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## Standardized Assessment for Victims of Sexual Abuse

### FINAL REPORT

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## Standardized Assessment for Victims of Sexual Assault

### Executive Summary

The Community Protection Act of 1990 provided state funding for treatment services for victims of sexual predators. This represents the first substantial state government support for victim treatment and is a major public policy initiative. The Advisory Board of the Washington State Institute for Public Policy (WSIPP) identified the concept of standardized assessment of victims as a priority area for investigation.

Assessment is standard practice in formal mental health treatment. Clients' presenting problems and historical and current variables affecting functioning are determined. This process allows the practitioner to develop a specific treatment plan and to measure progress. Results of standardized assessment are also useful to funding sources in order to insure that the reimbursement is for the intended services.

The project had three objectives:

1. Review current practice in state funded sexual assault treatment programs.
2. Determine the feasibility of standardized assessment.
3. Develop a standard assessment device.

The project methodology involved convening a group of 10 consultants from various funded programs. Consultants represent different regions and program types including: specialized sexual assault centers, specialized programs within mental health or social service agencies and private practitioners who contract with programs. The group met twice to review extant assessment protocols and discuss program models and approaches.

Programs providing formal mental health services already conduct intake assessments of clients. In many cases the content and breadth of the protocols are determined by funding sources. In most cases the programs do not systematically assess for assault specific symptomatology or negative outcome. Few programs routinely use client completed measures.

Consultants agreed that a brief checklist which permits documentation of assault specific symptoms and psychological problems would be helpful and not excessively burdensome. Such a device was developed and reviewed by the consultants.

The consultants emphasized that many victims and their families have multiple problems when they seek services, some of which may not be directly associated with the assault experience but may affect recovery. Programs located in more general settings tend to integrate assault specific treatment into the overall treatment program. Adolescent and adult rape victims were seldom identified as a major client population. This is likely due to the fact that most programs are primarily child serving agencies or provide specific services for adult survivors.

Recommendations from this project are:

1. DCD and DSHS funded victim treatment programs be encouraged to use the assault specific checklist or require therapists to specifically document assault related psychological problems.
2. DCD and DSHS maintain a compendium of extant protocols and assessment devices to be made available to programs and practitioners.
3. DCD and/or DSHS consider hosting a grantees' meeting once a year for information sharing and continuing education.
4. DCD support expanded treatment services for teenage and adult rape victims.
5. WSIPP consider further research on treatment approaches to increase effectiveness of intervention.

## Introduction

The Community Protection Act of 1990 recognized that treatment for the victims is an important ingredient of a comprehensive community response to sexual predators. For the first time significant state monies were allocated to support victim treatment services. The Office of Crime Victims' Advocacy in the Department of Community Development and the Division of Children and Family Services in the Department of Social and Health Services have administered the funding through RFP processes and contracts with community agencies. State funding of treatment for victims represents a major public policy initiative that has had a significant impact on increasing the availability of community based treatment services for sexual assault victims in the state of Washington.

Treatment has been broadly defined by the administering agencies to include a variety of victim services. Crisis intervention, advocacy, supportive counseling and formal therapeutic interventions are encompassed. All of the interventions have the goal of alleviating psychological distress resulting from victimization and the reporting and intervention process. There is currently no standardized system for determining whether current practice achieves this goal.

It is widely recognized that sexual victimization has negative psychological effects but only recently has an empirical literature accumulated. Even less systematic data exists describing specific interventions or evaluating their effectiveness. This can be attributed to the relatively recent development of the field of study of the psychological consequences of sexual assault. Although it was clinicians who first recognized the manifestations of psychological distress there has been the expected lag between the carrying out and publishing of scientific studies clarifying the specific nature of sexual assault effects and testing therapeutic strategies.

Assessment of the specific nature and extent of psychological distress for victims seeking assistance has therapeutic and policy relevance. It is standard practice in mental health intervention to conduct an initial assessment as the basis for developing a treatment plan and evaluating progress. Funding sources are interested in documentation that the money is spent for the intended purpose and is accomplishing the desired objectives.

The Community Protection Act included a provision to fund evaluation of the implementation of the law. The Advisory Board of the Washington State Institute for Public Policy at the Evergreen State College oversees the evaluation efforts and identified the concept of standardized assessment of victims as a priority area for investigation.

## Objectives

1. Review current assessment practices in DCD/DSHS funded victim treatment programs.
2. Determine the feasibility of a standardized assessment consistent with Crime Victims' Compensation requirements.
3. Develop a standardized assessment device acceptable to the programs.

## Rationale and background

The negative effects of sexual assault experiences have only recently been the subject of scientific inquiry. During the past two decades it has been established that sexual assault of children and women is widespread and increasing numbers of victims have reported their experiences. As more victims came forward it became apparent that there were both acute and long term psychological sequelae. Rape crisis programs were the first to establish specialized treatment responses to adult rape victims. As awareness increased and services became available, children were identified as comprising a large percentage of sexual assault victims. Sexual assault and child abuse programs expanded services to child sexual abuse victims and their families. Eventually, traditional mental health agencies recognized that sexual assault histories were common among clients seeking services for a variety of mental health disorders and deserving of therapeutic attention.

A clinical literature developed based on the experiences of practitioners. This literature reports numerous psychological consequences and negative outcomes in children and adults. Victims were described as suffering from a variety of specific symptoms and alterations in their sense of self, relationships with others and outlook on the world. Childhood sexual abuse was posited to interfere with the normal developmental process and produce harm manifested in deficits in adult functioning.

More recently an empirical literature based on studies of clinical and non-clinical populations has appeared. These studies have attempted to identify the specific effects of sexual assault on children and adults and the variables associated with outcome. While this inquiry is still in its initial stages, current data provide improved direction for assessment and treatment of victims.

Sexually abused children are found to have more emotional and behavioral problems than non-abused children and different types of problems when compared with children who have been physically abused, neglected or who are psychiatrically disordered. The most common symptoms noted in sexually abused children are fear and anxiety, depression and sexual behavior problems (for reviews see Berliner, 1991, Beitchman et al, 1991, Kendall-Tackett, Williams & Finkelhor, in press). Studies have shown that Post-Traumatic Stress Disorder (PTSD) is a common diagnosis in these children (see McLeer, et al, 1988).

There is variation in the level of disturbance reported, with a significant proportion of children presenting with few or moderate levels of distress (see e.g. Conte & Schuerman, 1987). Variables associated with impact include characteristics of the offense, perceptions of the abuse experience and the reactions of others. Belief and support following disclosure have been consistently found to be related to post abuse adjustment (see e.g. Everson et al, 1989). The impact of interventions such as investigative interviews, placement and testifying is not so severe as once thought, but does influence children's psychological status (see e.g. Runyon et al, 1988, Goodman et al, in press).

Studies of adult rape victims reveal that anxiety and depression are the most common

psychological symptoms. Immediately following rape experiences almost all women meet diagnostic criteria for PTSD and 47% are positive for PTSD three months later (Rothbaum et al, 1992). Women who continue to have PTSD symptoms are unlikely to improve without intervention. Kilpatrick et al (1987) reported that an average of twenty years post victimization 16% of women continued to meet criteria for PTSD. Rape victims also suffer from assault related alterations in their perceptions which restrict their activities and interfere with functioning. As with child victims, lack of support from significant others interferes with successful resolution.

Adults sexually molested as children have increased levels of anxiety, depression, somatization, dissociation and sexual problems (see, e.g., Briere & Runtz, 1987). Sexual abuse in childhood is a risk factor for the development of psychiatric diagnoses including depression, various anxiety disorders and substance abuse disorder (see, e.g., Saunders et al, 1992). High rates of abuse history are found in a variety of clinical populations including psychiatric inpatients, youth involved in prostitution, teenage mothers, and patients with eating disorders, multiple personality disorder or borderline personality disorder. It has been suggested that child abuse experiences, including sexual abuse, may be the major factor in the development of most psychiatric disorders (Briere, in press).

Cognitive-behavioral conceptualizations of sexual assault experiences have been proposed for both child sexual abuse (Berliner & Wheeler, 1987) and adult sexual victimization (Foa, Steketee & Rothbaum, 1989). In these models, aversive emotional and cognitive associations to the experience or avoidance coping responses produce symptomatic behavior. Cognitive appraisal, cognitive adaptation and coping are thought to be major components of the process of integrating the experience and eventual recovery (Koss & Burkhardt, 1989). These conceptualizations help explain why many victims, children and adults, may initially appear unaffected and only seek treatment later on when the negative effects become impossible to avoid or are manifested in other dysfunctional responses.

Although it is widely recognized that sexual victimization is harmful, and many victims are involved in therapy, treatment outcome studies are scarce. It has been shown that Stress Inoculation Training and Prolonged Exposure (cognitive techniques to reduce fear and anxiety) are effective in reducing symptoms in rape victims (Foa et al, 1991). Cognitive-behavioral therapy for children appears promising (Deblinger, McLeer & Henry, 1990) and several outcome studies using this model are underway (e.g. Berliner & Saunders, 1992). At this point the majority of practitioners base their treatment efforts on the developing conceptualizations, the accumulating data on the specific effects of victimization and standard therapeutic approaches adapted to the presenting problems of victims (e.g. Friedrich, 1990, Briere, 1989).

The traditional immediate response to victims has been short-term supportive crisis counseling. The crisis intervention model is no longer thought to adequately explain the range of effects of assault experiences nor to be a sufficient therapeutic approach (Kilpatrick & Veronen, 1983). Crisis intervention is a brief, directive intervention designed to provide information and support to stabilize a disrupted situation. It is now primarily considered useful as an immediate helping

response to the crisis of disclosure or reporting rather than a treatment for the effects of victimization.

It is standard practice in mental health intervention to conduct an assessment in order to determine the nature and extent of the psychological distress. This has not always been the approach to intervention with sexual assault victims. In part, this is because many victims present in an acute state of crisis which requires an immediate supportive response. In cases of child victims they may be brought for therapy simply because the abuse has been disclosed, regardless of whether significant symptoms are present.

One difficulty facing practitioners is that until very recently there were no specific assessment instruments or protocols designed to assess the impact of traumatic events. Research has shown that the usual measures of psychological distress do not necessarily capture victimization specific psychological problems. This situation is changing as researchers have developed instruments which discriminate assault survivors from individuals suffering from other disorders. Unfortunately, the psychometric properties of these measures are still being established and many are not widely available to practicing therapists.

However, there is a growing appreciation that therapy which is not informed by assessment of the clients' problems may not adequately target areas which are in need of intervention. As a result, therapy may be ineffective or progress may not be measurable. The large numbers of victims seeking service and the limited resources dictate a more systematic approach to victimization-focused therapy.

## **Methodology**

The Harborview Sexual Assault Center project managers convened a group of consultants from treatment programs funded by DCD and/or DSHS. Ten consultants representing a variety of program settings and communities of the state met as a group on two occasions. They reviewed materials, described their programs and treatment approaches, discussed the various constraints and accountability requirements of their programs and offered comments and suggestions. Project directors reviewed the literature, provided selected materials and developed an assessment device.

### *Objective 1: Review of current practice*

The participating consultants represented a variety of program types. Some of the funded projects consist of specialized components of mental health or social service agencies. Others are located in existing rape or sexual abuse programs and reflect an extension of services. Still others are clearinghouses or are sub-contractees providing specific treatment services as part of a broader community response. The specific focus of this project was on mental health assessment and therefore did not address other services designed to assist victims such as crisis



response, advocacy with the legal system, medical evaluation or self-help support groups.

Community Mental Health Centers and non-profit child and family serving community agencies generally offer a broad array of treatment services. Many of the children and families seeking services suffer from multiple problems in addition to a history of sexual victimization. The sexual assault experience may be the presenting complaint or may be uncovered during treatment for other problems. It is not uncommon for the children to have been physically or emotionally abused or neglected and their families to have a history of domestic violence, substance abuse or mental illness. Sexual assault services may be provided in a specific program within the agency and several participating agencies have longstanding specialized programs within the larger program. Others offer abuse specific services in the context of the overall treatment plan for the child and family.

Specialized programs designed to serve sexual assault victims were also represented. These programs often began as rape crisis centers and eventually evolved into more formal clinical programs. The programs continue to provide the rape crisis services of information and referral, brief crisis intervention and advocacy. They are often also involved with community and professional education efforts in addition to offering direct services.

The range of assault related treatment services includes crisis intervention, individual, family and group therapy. Some programs also provide evaluations for possible sexual abuse in young children. Group therapy appears to be the most common specific intervention for victims, with many programs offering groups for children and adult survivors. Some programs are specifically contracted to provide group therapy although in most cases group therapy is considered only one aspect of comprehensive victimization treatment.

The Community Mental Health Centers and child and family service agencies often receive Title XIX funding which has established eligibility criteria and accountability requirements. Therapists conduct a formal assessment and complete extensive documentation on standardized forms. The assessment usually includes a mental status examination, a developmental and social history, an assessment of current functioning, problem identification, a DSM-III-R five Axis diagnosis and a treatment plan (Appendix 1). The treatment plan and goals for intervention must be reviewed periodically and termination summaries document progress achieved and the reason for discontinuation of service (Appendix 2).

Programs which do not receive Title XIX funding and are not subject to those reporting requirements vary in the type and specificity of assessment protocols. Most programs have developed or use assessment protocols some sort. Depending on the program the assessment may focus specifically on the presenting complaint or may include a general assessment of functioning and problem identification (Appendix 3). Some of the programs have developed forms to describe the sexual victimization experience (Appendix 4).

A few programs incorporate measures of psychological functioning completed directly by the clients in addition to therapist evaluation. These measures may have been developed by the

program or drawn from other sources. They tend to be specific self or parent report measures documenting symptoms associated with the abuse/assault experience (Appendix 5). Because of the relative recency of the field there are no standardized measures which are in general use.

Currently, programs which provide formal treatment services assess clients at intake. The content and breadth of initial assessment protocols depends on the nature of the setting and includes both externally imposed requirements from funding sources and program driven materials. Some programs require periodic review of progress and use formal termination summaries.

*Objective 2: Determine feasibility of standardized assessment*

The variety of extant assessment protocols, in many cases linked to funding sources, suggests that a standardized comprehensive assessment package is neither necessary nor feasible. Most formal mental health settings already conduct thorough intake assessments. Although the formats may differ, in most cases the relevant historical and current functioning variables are systematically addressed.

The consultants did agree that most of their current assessment protocols do not specifically collect data on assault related symptoms or dysfunction. A diagnostic interview may establish Post-Traumatic Stress Disorder, the most common and specific trauma related diagnosis, but many victims will not have PTSD. It is also not clear whether all practitioners are familiar with the specific criteria which must be documented in order to make the diagnosis. Depression, the other most frequent DSMIII-R diagnosis found in victims, may have other sources or have predated the assault experience. Without documentation of onset and content of depressive thoughts it is difficult to ascertain whether the depression is assault related.

There are other negative psychological impacts which are not captured by diagnosis. In children, for example, sexual behavior problems may be present. There is currently no diagnostic category for these behaviors unless the behaviors are subsumed in a conduct disorder diagnostic category. Friedrich et al (1991) have developed a measure called the Child Sexual Behavior Inventory (Appendix 6) which systematically assesses for the presence of a variety of sexual behaviors. The clinical literature also reports on the types of sexual behavior which are considered problematic and provides guidelines for classifying sexual behavior in children (Appendix 7).

Sexual behavior problems in children is a particularly important area to assess because such behavior may be harmful to others and is thought to be a precursor to adolescent or adult offending. It is also difficult to assess because there is no clearly established standard for acceptable sexual behavior in children. Family beliefs and practice, as well as social attitudes, may influence perceptions about the nature and seriousness of the behavior. Careful screening is indicated, with or without a standard measure since such problems should be a focus of intervention. There is emerging evidence that sexual behaviors do not diminish with conventional sexual abuse treatment and probably require specific treatments.

Other post-assault effects may be primarily manifested through altered beliefs about self, others and the world. It is hypothesized that common assault reactions such as feelings of self blame, guilt, anger, distrust, powerlessness and shame may ultimately convert into decreased self esteem, relationship problems/revictimization, sexual dysfunction and impaired functioning. A whole range of disorders is thought to be associated with unresolved victimization experiences including eating disorders, somatization, dissociation, anxiety disorders, substance abuse disorders, adolescent pregnancy, suicidality and multiple personality disorder. There are no instruments which measure the precursors for assault reactions.

Current conceptualizations suggest that early uncovering and clarification of assault related cognitions and opportunity for ventilation of assault related emotions will be helpful in preventing the development of more serious mental health disorders. This implies that systematic assessment of such beliefs or feelings is an essential ingredient for identifying treatment targets. These efforts are sometimes complicated by coping strategies which may mask distress. Many victims try to avoid recalling or being reminded of the assault because the memories can evoke feeling as if the experience were reoccurring. Assault victims may present with denial of negative reactions. Careful, but specific, exploration of the assault related thoughts and feelings will permit the clinician to distinguish successful resolution from trauma-induced avoidance.

The purpose of assessment is to identify emotional or behavioral problems which will be the focus of intervention. The logical extension is that specific therapeutic strategies will be applied to the targeted symptoms or altered cognitions. Although the programs represented exhibit a high level of awareness and concern for victims, the treatment strategies employed appear to be somewhat non-specific. Most often conventional sexual abuse treatment consisting of support, education and reassurance was described. This reflects the state of the art in community programs and should not be considered a criticism.

However, there is a growing body of literature which suggests that this approach may not be sufficient. This is most apparent in the area of rape victims where treatment outcome studies have revealed that certain specific interventions have increased success. In fact, rape victims do not appear to be a large population receiving services in the programs. In part, this may be explained by the fact that most rape victims do not seek treatment immediately and may present subsequently for other reasons (e.g. depression, anxiety, substance abuse disorder). Unfortunately, unless the clinician discovers the past victimization and intervenes specifically to reduce assault related fear and depression, clients may not improve. There are also several self-report measures which have been shown to discriminate the effects of rape and are easily administered (Appendix 8).

Treatment of adult survivors may be the most difficult area. Many survivors are entering treatment with years of accumulated unresolved abuse reactions with numerous manifestations of distress. As a result, it has become conventional wisdom that long-term process-oriented individual psychotherapy accompanied by group therapy is the treatment of choice. Unfortunately, there are few low cost treatment settings where this type of therapy is available. This has lead to a situation where adult survivors may be denied treatment or only treated when

other problems such as substance abuse or suicidality force intervention. There is virtually no research on the effectiveness of treatment with this population as yet.

Since many of the children and families have multiple problems when they arrive for treatment it is not always possible to devise a treatment plan which addresses the sexual abuse problems separately from the other concerns. In some cases the sexual abuse may actually be relatively unimportant by comparison, at least at the point of entry. This may lead to a situation where the sexual abuse issues remain unaddressed because of other immediate, more pressing behavior problems (e.g. aggression, disruptiveness).

It would appear that the funded programs are sensitive to victims as a client population but do not currently collect systematic data on victimization-caused psychological problems. The consultants were interested in tools which would assist in this endeavor but would not require abandoning assessment protocols in current use and would not be overly burdensome.

The consultants expressed interest in learning more about specific treatments for victimization. They emphasized that in many cases this treatment would have to be incorporated into a broader treatment plan. In the absence of proven interventions it may be more appropriate that clinicians begin with identifying goals of successful intervention and rating clients at initial assessment and periodically over the course of treatment. One such measure (see Appendix 9) may be helpful to practitioners wishing to evaluate progress.

The consultants also remarked on the importance of identifying and supporting victim and family strengths. This is particularly appropriate with victims, since family belief and support are known to be associated with mitigated negative outcome. Unlike the characteristics of the assault experience which cannot be changed, family reactions are amenable to therapeutic intervention. Enhancing support and drawing upon natural resources may reduce the length of formal treatment. It was also observed that both the assessment protocols in use and the proposed victimization specific measures do not address cultural issues. Culturally specific programs which engage clients through familiar and culturally relevant exercises and conceptualizations may increase client commitment to therapeutic change (Appendix 10).

Crime Victims Compensation (CVC) is currently in the process of establishing specific reporting forms for initial assessment and subsequent updates. Concerns about the viability of the fund have again surfaced as increasing numbers of claims have been received. The largest increase has been for treatment services for sexual assault victims. This has led to proposals from CVC to limit services as well as require specific documentation of psychological problems resulting from the victimization. Although the reporting forms have not yet been finalized they will ask therapists to more specifically record the assault related symptomatology and may impose peer review or independent examination in cases where the treatment is longer than average or unconventional and cannot be clearly related to the victimization experience effects.

As previously discussed, it may not always be possible to differentiate assault related problems from disorders with other etiologies. The reaction of an individual to a particular life

experience(s) inevitably and naturally is the result of many previous conditions. It is not realistic to expect that either problems or interventions can be isolated from an appreciation of the whole person, his/her circumstances and life experiences. However, it is reasonable that there be an effort to systematically assess for the specific effects of victimization in the context of the full review of functioning.

*Objective 3: Develop a standard assessment device*

The consultants agreed that it would be useful to have a brief checklist which summarized assault related psychological problems. Such a device would help to identify symptoms which are the product of victimization and provide a structure for treatment planning. It would also serve as a systematic tool for documentation to Crime Victims Compensation which reimburses for victimization treatment.

A one page checklist was developed which lists the various known specific emotional and cognitive effects of victimization (Appendix 11). It is not designed to be a measure of distress *per se* but rather an organizing mechanism for clinicians. It specifically inquires about the diagnosis of PTSD. A structured interview schedule for making the diagnosis ensures that it is applied correctly (Appendix 12). The checklist also provides for notation regarding mitigating or exacerbating factors which may be a focus of intervention.

The purpose of this form is to be a supplement, not to replace current assessment protocols. It does not provide instruction on the elements of the client's emotional, cognitive or behavioral presentation which could serve as markers for determining whether the problem is present. One program has developed such a device (Appendix 13).

One of the complications for assessment is that some negative outcomes may develop over time as the result of various factors in addition to the victimization. While it is important to uncover the potential relationship to the past, it would not be helpful to clients if clinicians were to focus only on one possible contributing factor. For example, eating disorders have been associated with sexual victimization. However, this relationship appears to be true for bulimia but not anorexia. In addition, eating disorders are only found in a small percentage of all victims. Therefore, it is likely that other factors play a relevant role in this particular negative outcome.

It is also the case that simply identifying the etiological variables is not usually sufficient to address the specific problematic behavior. There are established treatments available for many of the disorders which may be helpful in assisting clients. This is particularly true for depression and substance abuse where there are well known extant treatments. In the evolving field of assault specific treatment there is an effort to combine helping the client understand the relationship of current difficulties to the past victimization with application of standard treatments which have been shown to be effective as well as more recently developed assault specific interventions.

## Conclusion

The project deliberations reveal that most agencies and practitioners already perform assessments of clients seeking services. Depending on the setting, the assessment protocol is more or less comprehensive. Programs that provide only a specific assault related service tend to be less likely to conduct a general assessment. In some cases this is because the client is referred for the specific service only or the service consists primarily of brokerage and referral. The consultants did agree that a specific assault related checklist would be helpful in documenting symptoms and assault related problems.

The consultants were as a group knowledgeable and experienced in dealing with sexual assault victims. They exhibit a high level of awareness and sensitivity to victims and families and recognize that victimization is correlated with many psychological disorders. It was clear that many programs are encountering children and families and adult survivors who are experiencing multiple problems. They struggle with the need to integrate assault specific treatment into an overall treatment plan as well as sort out assault related problems from other difficulties.

Interestingly, rape victims presenting with rape specific concerns do not seem to comprise a significant proportion of clients. This may be because rape crisis centers have traditionally fulfilled this role rather than community based counseling agencies. The research also reveals that many rape victims delay seeking treatment and may present with other problems when they do seek help. This is an area which deserves additional attention since there are standard assessment tools for rape effects and evidence available for specific treatments which are effective for rape related negative outcomes.

The consultants were interested in increasing their knowledge about assault specific effects and treatments. They are aware that in a developing field it is not always possible to keep abreast of the empirical literature from a practice setting. They also evinced significant interest in learning what other programs and practitioners are doing as a means of expanding their therapeutic repertoire. In some cases, programs are experimenting with particular approaches to treatment such as solution focused brief therapy. There is a wealth of experience and expertise represented by the various funded programs.

## *Recommendations:*

1. DCD and DSHS funded victim treatment programs be encouraged to adopt the use of the project developed checklist or establish within their own assessment protocols a mechanism for specifically documenting sexual assault related problems.
2. DCD and DSHS maintain a compendium of extant protocols and assessment devices which can be made available to programs and practitioners. A great deal of work has

already been done which would be very helpful to programs and practitioners and avoid the lengthy process of creating new materials.

3. DCD and/or DSHS consider hosting a grantees' meeting once a year for programs to share their activities and materials. This would allow programs or approaches which seem to be successful to be shared with others. In addition, it would provide a forum for training on the most current data on effects of sexual assault and treatment approaches. This meeting might be combined with another state meeting or conference.
4. DCD review its funding priorities to encourage the development of expanded treatment resources for teenage and adult rape victims.
5. Washington State Institute for Public Policy consider extending this priority area to further examine the nature of the treatment programs or approaches currently in use in the state of Washington.

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