self-care strategies, coping with symptomatology, improving functioning, and establishing a basic positive self-identity." (Chu, 1998)

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<sup>24</sup> There is evidence that sexual assault survivors are over-diagnosed and inappropriately diagnosed with borderline personality disorder, are subject to inappropriate therapies and stigmas on that basis, and have symptoms intensify. See Trippany, Helm, Simpson, "Trauma Reenactment: Rethinking Borderline Personality Disorder When Diagnosing Sexual Abuse Survivors." 28 J of Mental Health Counselling 95 - 110 (2006)

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This does not match well with the current focus on short term therapies in mental health care. Many of these short-term therapies are inappropriate for sexual violence survivors' issues, even those designed for PTSD. One reason cited in the literature is that therapy models designed to get the speediest possible results tend to be those that rely on reshaping thoughts and beliefs to achieve emotional changes. Much cognitive self-esteem therapy is predicated on "normal" physical brain structures that can respond to these approaches.

For survivors of prolonged trauma, such as childhood sexual abuse, studies beginning in the 1990's have shown that brain structures critical to the experience of emotion are frequently shrunken with poor dendritic connections (Bremner & Narayan 1998; Bremner, Southwick & Charney 1999; Bremner et al 1997; Bremner et al 1995; McEwan et al 1992). This means that despite cerebral intentions to change beliefs and therefore emotional responses, survivors with who have undergone prolonged trauma may have limited ability to change quickly due to physical effects of the abuse on parts of the "emotional" brain. Over the course of extended therapy, survivors are both emotionally and *physically* strengthening their (and their brains') ability to trust, which is not possible in short term approaches (Atkinson 1999). Most therapies for PTSD which involve flooding or recreation of trauma circumstances were not created with sexual violence in mind, and their consequences for sexual violence survivors are not yet clear.

Drawbacks to short term therapy for sexual violence survivors are recognized by specialized Nova Scotian counsellors:

*The [short term] confrontational kind of therapy is one of the biggest things that frightens people...and then they just walk away from it.*

*We recognized that people who...work too quickly can end up being wounded again, from being flooded with too much.*

*It is hard for [clients] to share the things [they] need to share with me. In order to build more trust with me and in order to be able to work through past trauma...takes time.*

A deliberate, paced and steady therapy is important to counter the roller-coaster of crisis that can be caused by short-term intrusive therapies as well as the sexual violence itself. (Chu, 1998)

Separating survivors' needs into short term and long term in itself was an artificial concept for most of the survivors participating in Antigonish's 1994 research. They felt the division did not reflect the way they personally experienced their needs. The duration of no-cost therapeutic counselling available through Avalon is severely limited by resources: Clients are offered short term time-limited contracts with mandatory breaks. Avalon counsellors report that this impedes the building of trust, particularly of those who are carrying severe and multiple trauma. It creates a sense of failure and discouragement to clients ("Why can't I change fast enough?") which adds to the burden of self-blame that survivors may carry. Being restricted to short-term counselling puts undue pressure on the client/therapist relationship, and undermines the

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process of building a working alliance between equals. Counsellors report that some women are unwilling to enter the time limited counselling because they know the limited number of sessions will open up but not heal their wounds.

**(e) Non-intrusive methods**

Specialized therapy for survivors needs to be respectful and empowering. First, survivors have experienced overwhelming, intimate violence, both bodily and psychologically. Violation and loss of control is part of the original trauma, and must not be repeated by insensitive intrusive therapeutic methods. Second, specialized therapies for survivors empowers them as equal partners in healing, and the primary decision makers about their journey, countering the experience of powerlessness ingrained through sexual violence trauma. (Chu, 1998) These specialized needs are incompatible with some notions of therapy, where the balance of power is weighted toward the professional.

Even skilful practitioners, as described by Thomas (2005) may “find themselves acting in a way that is likely to match to survivors’ internal abuser role...They want to help clients and are invested in the success of their interventions; they may not notice clients’ weak resistance signals; they may become anxious when clients dissociate and compensate by acting more definitively, they may be irritated by what seems to be client resistance, in the psychoanalytic sense, and they may enact the abuser role through projective identification.” These concerns highlight the need for specialized, non-intrusive and empowering partnerships with therapists rather than “treatment” in a conventional sense.

Avalon counsellors consistently adhere to this tenet of best practices for sexual assault survivors.

**(f) Limited caseloads, vicarious trauma support**

Due to the intensity of sexual violence therapy, and vicarious trauma, counsellors’ caseloads must be limited. At Avalon Centre, counsellors are limited to seeing four clients per day. Specific supports are needed for counsellors to deal with vicarious trauma. Avalon Centre and other survivor-centred and woman-centred organizations are described by specialized counsellors as very positive environments for preventing/addressing vicarious trauma:

*It is really important to have good people who are doing mentoring or supervision who are counselling. It was really important to me.*

*Not just supervision but peer support [among specialized therapists]. We offer to each other in moments when we need it.*

*I feel very grateful to be at the women’s centre...if I have heard something particularly awful I feel very blessed to be able to run next door to my co-worker and I can just unload and she will be OK with that...and it won’t go anywhere...this is one of the most supportive work environments I have ever been in.*

*There is an openness to self-examination that I think is unique to feminist organizations; there is an openness to critique...I am respected...even though we might not always agree. Other agencies would really tell me to toe the company line; at this agency there is [a] level of respect.*

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*Some of the people who are trying to do this work whose heart is in the right place are alone in that a lot of the time. Not so much in Halifax but you can be alone ideologically in more isolated areas. In Halifax, I am not saying it is easy, but there are more opportunities to find [other professionals] with a similar approach or philosophy, than in rural Cape Breton.*

Avalon Centre's specialized therapy is a model for other organizations: high-quality, holistic, survivor-centred and delivered by experts. However, even that organization's service delivery model is distorted away from best practices by under-funding. Specialized therapy is virtually unavailable in the rest of the province.

## 5.2 Basic Survivor Support

Basic survivor support can include listening, provision of information and options, and in limited ways at certain organizations, the provision of general ongoing emotional support and some advocacy. These services, however, do not provide therapeutic recovery. They do not replace therapy and do not address the root causes of symptoms in survivor's lives. Without therapy, basic survivor support clients may not progress which leads to repeat crisis interventions and longer term use of resources for basic survivor support than would be necessary if recovery was possible through therapy.

One of the only strengths of Nova Scotia's overall inadequate response to sexual violence is the quality of non-therapeutic, basic survivor support delivered by women's centres and the transition houses, as well as the two sexual assault centres. However, many of these organizations generally do not publicize these services for fear of being overwhelmed by population need.

### 5.2.1 Limits to Basic Survivor Support

It is recognized that the unique nature of the harms associated with sexual violence requires specialized responses. Currently, even basic survivor support of this sort is available in a very limited way in Nova Scotia. Mental health, addictions and other health-care system-based services do not offer explicit survivor services. Some counsellors in these systems have self-educated, and do have specialized knowledge, but referrals to them are dependent on word of mouth and the referring agency's knowledge of the particular counsellors' unofficial expertise in sexual violence.

Women's organizations, to an extent severely limited by resources, do explicitly offer basic survivor support. In addition to Avalon Centre in Halifax, and the Colchester Sexual Assault Centre, some specialized non-therapeutic support is available through women's organizations such as the women's centres and transition houses.

Although non-therapeutic support is a service provided by women's organizations serving all areas, this does not mean that the need is actually being met. The organizations do not conduct campaigns to advertise these services. Some have commented for this research on their fear that such advertising would create a flood of clients who would overwhelm the organization's resources. These services are not part of THANS members' mandates and are thus not funded unless associated with partner violence, and so, although THANS members

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may informally provide support to sexual assault survivors who are not targeted by partners, they do not advertise these services, nor actively seek to increase access by that clientele.

Women's centres participating describe that their resources have become disproportionately very highly focused on sexual assault in order to address the magnitude of the need, as clients disclose directly at initial contact or (often) in the course of gaining confidence in centre staff as women participate in other, non-specific programming such as self-esteem work. The unrecognized and under-funded nature of the provision of these supportive services undermines their visibility and potential as services.

### 5.3 Crisis Lines

A gap in services affecting the entire province is the absence of a 24-hour sexual assault crisis line.

Past studies have highlighted the need for a specialized crisis-line. Survivors in Pictou County's *Survivors Speak Out* prioritized the need for a 24-hour crisis line:

*They should have a 24 hour crisis line for people who need to talk to someone late at night. There's a lot of [survivors] out there...late at night who are suicidal.*

*I wish to God that Helpline was open a lot earlier.*

*When I'm having flashbacks, I get body memories and that's so difficult. You need someone who can get you talked down...at 3 AM."*

Many women participating in the King's/Annapolis Women's Project suggested a 24-hour crisis line staffed by those trained to give supportive counselling to sexual violence survivors. In this vision document, the crisis line would also serve as a dispatch to refer on-call advocates to callers if desired.

Despite recommendations in previous studies, there are still no 24-hour crisis lines for sexual assault survivors anywhere in the province. There are no crisis lines focusing only on sexual assault. Survivors do call existing general issue help lines, although their hours can be limited in ways that exclude the high needs times for survivors when assaults are taking place, or when flashbacks or suicidal ideation are occurring.

Every (large) region does have a 24 hour emergency line for partner violence, through the transition houses. Transition house staff and directors indicated that sexual assault survivors do call their emergency line seeking help. This appears to be particularly true in the aftermath of recent assaults, more than crises emerging from historical assaults. While transition staff do offer information and some support to these callers even if partner violence is not involved, this service provision is not recognized or funded by government.

Survivors do call Avalon Centre, Colchester Sexual Assault Centre and women's centres in crisis as well. Avalon staff receiving the call will assist with crisis issues. CSAC, with only one staff, may not be able to respond to crisis calls if the director is out of the office that day delivering programming, etc. Response times are generally limited to office hours. Cape



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Breton's collaborative work has led to preparation for a crisis line for sexual assault based in Everywoman's Centre in Sydney. A line was not operative as of this writing.

Counsellors with Avalon noted that the existence of a crisis line without accompanying therapeutic counselling resources available can lead to an unhelpful cycle for repeat callers: the same survivors may end up in crisis again and again because they are not receiving the in-depth therapeutic assistance needed to progress and stabilize. This means that staff at women's organizations hosting a crisis line can end up spending as much as three hours on a crisis call, and simply doing it again and again with the same survivors who are not receiving any help with long-term approaches to trauma symptoms.

Avalon also experienced a severe administrative drain organizing and running the crisis line, and eventually shifted resources away from this service and into therapeutic counselling. At first, training and partnership with Helpline was thought to be an adequate replacement, but this partnership has not continued.

Male staffing of generalized help lines may be an inappropriate response for sexual violence callers.

#### 5.4 On-Call Community-Based Advocates

It is important that coordinated community responses to sexual assault find ways to improve the accessibility and availability of advocates' services. Sexual assault survivors' advocates available for immediate response provide numerous benefits and can prevent serious negative consequences for survivors (Campbell 2005). There is strong evidence that advocacy is the primary need in the immediate and short-term aftermath of sexual assault, especially where there has been an official report to the police (Kelly and Regan, forthcoming).

In a study of secondary victimization, (Wasco & Campbell 2002) the relationship between social system contact and posttraumatic stress symptoms of survivors as a function of whether they had the assistance of an advocate was examined. Although the number of survivors in this study who had an advocate was small (21 in a sample of 102), they found that survivors who worked with advocates reported less distress after contacting the legal and medical systems.

In *Beginning With Us*, the AWRC identified the need for a specifically mandated sexual assault crisis intervention centre. This centre would provide a 24-hour crisis line, and advocacy: "a person to weave through different agencies and who will accompany survivors through medical exams, police interviews and other processes." Some organizations then providing crisis response were limited by their specific mandates; for example, St. F.X. University for students; Naomi Society for women assaulted by partners, and children and adolescents experiencing family violence. Ideally, one person, or at least one organization should provide continuous and reliable support beginning with immediate on-call advocate response. AWRC expressed its wish to provide more of these services, among other specialized services.

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As sexual assault nurse examiner (SANE) programs grow, it is important to remember SANEs are not advocates. While they can create a caring, supportive atmosphere for medical treatment and forensic exams, their role and training does not extend to the full advocacy and support survivors may need. To address this, in many SANE programs, advocates are on-call responders along with SANEs, working closely and collegially with SANEs. This is the case in numerous Canadian jurisdictions including SANE programming in British Columbia, Alberta, and Ontario. In these jurisdictions, SANEs offer survivors the option of having an advocate from a specialized community organization serving sexual assault survivors, attend at the hospital. In other jurisdictions (particularly where advocates and SANEs are employed by the same community organization) advocates are automatically called to the hospital along with the SANE, and offer the survivor their services directly. Informants from these programs estimate that when services are offered by SANEs, advocates are accessed at the hospital between 20-40% of the time, and when advocates offer their services directly, 80-95% of the time. Funding for these services may come from the SANE program host, or advocates may be provided through the independent funding of separate survivor services.

It is also inappropriate to rely on police-based victim services to fulfill this role. It is important that survivors have an advocate immediately available whom they can fully direct, and who is responding to the situation with no other responsibility than to the survivor. In the immediate aftermath of sexual assault, survivors may encounter pressure from the police to give a statement, or be subject to myths, stereotypes or rejection by police. An independent community-based advocate is needed in these circumstances. In any case, aside from volunteer domestic violence on-call response in the Halifax area, police-based victim services are not providing regular 24 hour on-call response to sex crime victims, although some volunteer support may be available from time to time.

Community-based on-call advocates bring their understanding of sexual violence as a social issue to immediate response, and are able to support survivors immediately to prevent self-blame, and dispel myths and stereotypes about sexual violence. If the on-call advocate is also connected to an organization providing supportive or therapeutic counselling, services to survivors are more seamless, and referrals and follow up by the survivor for counselling are more likely.

In Nova Scotia, the Avalon Centre does not offer advocates' services at the hospital, due to fiscal constraints. The Antigonish Women's Resource Centre (AWRC) offers volunteer on-call advocates associated with their SANE programming, but this is not a funded part of the first-year SANE program there. Volunteer on-call advocates do respond when available, which they sometimes are not. AWRC is concerned that these advocacy services may not be sustainable without core funding, due to the burdens associated with administering volunteer programming. Other women's organizations reported occasionally being able to provide an on-call advocate from among staff, but this was not a formal part of response, nor were they resourced to do so consistently or even frequently.

## 5.5 Justice System Accompaniment

No organization in Nova Scotia has ongoing funding to provide justice system accompaniment to adult sexual assault survivors involved in the investigation and trial of

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their assailant(s). Department of Justice Victim Services does have a program for a higher level of services including accompaniment “when there is a need” for some victims of crime. When seeking private funding for such accompaniment, Avalon Centre was surprised to learn of the widely-held impression, even among legal professionals, that such services were already funded and consistently available to survivors. They are not.

Survivors of any crime who are judged to be “highly traumatized” will receive a higher level of services from Department of Justice Victim Services, possibly including justice system accompaniment. This will not apply to most sexual violence survivors however. The decision as to who is “highly traumatized” is made based on whether victims self-identify as high need. This is not an evidence-based approach to determining level of trauma, as sexual violence survivors may not recognize in themselves the signs of trauma, may have a flat affect, may feel unworthy of support and fail to identify needs. There is, in fact, evidence that survivors who are “numb” are more, not less, traumatized and more vulnerable to secondary wounding<sup>25</sup>.

Victim Services can often arrange for family and friends to accompany victims to court for other crimes. But in the case of sexual violence, the circumstances may often make this inappropriate: the accused is likely to be a relative or friend of the survivor; family and friends may have rejected the survivor after disclosure, or may be subpoenaed to testify themselves and thus proscribed from attending the survivor’s testimony.

Department of Justice Victim Services often refer clients to Avalon for justice system support and advocacy because they identify (to Avalon) that they lack the specialized knowledge to address sexual violence issues as well as being limited by the demands of their caseloads.

Currently, Department of Justice Victim Services outside Halifax will usually turn to women’s organizations to arrange accompaniment. They express a preference for staff rather than volunteers to do this work, so that the information provided about the court process will be accurate, and so that trauma can be better prevented and identified. Women’s centres and transition houses respond on an ad hoc basis to requests for accompaniment depending on the availability of staff. When they are able to provide someone, it is generally for the period of the complainant’s testimony only; women’s organizations cannot devote staff to periods of time when survivors might be required to stay in the courthouse in case they are called back for further testimony. One Victim Services manager recounted a situation in which a survivor was required to remain isolated at the courthouse for four days as the trial proceeded. She spent this time alone in a room, awaiting a call back to the stand at any time.

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<sup>25</sup> Winkel, F., (1991) Rape victims' style of self-presentation and secondary victimization by environment: an experiment. *Journal of Interpersonal Violence*. 6(1):29-40.

Quote: "Rape victims differ in their style of communicating their experience to others in their environment. The present experiment tests the hypothesis that a numbed style of self-presentation, as compared an emotional one, will result more strongly in secondary victimization by those around her."

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Department of Justice Victim Services regional managers identified accompaniment as one of the highest priority gaps in a survivor-centred coordinated response to sexual violence as noted in the following comments:

*[We cannot do accompaniment] with caseloads of over 200, and we're looking at a woman sitting alone in a room by herself going, OK, this is wrong, this is not right. So you just feel so inadequate at this point.*

*Adult court accompaniment is not a service we are set up to provide, because we just couldn't. We have 6 courtrooms, plus Supreme Court, and 4 more, and we only have 7 people in the office.*

*We generally arrange or find out if they have support. But that might not be professional support; that might be family support. It would be beneficial to have professional support [because] they could explain what is going on in the system that day.*

In Halifax, Avalon Centre has provided some justice system accompaniment on a limited basis in the past. Accompaniment has also sometimes been provided by Bryony House staff. In 2008, private funding allowed Avalon Centre to hire a full time staff person for justice system accompaniment. The funding is provided on a trial basis only.

The provision of justice system accompaniment by women's organizations is not recognized or remunerated in their core funding. For transition houses, unless the accused is an intimate partner, the services are outside their funded mandate completely. Despite the justice system's urging of survivors to report, this minimal level of emotional support is not being supported.

## 5.6 Sexual Assault Nurse Examiners

All four previous research reports identified expert medical response as crucial to health and well-being of survivors and to the prevention of secondary wounding and long-term negative impacts. Currently only the Halifax area and the Guysborough-Antigonish-Strait Health Authority region offer sexual assault nurse examiner (SANE) services to survivors of recent assaults.

Implementation recommendations for province-wide SANE services were developed by Avalon Centre at the request of the Nova Scotia Department of Health in 2007. Community-based SANE programming, modeled on the successful (Mahon 2003) Avalon Centre program was recommended for the entire province, with immediate implementation beginning in the Sydney area. Specialized rural responses were also developed. Recommendations from that report are attached as Appendix B.

## 5.7 Services for Men

Although social responses to male and female victimization are distinct (Doherty and Anderson, 2004), specialized sexual assault services for men or transgender persons are rare across Canada, and are nearly absent in Nova Scotia. Both community organizations and health system managers recognize this gap and believe it needs to be addressed by the

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community and the province, in the context of developing a plan for province-wide comprehensive sexual assault services. Possible short term approaches include increased funding for specialized counseling for men, and partnerships with agencies that will or already do provide such counseling, such as various projects or services targeting LGBTI clients.

In the aftermath of a sexual assault, male survivors may find themselves dealing with myths like the following:

- ♦ As males, they should have been able to fight off the attack;
- ♦ Only gay males are assaulted;
- ♦ Gay males deserve/provoke/enjoy sexual assault;
- ♦ Erection or ejaculation during sexual assault means “you really wanted it” or “enjoyed it” or consented to it;
- ♦ If a man experiences emotional pain, he should be able to deal with it, alone

Due to stereotypes like these, some men may experience feelings of loss of manhood, sexual identity confusion, fear of being perceived as gay and some may manifest depression, rage and anger in gender-specific ways. Services need to be able to respond knowledgeably. Male survivors tend to present more depression and hostility immediately post-assault than females.

Recent research indicates a greater likelihood of adult male survivors to have physical or mental disabilities, to be homeless, to be anally or orally attacked, to be assaulted outdoors, to be assaulted by multiple attackers, to be assaulted with a weapon, and to be injured severely enough to be hospitalized after a sexual assault (Stermac, del Bove & Addison 2004). Society also tends to hold male survivors more responsible for their assault than female survivors (Smith, Pine & Hawley, 1988). Services must be cognizant of an increased likelihood of these possibilities when working with male survivors.

Gay men who are sexually assaulted may have specific concerns. They may be victims of hate crimes. Gay men may fear that seeking care after the assault may compromise their privacy regarding their sexual orientation, or the orientation of their attacker, if known to them, and cause harmful discrimination. One study suggests that a high proportion of gay men will experience sexual assault in the form of partner violence, but that this is underreported (McClennen, Summers, & Vaughan 2002). Personnel must be prepared to respond in supportive ways to these added gender-specific aspects of post-assault trauma.

The Colchester Sexual Assault Centre now provides basic survivor support for men and actively promotes itself as LGBTI-positive. In the New Glasgow area, both the women’s centre and sexual health centre (which are located in the same small building) increasingly serve men dealing with issues of poverty and sexual health. Follow up counselling for males using SANE services is through referral to Family Services.

Several transition houses identified their staff as having expertise that male survivors of sexual violence could benefit from. However, especially those in smaller communities also

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were concerned that some male survivors may also be batterers or abusers, which could create conflicts. Having counsellors serve male sexual violence survivors who were also woman-abusers could destroy women's trust in their organization both as individual clients and in the community's view. These organizations felt that separate counsellors were needed. Given that caveat, some transition houses still felt that a men's program could be run through their organization, if staff were separate. One survivor's remarks confirm that there is a danger in destroying therapeutic benefits to survivors if perpetrators are also treated by the same counsellors:

*The thing that turned me off about my psychiatrist, he was a good man but it was the fact that he also treated offenders. Turned my stomach. I stopped seeing him. - survivor, Pictou County*

CSAC does provide basic survivor support and other services to men. The director has felt that there have been no physical or psychological safety issues for women survivors using the service. CSAC is housed in a multi-agency building, which can involve the presence of men who are woman-abuse perpetrators, and CSAC warns clients of this issue, who then may choose to attend or not.

However, it is the consensus of most survivor-centred service providers that a gender-specific, rather than a gender neutral approach to services is the approach most likely to address male survivors' distinct needs, and least likely to compromise the needs of the majority of survivors who are female.

## 5.8 Professional Education to Eliminate Secondary Wounding

A growing body of literature indicates that survivors' interactions with professionals after an assault may be traumatizing in their own right, causing what is called "secondary victimization" or "secondary wounding." Secondary victimization is the re-traumatization of the sexual assault, abuse or rape survivor. It is an indirect result of assault which occurs through the responses of individuals and institutions to the survivor. (Campbell & Raja 1999)

Ahrens describes the impact on disclosures if survivors are subject to myths and stereotypes held by service providers and professionals (Ahrens 2002):

*For many victims, negative reactions from support providers may silence them, halting disclosure for a significant period of time...Qualitative analyses revealed three pathways to silence. Three survivors were silenced by blaming and insensitive reactions from formal support providers that heightened concerns about the effectiveness of disclosure and increased fears of negative reactions. Three survivors were silenced by inappropriate and ineffective support attempts by informal support providers that increased feelings of guilt and shame and led them to question the efficacy of disclosure. The remaining two survivors were silenced by both formal and informal support providers whose adherence to rape myths led these survivors to question whether their experiences qualified as rape.*

A 1999 study revealed the high prevalence of secondary victimization in the estimation of U.S. mental health professionals serving survivors. Probability sampling was used to survey

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a representative sample of licensed mental health professionals about the extent to which they believe rape victims are “re-raped” in their interactions with social system personnel. Most therapists believed that some community professionals engage in harmful behaviors that are detrimental to rape survivors’ psychological well-being (Campbell & Raja 1999).

Secondary victimization has been linked with a variety of negative outcomes, such as increased psychological distress, physical health symptomatology, and sexual health risk-taking behaviors (Campbell et al, 1999, 2001; Campbell, Sefl, & Ahrens, 2004). Negative social reactions to disclosure are strong predictors of negative health outcomes for survivors (Mcauslan 1999). Thus, a reduction in secondary victimization would have important long-term benefits for survivors.

Professional education was identified in previous Nova Scotia research as critical in preventing secondary wounding and serving survivors appropriately. The following is a brief summary of what each research project reported:

- ♦ The Kings/Annapolis Women’s Project identifies the highest need for training as among medical professionals. Medical staff, both in the experience of survivors and based on researchers’ interviews with these professionals, revealed a lack of understanding of the signs and symptoms of sexual assault, when to make referrals for appropriate help, or the problems associated with a history of sexual violence. Other professionals, including police officers, acknowledged their lack and expressed a desire for specialized training.
- ♦ In *Can No One Hear My Cry: Sexual Assault in Cape Breton*, professionals identified the lack of specialized training of many professionals as a barrier to recovery. Research participants emphasized the need for professionals to become comfortable and competent in responding to sexual assault and to understand sexual assault as a societal rather than an individual problem. Instances and prevalence of secondary wounding were identified in the medical, justice and mental health systems serving Cape Breton. The report recommended multi-disciplinary workshops “for all social, educational and medical service providers.” Judges particularly were identified as lacking in basic understanding of the realities of sexual violence.
- ♦ In Pictou County’s *Survivors Speak Out*, medical doctors, clergy, and police were singled out by survivors as poor responders who could be: (a) unfamiliar with the signs and effects of sexual violence, or the links between sexual violence and addictions, depression, suicidal ideation or eating disorders; (b) overbearing and insensitive in interviewing survivors; (c) unlikely to accept or encourage a client-directed recovery; and (d) disrespectful confidentiality (clergy). The report recommended that helping professionals consult with and learn from survivors, as well as participate in mandatory, specialized training.
- ♦ *Beginning With Us* identifies detailed, profession-specific training needs for professionals serving Antigonish County in the criminal justice system, the medical system, therapy and counselling, child protection, and the school system.

This needs assessment found that there has been no coordinated response to the identified needs for specialized training throughout the province. There is no current requirement for

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professionals serving survivors in the justice, medical, or counselling systems to participate in specialized sexual violence training (with the exception of SANE programming). As in the 1990's, these professionals continue to identify the need for such specialized education as demonstrated in the following example:

Researcher: Would professionals in your area be interested in specialized training around sexual assault?

Response #1 *Yes, absolutely.*

Response #2 *Yes, they are starving for it. And I mean every time I see people they ask me when are you going to do another sexual assault workshop or conference. They are starving for it and they are not always able to go out of the area to do that because of their agencies' limitations. So it has to be here; it has to come to them. - Cape Breton*

Response # 3: *In a lot of cases women [i.e. non-offending mothers] are treated very well by child protection, and they are looked after. And in a lot of cases they are not. It totally depends on the worker. It's an area where specialized training would be useful, most definitely. - Transition house staff*

Some service providers have made an effort to self-educate, but there is no system to recognize any individual professional's enhanced expertise. Referrals to informally specialized service providers tend to be based on community word-of-mouth concerning sexual violence expertise. Cape Breton police reported training in sex crimes investigation for investigators and major crime officers, especially regarding childhood sexual abuse. Staff turnover, particularly for RCMP, makes ongoing rather than one-time training imperative.

Secondary wounding and professionals' lack of understanding of sexual violence continues to be identified by survivors and their counsellors:

*Women aren't believed and they are held responsible for the abuse.*

*The Crown came in and was talking about the woman's reaction and the nurses noting the woman's reaction to the assault...and his job was like, if they're not being the "good victim" to explain why. Why don't we get rid of this notion of "good victim" and make [the Crown's] job a whole lot easier?*

*Very seldom does the justice system heal anybody, even though they [survivors] think it will in the beginning and they disclose because they want it to.*

*The child protection worker yells at her and tells her she is a bad mother. She has a massive history of trauma including relationship abuse and feeling bad about herself...[and it leaves her] trying to figure out where she is going to get services. Yeah, that is "helpful" - yelling at her for this guy abusing her, and taking her kids away. She is being punished for her partner's behaviour, for her history of abuse and the effects of that.*

Service provider #1: *The majority of women who come through here aren't even considering going through the legal process.*

Service provider #2: *God, no, it doesn't even come up.*



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Service provider #1: *They have heard about 6 months house arrest, or sentenced to community for raping a small child...I get a sense of women asking themselves why they would subject themselves to the ridiculousness of that.*

The Sexual Assault Nurse Examiner (SANE) programs in Halifax and Antigonish have provided specialized training to nurses; and, in the case of Antigonish, to nurses and doctors. It is important to recognize that this training enables professionals to handle sexual assault disclosures without causing harm *in the context of their own jobs*. It does not turn them into specialized sexual assault counsellors or advocates.

Avalon Centre, Colchester Sexual Assault Centre, and to a lesser extent, Antigonish Women's Resource Centre have delivered specialized training to professionals serving sexual violence survivors. This professional training is limited by the budgets of the respective agencies receiving it, and the resources of the delivering agencies. There is no regular schedule of ongoing training in sexual violence response, at any agency.

*We do training...but we don't have sustained funding...It would require a staff person and it is not a small job. - AWRC*

*Parent resource centres, mental health agencies or even more institutional agencies...recognize they have a gap in... how they are addressing sexual violence and they are looking to us as the sexual assault centre to provide them with the knowledge and the resources and the support to do that work in their own community. So even though we are not a provincial organization we are working in that capacity...and we are limited in our funding to travel to other parts of the province to do training. - Avalon*

*The demands are so high but it can take years for an agency to build up the funding themselves to bring us up to do something. We probably turn away up to five agencies each year because they can't afford it and we can't afford it. - Avalon*

In 2007, Avalon Sexual Assault Centre was funded by a one-time grant to deliver training to the staff of women's centres. In 2008, THANS received funding through the Nova Scotia Government Employees Union (NSGEU) to host a training workshop facilitated by Avalon for THANS member staff. Avalon also has one staff person who is primarily privately funded on a year-to-year basis to deliver both public and professional education.

The custom designed training programs that Avalon Centre provides focus on sexual assault awareness, response, support, investigation, and advocacy. Which aspects of this training that participants receive depends on their profession, their previous knowledge, experience, and skill level, and the nature of the training workshop. It may provide a broader understanding of the issues pertaining to sexual violence and survivors and a feminist analysis of sexual violence as a social issue. It may be skills-based, providing participants with the knowledge, skills, and techniques to respond to and provide support to victims of sexual assault within the context of their day to day work. They are not trained to be therapeutic counselors but rather to prevent secondary wounding, provide first response to disclosures, inform survivors of options, have a broader analysis of sexual violence as a social issue and to provide basic emotional support.

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## 5.9 Recommendations for Core Services

Based on the above findings, the following are recommendations for core services.

### 5.9.1 Specialized Therapeutic Counselling

- ♦ Specialized therapeutic counselling must be made available to survivors regardless of their location in the province.
- ♦ Specialized therapeutic services for survivors are best delivered through community-based specialized centres that accommodate counselling models and service delivery mechanisms geared to survivors' specialized needs. The Avalon Centre's holistic, survivor-centred activities and philosophy of service embody these qualities and should be adopted as the model for new sexual assault centres and services in Nova Scotia.
- ♦ The most effective counselling model for sexual violence survivors is not highly compatible with the operation of the general mental health care system. For reasons related to optimal recovery, survivors require specialized structuring of therapy, including:
  - *Very short or no wait time;*
  - *Specialists who can recognize the need for intervention and assess accurately;*
  - *Open-ended duration*
  - *Weekly frequency*
  - *Empowering, non-intrusive method*
  - *Limited caseloads, vicarious trauma support for specialized counsellors*
- ♦ Peer support and group work can also be beneficial but also present challenges related to secondary wounding, and should not be used as an inexpensive approach to services for survivors. These options should be viewed as an adjunct to individual therapeutic counselling, and stably funded and subject to standards within that context.

### 5.9.2 Basic Survivor Support

- ♦ The unique role of women's centres and THANS members in providing basic survivor support to sexual violence survivors needs to be recognized and resourced properly.

### 5.9.3 Crisis Lines

- ♦ A 24-hour specialized crisis line for sexual assault survivors should be accessible throughout the province.
- ♦ Crisis lines should be developed simultaneously with the development of therapeutic counselling resources for communities. Crisis lines are not sustainable as substitutes for therapeutic counselling.

### 5.9.4 On-Call Community Based Advocates

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- ♦ The provision of on-call advocates' services should be viewed as an integral part of comprehensive community response to sexual assault. Core funding for the provision of these services should be allocated to community-based survivor-centered organizations providing other survivor services.

### 5.9.5 Justice System Accompaniment

- ♦ Justice system accompaniment should be made consistently available to all sexual assault survivors attending justice system proceedings. Core funding for women's organizations to establish permanent positions is essential. Accompaniment should include all meetings with the police and Crown, preliminary inquiries and waiting time at the courthouse, not just time testifying at trial.

### 5.9.6 Sexual Assault Nurse Examiners

- ♦ SANE services should be available to all Nova Scotians. The recommendations with respect to SANE programming previously provided to the Nova Scotia Department of Health should be implemented.

### 5.9.7 Services for Men

- ♦ The gap in men's services needs to be addressed through separate, community-based counsellors and resources, with expertise in the unique needs of male survivors which are distinct. Forcing sexual assault centres or women's organizations to adopt a gender-neutral approach would adversely affect services to most survivors who are female and require an environment that is perceived as safe and require staff expertise in female service needs. Separate services for men staffed by specialized counsellors should be developed, which will respect the majority of survivors' needs for a trusted, woman-centred environment and approach.

### 5.9.8 Professional Education

- ♦ A planned approach to the training of justice, medical, mental health, child protection, and other staff should be developed by the province as part of an overall strategy to address sexual violence. Current organizations (Avalon, CSAC, and AWRC) delivering training should be provided additional core funding to continue doing so in an organized and long term manner that reaches all areas of the province. Training should be scheduled to be repeated at intervals and be custom designed, based on previous training to advance particular agencies' goals.



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## 6. The Need to Eliminate Barriers to Access

In addition to inadequate services, survivors and service providers identified barriers to accessing what services do exist. Highlighted barriers included the following which are described in this section:

- ♦ Transportation
- ♦ Cultural Competencies
- ♦ Access for persons with disabilities, and
- ♦ Rural challenges.

### 6.1 Lack of Transportation

Lack of access to affordable transportation has been cited in Nova Scotia research as a strong barrier to accessing many services (Ross 2006; Rubin 2005, 2007; Rural and Remote Working Group 2004). All four previous Nova Scotia reports on sexual violence response in the province's regions cite transportation as a primary obstacle in accessing services.

Although sexual violence affects people in all socio-economic levels, there is a relationship between poverty and vulnerability to sexual violence. Those living in poverty are least likely to have access to or be able to afford private transportation to services. If the abuser or assailant is a partner or father, they may control the survivor's access to a car.

Most of rural Nova Scotia is underserved with respect to public transportation - it doesn't exist, or is sparsely provided. This includes parts of rural Halifax County. Even in urban Cape Breton, public transportation to travel in and among the communities surrounding Sydney is severely limited. The time required to use public transportation in many areas, if it even exists, is prohibitive for survivors with work and family responsibilities. For the least moneyed survivors, paying for public transportation can be an obstacle too.

Transportation for sexual assault survivors is generally not provided by community organizations due to resource, safety and liability issues. To address the transportation barrier for survivors seeking counselling, a few organizations offer some basic support by telephone. These include CSAC, The Women's Place, and Cape Breton Transition House. (Others providing basic survivor support may do this by telephone, but did not specifically describe their services as such). These organizations are positive about their experiences providing telephone services. The CSAC director feels that the telephone option is appealing to some survivors whose confidentiality or trust issues prevent them from coming in personally for support.

All therapeutic counsellors interviewed felt that therapeutic counselling (as opposed to general support and information) was not appropriately provided by telephone. They felt that in-person contact was crucial to several key aspects of deep recovery for survivors, such as:

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- ♦ Building trust in the therapist and process, especially after secondary wounding elsewhere;
  - ♦ Modeling of a healthy caring relationship (which childhood survivors may never have experienced);
  - ♦ Therapists' accurate understanding, through facial expression, demeanour and body posture, of clients' emotions;
  - ♦ Intense work together as extremely painful memories and emotions are experienced.

If the survivor involves police in the immediate aftermath of an assault, police will usually provide transportation to hospital, or to transition houses in the case of partner violence. This is a less than ideal arrangement, as it can often mean a long car ride with police officers who may or may not have had training in survivors' post-assault needs, and the preventing of secondary wounding. The survivor may have called police but does not wish to give a statement. Reliance on police for transportation can add to the power imbalance between survivors and the justice system. Some local law enforcement officers may be part of the social network that includes friends or relatives of the perpetrator or the survivor, discouraging reporting, or even a long ride together to the hospital. Law enforcement resources may be limited in ways that prevent them from undertaking timely transportation to a hospital (Rubin 2007). Police do not assist with access other than response to the immediate aftermath of assault or reporting.

The lack of services and transportation options has caused some survivors to relocate to Halifax to access Avalon Centre, causing further disruption in their lives in addition to the effects of the violence. One survivor in previous research (Rubin 2003) spoke of having to give away the children's pets in order to find an apartment in Halifax, as they relocated from their rural single-family dwelling in order to access Avalon Centre services.

Avalon SANE program users (survivors up to 72 hours post-assault) have access to free taxi transportation in Halifax for SANE services. Cape Breton Transition House, which is mandated to serve only those affected by partner violence, reports occasionally paying for bus fare for clients, or sometimes a taxi if there is an immediate safety issue, when domestic violence is involved.

## 6.2 Cultural Competence

The ability to serve diverse populations in an environment that is safe and sensitive is critical to providing survivor-centred sexual assault services, at the core of which is trust. Cultural competence is expected and supported in many U.S. jurisdictions. Organizations serving survivors partner with diverse community groups and educate staff with respect to diversity issues. However, there is no resource support for long-term development of cultural competencies. This would include improving the representation of diverse populations, especially racialized women, among service providers, for which there is no government incentive or support.

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In recent years, Pictou County Women's Centre in New Glasgow has provided leadership in serving sexual assault survivors from culturally diverse backgrounds. In 2006, for the first time a culturally specific program for African Nova Scotian survivors of childhood sexual assault was offered. This program was well attended. Programming included staff from the community. The Women's Centre receives no additional funding to offer these programs.

Service providers interviewed for this research could identify *no other specialized sexual assault programming for any of the following survivor population groups*: visible minority (other than Aboriginal); foreign-born; non-English speaking; gay, lesbian, bisexual, or transgender; elderly; and other distinct communities.

In the Halifax area, a large international community is associated with the universities, often with significant cultural differences with respect to sex and gender roles. There is no specialized sexual assault programming for the international community.

Within the Aboriginal communities, some survivors have access to the Mi'kmaw Family Healing Centres, which deliver direct child welfare legislative and family violence protection, treatment and prevention services to all (13) Mi'kmaw First Nation Bands of Nova Scotia. Like other transition houses, they do have many clients who experience sexual violence. While the director of the Healing Centres indicates they will address sexual violence within a total family approach, they are not explicitly resourced to address sexual violence in specialized, survivor-centred ways.

Outside the family violence context, resources for Aboriginal sexual assault survivors are even more limited. There are current efforts to increase the availability of specialized counselling for survivors. Of particular note is programming at Eskasoni, led by Dale Sharkey. There have been and continue to be outreach efforts by some women's organizations based in the white community to Aboriginal women. Victim Services' managers report trying to be more responsive to Aboriginal survivors' needs, by working with the Healing Centres and with Eskasoni leaders to respond appropriately to culture and community. There is no stable funding for outreach efforts.

With respect to the needs of survivors from non-dominant groups, service providers commented:

*If they are used to being discriminated against for other reasons or if they are considered to be a "population at risk" or problematic in some way then they are not likely to disclose and they do not expect to be treated very nice. - Avalon staff member*

*The racism in the community is rampant. People are judged by where they come from or who they are. And if they are Aboriginal or Black they are [considered] "not from Truro." There is a hesitation to ask for assistance [with sexual violence] by people on the reserve or in the Black community because people already judge and now they'll judge them again. There is fear to reach outside because it will create another issue for people to judge their community. - Truro*

*[Colchester Sexual Assault Centre] could be perceived as a white service because I am the person who is here. Once people access the service, a lot of times we do hear "I*

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*needed to get out of the community to go somewhere where no one was going to know me.” And to be safe to talk about it because if it was someone from the community who assaulted them there is a lot of pressure on them not to tell. - Truro*

*We are finding that we are not serving the Acadian communities in a way that they deserve [with respect to partner violence.] And if that is true for domestic violence then it is also true for sexual violence. - Yarmouth, Juniper House*

*In Metro we are seeing an influx of the Arabic-speaking population and sometimes there can be a language barrier there. I would like to see services grow in Metro to meet those demands for that population. - Victim Services*

*We have a very large Black community in CBRM. It is a very closed community and there is no specific cultural service for them. It has always been an issue when it comes to domestic violence. It has been tried to bridge that gap before, but that bridge seems not to go anywhere.*

*Eskasoni in particular have their own Mental Health and Social Work and there is amazing work being done out of that agency. They deal with a lot of sexual assault they deal with a lot of sexual assault clients. And, really the driving force is their administrator right now Dale Sharkey who has a great concern and is very committed to [increased sexual assault services.]*

*We don't have a lot of bilingual or multilingual accommodation here at all. I know when speaking with the Francophone community they talk about the difficulty in finding a doctor who would treat them in their first language. As far as other cultures or language that is a real difficulty. Efforts are made to try and find someone who can translate and then you're bringing in a third party in which is awkward and invasive as well. - urban service provider of Anglo-European descent*

*We have a small immigrant community and they are predominantly highly educated and close knit. And I have had experience dealing with women in the domestic violence situation; it was very difficult. We all assume that everybody speaks English and we all assume that people will understand when we say that violence is not acceptable. But unfortunately that is an assumption we make coming from a very Anglo-Western world perspective and when we encounter someone from another culture I think it is as much of a learning curve for us and it is for them. A couple of instances dealing with women in that culture we had a real hard time finding someone to even help us understand how to deal with the client or even a translator. Either they do not want to come outside of the culture or they don't agree with what we are saying [about violence]. We have had quite a bit of difficulty...in respect to violence against women and going outside their community.*

*Very quickly upon the woman beginning to [access services, a prominent immigrant community member] wanted to make us believe us that she was crazy and that she had all of these issues. And also, he felt and he tried to encourage her to go back to her partner because he was an “upstanding citizen.” This was a doctor we had come to trust and we lost that with this particular case. - urban service provider of Anglo-European descent*

*There are no specific services but at least we have a positive environment for GLBT survivors. - urban service provider*



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*We do have some individuals on staff who speak French. There is probably more of a need for French services...in the Cheticamp area. The...First Nations communities present a challenge in terms of offering services. We have to work closely with people in those communities in order to develop and implement services. In the Eskasoni First Nation, we set up a one day conference where we talked to youth about victim issues for a whole day and that was really good. We have a committee started now with different people looking at issues in relation to have to have victims accessing services for victims, because most don't. And what can we do to increase the access, even if it comes to hiring someone at the first nations to work in the First Nation communities. We are starting to look at that kind of thing. We are working with agencies in the community that we would interact with in relation to offering services to victims. That is the kind of stuff we are starting to do this year. -- Victim Services*

Cultural competency is not a specifically funded goal at the community agencies responding to sexual violence survivors. This is a serious gap, particularly considering the overrepresentation of non-dominant populations among survivors.

### 6.3 Access for Persons with Disabilities

Persons with disabilities are highly over-represented among sexual assault survivors. This is recognized in victimization research<sup>26</sup> and in the experiences of service-providers:

*People who are committing sexual offenses are taking advantage of those with disabilities. We have a number of individuals who are [living with] disability that were sexually abused and usually by someone close to the family. I would say that 90% of the time it is [someone] with close family ties and they take advantage of the disabled person. - CBRM police officer*

It is difficult for anyone to report abuse. As reported by the Disabled Women's Network in Ontario, it may be more difficult for women with disabilities because:<sup>27</sup>

- ♦ *We may not know who to turn to for help.*
- ♦ *We don't know if services are accessible to us or if sign language interpreters are provided.*
- ♦ *There is almost no information on sexual assault in Braille, on audiotape or computer diskette or in large print.*
- ♦ *Many disabled women do not know services for victims of violence exist.*
- ♦ *We feel afraid, violated and alone.*

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<sup>26</sup> Among adults who are developmentally disabled, as many as 83% of the females and 32% of the males are the victims of sexual assault. (Johnson, I., Sigler, R. 2000. "Forced Sexual Intercourse Among Intimates," Journal of Interpersonal Violence. 15 (1). Developmental Disabilities.) In one study, 40% of women with physical disabilities reported being sexually assaulted. (Young, M. E., Nosek, M.A., Howland, C.A., Chanpong, G., Rintala, D.H. 1997. "Prevalence of Abuse of Women with Physical Disabilities." Archives of Physical Medicine and Rehabilitation Special Issue. Vol. 78 (12 Suppl. 5) s34-s38.)

<sup>27</sup> Adapted from Disabled Women's Network Ontario [http://dawn.thot.net/sexual\\_assault.html](http://dawn.thot.net/sexual_assault.html)

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- ◆ *We may not be able to speak to someone in our own language.*
  - ◆ *Our caregiver or someone we live with may try to prevent us from getting help.*

Accessibility and special competencies for serving survivors with disabilities is not funded in Nova Scotia. In current planning for new services in the United Kingdom, accessibility for mobility-, visually- and hearing-impaired survivors is to be resourced. The United States by federal law establishes the right to accessibility for Americans living with disabilities, such as through the 1990 *Americans with Disabilities Act*, providing accessibility and anti-discrimination regulation and enforcement beyond what is ordinarily applied in Canada.

The lack of resources to ensure accessibility for persons with disabilities to survivor services is a serious gap, particularly considering their great overrepresentation among survivors.

## 6.4 Rural Challenges

Many rural barriers to access have been identified in literature that reviews sexual assault services in North America. Sexual assault service providers report that sexual assault in rural areas is highly acquaintance-perpetrated and much underreported. Lack of anonymity and an insular rural culture can limit healing and justice (Lewis 2003). In general, the following challenges have been identified with respect to the delivery of sexual assault services in rural areas in Canada: (AASAC 2006)

- ◆ Insufficient funding for rural services
- ◆ Safety issues and burnout of sexual assault workers
- ◆ □High staff turnover
- ◆ Public scrutiny/lack of anonymity (survivor's service use)
- ◆ Retractions of sexual assault disclosures
- ◆ Lack of access to specialized treatment and diagnostic resources
- ◆ □Lack of other specialized service providers
- ◆ □Geographical isolation
- ◆ □Limited telecommunications
- ◆ Turf wars and service provider resistance to change
- ◆ Problems with the criminal justice system
- ◆ □Delayed court proceedings
- ◆ □Ideological loneliness of some service providers
- ◆ Denial of existence of sexual assault by some service providers
- ◆ Denial of existence of sexual assault by community residents

(here, "service provider" refers to any person or organization providing any services to sexual assault victims, whether these are specialized or not.)

Recent research on the experience of rural Maritime women and girls and their anti-violence service providers affirms that these circumstances are the experience in rural areas of Nova Scotia as well (Blaney, 2004).

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## 6.5 Recommendations for Eliminating Barriers to Access

Based on the above findings, the following are recommendations for eliminating the barriers to accessing services.

### 6.5.1 Transportation

- ♦ Transportation for Nova Scotians to access sexual assault services must be resourced.

### 6.5.2 Cultural Competency

- ♦ Groups accorded lower power and status by the dominant culture are disproportionately vulnerable to sexual violence. Increased cultural competencies at organizations serving survivors should be made an explicit and resourced priority now, and for future expansion of sexual assault services. This should include support for training, recruitment and retention of staff from diverse populations. The outreach and programming developed by Pictou County Women's Centre should serve as a template for other organizations.

### 6.5.3 Persons with Disabilities

- ♦ This group of the population is enormously overrepresented among survivors of sexual violence. Accessibility and competency in sexual assault services for persons with disabilities should be funded now, and in any future expansion of services.

### 6.5.4 Rural Barriers:

- ♦ Many barriers unique to rural areas and culture can interfere with access to sexual assault services. Specific rural solutions to access must be developed as part of a comprehensive provincial response to sexual violence.

### 6.5.5 Child Care:

- ♦ Child care so that survivors with children can access sexual assault services should be resourced.



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## 7. The Need to Create Local Service Structure

This section identifies the need to create and strengthen the local service structure in key areas of Nova Scotia and to develop coordinated approaches in order for sexual assault services to be delivered effectively and efficiently throughout the province.

### 7.1 New Brunswick Efforts

Creating provincial and local service structures to respond to the severe gaps in sexual assault services must be undertaken carefully. Proper implementation will require coordinated developmental efforts. Such an effort is under way in New Brunswick at this time. Funding (\$800,000) has been provided over 5 years (beginning in 2005) to the Fredericton Sexual Assault Centre (the provincial leader in sexual assault services). The Centre currently leads a development process that includes community-based women's organizations, sharing its vision and model for services, and preparing for the roll out of sexual assault services accessible to all residents of New Brunswick.

### 7.2 Halifax, Avalon Centre and the Avalon Model

The Avalon Centre is Nova Scotia's provincial leader in sexual assault services and Nova Scotia's only full time centre. Currently, Avalon is not funded adequately to provide core components of a comprehensive sexual assault response.

Avalon Centre's excellent survivor-centred support, therapy and advocacy is recognized and highly valued by survivors, and by the many different agencies with whom they are connected. Avalon's service standards and leadership are recognized nationally and internationally by other sexual assault services and by multi-agency organizations addressing sexual assault.

To summarize the combination of high-value aspects in the Avalon model, discussed elsewhere in this report:

- ◆ Survivor-centred approach: empowering survivors as decision makers in their recovery; always responsive to their needs and lead.
- ◆ Social analysis of sexual violence: putting the violence in context and addressing root causes; avoiding a narrow practice approach only based in psychopathology; demonstrating to survivors that they are not alone societally and are not to blame
- ◆ Specialized therapeutic counselling that recognizes and addresses the special needs of sexual assault survivors, including expertise in PTSD, secondary wounding, child abuse, gendered impacts of sexual assault, therapist/client power balance and trust, and feminist counselling.
- ◆ Prevention and education emphasis to address root causes of violence and secondary wounding. Prevention and education is informed by survivor-centred expertise. High quality customization of professional education.

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- ♦ Community-based and independent: as a non-profit community-based organization, Avalon can be responsive to community needs and partners, and choose direction based on survivors' and community priorities.

Their model and leadership is highly attractive to other Nova Scotia communities wanting sexual violence services, and many service providers participating in this research expressed their wish for their community to “have an Avalon,” or follow the “Avalon model.”

However, this enthusiasm should not obscure that Halifax is underserved based on population, and that Avalon, due to financial constraints, cannot offer a full range of services, nor serve clients optimally in terms of frequency and duration of counselling. They cannot offer, for example, on-call advocates, and do not have core funding for accompaniment, nor public funding for professional education. As described earlier, Avalon limits the duration (usually ten weeks) and frequency (usually bi-monthly) of therapy due to financial constraints, not meeting the full needs of survivors and at times resulting in setbacks.

Further, Avalon has had problems with retention of specialized counsellors due to the non-competitive salary that must be offered at their budget level. Avalon's sexual assault counsellors are among the most highly specialized of counsellors in the province, and among the lowest paid. The current funding approach by government to these community-based counsellors is not sustainable. Avalon Centre will cut back staff and services this year in order to offer more competitive salaries and retain highly specialized staff (who can easily find more remunerative positions in government or the private sector.) Of two counselling positions vacated this year, only one will be filled. As described earlier, due to staff size, the Avalon Centre's case load of therapeutic clients is limited to just over two hundred per year, very far short of the estimate of Halifax area survivors. Further cuts to staff will exacerbate this problem. The unsustainable nature of Avalon Centre's funding has led the organization's board and treasurer to begin discussing closure of the Centre.

### 7.3 Cape Breton Regional Municipality

Many Cape Breton Regional Municipality (CBRM) service providers expressed having long desired “an Avalon.” CBRM agencies and professionals have organized collaborative efforts to move toward coordinated response and improved services, as described earlier in this report. There was growing frustration reported among the CBRM professionals making these efforts, at the lack of government action to establish and support a sexual assault centre serving Cape Breton. Population and identified needs demonstrate that a sexual assault centre is long overdue for this area.

### 7.4 Truro Area

Truro has the unique asset of the Colchester Sexual Assault Centre, the only other sexual assault centre in Nova Scotia besides Avalon. This has resulted in higher visibility of sexual violence issues, and a higher level of awareness and specialized service for this area. However, having only a single permanent part-time staff person is not a sustainable approach for all of the support and education needed for the area, as higher community awareness and

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visibility turn into a higher demand for information and counselling services for individuals. Resources also need to be added to accomplish education, and policy and social development in a sustainable way.

## 7.5 Antigonish Area

Antigonish Women's Resource Centre has long provided leadership in sexual violence response in this region: It is the *de facto* sexual assault centre serving its area. Collaborative community action involving justice, health, education and other professionals is significantly formalized in Antigonish, under the leadership of AWRC.

AWRC administers and leads a constellation of community services presently, including a Women's Centre, a Sexual Assault Nurse Examiner (SANE) program; Lindsay's Health Clinic, as well as sexual assault services and education. However, its function as the region's *de facto* sexual assault centre is not officially recognized and is not specifically funded. Service provision, as in all areas, does not meet population need since funding for services to survivors is not tied to the size of the victimized population. Compared to other rural areas, Antigonish also has a higher-than-average presence of university-age population, an age group with higher sexual assault services needs.

## 7.6 Other Geographic Areas

Leadership in sexual assault response has been provided mainly by the transition houses and women's centres serving other areas of Nova Scotia. In addition to individual interviews with professionals, discussion groups were also held in the following areas with respect to implementing sexual assault services in their areas: Bridgetown, Port Hawkesbury, Sheet Harbour, and Yarmouth. Different models were discussed. Some groups were cautious about the idea of a stand-alone sexual assault centre for their area due to confidentiality concerns about clients being seen to enter the premises, as well as the efforts required to maintain an additional organization in under-resourced communities. However, several groups (including some who voice the previous concerns) also liked the idea of a stand-alone centre's visibility and statement to the community about a comprehensive response to sexual violence, and a sexual assault centre was viewed as an appropriate anchor for such a response, if it were sustainably resourced.

The prevailing view was supportive of immediate enhancement of staff and services at existing women's centres and/or transition houses in an interim way that did not preclude establishing a sexual assault centre as part of a community-developed response.

A major concern for all regional discussion participants was that the regions be included in developing any implementation plans for their area. It was their strong message that a provincial plan be rolled out only with their ongoing participation in its development and implementation. On-the-ground development work based in their community was strongly preferred, in contrast to using one provincial Halifax-based employee to develop all regional responses.

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## 7.7 The Need for a Coordinated Response

Many U.S. and several Canadian communities and have created multidisciplinary bodies, such as sexual assault response teams (SARTs) to “oversee coordination and collaboration related to immediate response to sexual assault, ensure a victim-centred approach to service delivery, and prevent future victimization.” (Littel, 2001). A study examining four such teams (Campbell, et al. 2001) concludes that “secondary victimization may be prevented by redefining the larger context of service delivery. Selected communities throughout the United States have developed coordinated care programs, which bring together police, prosecutors, doctors, nurses, social workers, and rape victim advocates to work as an integrated team in assisting rape survivors.”

This coordination potentially offers benefits to Nova Scotia:

- ♦ It helps victims receive more comprehensive services in the initial setting.
- ♦ Following the initial response, SART members can make more effective efforts to link victims with resources in the community (Fulginiti et al., 1996).
- ♦ Improvement in overall service delivery to sexual assault survivors. (Campbell, 1998; Campbell & Ahrens, 1998; Campbell & Bybee, 1997);
- ♦ Survivors and community receive consistent messages about sexual violence.

### 7.7.1 Status of Regional Coordination Efforts

In Nova Scotia, Antigonish has had a SART team since 2007, with formally developed protocols for collaboration among law enforcement, community organizations, and health care providers for a more systematic approach to help ensure victims receive appropriate services, without secondary victimization. This is the culmination of work begun even before it was documented as a community goal in the 1994 report “Beginning With Us.” The Antigonish Women’s Resource Centre provided the critical leadership for SART formation, and success depended heavily on the expertise and administration of AWRC, although AWRC was not remunerated for this work. This is not a sustainable approach to coordinated response development, as women’s organizations receive public funding that is inadequate to achieve their existing responsibilities.

Similarly, in Halifax, led by Avalon, a community response team involving police, prosecutors, the manager of the province’s sex offender treatment programs, and others, has met regularly since 1998 to improve responses to sexual assault. Early recommendations for a specialized police squad and a protocol document for the public prosecution service have been achieved, and members of the group have been involved in a SANE advisory committee. However, no formal protocols or philosophy of service have been agreed upon. This group is not yet functioning as a SART team, sharing information, and progressing together. The lack of resources to drive this process is a factor, as Avalon must lead this effort without additional staff or other resources to carry it forward.



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In CBRM for the last several years, a collaborative committee representing many agencies and individuals involved in immediate response to sexual assault has met to discuss a comprehensive sexual assault response for the area. Members of this group have identified a SANE program and a crisis line as priorities. Some also focus their vision on an independent sexual assault centre modeled on Avalon, that would serve as the lynch pin of a comprehensive response. Lack of progress has frustrated some, who are beginning to withdraw energy from the collaborative meetings. Others remain strongly committed to the ongoing discussion. The effort is led by the Cape Breton Regional Municipality Interagency on Family Violence.

In 1994, the King's/Annapolis Women's Project created a highly developed blueprint for coordinated services in their area. This planning process itself represented a multidisciplinary collaboration, as many different responders were involved in advising the project. However, a lack of government response ended the momentum. Thirteen years later, inspired by the Avalon "Making a Difference" conference in 2006, service providers in King's County have been trying to hold an initial meeting. As of April 2008, this has yet to happen, due to the stress on these agencies' resources.

Professionals in Lunenburg/Queens had an initial group meeting in 2007 to discuss the formation of a SART team. Unfortunately, women's organizations were not able to participate in the initial meeting, and there has been no follow-up.

Other areas of the province have not yet started the work of establishing coordination among all responders. There is informal collaboration from time to time among sexual assault responders in some communities. In other communities, women's organizations feel isolated from other first responders. Community agencies are contacting Avalon regarding such development. Many see movement towards a comprehensive sexual assault response as highly important in their community, and see multidisciplinary collaboration as crucial. They identify however, that it is impossible for these efforts to be moved forward, "off the side of someone's desk"; i.e. without additional resources and staffing.

Many community organizations reported negative experiences with the province's recent multidisciplinary collaborations to develop high risk for lethality community protocols. This work, again, unsupported by additional funds, has been a large time burden on the directors of women's organizations, and a slow process. Women's organizations are leery of engaging in another under funded multidisciplinary planning process that is time-consuming, and that organizations lose interest in, as it fails to progress.

Internationally, and in other Canadian jurisdictions, women's organizations are beginning to question the efficacy of investing their sparse resources in driving the coordinated response protocol effort, or other system collaborations. Some have indicated that it has resulted in little increased benefit for women while absorbing enormous amounts of time, and removing them from grass roots identification.

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## 7.8 Recommendations for Creating Local Service Structure

The following are recommendations for creating local service structure throughout Nova Scotia.

### 7.8.1 Overall

- ◆ Resources are needed for Avalon Centre to continue to lead development efforts to establish a model and standards for sexual assault centres in Nova Scotia, and develop an implementation strategy for a comprehensive response to preventing and addressing the harms of sexual violence in Nova Scotia.

### 7.8.2 Halifax

- ◆ Addressing the gaps in sexual violence services must include ensuring that Avalon Centre, the organization that is looked to as a provincial model, can offer all core services at a level that reflects survivor population needs.
- ◆ Permanent financial support is needed to:
  - Establish more specialized therapeutic positions and stabilize existing positions, reflecting more accurately the prevalence of sexual violence and the population need (Based on serving a population of approximately 400,000, with 16,000 estimated survivors based on 2004 General Social Survey data.)
  - Bring the compensation of Avalon staff in line with professional norms, to stop the current threat to Avalon services due to inability to retain specialized staff at current sub-par levels of compensation.
  - Stabilize and maintain the provision of justice system accompaniment to survivors;
  - Establish and maintain on-call advocates who can respond in person to survivors of recent assault
  - Establish regular professional education for all government actors who are serving survivors in the course of their work. This would include police, public prosecutors, the judiciary, corrections, drug and alcohol dependency staff, mental health services, and others.
  - Do prevention and public education work on a strategic ongoing basis

### 7.8.3 Cape Breton Regional Municipality

- ◆ A sexual assault centre should be established to serve the Cape Breton Regional Municipality. It should be modeled on the Avalon Centre's philosophy and standards of service, work closely with the women's centre and transition house serving the area, and set a precedent for service expansion elsewhere. It should provide services comparable to those of the enhanced Avalon model as recommended above.

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#### 7.8.4 Truro

- ◆ Colchester Sexual Assault Centre should be supported with permanent full-time staff positions and other enhanced support and funding, to bring it closer to the enhanced Avalon model.

#### 7.8.5 Antigonish Area

- ◆ A sexual assault centre, functioning as one of the family of service centres administered by AWRC, should be recognized and funded to provide core sexual assault centre services in line with those of an enhanced Avalon model.

#### 7.8.6 Other Geographic Areas

- ◆ The establishment of core sexual violence services and resources is needed in all other areas of the province as well. The particular form and implementation of a strengthened response should be based on community-developed approaches. The provincial government should explicitly support community organizations currently serving survivors, in all planning and implementation processes through government's explicit commitment to local community development funding for this purpose. The current New Brunswick approach to provincial leadership but community-based development should be followed, with resources provided, so that Avalon Centre can share models and standards with regional service providers considering the development of their own sexual assault centre.

#### 7.8.7 The Need for a Coordinated Response

- ◆ Community development funding should be allocated to a staff position based in the community organizations currently leading the response to sexual violence in each region, in order to drive forward the establishment of coordinated response in all areas of the province. This should include Halifax. The Antigonish SART team protocol should be used as a reference point by other communities. Under no circumstances should emphasis be placed on achieving coordinated protocols without adequate support for this work.



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## Appendix A: Justice Innovations and Women's Safety Recommendations

1. *An explicit philosophy and approach for the justice system that prioritizes women's safety. This should be explicitly included within guiding principles and policy documents as well as embedded in job descriptions.*

A unified Nova Scotia response to violence against women should:

- Use gendered language to discuss woman abuse
- Explicitly give top priority to survivor safety in philosophical statements, goals, objectives and job descriptions.
- Explicitly recognize that social and economic inequality create safety issues for women
- Take a vigorous prosecution approach, including "first time" or "low-end"
- Include effective means of determining self-defense, third-party defense and dominant aggressor status
- Be prepared and resourced to deliver an effective "victimless" prosecution
- Not emphasize a treatment, therapeutic or rehabilitative approach centred on batterers.
- Not be diversionary
- Include specialized responses to sexual violence

Prosecutors and policy makers should work together with women's equality seeking organizations and other justice and community agencies

- to exchange ideas and information on effective victimless prosecution
- to develop charging and trial strategies with community support

2. *Specialized personnel*

Site visits and literature clearly demonstrate that there are benefits to women from specialized personnel handling crimes affecting women's safety.

It is recommended that specialized judges, prosecutors, police, probation, and court administration roles be developed in Nova Scotia.

With regard to specialization within the judiciary:

- WIJI supports much more extensive judicial education for all judges on violence against women and relevant women's equality and status issues, and how the courts' decisions can affect women's safety and autonomy.
- Specially trained judges with expertise in violence against women and relevant women's status issues, and how the courts' decisions can affect women's safety and autonomy should be used in hearing cases involving violence against women, as part of a specialized court or other specialized approach.
- Judges should be involved in a collaborative team approach, as in Whitehorse, that includes judges regularly meeting with community-based women's organizations to learn about issues that concern service-providers, victims and perpetrators

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- Judge's tools and benchbooks respecting violence against women should be developed for Nova Scotia using a coordinated, collaborative team approach involving women's equality-seeking organizations.

Detailed recommendations for prosecutor specialization are offered:

- Fixed, specialized prosecutorial staff addressing violent crimes against women should be part of the Nova Scotia court system, either with or without the base of a specialized court. Special approaches for rural areas should be developed.
- The number of specialized prosecutors should be congruent with the percentage of violent crimes involving women addressed by the office (eg., one specialized prosecutor in a large urban pool is inadequate).
- All crimes of this nature should be handled through a specialized prosecutor, not simply high-profile or "high-risk" cases.
- Specialized staff should be a mix of senior and junior prosecutors, with formalized mentoring.
- The Nova Scotia Department of Justice, the Public Prosecution Service and the Government of Nova Scotia should work together to create an atmosphere of prestige and respect for those specializing in the prosecution of these crimes.
- Specialization should require a minimum commitment of 3-5 years
- Specialized staff should meet regularly with community agencies to learn more about issues relevant to women.
- Specialized staff training should reflect a philosophy of vigorous prosecution, and, where necessary, victimless prosecution. Formal training in addition to mentoring should be required, including training in specialized trial strategies, in meeting survivors' expectations of respect, in the identification of a dominant aggressor, and in current research regarding effective approaches in sentencing and the prosecutor's role in women's safety.
- Specialized staff should be funded to regularly attend conferences and educational events regarding violence against women.
- Cases involving a particular perpetrator or a particular victim should follow the same prosecutor through the progress of a case (i.e. bail hearings, preliminary hearings, through trial and sentencing). Re-offenses involving a particular perpetrator or victim should be assigned to that same prosecutor.
- It is recommended that specialized police approaches be developed as a collaborative effort of women's organizations, police services and other stakeholder. Options are discussed here, but no one model is recommended. Opportunities for collaborative police/women's organization work used in other jurisdictions are described here, though any move in this direction will require thinking through the benefits and risks of being closely identified with police activity.
- Women's equality-seeking organizations and police services should work together with other relevant stakeholders to develop a template for specialized police response for partner violence that explicitly prioritizes women's safety that would be consistent across Nova Scotia's regions.

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Specialized response should include:

- Early coordinated, collaborative information-sharing and actions with agencies and organizations serving women.
- More training and resourcing for investigations that gather physical and other evidence besides victim statements. Specialized police response should include ident-capabilities within specialized violence against women resources.
- Strategies to standardize the provision of high quality briefs to Crown.

Responsibility for fulfilling policies and protocols related to violence against women should be enforced by a senior manager internal to the police, as well as lower-level victim-services-based domestic violence coordinators.

3. *Community inclusion*: community inclusive leadership, case management and community-based women's advocates are key recommendations here. Some of the most effective responses around the world are community collaborative responses where community organizations have real decision-making and oversight powers. While there have been some starts in this direction in Canada, they have mainly been restricted to information sharing. Far greater community involvement in justice responses is recommended. In particular, court-connected "victim-services" should not be a replacement for community-based women's advocates.

Recommendations:

- Community-based organizations serving women must be an equal part of a coordinated, collaborative team addressing violence against women.

They should participate in the following ways:

- *Leadership*: having a voice in any court development and implementation by participating as steering committee members and members of other relevant committees along with other justice leaders
- *Women's services*: supporting individual women in the system, as part of the formal court structure, through automatic police and docket-based referrals. This should include:
  - Involvement in the courts' day to day decision-making through participating in team information-sharing and case management on a formalized, docket basis along with other professionals, with women's permission and support
  - Flexibly meeting women's self-identified needs
  - Addressing the safety issues that arise from social and economic inequality
  - Court accompaniment.

Women's advocates should be staff members of existing community agencies rather than of a government-based service. System-based "victim services" staff should be renamed Crown or police "witness liaisons" to be more reflective of their actual role.

- *Oversight*: monitoring and evaluation of the achievement of court goals as part of an independent community-collaborative coordinating body.





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## Appendix B:

### Sexual Assault Nurse Examiner (SANE) Programming Recommendations

#### **Summary of Recommendations**

(from *Building A Sane Network For Nova Scotia 2007*)

1. A provincial coordinator position should be established for efficient start-up and maintenance of SANE programs for Nova Scotia. This position should be based in the Avalon Centre, to take advantage of Avalon Centre's existing leadership role and expertise, and to demonstrate confidence in community-based development of SANE programs. The provincial coordinator will ensure that SANE program implementation is congruent with overall sexual assault service expansion for the province.
2. The provincial coordinator will develop guidelines and template documents for all Nova Scotia SANE programs' collaborative protocols, training, practices, philosophy of service, locations of service, nurse examiner retention, and access for diverse service users.
3. Community-based programs should be the standard governance model for SANE programs in Nova Scotia. The decision regarding which community organization will manage the program in each region should be part of the collaborative community development process of implementing a SANE program, and remain the choice of the local communities.
4. The target geographic areas and populations to be served should be determined as part of the collaborative community planning necessary for SANE implementation, with provincial support for effective analysis. Flexibility and responsiveness will be important to consider in the structuring and funding of a coordinated provincial network of SANE programs.
5. The provincial coordinator should conduct asset-mapping and needs-assessment for specific communities/regions targeted for SANE programs, with respect to sexual violence and community response, in order to facilitate a coordinated community implementation process. From this, community partners for collaborative work, including sponsoring agency(ies), for SANE programming, can be identified.
6. The provincial SANE coordinator should facilitate collaborative community planning in areas targetted for SANE programs. The provincial SANE coordinator should develop protocol templates that address the role of SANE programming and interaction of the various sectors with the SANE program, which can then be collaboratively adapted for use in specific communities.

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7. Because community sexual assault service providers have limited resources to participate in collaborative work outside of service provision, resourcing must anticipate costs for their inclusion in the collaborative implementation process.
  8. Because positive relationships with hospitals has been identified as a significant factor in implementation success, hospital personnel who are passionate about bringing a SANE program to their area should be recruited/identified at an early stage, and be part of all collaborative community efforts.
  9. The provincial coordinator should arrange initial and ongoing opportunities for provincial bidirectional training with SANEs, and staff from law enforcement, prosecution, sexual assault centres, hospitals and other community partners.
  10. It is essential for SANE services in rural areas that local, discreet, non-emergency department options be available. (See further discussion of these options under “Locations for Service Provision,” below.)
  11. Police and non-police resources for transportation to SANE programs should be part of asset mapping in communities considering SANE programs. Innovative planning for transportation will be important to rural success.
  12. In order to counter the misperceptions around sexual assault in many rural areas, SANE Coordinators must collaborate with current educators (where they exist) or be adequately resourced to address the intense need for community education around sexual assault and available services.
  13. Resources for ongoing training for law enforcement must be contemplated for the sustainability of rural SANE programs.
  14. SANE implementation should be recognized as only one part of comprehensive community response to sexual assault. SANE program success depends on coordinated, responsive efforts from law enforcement, prosecution, educational institutions, community service agencies and others. Department of Health leadership should encourage other Departments (such as Community Services, Justice and Education) to participate in comprehensive provincial response to sexual assault, and not unduly rely on SANE programs to address all sexual violence issues.
  15. Tracking of the connection between forensic evidence gathered by SANEs and justice outcomes should become an integral part of SANE programming in Nova Scotia. Protocols should be developed whereby SANEs represent accurately to victim/survivors the likelihood that evidence collected through their examination will be processed, used, or have an impact in justice outcomes.
  16. More research should take place with victim/survivors who have undergone a rape kit, to ascertain their perceptions of forensic evidence collection. This should be longitudinal,

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addressing perceptions after examination, and then again after the various stages of justice system involvement (charging decision, investigation, pre-trial, trial, sentencing.)

17. Evaluation should take place both in the medical follow-up call of the SANE program, and in an anonymous paper evaluation. Victim/survivors should be encouraged to speak in their own words about their experience. Protocols should be developed to address issues as they arise, from service users and other professionals.
18. The provincial SANE coordinator should develop guidelines for holistic, victim/survivor-centred care, and facilitate and monitor their implementation in new SANE programs through template protocols.
19. For SANE programs to accomplish the goal of holistic, victim/survivor-centred care, services must be gender inclusive, gender-sensitive, and reflect a contemporary analysis of sexual assault prevention and community change. Commitment to this should be explicit in protocols for all Nova Scotia SANE programs, developed by the provincial coordinator.
20. Nova Scotia's sexual assault centres and women's organizations are the Nova Scotia community organizations most expert in these areas, and the value of their contribution to SANE programming should be explicitly supported by SANE program mission templates developed by the provincial coordinator.
21. The provincial coordinator should be responsible for developing educational tools and opportunities for SANE community partners, sharing a contemporary analysis of the causes and impacts of sexual violence.
22. The establishment of non-ED and non-hospital settings for SANE service provision should be a key goal of SANE planning for provincial implementation. Sites should be identified through the collaborative community development that is part of SANE implementation.
23. Support opportunities for ongoing education, information sharing and teambuilding, in implementing SANEs in other parts of Nova Scotia. This could include a provincial coordination role in arranging these opportunities for all Nova Scotia SANEs.
24. Keep up to date on salary structures and pay rates for SANEs in Canada and the United States, as well as salaries for nurses in hospitals and community-based settings. Maintain a pay rate that is uniform across Nova Scotia, commensurate with similar jobs elsewhere.
25. The provision of on-call advocates' services should be viewed as an integral part of comprehensive community response to sexual assault and should be defined and developed in conjunction with development of SANE programming throughout the province. As enhancement of long-term health benefits has been associated with advocates' accompaniment to victim/survivors who access the legal or medical system,

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sustainability of an advocacy program should be addressed in SANE program implementation in the province.

26. Diverse communities and groups that would be served by a SANE program should be identified early on in the community development process leading to the implementation of a SANE program. Representatives should be involved in planning. Provincial protocols for respectful and excellent care that is sensitive to unique needs for various diverse groups should be developed for all NS SANE programs. Resources should be included in SANE budgets to provide ongoing outreach to diverse service users.

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