

Not either/or but both/and: Why we need Rape Crisis Centres *and* Sexual Assault Referral Centres

The development of provision for victims-survivors of sexual assault has historically been piecemeal and locally specific. Rape Crisis Centres (RCCs) and, more recently, Sexual Assault Referral Centres (SARCs), have been established in certain parts of the UK but there is a lack of uniformity.¹ There is currently confusion at the political and policy levels in understanding the role each type of service plays in supporting victims-survivors and in terms of which is most actively promoted. It would even appear that the government is an exponent of SARCs whilst the opposition supports RCCs². This briefing shows that both RCCs and SARCs are vital for survivors and delivery of policy targets: this is not a case of either/or but both/and.

A bit of history

Following the work of feminist campaign groups publicising the scale of rape and the insensitive treatment of rape complainants by the police, the first RCC opened in London in 1976. It was a grassroots response to the prevailing culture of scepticism and woman-blame surrounding rape and sexual assault. The aim was to provide a means for women and girls to talk with other women about their experiences and to name male sexual violence, often for the first time. Most did not report to the police, with many talking about events from the past, including child sexual abuse. The first RCCs in the UK must be seen against a background of a total lack of provision, since there were no services responding to these issues previously. Over the course of the late 1970s and 1980s, RCCs opened across the UK.

The first UK SARC arrived some ten years later in 1986 in Manchester, where it continues to operate today as St Mary's Centre. Again, the wider context of this development was one of limited provision. St Mary's was established to improve the experience of reporting rape for victims, particularly the aspects of the forensic medical examination and aftercare, at a time when there was widespread public concern about police responses to rape victims³, and several government policy documents had decried the state of forensic facilities nationally (see, for example, Women's National Commission, 1985). The SARC model derived from North America and Australia, and sought to provide a more supportive, prompt and professional examination environment and short-term health and social support to both police and self-referrals.

¹ There are other examples of voluntary/third sector sexual violence services but these are outside the remit of this briefing.

² In a speech in November 2007, David Cameron pledged long-term funding support for RCCs (see http://www.conservatives.com/tile.do?def=news.story_page&obj_id=140334).

³ Partly prompted by Roger Graef's documentary in the *Police* series, where Thames Valley police officers bullied a rape complainant when interviewing her.

What are the key differences

Some of the key differences between RCCs and SARCs can be identified in this history and the factors prompting each into existence.

RCCs can be seen as:

- rooted in the women's movement efforts to name violence and support survivors;
- responding to recent and historic sexual assault;
- providing long-term survivor-led support, including advocacy;
- working on awareness raising and prevention.

SARCs:

- strive to improve forensic response to victims-survivors;
- respond to recent sexual assault;
- provide health and medical checks and crisis intervention;
- may provide short-term counselling and advocacy;
- refer out to other specialised and community-based organisations;
- tend to be city-based.

What do they offer?

There is no blueprint for service delivery in either RCCs or SARCs but there are some broad common strands.

Typically, RCCs provide some combination of:

- telephone helpline;
- face-to-face counselling;
- support groups;
- accompaniment to court;
- advocacy with agencies such as housing, health and mental health, and the criminal justice process.

Fifteen of the new Independent Sexual Violence Advisors (ISVAs) presently work in RCCs. Increasingly, however, as a result of funding pressures, a number of RCCs are only able to offer telephone-based support, and for some this is a skeleton service only.

SARCs offer some combination of:

- crisis intervention with respect to recent sexual assault;
- forensic medical examinations;
- immediate medical care and follow-up tests;
- telephone support;
- advocacy and case tracking;
- short-term counselling.

In some cases, ISVAs are located in SARCs or work in conjunction with them, some SARCS employ a support worker. In a number of SARCs forensic nurses are responsible for conducting forensic examinations, which is the model most commonly followed in North America.

Who do they serve?

RCCs have traditionally served female victims-survivors of rape, sexual assault and sexual abuse in childhood.⁴ This is because RCCs were conceived of as a safe, women-only space free from male violence. Because they address historical sexual abuse, which affects a significant proportion of their service users, as well as more recent rape and sexual assault, RCCs have no criteria on when someone has to have experienced sexual violence in order to be eligible. They have also historically tried to provide support for as long as it was needed. RCCs support some of the most vulnerable victims-survivors, including those struggling with mental health issues and self-harm. RCCs aim to provide a holistic service to victims-survivors: while they primarily support women and girls directly affected by sexual violence, they also assist their family members, partners and other supporters. Referrals are made by agencies and individuals, many of whom do not want to report their assault to the police.

SARCs serve both female and male victims-survivors. Service users are usually aged 16 and over, although some SARCs have begun to develop specialist services for children. Because one of their key roles is to provide forensic examinations, SARCs work with those who have recently assaulted. As forensic evidence deteriorates quickly, the painstaking and uncomfortable examination becomes less and less useful the more time has passed since the assault. However, they do assist those who do not wish to be examined and require support or other medical tests only. SARCs tend to receive many of their referrals from the police; other key referral sources are from the health sector, including hospitals and GPs, and they also see a proportion of self-referrals.

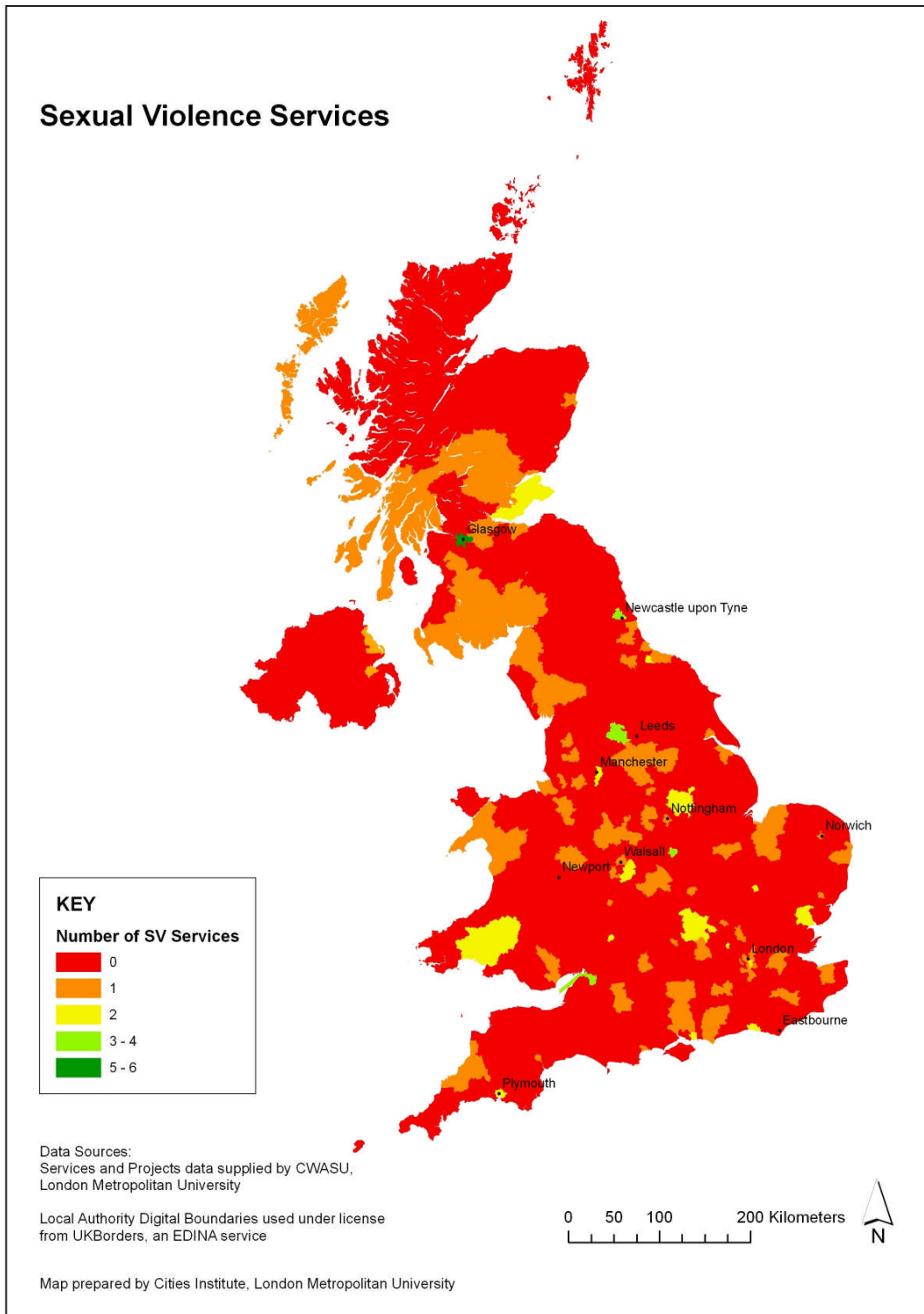
- RCCs predominantly work with female service users about sexual assaults from any time in the past who do not want to report
- SARCs tend to work with adult female and male service users who have been sexually assaulted in the recent past and have reported

How many are there and where are they located?

A recent report, *Map of Gaps* (Coy et al., 2007), plotted the geographical location of sexual violence support services across the UK. Provision is woefully inadequate: one third of local authorities lack any form of specialist violence against women service, and less than one in four has any sexual violence service (see Map 1). The majority of victims-survivors, therefore, have no access to either a RCC or a SARC.

⁴ However, a small number of RCCs operating today do support male service users too.

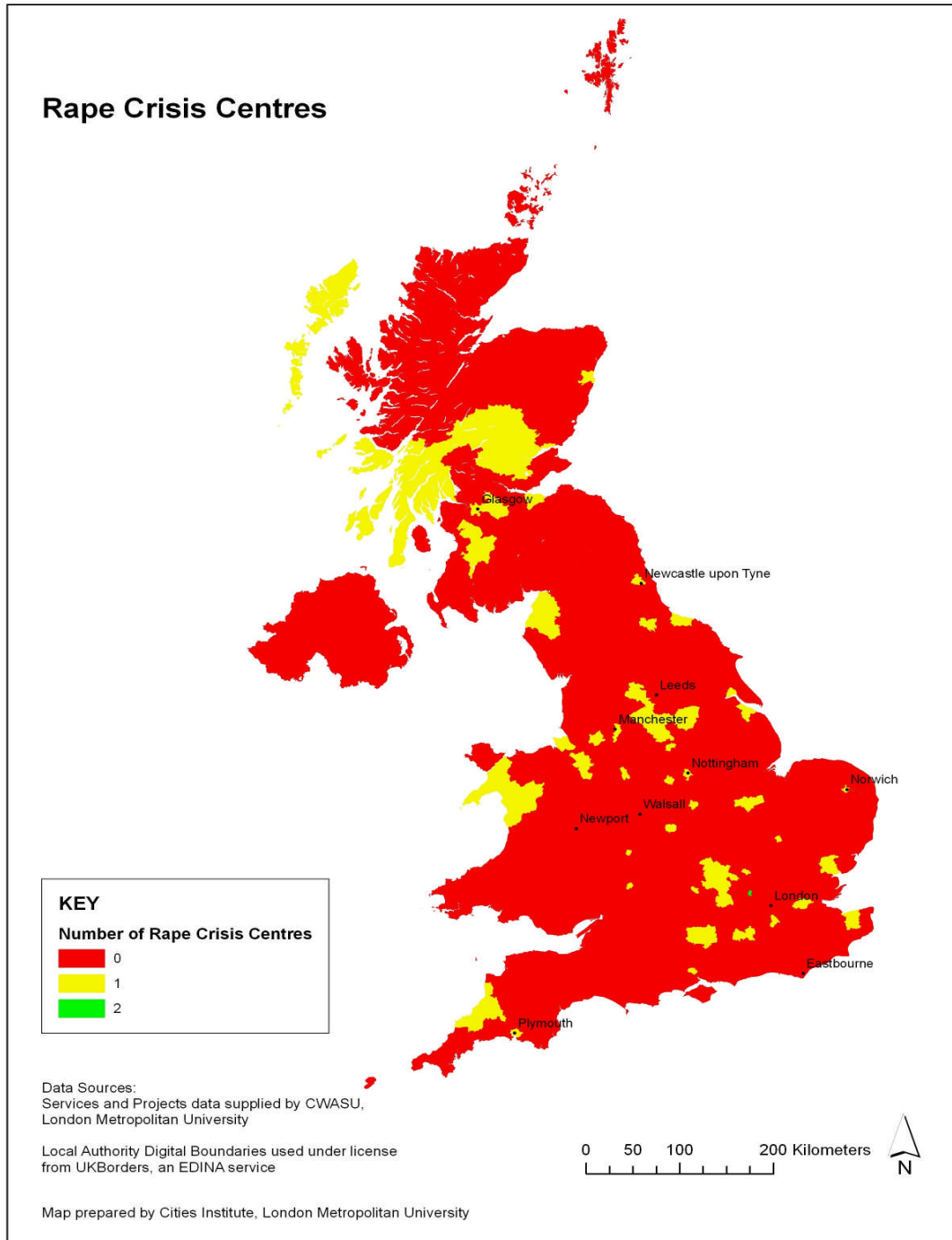
Map 1: Sexual Violence Services



Source: Coy *et al.* (2007)

The first RCC opened in London in 1976 and by 1984 there were 68 (Jones & Cook, forthcoming). Today, the number of active centres in the Rape Crisis Network England and Wales has dwindled to just 38, with many forced to close due to funding shortages. For example, there is now no RCC in the central London area, only one in Wales and none in Northern Ireland⁵ (see Map 2).

Map 2: Rape Crisis Centres



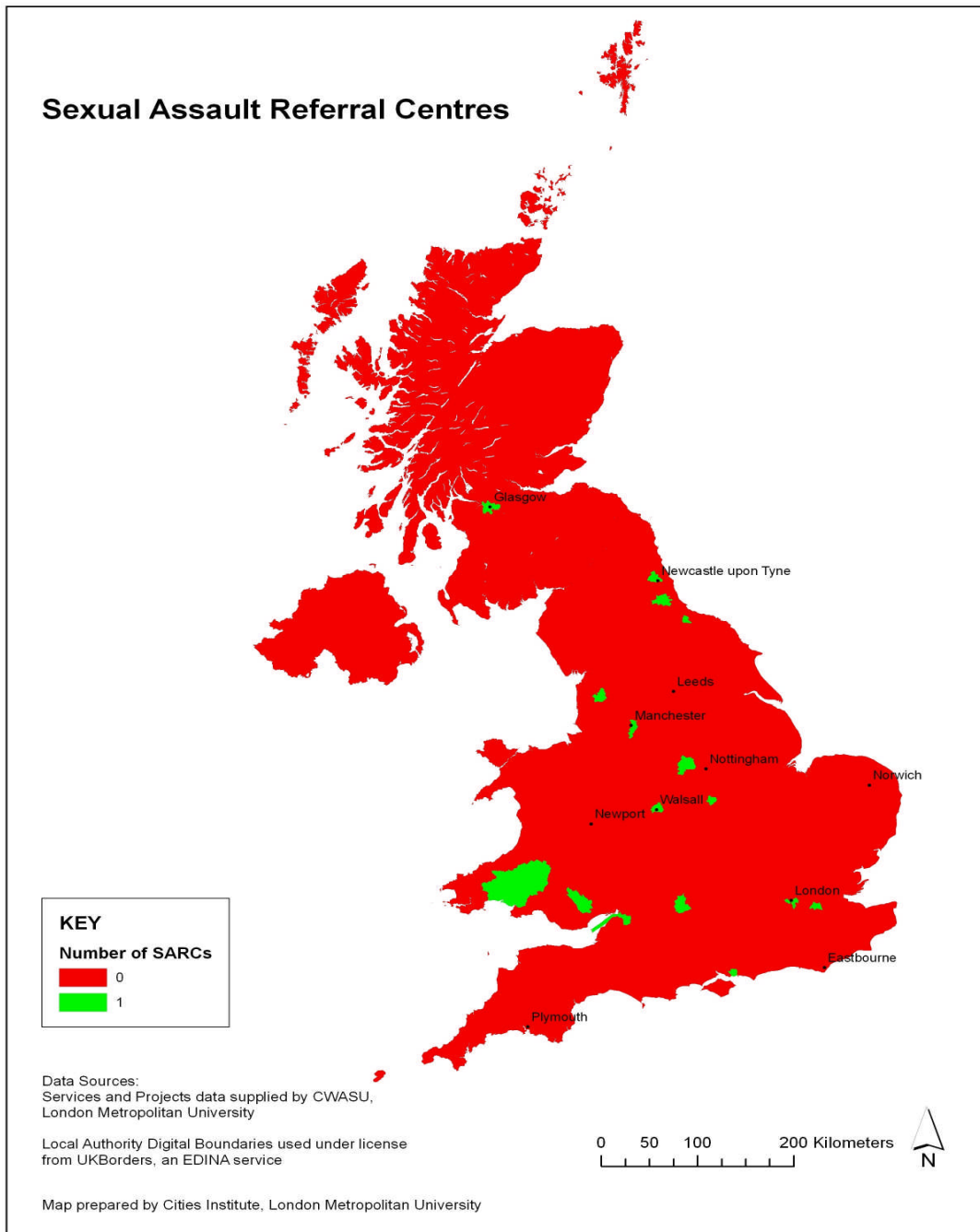
Source:

Coy *et al.* (2007)

⁵ In 2005 funding for Belfast Rape Crisis was withdrawn, although an unfunded skeleton service continues to operate.

The first SARC opened in Manchester in 1986. Only three further SARCs opened throughout the whole of the 1990s, and it was not until the mid-2000s, when the government actively promoted SARCs, that a broader network began to emerge. Today, there are a total of 19 across England and Wales (see Map 3), with a further 18 under development. There is also a SARC being piloted in Scotland.

Map 3: Sexual Assault Referral Centres



Source: Coy *et al.* (2007)

How are they funded?

The historic policy focus on domestic violence services in the UK has meant limited funding options for the sexual violence sector. RCCs are funded through a combination of charitable donations and, in some cases, money from local authorities, Health and Social Services. However, local funding arrangements vary widely. Since 2005, funding has been available for some RCCs under the Victims Fund, and since 2006 under the ISVA scheme; these represent the only sources of central government funding for sexual violence services. Commonly, funding cycles are annual, meaning a lack of long-term security for staff and services, in breach of the government's Compact with the Third Sector.

SARCs tend to be jointly funded by Police and Health. Whilst central government funding has been provided for start-up costs, sustainability is through local agreements. Funding limitations mean that many of the newer projects do not provide the holistic 'one stop' model intended.

How they work together

Those who report sexual assault deserve high-quality responses – forensic medical examinations, follow-up and support and advocacy – which only a well-funded SARC can provide. Those who choose not to report, or who have unresolved issues from historic assaults, also need access to high-quality responses - long-term practical and psychological support and advocacy - which a RCC can deliver expertly. If we are ever to meet the needs of survivors better we need RCCs *and* SARCs.

References

Coy, M., Kelly, L. and Foord, J. (2007) *Map of Gaps: The Postcode Lottery of Specialised Women's Support Services*, London, End Violence Against Women.

Jones, H. and Cook, K. (forthcoming) *Rape Crisis: Responding to Sexual Violence*, London, Russell House.

Women's National Commission (1985) *Violence Against Women*, London, Cabinet Office.