

**Sexual Assault Victims' Rights Amendment Act
Task Force
Juvenile Survivor Workgroup**

Issue: How to establish a juvenile victim's right to an independent advocate

**Conference Call Meeting
May 19, 2015**

Present: Cortney Fisher, Elisabeth Olds, Heather DeVore, Michelle Palmer, Nikki Charles

Absent: Laurel Wemhoff, Jennifer Schweer, Tonya Turner

On Tuesday, May 19 at 2:00 pm, the Juvenile Survivor Workgroup convened the first conference call to discuss the ways in which the Workgroup was going to gather information from interested parties about the issues under discussion.

Cortney Fisher summarized what she has done so far to solicit feedback.

- Arranged for two focus groups through the Men Can Stop Rape MOST and WISE Clubs, one held on Tuesday, May 19 at 11:30 am and attended by Michelle Palmer and Cortney Fisher and the second to be held on Thursday, May 21 at 3:30 pm and to be attended by Elisabeth Olds and Heather DeVore. Tonya Turner has tentatively RSVP'd that she will be in attendance if she can be.

Cortney Fisher and Michelle Palmer briefly reviewed the substance of the MCSR Focus Group. Notes from that focus group are distributed separately.

- Arranged for a meeting with Commander Hickson of the MPD Youth Division to be held on Wednesday, May 20 at Children's National Medical Center. Cmdr. Hickson offered to convene members of the Multidisciplinary Team at this meeting if possible. Tentative attendees at this meeting include Elisabeth Olds, Kelley Dillon, Cortney Fisher, and Heather DeVore. Michelle Palmer can call in to the meeting, but she is traveling at that time.

In addition, Cortney Fisher relayed that there had been two communications regarding the Workgroup.

- Sherelle Hessel-Gordon has declined to be on the Workgroup but has requested that Amanda Lindamood be on the Workgroup. Since non-Task Force members cannot be a part of the Workgroup, Cortney offered that the Workgroup will set up an appointment with Amanda to discuss her insight into the issues facing juvenile victims.
- Michelle Booth Cole had scheduled and held a meeting with Smitty and Cortney Fisher to discuss her concerns with the recommendations of the Task Force and her concerns that members of the MDT were not members of the Task Force. Smitty and Cortney reiterated that Michelle is the representative of the MDT on the Task Force and that the Juvenile Survivor Workgroup is committed to reaching out to the members of the MDT individually or as a group to solicit feedback and information about how a right to an advocate will be implemented. The Workgroup discussed ways to better include the MDT and other members of the VAN with a vested interest in the outcome.

Michelle Palmer suggested that all members of the Task Force provide their resumes to Kelley Dillon so that the public and the other members of the Task Force can understand the breadth of expertise that exists on the Task Force. All members of the Workgroup were in favor of this action. Cortney

Fisher agreed to ask Kelley Dillon to collect the resumes and forwarded her own resume to Kelley Dillon at the same time.

To better facilitate more communication with service providers working with children and adolescents, the Workgroup agreed to reach out to the following agencies and organizations:

- **Cortney Fisher** agreed to connect with **Timothy Elliott at Whitman-Walker Health** to get perspectives on the LGBTQ adolescent population
- **Michelle Palmer** agreed to connect with **Child and Family Services Agency** and set up meetings regarding their processes of opening an investigation and their opinion on DC's mandatory reporting law
- **Nikki Charles** agreed to reach out to **Cecilia de los Santos from the Latin American Youth Center (LAYC)** to get perspectives about serving Latin American youth.
- **Jennifer Schweer** will convene a **college-age focus group** to gather their perspectives
- **Cortney Fisher** agreed to reach out to **Laila Leigh at Break the Cycle** to set up a meeting with the Workgroup to gather their perspectives
- **Heather DeVore** agreed to secure an opinion from the **International Association of Forensic Nurses** about best practices for providing medical forensic care to adolescent and child victims of sexual assault
- **Michelle Palmer** agreed to reach out to **Fair Girls** to set up a meeting and gather their perspectives on working with juvenile and adolescent victims of sex trafficking
- **Cortney Fisher** agreed to reach out to **Nelly Montenegro at Ayuda** to facilitate a discussion about serving immigrant youth and adolescents.

The group asked for a standard set of questions to ask each contact or with which to facilitate each meeting. Cortney Fisher agreed to send the questions that she has posed to Cmdr. Hickson and to the MCSR Focus Group.

The Workgroup will seek to set up another conference call next week after more meetings are established.

Meeting adjourned.

**Sexual Assault Victims' Rights Amendment Act
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Issue: Whether a juvenile victim of sexual assault has the right to an independent advocate

**Focus Group/Listening Session
May 19, 2015
McKinley Technical High School
Men of Strength Club Members**

On Tuesday, May 19 at 11:30 am, Michelle Palmer and Cortney Fisher attended a Men of Strength (MOST) Club meeting at McKinley Technical High School. The MOST Club was attended by 11 young men of color (all of whom are in high school) and facilitated by a MOST Club facilitator, Duonte Peoples.

We asked the following questions.

(1) How many people in the room know someone or think they know someone who has been sexually assaulted?

5 of the 11 men in the room raised their hands.

(2) How many of those people (those who were sexually assaulted) have not told their parents or another adult?

All 5 men raised their hands again or nodded again at the question.

(3) Michelle did a lot of explaining about how the adult process works now vs. how the juvenile process works now, clarifying that when an adult is sexually assaulted and wants to get a medical forensic exam, the adult is met at the hospital by a specially trained nurse and an advocate together. Michelle clarified the role of the advocate as someone who helped the victim make choices about what to do next.

One of the students asked if an advocate was someone who "stood up for you" and Michelle affirmed that was the case.

Do you believe that a young person who is sexually assaulted (or really victimized in any way) should have the right to have an advocate with them for a medical forensic exam or to go to the police?

All 11 men in the room stated pretty clearly that they believed that young people should have a right to an advocate and that advocate has to have the trust of the young person.

The men stated that the advocate should "sign a paper" saying that they would never tell what was told to them unless the person was going to commit suicide. The men also stated that an advocate should be trained to get kids to open up because they naturally don't trust many people and that the trust from the kid to the advocate was essential.

The men were very knowledgeable about CFSA and law enforcement and seemed very interested in CFSA and law enforcement not being involved unless they wanted them involved.

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One young man said "13 year olds are not children. They are in 8th grade. They are making their own decisions."

The young men also seemed to make a distinction between 13 year old adolescents and "children", stating that a "third grader can't do this without their parent" but noting that the 3rd grader should have an advocate because the parents can't do it. We asked a follow-up question about parents being advocates.

(4) What do you think about having your parent or caregiver be your advocate?

The men stated somewhat unanimously that their parent couldn't be an advocate. One man said that it "doesn't make sense for your parent to be an advocate because they aren't trained and don't know what's going on". Another young man stated that "parents are too emotional and they will be enraged". Another young man stated that "not all parents are easy".

The men did acknowledge that the parent often knows the child better than anyone else and would be helpful. However, they did not think that made the parent the advocate. In their mind, advocates are trained and should be available for the parent as well.

One man said that he sometimes told other people things so that they would tell his parents and acknowledged that an advocate could be helpful in him telling his parents something like this. The men unanimously seemed to understand that the presence of an advocate doesn't preclude the parent as a support but actually helps the parent be better supports.

(5) Do you think that you or your friends would delay seeking help or would not seek help at all if they thought that seeking help was going to result in their parents finding out, the police finding out, or CFSA finding out? Why or why not?

All 11 men believed that their friends/themselves would not seek help if they thought their parent was going to find out, and they especially confirmed that if they thought the police or CFSA was going to find out, they wouldn't say anything.

(6) What do you think those advocates should know if they are going to be working with young people?

When we asked them if there was anything more that they wanted to tell us and asked what they would want from these advocates, they said that they wanted a "variety of advocates in the group". Michelle followed up on that and asked if they were talking about gender and race and they said yes. Some of the young men felt comfortable with women being their advocate; some felt that they would want a male advocate. The age of the advocate seemed to be less of an issue than race or gender.

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Issue: How to ensure that a juvenile victim of sexual assault has the right to an independent advocate

Focus Group/Listening Session

May 20, 2015

Children's National Medical Center Child and Adolescent Protection Center

Multidisciplinary Team Members (MDT)

On Wednesday, May 20 at 1:30 pm, Cortney Fisher, Elisabeth Olds, Heather DeVore, and Kelley Dillon attended a meeting of the Multidisciplinary Team (MDT) which was convened by Commander Danny Hickson, Commander of the MPD Youth Division. The meeting consisted of Dave Rosenthal (OAG), Cmdr. Hickson (MPD), Allison Jackson (CNMC), Herman Tolbert (CNMC), Rose Gordy (Safe Shores), and Kelly Higashi (USAO). There were three members of the MDT that arrived later and either did not introduce themselves or provided names that we didn't catch. They were representatives from CFSA and the OAG. One was a forensic interviewer from the USAO.

Cortney Fisher began the meeting by giving the MDT a background of the Task Force and the questions that the Juvenile Survivor Workgroup was attempting to answer. Cortney Fisher read the following, nearly verbatim:

I am a member of the SAVRAA Task Force and we've been given a set of questions to answer by the legislation. Specifically, the SAVRAA Task Force was specifically directed by legislation to make a recommendation about "whether a need exists to expand the right to a sexual assault victim advocate to juvenile sexual assault victims. If a need is identified, the Task Force shall: (A) identify where the need exists and to what extent; and (B) make recommendations on how best to fill that need, whether legislatively or otherwise." The Task Force voted unanimously on Wednesday to recommend to Council that the right of an independent advocate be extended to juvenile sexual assault victims. NOTE: The Task Force made VERY clear that this only extends to juvenile sexual assault victims (under the age of 18) who were victimized by someone not a caregiver and with no custody of the victim. To fulfill the Task Force's responsibility to (A) and (B) of the legislation, the Task Force decided to convene a Working Group on this issue. That Working Group will be meeting (between now and the June meeting of the Task Force) with everyone we can think of who are not on the Task Force but who have a vested interest in this outcome.

The Task Force voted unanimously that all victims of sexual assault, i.e. sexual assault that is not committed by a caregiver or person with custody of the victim, are entitled to an independent, community-based advocate in the same manner as an adult victim is granted that right under SAVRAA. That is, the Task Force will be recommending that a juvenile victim of sexual assault be provided an advocate as soon as that juvenile victim accesses medical forensic care.

Our questions now are as follows:

- (1) How do we ensure that victims over the age of 13 are able to access medical forensic care without report to law enforcement, as is required by VAWA?*

(2) How do we ensure that victims under the age of 18 who do not access the DC SANE program are provided an independent, community-based advocate at the medical forensic exam?

The response of the MDT to the questions was to challenge the central premises of the questions themselves, so it was very difficult to gather any information about the process of the MDT or the process for juvenile victims of sexual assault.

NOTE: A suggestion was made by Dave Rosenthal that the Task Force not use the word "juvenile" to describe sexual assault survivors under the age of 18. He suggested using the term "minor" or "child" since those are the words used in statute.

The following represents the challenges of the MDT to the central questions to be answered:

- (1) There is no need for an independent advocate because the MDT and the parent, as well as the doctor or nurse in the case, act as an advocate for the client. Elisabeth Olds tried repeatedly to explain the role of an advocate and the way in which advocates interact with minors in the DVIC setting. The following are concerns expressed specifically about the advocate:
 - The MDT expressed concern that the advocate would interfere with the parent-child relationship. For example, what happens if the parent does not want their child to have an advocate? Does the child's right to advocate trump the parent's right to parent the child?
 - The MDT expressed concern that the advocate would be one too many people involved in the child's case
 - Safe Shores acts as an advocate in the sense that they are working with a non-offending caregiver, and that is the extent of advocacy that a minor or child should have
 - An advocate for a child would need advanced credentialing to work with the child
 - An advocate would create issues within the criminal case because the advocate would be another person interviewing the child and then could become involved in a case
- (2) Their interpretation of the District's mandatory reporting law requires that any citizen report any crime committed against a minor or child.
- (3) Their interpretation of VAWA specifically states that it does not supersede a state's mandatory reporting laws so an advocate would have to report to CFSA regardless.
- (4) The MDT does not believe that the notification of a parent or the police is a barrier to seeking service for the child and adolescent population. The MDT believes (apparently unanimously) that the only delay in reporting is caused by the offender's grooming of the victim, and the offender telling the victim that they (the victim) are at fault. Cortney Fisher asked again about this age group, indicating that in her personal experience, college students are hesitant to seek any service if they believe that their parent will find out. The MDT indicated that was unique to college students because they were away from their parent.

Some information that was shared by the MDT during the course of the meeting:

- (1) Over the course of 2 ½ years, the CAPC has completed 95 PERKS on minors with an acute assault case. 75% of those cases are not intra-familial. 12% of those cases were children under the age of 12. Therefore, the vast majority of ACUTE cases that CAPC sees, are children over the age of 13 with a peer-to-peer assault.
- (2) CNMC employs a “don’t ask, don’t tell” policy with regard to the acute cases. (The “don’t ask, don’t tell” phrase was not used in the meeting. It is used here to describe the policy.) If the minor survivor does not want to identify the perpetrator, CNMC staff does not push them to reveal the perpetrator or any details of the case.
- (3) CNMC does contact the CFSA hotline to report the crime, however. In cases that are not caregiver cases, CFSA does not open an investigation but does report the crime to Youth Division.
- (4) Minors age 14 and older can come into CNMC to access a medical forensic exam without a parent. However, CNMC will contact CFSA to notify them of the crime. Parental notification is necessary because there are medications to be provided.
- (5) The process of the acute exam for minors is different from the process for adults in that the minor comes back to the CNMC Clinic after the acute phase has passed to receive medication and a further check-up.

Cmdr. Hickson suggested that there may be a role for an advocate when the MDT has to “handle” the “runaways and prostitutes” that are coming in because there is no parent involved.

Allison Jackson suggested that there may be a role for an advocate for college students who are minors because they are away from their parents.

The MDT has significant concerns with the composition of the Task Force, believing that there are no members of the Task Force with sufficient experience with youth and adolescents. Cortney Fisher provided information about the Task Force composition and made clear that there is a representative from the MDT and that representative is Michelle Booth Cole. Cortney Fisher also stated clearly that Michelle Booth Cole has only attended two partial meetings of the Task Force.

The MDT has asked that the Task Force be expanded to include more MDT members. Cortney Fisher said that she’d take that recommendation back to the Task Force.

There were twenty girls in attendance, all freshmen at McKinley Tech. We introduced ourselves and explained why we were there, i.e. to gather information about what they were experiencing in their peer group and that we were trying to improve the response to sexual assault for people their age.

- (1) How many people in the room know someone or think they know someone who has been sexually assaulted? Of the 20 girls in the room, 9 raised their hands. We didn't define sexual assault for them, but left it to their interpretation. This produced an interesting discussion later on in the conversation.

- (2) How many of those people (those who were sexually assaulted) have not told their parents or another adult? All 9 girls put their hands down to indicate that none had told their parents, or to their knowledge, another adult. We elaborated on this and asked them why they thought that was. The answers we got were:
 - a. Afraid their parents will think they're lying;
 - b. Afraid that the adults will blame the victim for doing something they're not supposed to be doing, i.e. at a party, drinking, hanging out with people they shouldn't be.
 - c. Religious implications if your parents or you are religious and your parents think that you're "ruined" now.
 - d. Fear that their parents would go to the police and the person's reputation would be ruined among their peer group and then the reporting victim would ultimately be ostracized.
 - e. "Self-pity" or blaming themselves for the incident.

One participant asked what happens in a rape kit. Heather explained that to the group.

We asked them what their priorities would be or what they think their peer group's priorities would be if that happened to them:

STD's and Pregnancy were first and foremost, followed in order by offender accountability, getting counseling or finding someone who is going to be supportive. One student asked about whether they had to see the offender in court and said that knowing those sorts of details up front would help them make a better decision about what to do.

- (3) [Adding some explanation of the process up front so they are somewhat aware of what we are talking about...] Do you believe that a young person who is sexually assaulted (or really victimized in any way) should have the right to have an advocate with them for a medical forensic exam or to go to the police? (NOTE: Michelle did a lot of explaining about what an advocate was and what the process looked like for juveniles and what the process looked like for adults)

The group agreed that if there was no parent available they would need an adult to be there for them. It would help with backing out and making excuses or not feeling like they needed to do that.

The conversation also circled back to why parents might not be told:

- CPS might be called.
- They don't want the relationship with the offender to actually end.

(4) What do you think about having your parent or caregiver be your advocate?

They said an advocate would be good because even parents may not understand the system.

One student cited the idea that parents may have an agenda totally different from the child, i.e. start making the child do things that were not helpful because the parent is so enraged.

Made the point that the situation happened to me, not to her mother so she should be allowed to make decisions for herself in some instances.

Another student said the advocate knows the system and the parent is emotionally involved.

One student stated she felt the opposite way and that having yet another stranger in the situation might be bad.

(5) Do you think that you or your friends would delay seeking help or would not seek help at all if they thought that seeking help was going to result in their parents finding out, the police finding out, or CFSA finding out? Why or why not?

Uniformly they said this was the case, in part because then they will have destroyed their peer group, be ostracized from it, feel like they did something to someone.

(6) What do you think those advocates should know if they are going to be working with young people?

Said they shouldn't be over age 35, and that they should have experience in the field, and preferably be a survivor themselves. A discussion was had about whether it needed to be gender specific and said that for girls, yes it needed to be women, but for boys it might be different.

Sexual Assault Victims' Rights Amendment Act
Individual Interview with Amanda Lindamood

On Friday, May 29 at 9:00 am Elisabeth Olds and Laurel Wemhoff met with Amanda Lindamood, from the DC Rape Crisis Center at OVS' offices. The notes below are summarized from the open conversation that was had about the Task Force Recommendations for allowing advocates for minors.

Amanda stated that the youth will have so many questions about having an advocate involved in the process, and the lack of trust with any adult will most likely be present.

The unknowns need to be limited as much as possible.

Whoever or whichever group is responsible for carrying out and implementing the advocate response for minors is a key component of the success of having this process work.

- She expressed concern about how the group was defining an advocate, i.e. only within the medical/legal context, particularly given that teens don't want to go that route most of the time.
- Open question posed about how advocates are trained and said that they can't be both a lawyer and an advocate or a nurse and an advocate because this presents an inherent conflict of interest. They have their own agendas separate from the client/patient.
- Flexible entry points and access points are key for this population. Cost of transportation, days off from school, etc. are important to consider as well.

Amanda suggested having a focus group with individuals who:

- currently work with youth
- currently work with youth survivors
- are actual youth survivors
- community level authority

Youth do not access the formal system. They are scared and don't trust it.

The risk of reporting doesn't outweigh the benefit for most of the youth. Example: If the perpetrator was a friend in their group, telling their parents or an authority figure could jeopardize their social circle and lead to feeling isolated.

Youth are calling the DCRCC hotline as an anonymous way to report and seek services. No hard numbers exist as to how many youth this is.

With youth there are always survivors and perpetrators in every classroom.

We should not over-estimate the willing-ness of youth to go to adults for help.

Amanda brought up the fact that jurisdiction might play a role in if the youth report or not, whether they live in MD, DC, or VA.

Mandated reporting and confidentiality laws need to be worked out as well.

The perception is that if a youth is in danger, their consent is not taken into account.

The training for advocates serving youth needs to be really intentional about giving them tools for self-advocacy. The trainers need to be youth competent more so than survivor competent.

If the youth is in any system they're asking the following:

- Which advocate, who do they work for, who are they with an emphasis on personally knowing that advocate, i.e the teen would likely ask if you the referring person knows the advocate.
- Do my parents find out?
- What do I get out of this process?
- Location matters in limiting the unknown, i.e. having them go to a separate or secondary location unfamiliar to them to talk to this advocate might not work well.

Teens want more tools and information and are trying to find a loophole in the mandatory reporting system to get tools and help that actually works for them.

Nikki Charles and Heather DeVore spoke with Sandy Bromley on 6/4. She was not familiar with the concept and was unsure how you legislate the "right" to an advocate. However, she provided this research:

DC Juvenile Victim Workgroup

(1) How do we ensure that victims over the age of 13 are able to access medical forensic care without report to law enforcement, as is required by VAWA?

- **NJ Attorney General**

Standards <http://www.nj.gov/oag/dcj/agguide/standards/standardssartsane.pdf> Page 12, Standard 6 highlights the standard for when to report to CPS.

- **OVC SANE website**: SANEs release evidence to law enforcement agencies only with the victim's consent in cases where the victim has agreed to report or has already reported the crime. SANEs are mandated, however, to report to the proper authorities in cases of sexual assault of vulnerable adults (e.g., an older person dependent on a caregiver); sexual assault of minors by family members, caretakers, or persons in positions of authority over them; or sexual assaults of minors that were the result of parental neglect.¹⁴ Depending on state statutes and local enforcement policies, SANEs may or may not be mandated to report cases of statutory rape if adult perpetrators were not caretakers or were not in positions of authority over minors.¹⁵

- **OLD Linda Ledray**

manual: <http://www.imprimus.net/PDF%20Files/Downloadable%20Files%20Page/saneguide.pdf> page 97 has some language on minors

- **National Protocol for Sexual Assault Medical Forensic Examinations Adults/Adolescent:** <https://www.ncjrs.gov/pdffiles1/ovw/241903.pdf>

Also, jurisdictional statutes regarding mandatory reporting to law enforcement or protective services in cases of vulnerable adult and minor sexual assault victims must be observed. Page 51 States are required, as a condition of eligibility for STOP Violence Against Women Formula Grant funds, to allow victims to receive examinations and to have the examinations paid for regardless of the level of participation of victims in the criminal justice process. Page 52

(2) How do we ensure that victims under the age of 18 who do not access the DC SANE program are provided an independent, community-based advocate at the medical forensic exam?

- **NJ Attorney General**

Standards <http://www.nj.gov/oag/dcj/agguide/standards/standardssartsane.pdf> Page 12, Standard 6:

Victims age 12 or older and their family will be offered the services of a rape care program. Advocates are also available to offer support services to non-offending family members of all child and adolescent victims, regardless of the child's age or when and where the assault occurred.

Page 5 also indicates: [even if the victim chooses not to undergo a SANE] Nonetheless, the victim is entitled to and should be offered the services of a rape care advocate and a complete law enforcement investigation.

- National Protocol for Sexual Assault Medical Forensic Examinations Adults/Adolescent: <https://www.ncjrs.gov/pdffiles1/ovw/241903.pdf>

Page 87: **Advocates should be able to provide support and advocacy during the history if desired by patients.**

- **Pima County**
Protocol: <http://www.pcao.pima.gov/documents/SexAssaultProtocol.pdf> - discusses mandated reporting, calling advocate out even in minor cases.

Her other comments were:

- Look closely at the current legislation. What is the age that adolescents can access mental health services? Advocacy should possibly align with this legislation.
- Encourage parental involvement
- Make sure there is a clear distinction between advocacy v. "best interest" like a GAL v. legal representation
- She expressed concern that there may be a VAWA protocol violation with CAPC contacting CFSA who contacts MPD youth division for every report of assault.
- She was not familiar with the mandatory reporting statutes in DC

Jen Schweer

6.8.14

Interview with Timothy Elliott, Whitman Walker

Barriers for LGBT youth survivors:

- Understanding how to access services
- Concern (and experience) of being seen and/or treated like a perpetrator, rather than a victim
- Managing concerns around helper bias- using wrong pronouns, assumption about sexual behavior based on sexual orientation or gender identity, focus of appointment becoming on sexual or gender identity, rather than the assault.
- Experience they have previously had with medical providers/systems who were not competent ... and knowledge of their peers experience with providers/systems.
- Long wait for appt times for providers discourages follow-up

We discussed the red carpet program that is in place for HIV care and treatment (<http://doh.dc.gov/service/red-carpet-entry-program>) as a model. Timothy emphasized that it's critical that LGBT youth survivors have quick access to medical/advocacy/legal help, as he sees many get appts scheduled for weeks or months away, and in that time they give up and start to believe the message that perhaps they were at fault, or it wasn't that big of a deal. (And the loss of potential forensic evidence and immediate need for medical follow-up.)

When discussing involvement of parent/guardians, he felt that of course it's best to have them involved whenever possible, but (especially with LGBT youth) it must be done mindfully, taking into consideration safety around the disclosure, where they are in coming out process, previous history of abuse, etc. Will involving more people create more trauma and become something to manage in addition to the sexual trauma?

Overall, very supportive of idea to have independent advocate for minors and feels that if done in the right way, it has the potential to get more survivors care and response. Considerations:

- Access points and how will it be rolled out?
- Having advocates and medical providers who are trained and experts in both LGBT issues AND youth.
- Understanding the need for developmentally appropriate youth intervention (cannot necessarily look like the adult model)
- Must have same advocate and no lapse in response time to survivor until there is resolution to care and/or case. (He expressed that a lack in responding, long wait times for meetings, return phone calls will "lose" the client. They will give up and not trust the system... and potentially feel that the provider doesn't see them as a "real" victim or that it was that big of a deal, something that is constantly reinforced by others in their life.)

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Interview

June 9, 2015

Break the Cycle

Laila Leigh, Manager of Legal Services, and (2) Youth Advisory Board members

On Tuesday, June 9 at 9:00 am, Cortney Fisher met with Laila Leigh, Manager of Legal Services for Break the Cycle, and two members of the Break the Cycle Youth Advisory Board in the Break the Cycle offices.

I began the interview by summarizing the standard script agreed upon by the Work Group:

I am a member of the SAVRAA Task Force and we've been given a set of questions to answer by the legislation. Specifically, the SAVRAA Task Force was specifically directed by legislation to make a recommendation about "whether a need exists to expand the right to a sexual assault victim advocate to juvenile sexual assault victims. If a need is identified, the Task Force shall: (A) identify where the need exists and to what extent; and (B) make recommendations on how best to fill that need, whether legislatively or otherwise." The Task Force voted unanimously on Wednesday to recommend to Council that the right of an independent advocate be extended to juvenile sexual assault victims. NOTE: The Task Force made VERY clear that this only extends to juvenile sexual assault victims (under the age of 18) who were victimized by someone not a caregiver and with no custody of the victim. To fulfill the Task Force's responsibility to (A) and (B) of the legislation, the Task Force decided to convene a Working Group on this issue. That Working Group will be meeting (between now and the June meeting of the Task Force) with everyone we can think of who are not on the Task Force but who have a vested interest in this outcome.

The Task Force voted unanimously that all victims of sexual assault, i.e. sexual assault that is not committed by a caregiver or person with custody of the victim, are entitled to an independent, community-based advocate in the same manner as an adult victim is granted that right under SAVRAA. That is, the Task Force will be recommending that a juvenile victim of sexual assault be provided an advocate as soon as that juvenile victim accesses medical forensic care.

Prior to asking the agreed upon questions, I first asked the group whether they believed that victims of sexual assault under the age of 18 should have the right to an advocate. Prior to their answering, I briefly outlined the current juvenile system, i.e. that minor victims of sexual assault are entitled to a family advocate through Safe Shores, as well as a victim witness specialist assigned by the prosecutor's office. I also explained that Safe Shores helps the parent of the juvenile to understand the system and advocate for their child, and that the doctor or nurse that provides the exam also advocates for the child.

[For the majority of the meeting, Laila Leigh allowed the Youth Advisory Board members to answer the questions and direct the dialogue. For that reason, I will note specifically what Laila's contributions were]

The women answered emphatically that youth survivors need to be given an advocate that are separate from their parent, or at least be granted the option of having an advocate. The women noted that some people may not want their parents to know.

One of the women remarked that when there are 17 year olds on college campuses, the prospect that their parents (who may be several states away) would be notified would further chill reporting on a college campus.

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The same woman also remarked that where there are intersections of marginalization (LGBTQ, homeless, runaway, sex workers) the teens are further discouraged from reporting for fear that someone may come to know of secrets that they are hiding.

[I asked the women what they believed an advocate for a teen survivor would look like] The women remarked that the advocate had to be ready to listen, have information, and be non-judgmental. They should be trained on the dynamics of victimization and the teen experience.

[I asked the women whether they felt that a parent should have the ability to block access to an advocate] The women remarked that no, the right to an advocate had to be directed by the youth survivor. Minor victims also have the right to consent to legal services. Laila Leigh remarked that the rights of the parents in this situation have to be analogous to the parents' rights in the rest of the law. Minors can access contraception/STI testing in high school, substance abuse and mental health resources, "sensitive and emergency services" without the parent's consent. Laila remarked that the bigger question is whether the minor victim has confidentiality and the right to privacy after the emergency services ended.

One of the women remarked that cultural ideas of shame in many immigrant populations would make the parent as advocate a particularly difficult relationship. Appointing someone with that type of veto power over an advocate, when they may be already shaming the survivor, is a bad idea.

The goal of the policy needs to be survivor and trauma focused. Teens have a natural fear of being judged, losing privileges from their parents. The focus of the Task Force needs to be less parent-focused and more survivor/teen-focused.

With regard to teen victimization, the adults working on the Task Force have to not make assumptions about the reality of the teen victimization.

- Don't assume that the victimization is going to happen over and over again. That is often not the teen's reality.
- If the teen survivor is telling you what they want to do, listen. They are the experts in their own life.
- "Just because you are reporting something to the police doesn't mean anything is going to happen" – The women were clear that they know and most teens know that a report to police doesn't necessarily mean an arrest or prosecution. What if you force a teen into a mandatory report process and there is no arrest or prosecution? Are these people going to be there to help the teen recover their life?

Laila Leigh noted that with regard to the concerns that folks have about medication, access to medication is already permitted in the regulations. Teens have access to STI testing and treatment already. "The services already exist. The question is about letting the teens know that they exist and about streamlining the services."

The women noted that there has to be clarity about what the services are. While the women were opposed to strict mandatory reporting of all crimes to all children under the age of 18, they noted that if mandatory reporting was going to be the law, there needed to be an advocate that explained to the teen survivor what was going to happen BEFORE anything happened, and to tell them what their rights were within that system.

[Since one of the women repeatedly brought up the idea of cultural differences and intersecting areas of marginalizations, I asked the women about how a policy requiring an advocate independent of the parent would impact victims and parents of color who are often used to being marginalized] The women stated that people of

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color needed an advocate more than anyone else because of how they have been treated by many systems. People of color needed to be treated with the same level of dignity as white people and that most often means that both the parent and the child should have an advocate.

- Advocate should be viewed as an independent liaison, with no allegiance to any system other than what the victim wants, between the minor survivor and the rights and services that are available to the victim.
- "Parent's rights and feelings should not be more important than the victim's feelings"
- It is important for survivors to understand exactly what is going to happen. This process often leads to feelings of betrayal and mistrust of the system. It's important for the survivor's healing that they can direct their own process, particularly for people of color.
- "If people are telling you that Black parents don't want an advocate for their child, those people are part of the system" – noting that Black parents especially know what the systems are like for their Black children. If they don't want an advocate for their child, they are likely going to be unsupportive themselves.

Laila commented on Break the Cycle's experience of providing free legal help to mostly minors. The relationship between the parent and the attorney is not adversarial. Even if the parent disagrees with the decisions of the child, the attorney has to work for the child. They are able most often to bridge that gap between the parent and the child.

- What is the case fails? Aren't you putting a pretty substantial burden on the parent to protect their child in the face of a failed criminal justice prosecution?

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**Juvenile Survivor Work Group Update
June 10, 2015**

Work Group Members: Cortney Fisher, Elisabeth Olds, Heather DeVore, Michelle Palmer, Nikki Charles, Laurel Wemhoff, Jennifer Schweer, Tonya Turner

The following is an update on the actions of the Work Group since the last Task Force meeting of May 13, 2015:

- Meeting with (an informal) gathering of many members of the District's Multidisciplinary Team on May 20, 2015 (Elisabeth Olds, Cortney Fisher, Heather DeVore, Kelley Dillon)
- Meeting with Michelle Booth Cole, Director of Safe Shores (Smitty Smith, Cortney Fisher)
- Meeting with male high school students at McKinley Tech High School (Michelle Palmer, Cortney Fisher) on May 19
- Meeting with female high school students at McKinley Tech High School on May 21 (Heather DeVore, Elisabeth Olds)
- Meeting with Amanda Lindamood, DC Rape Crisis Center, on May 29 (Laurel Wemhoff, Elisabeth Olds)
- Meeting (via phone) with Sandy Bromley, JD, Countywide Domestic Violence Coordinator in Fairfax County, VA, with special legal expertise in juvenile survivors of violence on June 4 (Nikki Charles, Heather DeVore)
- Meeting with Timothy Elliott, Metro Teen AIDS/Whitman-Walker Health on June 8 (Jen Schweer)
- Meeting with Multidisciplinary Team (Elisabeth Olds)
- Meeting with Laila Leigh of Break the Cycle, and two members of the Break the Cycle Youth Advisory Council on June 9 (Cortney Fisher)
- Preliminary academic research about the help-seeking behaviors of youth who have been sexually assaulted and the youth's perceived barriers

The Work Group agreed that the following outline/standard questions would frame each conversation:

I am a member of the SAVRAA Task Force and we've been given a set of questions to answer by the legislation. Specifically, the SAVRAA Task Force was specifically directed by legislation to make a recommendation about "whether a need exists to expand the right to a sexual assault victim advocate to juvenile sexual assault victims. If a need is identified, the Task Force shall: (A) identify where the need exists and to what extent; and (B) make recommendations on how best to fill that need, whether legislatively or otherwise." The Task Force voted unanimously on Wednesday to recommend to Council that the right of an independent advocate be extended to juvenile sexual assault victims. NOTE: The Task Force made VERY clear that this only extends to juvenile sexual assault victims (under the age of 18) who were victimized by someone not a caregiver and with no custody of the victim. To fulfill the Task Force's responsibility to (A) and (B) of the legislation, the Task Force decided to convene a Working Group on this

issue. That Working Group will be meeting (between now and the June meeting of the Task Force) with everyone we can think of who are not on the Task Force but who have a vested interest in this outcome.

The Task Force voted unanimously that all victims of sexual assault, i.e. sexual assault that is not committed by a caregiver or person with custody of the victim, are entitled to an independent, community-based advocate in the same manner as an adult victim is granted that right under SAVRAA. That is, the Task Force will be recommending that a juvenile victim of sexual assault be provided an advocate as soon as that juvenile victim accesses medical forensic care.

[When interviewing or meeting with other professionals] Our questions now are as follows:

- (1) How do we ensure that victims over the age of 13 are able to access medical forensic care without report to law enforcement, as is required by VAWA?
- (2) How do we ensure that victims under the age of 18 who do not access the DC SANE program are provided an independent, community-based advocate at the medical forensic exam?

[When interviewing or meeting with a focus group of youth]

- (1) How many people in the room know someone or think they know someone who has been sexually assaulted?
- (2) How many of those people (those who were sexually assaulted) have not told their parents or another adult?
- (3) [Adding some explanation of the process up front so they are somewhat aware of what we are talking about...] Do you believe that a young person who is sexually assaulted (or really victimized in any way) should have the right to have an advocate with them for a medical forensic exam or to go to the police? (NOTE: We did a lot of explaining about what an advocate was and what the process looked like for juveniles and what the process looked like for adults)
- (4) What do you think about having your parent or caregiver be your advocate?
- (5) Do you think that you or your friends would delay seeking help or would not seek help at all if they thought that seeking help was going to result in their parents finding out, the police finding out, or CFSA finding out? Why or why not?
- (6) What do you think those advocates should know if they are going to be working with young people?

The following is a summary of the pending activities of the Work Group:

- Cortney Fisher will meet with Nelly Montenegro and the parent of a survivor of child sexual abuse on Monday, June 15.
- Nikki Charles agreed to reach out to *the Latin American Youth Center (LAYC)* to get perspectives about serving Latin American youth.
- Jennifer Schweer will convene a *college-age focus group* to gather their perspectives
- Heather DeVore agreed to secure an opinion from the *International Association of Forensic Nurses* about best practices for providing medical forensic care to adolescent and child victims of sexual assault
- Michelle Palmer agreed to reach out to *Fair Girls* to set up a meeting and gather their perspectives on working with juvenile and adolescent victims of sex trafficking

- On June 16 and June 18, 2015, the Work Group has convened two publically-accessible “Listening Sessions” to gather the perspectives of youth-serving organizations or youth that have not yet been represented. The information about these Listening Sessions has been widely disseminated and will be posted on the OVS website.
- Elisabeth Olds is preparing a survey to be distributed widely to determine the following questions (a) the prevalence of sexual assault among minors (under the age of 18), (b) their help-seeking behavior, if any, and (c) their perceived barriers to help-seeking.

The recommendations of the Work Group (at this point) are as follows:

- Request a 3 month extension from the DC City Council on the findings of the Task Force to allow an additional 3 months for the Task Force to sufficiently engage all members of the youth serving community in DC and for the Task Force to thoughtfully make recommendations about this question to the DC City Council.
- Convene an ad hoc, but regular, Work Group meeting with interested parties for the duration of this process. The Task Force will continue to meet as normal (2nd Wednesday of every month at 1:00 pm). Members of the Work Group will commit to meeting on another date and time, chaired by Elisabeth Olds, with members of the Multidisciplinary Team and other youth-serving agencies within the District, as well as youth representatives who are interested in participating.

The purpose of these meetings will be:

- To gain consensus on the District’s laws as they pertain to youth victims of crime;
- To gain a comprehensive understanding of the Multidisciplinary Team and their processes;
- To gain a comprehensive understanding of the needs of youth victims of crime, from the providers who work with them and the youth themselves;
- To promote transparency and a comprehensive understanding of how the Work Group (and by extension the Task Force) are reaching decisions; and
- To encourage productive conversation between all parties.

No later than November 1, 2015, the Work Group will make formal recommendations to the Task Force, based upon the meetings of the Work Group and the survey. At each Task Force meeting in between June and November, the Task Force shall receive regular updates about the progress of the Work Group. During the November 2015 Task Force meeting, the Task Force will vote on the recommendations of the Work Group and finalize its recommendations to the DC Council.

Sexual Assault Victims' Rights Amendment Act
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Issue: Whether a juvenile victim of sexual assault has the right to an independent advocate

Interview

June 15, 2015

Ayuda

Client of Ayuda/Mother of child sex abuse victim

On Monday, June 15 at 9:30 am, Cortney Fisher met with a mother of a child sexual abuse victim and Nelly Montenegro, Domestic Violence and Sexual Assault Program Manager, at the Ayuda offices. Nelly provided interpretation services during the course of the interview. The interviewee did not provide her name, and wanted the names of her children to be anonymous as well. For the purpose of these notes, I will refer to the mother as Rosa, and the children as Anna and Jose.

I began the interview by asking Rosa to provide as much or as little information as she felt comfortable providing and that I would only share this information with members of the Task Force, but without any revealing information.

Rosa revealed that the police were good. Rosa reported to the police with her 11 year old daughter, Anna, on the same day that Rosa's husband (Anna's step-father) attempted a sexual assault on Anna. Rosa and Anna were assigned a detective. The detective took Rosa, Anna, and the third child, Jose to "child protection". Anna and Jose went straight into an interview with "child protective services".

After the interview, Rosa asked about whether Anna should go to the hospital. "They" told Rosa that she would have to go back to "child protective services" the next day to get an appointment at Children's National Medical Center (CNMC). Rosa noted that this didn't seem right to her because she had another experience with Anna and when the police responded to that incident, the responding officer was a Spanish-speaking female officer. Anna was taken to CNMC right away and an exam was done right away. This time, Rosa was told to bring Anna back the next day and that didn't seem right to her.

[I clarified when the last assault took place.] Rosa responded that an attempted assault took place that morning, but the last completed assault took place one week prior to the police interview.

[It seemed as if Rosa was moving on from the police process, and I asked her about another part of the process. Nelly prompted Rosa to discuss the police further.] Rosa restated that the police were good, but there were two pieces of concern. When Rosa was in the police station, the offender was brought to the same police station and was in the same station as Anna and Rosa. And during the interview, the detective asked Anna if she was lying or making up stories because she hated her step-father.

Rosa also mentioned that there was a significant delay in the police collecting the evidence at the house. During the delay in collecting evidence, the police told Rosa that she wasn't allowed to leave the house. Rosa expressed feeling very uncomfortable with staying in the house but didn't think she had an option. She spent a lot of time at her aunt's house in that period of time. When the officer did the evidence collection, there were significant challenges to the collection of evidence by the prosecution. The case was charged as a

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misdemeanor as opposed to a felony. The offender was sentenced and is serving a minimal sentence in prison.

After the police interview, Rosa went home that evening. The next day she brought Anna back to "the school" (Ed: I'm assuming this is the Bundy School) to get an appointment at CNMC. Rosa and Anna got an appointment at CNMC one week later. Rosa described her experience at the school as if she was bothering someone. She felt that the staff was rude. She noted that she was never offered an interpreter.

During Anna's appointment at the hospital, Rosa described her experience at CNMC as very good, and the doctor as very nice. While at the hospital, the doctor referred Rosa to SAFE to get a protective order. Anna expressed to the doctor that she was afraid of the offender, that the offender had strangled her on several occasions, that the offender had threatened to kill Anna, her mother, and her brother. Rosa went to SAFE to get a protective order and SAFE referred her to an attorney through Ayuda, which is how Rosa came to be represented by Ayuda's legal services. Ayuda represented Rosa in an "on behalf of" petition for a protective order covering both children and Rosa.

[I asked if an advocate was ever offered to Anna, specifically, or if Rosa felt that anyone was her advocate] Rosa responded that she was never offered an advocate until she met with the prosecutors at the USAO.

[I asked if Anna has been able to access therapy through CNMC] Rosa stated that the paralegal at Ayuda helped Anna get therapy through Anna's school. CVCP helped to pay for therapy for Rosa and her other child, Jose.

[I asked Rosa if she felt that she or Anna had an advocate before the USAO (and Nelly explained what an advocate was) and if not, if she felt that would have been helpful] Rosa indicated that an advocate would have been very helpful. She would have liked if they would have offered an advocate to her and to Anna.

[I asked Rosa would have been upset or offended if Anna would have had an advocate that wasn't allowed to talk to Rosa] Rosa said that she wouldn't have been upset. She said that she understands that sometimes girls aren't comfortable telling their mom everything.

Rosa did note that the victim-witness staff were really good to her and her daughters, but that she didn't like the way that the prosecutors rotated through the case. Every time there was a new prosecutor, the prosecutor had to re-interview Anna. The last prosecutor worked really hard for Anna and he gained the trust of the family. He had to "fight" to stay on the case after his rotation was over.

[I asked how Anna was doing] Rosa said that Anna was doing good. She was still in therapy and is helping out other girls at her school who have been through something similar.

[I asked Rosa if she had any thoughts about what she would have changed or what could have been done better] Rosa said that she wishes that the prosecutors didn't change as much as they did. She also said that she really wishes that someone would have spoken Spanish. She was never offered an interpreter and it was

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really difficult for her. Her aunt had to interpret for her and sometimes her aunt didn't tell the police or the prosecutors exactly what Rosa was saying because she was embarrassed or her aunt didn't feel comfortable saying certain things.

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Issue: How to establish a juvenile victim's right to an independent advocate

Juvenile Survivor Work Group Listening Session
June 16, 2015

Work Group Members Present: Cortney Fisher, Elisabeth Olds, Heather DeVore

Participants: Jabeen Adwai (NVRDC); Tamaso Johnson (DCCADV); Jelahn Stewart (USAO); Dave Rosenthal (OAG); Erin Cullen (OAG); Allison Spangler (Safe Shores); Michelle Booth Cole (Safe Shores); Charity (DCSAFE); Carol Day (Georgetown University); Cecilia de los Santos (Latin American Youth Center)

The following is a summary of the information gathered at the Listening Session on June 16, 2015:

- The USAO disagrees with providing youth an independent advocate because it will empower child predators. Children are often reluctant to report to law enforcement, so if they are given that option, it will allow predators to walk away.
 - Other participants strongly disagreed with this assertion because having an advocate will empower marginalized populations to come forward and make a report once they know they are represented. The system isn't capturing these people now at all.
- The USAO disagrees with providing youth an independent advocate because If a child is prescribed medicine and the parent isn't aware, that could endanger the child
 - Members of the group clarified that In DC youth under 18 can access many medical and reproductive health resources without their parent's consent. Getting a medical forensic exam should be one of them
- A representative from DC SAFE discussed the role of sexual violence in an intimate partner violence situation. If both parties are minors, independent advocates could be beneficial to them
- Independent advocates can help juveniles make a better informed decision about reporting, especially youth who are experiencing dating sexual abuse or peer-to-peer abuse

- The participants raised the issue of making the Task Force recommendations age appropriate (17 year old v. 13 year old vs. 8 year old) – The ability to make informed decisions, particularly under age 13, is lower
- The participants in the group wanted the Task Force to differentiate between predator situations and dating violence
- Trained advocates understand the complexity of the systems, so they are beneficial to all ages
- The participants strongly encouraged the right to “opt out” of having an advocate, but only if the decision to opt out was the decision of the minor survivor.
- The participants raised the question of the current assigned advocates. What’s the difference between an independent advocate and the current assigned advocate, i.e. trained social workers that work for Safe Shores or the USAO, indicating that the current advocates are more than adequately trained to work with children?
 - The independent advocate, as defined by SAVRAA, is someone who works only for the minor survivor, and not the system or the parents
 - It needs to be clarified whether the current advocates operate under empowerment model and give victims the option to not cooperate with the police
- The participants raised the issue of evidentiary privilege. SAVRAA grants advocates the right to evidentiary privilege. Systems-based advocates do not have that privilege; Safe Shores advocates do have this privilege
- Participants raised the question of parental involvement – The domestic violence system enables judicial oversight into the minor’s decision to get a protective order without the parent’s consent. This process would grant the minor that option without any oversight.
- The Work Group participants raised the question of Jane Doe laws, i.e. when a person has the ability to get an evidentiary exam and have it processed, without adding their name to the case. These have been shown in other jurisdictions to increase prosecutions.
 - There was a suggestion that these aren’t permitted under the confrontation clause. The Work Group clarified that the confrontation clause is not implicated because the victim either ultimately decides to report (after being made aware of the suspect’s cases in other jurisdictions) or the other jurisdictions prosecute the cases, using this kit as additional evidence.

- There was a suggestion that the recommendation be that all advocates be licensed attorneys or working under licensed attorneys so as to avoid the current mandatory reporting laws.
 - The participants raised a concern about trafficking victims - If trafficking happens in VA or MD, but the victim lives in DC, what does the process and advocate look like?
 - Trafficking is now a mandatory reportable crime under local and federal law

Questions for the Task Force to consider moving forward –

- If the juvenile receives a medical exam, and that person is a mandatory reporter, how will the independent advocate and new reporting framework function?
- Who determines the “track” the child goes through (depending on who the perpetrator is and if abuse/neglect is involved) and how they’re trained is important
- Should also consider what happens if you find out later the abuse/neglect is involved that wasn’t in the initial report, which would require a call to the hotline
 - How complex should the work group’s recommendations be to cover all different scenarios that could come up?
 - Confidential advocate can actually encourage children to report if this type of abuse is occurring and help them work through it; gives the child a safe space
- How involved will parents be in the process? Can children, their guardians, or parents opt out of having an advocate? And will the parent need to be present for that conversation?
- What does the entry point look like for an advocate for juvenile survivors?
 - If the entry point happens at the hospital, the doctor is a mandatory reporter
 - How do we create exceptions in the mandatory reporter law so that peer-to-peer violence or sexual violence where notification of the parents may become a problem, e.g. LGBTQ youth, are exempted

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Issue: How to establish a juvenile victim's right to an independent advocate

**Juvenile Survivor Work Group Listening Session
June 18, 2015**

Work Group Members Present: Cortney Fisher, Elisabeth Olds, Heather DeVore

Participants: Kimberly Waller (Children's National Law Center); Geoffrey Middleberg (OVSJG Intern); Rose Gordy (Safe Shores); Ashley Harrell (Safe Shores); Jennifer Clark (USAO); Lorraine Chase (USAO); Timothy Elliott (Whitman Walker Health); Alexa Weatherly (DCRCC); Amanda Lindamood (DCRCC); Indira Henard (DCRCC); Mark O'Brien (USAO); Karen Gianna Koulias (USAO); Kenya Davis (USAO); Tracy Owusu (USAO); Laila Leigh (Break the Cycle); Sarah Colome (Break the Cycle); Anoosha Rouhanian (DYRS); Ashlynn Profit (OVSJG Intern)

The following is a summary of the information gathered at the Listening Session on June 18, 2015

- The USAO expressed concern that the USAO was not a member of the Task Force. It was explained that they were invited to be members of the Work Group but they requested a seat on the Task Force.
- There was a request that the Task Force invite a parents' group representative to be a member
- There were several questions presented to the members of the Work Group about how this question (whether a juvenile victim should have a right to an advocate) was derived. The Work Group explained that this was posed to the Task Force by Council after significant public input about their experiences with the system.
- "Ashley", who is a current staff member of Safe Shores, spoke of her experience when she was a staff member at RAINN working on the hotline. She spoke to a lot of minors who had been sexually assaulted and most minors did not want to make a report, but only wanted medical care. This presented difficulty for RAINN because that minor literally could not get information to make decisions without triggering a report. There is a big difference between a 9 year old and a 16 year old. Most 9 year olds can't functionally get to services without their parent, so that is a very different story than the 16 year old who can access a lot of services without their parent or caregiver and does already. "Older kids are pretty saavy" and they regularly access services without saying that there was a sexual assault so as not to trigger a report. The just can't access the breadth of services.
- There was a lot of concern about the victim's safety if there was a confidential advocate. How could we guarantee the victim's safety if the advocate is unable to tell anyone what the victim said? By not making a space for a parent or guardian, we are limiting the child's ability to have access to safety.

- There was a lot of concern that we are trying to “renegotiate” issues that have already been determined. Minors have access to a lot of emergency services already and the concerns about the minor’s ability to get those services without parents or guardians has already been negotiated.
- There was a concern that parents don’t know any more than the 8 year old about what to expect or what the child’s rights are and without an advocate, they aren’t going to be able to effectively advocate for anything. It is also traumatic for the parent to have to negotiate this for their child.
- “Sarah” from Break the Cycle spoke a lot about her experience as a rape crisis volunteer in Chicago and the model that they used. She clarified that the definition of an advocate is someone that represents the wishes of the victim, making sure they understand their options and the law, even if the law requires a mandatory report. Advocates can work with the parents as well, but not to the exclusion of the minor victim, and not if the minor victim wants something different than the parent wants. Advocate can also limit the parent’s involvement if they are not supportive, or if the parent is emotionally abusive.
- Concerns were raised about marginalized youth communities. There are unique needs of LGBT youth, youth sex workers, and youth in Wards 7 and 8. Advocacy in these populations means a service that is ongoing, not a service that ends at the point of the hospital. Vertical advocacy is needed.
- There is a group called Black Moms Matter in Wards 7 and 8 and they are very organized. The Work Group should reach out to this group.
- Timothy from Whitman-Walker Health discussed the need to talk about disproportionately impacted communities, particularly LGBTQ youth. Youths who have tried to access services have not been served appropriately and are therefore turned off from accessing care. An advocate’s role would be talking through with them what to expect.

Editorial thought: What about including an imminent danger exception to mandatory reporting laws where the victim is 13-17 years old and the child is in imminent danger. Can parallel Tarasoff requirements for mental health professionals...

- Amanda from DCRCC spoke about serving her youth clients. Youth know that we are reducing their needs to a definition of safety that we’ve determined. There is no safe place for youth to get their options and opt in to one service at a time. The systems reinforce their experience of trauma when we aren’t allowing them to have options. We are “appealing to each other in this room as adults and not appealing to each other who were once minors”.
- Indira from DCRCC spoke of the GEMS group in NY, managed by Rachel Lloyd, who works with commercial sex exploitation.
- Whoever the advocates are, there has to be a fluidity with who is allowed in the forensic exam room. Youth may need their friend in the room.

- Training for the advocates has to encompass cultural competency around LGBT youth and sex workers
- There was a representative from DYRS in the room who raised the concern about the lack of resources for youth who are now incarcerated and were previously victimized. Incarceration exacerbates the effects of trauma but DYRS lacks the resources to address that trauma.
- Sarah from Break the Cycle discussed the training curriculum from Chicago for advocates. Rather than the 40 hour training curriculum, the training curriculum was 56 hours and includes information about systems of privilege and oppression. Sarah reiterated that the advocacy needs to be vertical advocacy. “No one knows the correct decision for anyone else” but that doesn’t necessarily mean that the parents aren’t included. They just have to be included with the consent and knowledge of the minor victim. “We aren’t more educated than the survivor, no matter what our education is”
- There was a concern about how we define “child” in the context of wanting that child to make decisions for him or herself and how the prosecutors have to contextualize the child when there is a statutory rape case. In one instance, we are telling juries that the child is too young to consent to sexual activity, but in another instance we are indicating that the child is old enough to make decisions for him or herself.
 - In response to that concern, Laila from Break the Cycle reminded the group that many of these concerns have already been negotiated when we gave minors access to emergency and sensitive services.
- There was a concern that not everyone goes to court and even if they want to go to court, the criminal justice process is retraumatizing.
- The USAO indicated that their issue or concern was not with the advocate, but with the possibility that there wouldn’t be mandated reporting.
- Rose from Safe Shores clarified the MOU that governs the Multidisciplinary Team:
 - Everyone 12 and younger is routed from Youth Division through Safe Shores
 - 13-17 year olds with a familial case are routed through Safe Shores
 - 13-17 year olds with a case that is not familial does not come through the MDT process.
 - She clarifies that there are minor victims all the time who refuse to participate in the process.
 - 30-40% of the cases that come through Safe Shores are juvenile on juvenile
 - “Tons of these cases are unfounded by MPD”

- There was a concern that as the process stands now there is no point of entry of services that does not trigger a mandated report. The minor needs to be able to access information without triggering a report.
- Lorraine from the USAO indicated that this is a matter of the training that is received by the advocates. Organizations that are currently responding aren't trained thoroughly and they are advising clients that a delay in reporting won't hurt their case and it will.
- There was also a concern that there were not enough services for youth and that when the victim witness specialists at the USAO seek to get them services, there is a significant waiting list.

Cortney raised the issue of Jane Doe kits and whether the folks in the room found them harmful or helpful—

- USAO stated that overall the idea is a good idea, but that it has consequences. We need to tell victims that delays in reporting adversely impacted the case. Eyewitness testimony, surveillance, bed sheets, cell site data, text messaging data are all evidence that disappear after a period of time.
- Can information collected at the time of the exam be submitted to police at the time of the report (without the victim's name) so that the police can collect the evidence, even if the evidence is collected separate and apart from the victim at the beginning?
- Change the name to J. Doe reporting, or anonymous reporting, so that it is not gender specific.

**Sexual Assault Victims' Rights Amendment Act
Task Force
Juvenile Survivor Workgroup**

Issue: Whether a juvenile victim of sexual assault has the right to an independent advocate

Meeting Minutes

June 24, 2015

ATTENDEES:

Elisabeth Olds (Chair), Independent Expert Consultant
Cortney Fisher, Office of Victim Services and Justice Grants
Jabeen Adwai, Network for Victim Recovery of DC
Mark O'Brien, US Attorney's Office
Sarah Colorne, Break the Cycle
Nikki Charles, Network for Victim Recovery of DC
Rose Gordy, Safe Shores
Laila Leigh, Break the Cycle
Lorraine Chase, US Attorneys' Office
Amanda Lindamood, DC Rape Crisis Center
Brianna Johnson, Break the Cycle Youth Advisory Council
Fair Girls
Tonya Turner, Office of the Attorney General

DOCUMENTS:

One page overview and background compiled by Elisabeth Olds
Agenda

Elisabeth Olds convened the meeting and facilitated introductions.

Elisabeth began the discussion by introducing the purpose of the Workgroup: The Work Group was established by the larger SAVRAA Task Force, which was established by the statute. The Work Group was convened to answer the questions of (1) whether a minor victim of sexual assault should have a right to an advocate and (2) how that right would attach, who would provide those services, and how that right would practically be implemented.

- Elisabeth referenced the second page of the handout: there is a list of people that the workgroup interviewed or has on the agenda to interview. Is there anyone else that we need to interview? Is there anyone else who should be on the Work Group?
 - Courtney's House
 - Casa Ruby
 - Women's Leadership Institute within SMYAL
 - HIPS
 - VAWA Compliance expert

- ABA Commission on DV

The USAO suggested that the Work Group convene a meeting with the Office on Violence Against Women. Concerned that there is a nuance around mandatory reporting. The doctor, for example, may be a mandatory reporter. Cortney Fisher mentioned that the VAWA requirement is that the person not have to cooperate with the police; not that there has to be no mandatory report. Cortney Fisher also mentioned that OVSJG is in constant contact with OVW because OVSJG has to certify our compliance with the law every year, they are our grant monitors.

The USAO also suggested that the Work Group reach out to parents of sexual assault victims.

Elisabeth asked about focus groups. The Work Group met with three focus groups. Two members of the Work Group went to two focus groups, one with all male participants and one with all female participants. Both yielded a fascinating conversation. Women were amazing. Same with the men. Do we want to get youth and parent focus groups together?

- Amanda: Want to do a survey. EO clarified that there is a survey pending of adults and youth.
- The USAO suggested convening two focus groups: one that seeks to get the perspectives of kids who have thoughts but haven't been through the system and the second that seeks to get the perspectives of kids and adults who have gone through the process. Are we interviewing kids who have been through the processes and are happy with it?
 - USAO has experience of folks who have been through the serious and really like the process

The USAO states that mandatory reporting is the concern of the USAO. The USAO is not concerned with the child having an advocate.

- If we have a system where the police aren't informed, there are negative consequences because some kids who would have disclosed are now not going to disclose. There are going to be a large number of kids who are not going to disclose if they have the ability to do so.
 - Smitty Smith agrees that there may be a trade-off. But how many do we lose? We don't have the data for that.
 - Tonya Turner contends that we are going to gain more than we lose if we establish a system that sets up a right to a safe advocate. The 16, 17 year olds are being treated as 9 year olds, and they aren't going to willingly enter a system that they know will do that to them.
 - Break the Cycle suggests that the group focus on the ultimate goal of the policy? If the goal of the policy is making sure that these young people get the services they need, then we need to design a system that allows them to safely do that. These

youth are already making these decisions; we just aren't hearing about them because the decision is to not seek help.

- It's important that the youth have a safe space to talk to someone that is clear about what is going to happen, and that provides the accurate information up front. The advocate shouldn't be the mandatory reporter, but should make it clear that there are others who are mandatory reporters. If the abuse continues, there is someone who is able to be a trustworthy individual that they will come back to. The youth will find a way to return to the abuse if they aren't ready to leave it, just like adults. Advocates are able to talk to the kid as though their friends are experiencing the abuse, until the kid is able to admit their abuse.
- Courtney stated that in the focus groups, the youth involved were very clear about who CFSA was. It wasn't clear to her whether the youth understood CFSA so well because they had personal experience or because they had friends with experiences, but they were clear. And they were clear that they didn't want to be a part of that process.

The USAO makes the point that they have to work on behalf of the child's best interests, but also on behalf of the best interests of society as a whole.

- Jabeen Adwai from NVRDC clarifies that the goals of working on behalf of an individual and the criminal justice system working on behalf of society are not mutually exclusive. An attorney can be working for a client's best interests while the criminal justice system moves through its own process.

Michelle Palmer from the Wendt Center states that we have to get a better cross-section of the City. We need to look at the different quadrants of the City, and be intentional about including victims in marginalized populations.

Tonya Turner from the OAG re-states and clarifies that the issue on the table is about peer-to-peer sexual assault, not sexual abuse perpetrated by a caregiver or a person in a position of authority. Michelle Palmer concurs that there isn't enough of a nuanced distinction between victims of sexual assault and sexual abuse.

Several members of the Work Group meeting believe that there has to be a focus on education and prevention.

- It's important to have a consistent message and there has to be transparency. There has to be a consistency in the message.
- DCPS does not address sexual assault in health classes; they talk about sexual health and distribute condoms.
- Conversation needs to begin in elementary school
- USAO asked Breanna, the Break the Cycle volunteer, whether having a police officer, a prosecutor, and an advocate come to a class would have been helpful. Breanna clarified that having an

advocate come to class would have been helpful, but only if they were able to accurately state what would happen if someone reported a sexual assault.

- Suggests that any conversation plug into the curriculums that are already mandated; we don't need to be another vehicle for education. The vehicles are there.

Cortney Fisher clarified that education and prevention are not the issues that the Task Force or the Work Group was convened to address. Cortney asked Breanna directly what she thinks should happen, or what the system should look like.

- Breanna stated that minors need a right to an advocate. When you are forced to do something that you don't want to do, you aren't going to talk. You will get more kids talking if you don't force them.

USAO states that if we took mandatory reporting off the table, the USAO would have nothing more to say. Further, if we are dealing with peer-to-peer 13 and over, he would have a lot less concern.

Tonya Turner states that if a 16 or 17 year old in college or parenting are afraid to get help because they are afraid of MPD or CFSA, that's a problem. A 6 year old who is being abused by a teacher is a different story.

- Elisabeth again clarifies that we are talking about is peer-to-peer assault. 13 and above
- The USAO has requested that a definition of peer-to-peer assault be in writing.
- Jabeen suggests three classifications:
 - Person in the position of authority/family member/caregiver – where there is a grooming environment.
 - Peer-to-peer assault, e.g. dating violence or assault by an acquaintance
 - Stranger assault where the victim is a minor

We are talking about the bottom two categories, where there is no grooming relationship, little risk of on-going abuse except in the context of an intimate partner violence relationship for which there are already options for children 12 and older.

Lorraine Chase suggests that we push the survey through the ASK and UASK app and website. Cortney said that she would look into it, but using UASK for college students has become problematic because of the mandatory reporting system that applies even to minors who are in college.

Elisabeth Olds concluded the meeting by stating that the Work Group is looking at November 1 as a deadline for developing a recommendation. An email with definitions and a work plan to move forward will be forthcoming.

**Sexual Assault Victims' Rights Amendment Act
Task Force
Juvenile Survivor Workgroup**

Issue: How to establish a juvenile victim's right to an independent advocate

**Dr. Kathy Woodward
CNMC Adolescent Medicine
June 25, 2015**

Present: Cortney Fisher, Elisabeth Olds, Dr. Kathy Woodward

On Thursday, June 25, Cortney Fisher and Elisabeth Olds met with Dr. Kathy Woodward at the CNMC Adolescent Health Division to discuss her perspectives on the question of whether juveniles should be entitled to an advocate and the barriers to reporting sexual violence in the population that she serves.

Elisabeth Olds introduced herself and explained SAVRAA, as it applies to adults, and the right to an advocate in the hospital setting to advise them of their rights and sit in on police interview.

Dr. Woodward interrupted Elisabeth to clarify that "Minors have no rights. Their rights are all based on their parents. So let's start there." Developmentally the approach at the Bundy School is vital in so far as it limits the amount of times that the child has to tell the story.

Advocates are an unnecessary addition to a system that already works well. Communication with adults is inherently threatening to adolescents, whether with a Safe Shores person or another person so adding another person is not helpful. The more people that are around, the less the child is going to be truthful. Would not advocate for the advocate that you are suggesting.

Elisabeth Olds asked about the population that is seen here, explaining that the Task Force and the Work Group are concerned about highly marginalized populations that won't report to anyone or get help for anything if they have to engage with the criminal justice system.

- Dr. Woodward stated that "minors don't have the right to consent to anything until they are 18." Cortney clarified that they do have the right to consent to care for sexually transmitted diseases or sexual health care. Dr. Woodward continued that most of them don't find the STD clinic at DC General. For general medical conditions, they have to have a guardian consent.
- Dr. Woodward continued that many of them don't have any documentation to prove who they are. If they go to the free clinics or Planned Parenthood, they don't have to prove who they are but most medical systems force the teenagers to produce ID.

Elisabeth asked about unaccompanied minors.

- Dr. Woodward stated that unaccompanied minors aren't an issue because they don't come to traditional health systems. If they do come, and try to work the system, CFSA is called and CFSA routinely takes custody.

- For adolescents who are in school are able to access care through the school-based clinics. For adolescents who are not in school, they are often bartering their body for survival. If that population presents to CNMC, they are reported to CFSA if they are under the age of 18. CFSA takes custody.

Elisabeth asked about the age of minors that are seen in Dr. Woodward's practice.

- Primary age for her practice is 12 to 22. If there a suspicion of sexual assault, it gets sent to CAPC.
- Any sexual activity of someone 12 and under is reportable to CAPC

Elisabeth asks about the concerns that the child or their parent has before they are referred to CAPC.

- Dr. Woodward clarifies that the child doesn't have any rights so they don't have concerns. Their parents are advocating for them.
- Other than that, they would be concerned that there isn't sufficient training. The type of training that providers have is essential. The early and middle adolescents haven't found their voice so their ability to express themselves isn't there. Using play therapy and art therapy is helpful in getting people to talk. The medical support is more stressful so separating the mental health and support is helpful.

Elisabeth clarified that no decisions have been made about who these providers should be. Asked Dr. Woodward if she had any thoughts about who the providers should be and what their training should be.

- Dr. Woodward answered that people with the MDT are sufficient, or those who have a mental health or a medical background.
- LCSW and psychologists would be sufficient, if they specialized in kids and trauma
- Dr. Woodward clarifies that everyone working in the justice system has been very competent

As to solutions for the problem of sexual assault of minors, Dr. Woodward suggests:

- Solution is multi-factorial. Trying to catch kids in elementary and middle school before they put themselves into harm needs to be a focus. Catania's school-based clinics are a good thing.
- Young adults need to not be able to refuse mental and medical health care
- Arbitrary cut off points that aren't related to the condition aren't helpful.
- If there are going to be helpful components, everyone needs to work together.



Position Statement

Collaboration With Victim Advocates

Statement of Problem: Violence is an international public health crisis that requires a comprehensive approach to adequately address the problem.¹ Part of this comprehensive approach includes acknowledging and supporting the integral role of the victim advocate as part of a comprehensive response to victims of violence.

While advocates currently provide services to victims in many settings, there are still situations in which advocates are either not invited to participate as part of a comprehensive response, or they are not included as part of the initial response.

The purpose of this statement is to acknowledge the importance of the Victim Advocate role, to recognize the benefits of the timely inclusion of advocate support when responding to victims of violence, and to encourage the creation of strong collaborative relationships between forensic nurses and advocates in order to provide compassionate evidence-based care to victims.

Association Position: The IAFN recognizes and supports the role of the Victim Advocate as part of a victim-centered, coordinated, multidisciplinary team approach to providing services to victims of violence, and particularly to victims of sexual assault. We believe that victim advocates should be involved as first responders in any Coordinated Community Response Team providing services to victims, families, caregivers and others. (A first responder is defined as those individuals who respond immediately to the incident to provide care and treatment.)

Further, we support the policy that victim advocate services are offered and made readily available upon initial victim identification or disclosure. Additionally, it is our considered opinion that nurses and all other team members should collaborate closely with advocates in the development and implementation of community protocols that provide timely access to services for victims. Protocols should also clearly demonstrate understanding and respect for the roles of all members of the Coordinated Community Response Team.

Rationale: As stated in the **A National Protocol for Sexual Assault Medical Forensic Examinations**, developed by the U.S. Department of Justice, "Advocates can offer a tangible and personal connection to a long-term source of support and advocacy."² The Protocol goes on to recommend that, in order for health care responders to facilitate a victim-centered approach they should "understand the importance of victim (support) services within the exam process....(and) involve victim service providers/advocates in the exam process



(including the actual exam) to offer support, crisis intervention, and advocacy to victims, their families, and friends.”³

The **Protocol** recognizes that a coordinated community approach “can help afford victims access to comprehensive immediate care, minimize trauma victims may experience, and encourage them to utilize community resources. It can also facilitate the criminal investigation and prosecution, increasing likelihood of holding offenders accountable and preventing further sexual assaults.”⁴

Research demonstrates that victims of sexual assault that receive medical care at a facility that provides a Rape Victim Advocate obtain rape examinations and forensic evidence collection at a higher rate than victims who did not have advocacy services.⁵ Victims provided with advocacy services also demonstrate fewer secondary victimization behaviors and secondary victimization emotions.⁶

In addition to the **National Protocol**, the World Health Organization also encourages collaboration with other service providers when giving care to victims of sexual assault, stating “It is important that health care facilities which provide services to victims of sexual violence collaborate closely with law enforcement, social services, rape crisis centers, nongovernmental organizations (NGOs) and other agencies to ensure not only that all complex needs of the patients are met but also a continuity in the service provision.”⁷

References

¹ **World Health Report on Violence and Health: Summary**, World Health Organization, Geneva, 2002.

² **National Protocol for Sexual Assault Medical Forensic Examination**, United States Department of Justice 2004. p. 34

³ *Id* at p. 27.

⁴ *Id* at p. 1.

⁵ Campbell, R. (2006) Rape survivors’ experiences with legal and medical systems: Do rape advocates make a difference? **Violence Against Women Volume 12 No 1** p. 42.

⁶ *Id* at p. 43.

⁷ **Guidelines for Medico-Legal Care for Victims of Sexual Violence**. (2003) World Health Organization, Geneva p. 20

**Activating Advocates
SART Listserv
September 2007**

States are listed as a reference; not as a statewide perspective

Background: SANEs in a particular community refuse to allow advocates to support victims during the medical forensic exam. Do victims have a right to an advocate during the exam if they choose?

Alaska

- We have quarterly meetings and usually have 15-20 people in attendance, including our military folks.
- The whole team, SANE, Law Enforcement, and Advocate is activated at the same time.
- We call the forensic exam kits 'PERK', which stands for Physical Evidence Recovery Kit, much better than "rape kit". Rape kits are what rapist use to commit their crimes.

California (Napa)

- It should always be the victim's choice not the nurses/SANEs.
- I am a SART Nurse. I always want the advocate there and in the room if the victim wants her there.
- It certainly makes the process easier with an advocate to support the victim and to explain the criminal justice process with all the legal twist and turns.

Michigan

- The patient makes the choice as to whether an advocate is present during exams.

New Hampshire

- The medical provider or law enforcement might not always wait for advocate to arrive before beginning the exam or interview.

New Jersey

- Advocates are part of the SART response and are allowed in the exam room if victims agree.

New York (Suffolk County)

- Advocates are activated and very rarely does the victim refuse advocacy support.
- Advocates also assist families, which forensic examiners cannot do when they are with patients.
- It is also beneficial to have another person in the room for security when law enforcement is not involved. There have been instances when the victim has been going through drug withdrawal and became psychotic and physically combative. (The exam room is in a remote area of the hospital).

Oregon

- The advocate is always called and reports to the hospital.
- We stay with the survivor through the forensic exam, LE interviews and assist with any follow-up support including filling out crime victim comp applications (if the crime is reported).
- Advocates and SANE programs work hand-in-hand to make the process as seamless as possible.

South Carolina

- It is the victim's choice. If the victim desires to have an advocate present during the rape kit and exam then the advocate stays.

Texas

- We cross-train (advocates participate in forensic medical examiner training and forensic examiners participate in advocate's training. It helps establish mutual understanding and builds relationships.
- There is a law that says an advocate MUST be allowed present, if victims choose.
- We had to fight hammer and tongs to get this law....at first there were objections from law enforcement that somehow having an advocate present would compromise the exam or the gathering of evidence.
- We negotiated a response that has worked fairly well, although we do still hear occasional horror stories
- There are over 1800 law enforcement agencies in Texas and I no longer know how many emergency rooms, so this is part of the challenge! Just getting the word out to everyone is a 10 year process at minimum!

Washington

- A victim has a right to have an advocate with them at any point.
- We have an agreement with our emergency department to call advocates once a victim presents at the hospital.

Location Unknown

- We've had this issue in our area with one of three SANE programs. The nurses felt that the victims were not asked if they wanted an advocate to be present at all during the exam after many years of automatic call.
- After several meetings with our SART, law enforcement agreed to ask victims if they wanted an advocate during the exam. Law enforcement agreed to notify the crisis center when they activated the forensic medical examiner.

Role of the Advocate in a Medical Setting

edited by Sexual Assault Resource Services

It may be that your first meeting with a rape victim is at the hospital. In many respects, this can be an ideal setting because help can be provided several areas at once. The advocate can assist in explaining procedures and policies, offer concrete aid as needed, assist in clarifying options about such issues as reporting or possible pregnancy, and most importantly, be with the survivor at a painful and lonely time. You may need to repeat or to check with her for understanding. A calm soothing manner can be helpful to the survivor. Try to avoid technical language, medical jargon or words that the victim/survivor may not understand. When the person has adequate and accurate information about what to expect, choices to make, and her rights in the situation, anxiety and helplessness can be significantly reduced. Empowerment and healing can begin.

Your primary responsibility is to the survivor. Be courteous and tactful to the hospital, but do not forget your awareness of the needs and rights of the victim. Try to stay out of the way of hospital personnel performing their tasks and examinations. If you do not know the answer to a question or the reason for a procedure, ask the attending nurse or physician to explain. Many hospitals have had training to sensitize personnel to issues of sexual assault victims. The ethic of healing and caring is shared by you and hospital workers. But hospitals can be extremely busy places, (especially emergency rooms) and sometimes procedures can become bureaucratic. If you feel that a staff member is not sensitive to the person's needs, ask to speak to them in the hall. Explaining how the victim/survivor is feeling and the effect their behavior has on her can be effective.

You may have arranged to meet the survivor in the emergency room, been called by hospital personnel, or be accompanying the individual to the hospital. If you enter with the victim, let her/him give name and reason for being there. Introduce yourself to the hospital personnel you meet as an advocate from the rape crisis center as someone who is there to support the victim. If you are meeting the victim there, inquire of the person in charge of the emergency room for the name and/or location of the victim/survivor.

When you meet the survivor, assess her emotional state and what her needs are. These may include:

- support and understanding
- desire to talk about the assault
- information: medical, legal, etc.
- concrete assistance: notifying a significant other such as a family member or friend; a change of clothing; transportation home; a safe place to go after leaving the hospital.

Use the time you have together to begin meeting these needs. A wait before or between examination can be used to process feelings, give explanations, or make arrangements. Explain the medical exam. Stress the importance of this exam to be sure she is physically okay and to begin treatment for any injuries. By emphasizing the person's safety, well-being, and

health, you can help the victim/survivor to deal with feelings of being scared and hurt by the assailant.

Women who have never had a pelvic exam before may be very anxious about the procedure. Waiting time can be used to explain what will happen if she seems anxious about it. Women who have had pelvics before should be assured that the procedure is basically the same as those they have had before. A rape victim may be worried that the exam will be painful because of her possible injuries. And it may be. She should be assured that the physician will be as gentle as possible.

In the victim's mind, this exam may be the second time in a short period that a man has had access to her genitals against her will. It's understandable that the process may bother her. It *may* help if the advocate, a family member or friend is in the room with her during the exam. Explain that some women prefer to be accompanied and some women do not. It is her choice.

If she does choose to have an advocate with her in the examining room, there are a number of ways you can be helpful. She may tense up from fear making the exam more uncomfortable. Try to help her relax, using deep breathing techniques, holding her hand, talking in a soothing manner, explaining the procedures, etc. Take your cues from her. Not all women may want a "play-by-play" of what's occurring.

Whether to report the assault may be an issue to help clarify for the victim/survivor. By reporting the crime, a survivor is providing evidence the police may use in apprehending and prosecuting an assailant. In certain counties, reporting the crime may be required for the county to pay for the exam. Check your county's policy. If she seems uncertain or does not want to report the crime at this time, you might suggest that having the evidentiary exam will keep options open for the future. Without the evidence the victim has foreclosed options for the future in case she should decide to report or wish to press charges. The choice is the survivor's. You might offer to contact law enforcement if the survivor so desires. (For further information, see the chapter on Legal Issues.)

If the person is alone, ask if there is anyone she would like to have called. The survivor may wish to ask them to come to the hospital or just let them know where she is. An advocate should check with the victim/survivor about what kind of information to convey: is it okay to say that the individual has been sexually assaulted? Is it okay to talk with whomever answers the phone, or should the advocate talk only to the specific person named? If family or friends are already present or are contacted, the advocate can inform and reassure them about the victim's condition. Some preliminary assessment of how these significant others respond to a sexual assault, and some brief information from you, can ease issues they may face later. This is not the time for full consciousness-raising, however. Assuring them that a violent attack is very scary and how the individual is now safe can put the priority on the violence rather than the sexuality right from the start.

Help a woman determine whether there is a possibility of her being pregnant and inform her of her options. Be sure to listen in a non-judgmental way and to enhance her choices.

Some survivors may wish to talk about the rape incidents now, either to you or to medical and police personnel. Let such persons do so freely. Sometimes in shock, victims may repeat the story as if in a daze or because the events seem so unreal. Others may not wish to talk about these traumatic events. They may find medical or legal questioning distasteful and frightening. They may be withdrawn or expressive. Whatever the feelings or style, validate them. Someone who can't stop crying may feel that they do not understand what is happening or that they are going crazy. Your reassurance can be important.

Let all survivors know that you or other advocates at your rape crisis center will be available to talk with when they want to do so. Be sure that before you leave her, the person has the phone number of your center.

The advocate should check about a person's safety when she leaves the hospital. If going home is not a possibility for some reason (for instance, the attack occurred there), the advocate can help arrange for a safe place for the survivor to go (to the home of friends, other family members, women's shelters.) They may decide to go home but wish someone to accompany them or stay with them, especially immediately after an assault. The advocate can help to identify such persons and contact them.

Activation of RCC Advocates

How long after a survivor arriving at the hospital is a rape crisis advocate called?

At one of the SANE designated hospitals, of which there are 7 in Boston, as soon as an individual identifies sexual assault, a page goes out to SANE and the advocate program.

Our protocol states that the hospital will call Voices of Hope once the patient has been triaged and identified as a sexual assault victim. Unfortunately, we don't have a specific time outlined. The victim advocate however is committed to arriving to the hospital within 30 minutes of the call from the hospital. We have had occasions where the victim reports to the advocate that they have been at the hospital for hours prior to the victim advocate being contacted. However, we are changing the protocol to include all responders in the victim interview (if they don't choose the anonymous reporting option).

Not immediately – We are called once she is in the ER room and the nurse has taken her basic info. Unfortunately, usually law enforcement is called first.

We moved to this model more than a decade ago, and it's been a huge success. - the SANE nurse is called by the ER staff, then the SANE nurse calls the RCC advocate before she leaves for the hospital. the advocate often arrives before the nurse, depending on how far each is travelling.

Typically right when law enforcement and SANE are called... within half hour of patient being registered/triaged which is when social worker would be notified. In central Ohio adult hospitals, the protocol is for the social worker (or RN or SANE if no social worker)who meets with survivor soon after her/his arrival to let the survivor know that we have a team who work with patients who have been sexually assaulted... part of the social worker role is to call in the team members which are law enforcement, SANE and advocate... survivor decides who if any of the team members she/he wishes to speak with when they arrive and introduce self/role.

As per our SART protocols the advocate is dispatched immediately upon a survivor presenting at the hospital.

An advocate called as soon as a survivor presents and discloses. Advocates are expected to respond to the hospital within 20 minutes.

The Emergency Department Charge Nurse pages out the SANE team- the on-call SANE calls the ED CN back and then calls our crisis center to request an advocate for the case. We want someone to be present with the patient so whomever arrives first attends to the patient right away. .

A Rape Crisis companion is notified at the time the patient is triaged and conveys that they have been sexually assaulted.

We try and call the advocate fairly early in the process to give them time to change directions and come to the hospital.

What information is given to the advocate?

We have supervisors that call the hospital in response to the page. The information that they are looking to gather is as follows: Survivor age & gender, is the survivor an inmate, is the survivor medically cleared (meaning are they alert, able to consent to evidence collection and not in need of further medical attention including x-rays, stitches, etc.). We also ask the name of the attending nurse so that we can easily locate the survivor when our advocate arrives at the hospital.

Typically, the hospital calls and reports they have a sexual assault victim and need an advocate. They often offer the name of the charge nurse so we know who to contact. They have a designated room at each hospital so we automatically know which room to head to.

Depending on the hospital – at a minimum: the nurse’s name but more often the survivor’s first name and age

the advocate is only told there's a patient at the ER - no further information is given as a matter of course. (if the victim is Spanish-speaking or there's another complication that might affect which advocate responds, that info should be relayed at that point)

The social worker calls our dispatch service and gives their name, call back number and hospital. Dispatch relays that to the advocate who then calls the social worker back with an ETA. Typically that is all that's shared before the advocate arrives.

Gender, approximate age, acute assault vs sex trafficking.

That there is a sexual assault victim at the hospital and language preference.

The advocate is informed of the age and gender- the SANE and advocate are present when the interview starts. The patient can choose to have the advocate present or not for the assessment/evaluation/evidence collection.

We use a scripted request. “I think we may have a sexual assault in the Emergency Department”.

The ER calls our hotline and lets them know that they need an advocate, the age and that’s about all. How and when is the option of speaking to an advocate presented to the survivor?

We ask that the advocate be called regardless of what the situation is. When the advocate arrives at the hospital, they are offered to the survivor. We do this because in the past we were hearing stories about nurses asking survivors if they wanted to see an advocate in the following manner. – “Well, if you want to talk to an advocate, I can call one even though it’s the middle of the night. I’m sure she won’t mind getting out of bed and coming down here.” We found this to be restrictive to survivors who didn’t want to inconvenience anyone. To avoid this, we say that we are happy to come to every case. If the survivor doesn’t want to see an advocate when we get there, we simply leave literature for them and go on our way. This ensures that they get the information they might need in the future.

That seems to vary. Sometimes the hospital doesn’t notify the victim until the advocate arrives, other times they ask the patient if they want an advocate called. It’s been our experience that if a victim is

given the option to call an advocate they often feel guilty about waking someone up in the middle of the night and refuse. However, if an advocate is already there, they almost exclusively want to talk to us. Sometimes law enforcement is already there and/or the SANE and they present the option.

Not ideal - but the nurse says "Would you like us to call CARE, they are victim advocates?"

the advocate introduces herself when she arrives (ER staff assist in making the connection) and explains her role and how she can help, and that it's totally up to the victim to decide, and that she can change her mind. the nurse and advocate may meet the victim together, or if the nurse got there first and started the process, she'll have mentioned to the victim that an advocate is on her way

The social worker is to mention the advocate as part of the team and to share that the advocate will further describe her/his role upon arrival. Both the social worker and the advocate are to indicate that the survivor can decide if she/he wants to talk with the advocate.

During the checking process. The staff lets them know an SA advocate is on the way and that we will explain our role upon arrival.

When the advocate arrives they introduce themselves to the patient and explains their role. They ask if the client wants them there or not.

The patient can decline any and all of SANE services- including having the advocate present. We prefer that the advocate responds first and if need be they can leave, rather than not have someone come at all. We have had situations in which the family or visitor is in need of the advocate more so than the patient.

At the time the SANE Nurse arrives and reviews options for care. The patient is instructed that there is a rape crisis companion at the Hospital currently and it is their option if they wish to speak to them. If they say no, the companion is notified and if the patient says yes we have the patient sign a consent and then the companion is brought from the main waiting area to the private family waiting room where the patient is.

Once the advocate is there, the nurse tells the survivor that they "have an advocate from Saving Grace on site....would you like to meet her?" at that point, it is totally up to the patient if she'd like to or not.

How do you balance survivor choice with automatically calling an advocate?

The survivor always has a choice. The advocate is there if they are needed and will leave with no questions asked if the survivor declines.

When we arrive we explain who we are and that our job is specifically to offer them support and be present with them through this experience and that our presence is totally up to them. We check in regularly to see if they are still comfortable with our presence throughout the process. Of course there is the concern that a client might not feel comfortable asking the advocate to leave and then does the advocate's presence compromise her/his freedom of choice? I guess that's a careful balance. It is the

responsibility of the advocate to be attuned to the needs of the survivor and consistently assessing the level of control the survivor appears to have. Though we are not mind readers, we are in the business of empowerment which requires honest and straight forward communication

Once the advocate gets to the hospital, if the victim does not want to talk to us, we just introduce ourselves, explain our role and provide written info. We remain outside the room for a while in case she changes her mind.

It is absolutely up to the victim to decide if they want the advocate present, and we're clear about that at every step. The advocate can wait with the victim but not go in the exam room, be present throughout, etc. (we are the ones who review the crime victims comp forms and much of the material in the SANE folder with the victims, which frees the nurses to do their jobs).

The survivor always has the choice of whether or not to meet with the advocate... same as whether or not to talk with the SANE and with law enforcement. Our protocol was established to allow the advocate to explain her/his role directly though and to eliminate any burden on the survivor of whether or not to call someone out of bed at 3am. It also reinforces the advocate's role on the team.

We explain upon arriving we are there solely for them but only if they want us. We are prepared to leave at any time.

Survivor always has the option to tell us to leave but we will show up regardless. We also provide advocacy and support to secondary survivors who may be accompanying the victim and limited advocacy and general information to systems folks (rookie law enforcement, newer nurses) who may be triggered by a sexual assault call; This advocacy stays focused on the systems person's experience and not on the survivor who is presenting.

Advocates have a role in the care of SA patients and should be offered in-person. It is obtrusive to have someone show up later in the case and the advocate would not be accepted as part of the team. The patient may not know how the advocate can help them until they experience their presence. If the patient isn't comfortable- that is conveyed to the SANE and the advocate can be relieved of their duties or for a certain aspect of the process (excused for assessment/evidence collection but present for the discharge instructions and education).

We do not disclose the patient's name or any other personal health information when rape crisis is contacted. The patient has the choice of whether to speak to someone from rape crisis or not and is responsible for making that decision.

Since she is given the option to meet her or not, it's totally her choice. We as advocates understand that we might get there and have her say no, she doesn't want to see us and that's fine. We'd rather get there onsite before the offer happens so that she doesn't feel like it's an inconvenience.

How do you balance HIPAA with automatically calling an advocate?

The advocate doesn't need any identifying information about the survivor to respond to a case. The choice is always that of the survivor.

The hospital is a mandatory reporter of violent crimes in Nebraska, so they are required by law to contact law enforcement and report the assault. While that does not hold a requirement of the hospital to report to the rape crisis center, it does set the system into motion and law enforcement is in agreement under our protocol to contact the rape crisis center if we have not already been contacted by the hospital. When the hospital does call the rape crisis center, they do not offer identifying information aside from age and gender of the victim.

Because we are not provided with a name, there is no breach of confidentiality.

we don't see a HIPAA conflict because absolutely no medical information is disclosed to the advocate by the hospital. we don't even get her full name until she's decided to have an advocate provide support, at which point *she's* disclosing the information and *she's* requesting that the advocate be present - it's not the hospital releasing any info. (if she wanted her mom or her pastor in the room, there wouldn't be HIPAA concerns - it's essentially the same thing)

Advocates have to sign annual confidentiality statements - same as ED staff (SANEs and social workers).

We have no identifying information prior to arrival. The SANE asks again before we enter if it's ok and we confirm again after our explanation of our role.

No patient information is given prior to our arrival so no HIPAA violations are present

The information provided to the advocates are non-patient identifiable information until they are in the room with the patient (consultation room or ED exam room if medical clearance needed). We have a business agreement with our crisis center for HIPAA compliance.

No personal health information is disclosed.

Don't disclose the patients name etc.

Approximately how often does a survivor consent to speaking to an advocate when the advocate is already present or on route to the hospital?

I would say more than 90% of the time, survivors want to speak with an advocate.

I don't have the specific information on this, but it is my sense and those that I've asked that it is probably 95% of the time that the survivor will consent to speak with an advocate.

99.99% of the time.

With the advocate already present and clearly a knowledgeable, compassionate support person, almost all victims want her to stay, for some or all of the process. It's nearly 100% - even with very young children, we're there to support the parent or caregiver so he or she can best support the child

I don't have exact numbers in front of me (but can get some together if needed) but typically survivors consent to advocates.

Approximately 99% of the time.

They usually (98%) say they want the advocate to stay.

We are currently keeping track of those numbers. We recently had a process change with directly notifying rape crisis when someone presents to the Emergency Department versus what we used to do which was to get consent prior to contacting them to come to the Emergency Department. Orange County Rape Crisis has seen an increase in calls with the change of this process.

It sounds like it's pretty rare for them to say no to an advocate once we are onsite. We used to do it the other way where they would offer to call an advocate and that was refused way more often.

Additional Feedback

We are all about victim empowerment, and basically what we've done is move the point of choice from whether to *call* an advocate to whether to have her *stay* - and it's transformed the process. In the old days, asked at 3a if they want someone woken up to come meet them at the hospital, and who knows how long that will take, the majority of victims said no thanks. Having an advocate there at the ER also helps a lot with connecting survivors with RCC resources going forward - it's a lot easier for them to ask for counseling, or legal/court advocacy, when they've already met someone from the RCC. (we ask their permission to make a follow up call in a couple days to see how they're doing and how RCC could help them, and only call if they say it's ok)

An advocate would be called as soon as a sexual assault victim presented in the ER. We were given no additional information other than a sexual assault victim was in the ER. We found that asking the victim if they wanted one prior to that was not productive. Patients didn't want to 'bother' anyone in the middle of the night, or were unsure how they felt about an advocate based on the description provided by ER staff.

When the same patient was asked if they wanted to meet with one who was already in the building, they almost always agreed. Once they met with the advocate, and their role was sufficiently explained, they were happy to have one there.

We provide advocates in Baltimore: The advocate is called when the victim arrives to the ER/SAFE program. The sex offense detectives may also call for an advocate en route to the hospital or to come to the unit. Generally, the only information given is that there is a rape or DV victim present. The charge nurse lets us know if there is any reason to delay coming - ie intoxicated, unresponsive, etc. No

identifying information about the patient is given. When the advocate arrives, she either introduces herself or might be introduced by an ER nurse. At that time, the victim has the option of speaking with the advocate or not. If not, the victim has the choice of receiving an information packet and also whether she/he would like any follow-up from our agency (if so, certain information is then obtained from the victim – such as contact info and any special instructions). About 98% of the time victims indicate they would like to speak with the advocate. Of the victims who do speak with an advocate, about 95% request follow-up. We have been doing this for a long time and have found that if an advocate is present and available, victims/survivors usually want to speak with the advocate. There is no pressure for them to do so, but in my experience many victims do not want the ER to “get someone out of bed” in the middle of the night. Sometimes the family wants to speak with an advocate for their own support – we make it clear we cannot share any information about the victim but do try to answer general questions and focus on what family/others might need re support. We usually see between 300-350 victims a year, after hours in the ER. I completely support procedures that call out the advocate at the beginning of the process. The advocate is the best trained person to determine what other resources might be needed. When these procedures are not in place, there is a lot of “gatekeeping” by nurses and SAFE’s which of their patients “needs or should have” an advocate. I think the initial call out is the best way to increase victims’ access to services and resources.

We have had a mix of interest in patient preference regarding whether an advocate stays or leaves. For instance- we have had patients request that an advocate not be present for varying reasons, such as the patient stated to the nurse that she did not like the advocates voice, or that the advocate was in their space too much and created discomfort, they did not present professionally (appearance or behavior). We have been working with our crisis center in re-vamping new advocate orientation (and approaching those that are already in the role) to include appropriate behavior and appropriate attire (no cell phones ringing during patient care, no touching the patient unless asking them first, do not wear sweatpants at all, let alone something with “Babe” across the back end, cleavage showing, etc.) Our expectations in the hospital can be different from others working in non-hospital/clinic settings and it best to spell it out directly.

It can’t be assumed that all patients will know how an advocate can benefit in their care and treatment as well as how they can assist in expediting their care. For instance, our advocates work as a team with our nurses and provide assistance that is important beyond advocacy- in taking hospital lab specimens to the desk (nurses cannot leave the room once evidence collection has started), they retrieve warm blankets, can make trips in/out to speak with family, retrieve patient food tray, can start to introduce the patient to after care items such as crisis counseling services and self-help reading materials, go over CVC and SAFE Fund forms.

Our policy is that either the officer or the hospital page an advocate to respond to all sexual assault calls. The advocate is given the victim’s name and where they need to respond to. Once the advocate arrives she will introduce herself and let the victim know who we are and what we do. At that point it is the victims choice to meet with the advocate. Our finding has been that if the victim is just given the choice without actually meeting the advocate they don’t really understand what we can do. If the victim chooses not to have the advocate we can at least leave the resource packet and our contact information for them. That being said very rarely do we have a victim chose not to access our services. Out of the 151 calls we responded to last year only a handful declined to meet with the advocate.

Advocates are presented to the victim by either the medical or hospital social work personnel or by law enforcement and are introduced as part of the victim's "team." It is explained that our state allows and pays for this free service for the benefit of the victim's recovery at their discretion. We have never been turned away. Activation of the SART includes all the members of the team as appropriate. Law Enforcement, Medical Forensic Examiner and the Advocate. HIPAA was intended to protect the patients health information for being disclosed - it was not designed to hinder services to victims of sexual assault. Offering the Advocate is as vital as medically stabilizing the pt. Each sexually assaulted patient at triage activates the SART. Upon arrival the SART members can be dismissed by the patient- example victim does not want to report. Victim declines medical forensic exam. SANE goes home - law enforcement writes no report and gathers no information on the patient. How do you balance HIPAA with automatically calling an advocate? Include a bullet on the HIPAA release form that includes the local rape crisis center - simple! In my 20 + yrs I have not ever been asked to leave by a victim. IF a victim did ask me to leave I would request to sit with the family and begin to build a rapport with them. I would NOT leave the hospital until the patient is discharged.

In our program at North Central Bronx Hospital, we dispatch the advocate without giving the name. They are routinely provided general details as to location, age, gender and preferred language. After they arrive, the survivor will be asked if s/he wants to speak with an advocate. In my experience of 8 years at the program, this has occurred only once. The advocate plays a critical role in the healing process, and the survivor's positive experience is instrumental in the survivor following up with medical and psychological care.

Best practice in Indiana is to call a rape crisis victim advocate to the hospital once a patient presents and identifies. Advocates are told only that there is a patient at the hospital presenting as a victim of rape - no other information is given. There is no HIPAA violation and advocates are trained to be dispatched 24/7 with the knowledge that they may show up at the hospital only to turn around and go back home without having had any contact with the patient.

The SANE, prior to any examination will discuss the option of having an advocate in the room and/or the availability of an advocate before/during/after.... At this point the advocate should be outside in the waiting area. Generally speaking this is the recommended so because a patient will decline an advocate if he/she thinks that someone will have to be called out, gotten out of bed, just to come out and be with him/her. If that patient is told that the advocate is simply outside in the waiting area then it removes any issues of "guilt" (I can't tell you the number of advocacy calls at 2-3 am where the patient has apologized to me for getting me out of bed, etc. - so if I am already there and it is presented as though if wanted the advocate is already at the hospital and available if wanted it removes all of that responsibility from the patient and simply lets him/her accept or decline a service). The survivor's choice this way is never eliminated. If the patient declines advocacy services the SANE will generally go out in the waiting area - let the advocate know that the patient has declined services - the advocate will leave the information they have brought with him/her for the patient and is able to leave the hospital. Sometimes there are support people in the waiting area and the advocate will be connected with that person to provide support - this is a request the SANE will inquire from those individuals as well before making the connection to the advocate who has arrived at the hospital. In my experience the majority of the time when an advocate is already on-scene at the hospital or en route the patient accepts advocacy services (I would say 90% of the time) - when the patient is asked prior to dispatching the call to have an advocate come I would say that the acceptance rate for advocacy services drops to around 50-60%. A lot really depends on the wording used - the simple

phrase difference between there is an advocate available for you right now versus an advocate can be called in for you is what affects the decision in my opinion.

When advocates are trained to respond 24/7 with this mindset I've never encountered or heard of an advocate who was upset about being told by the hospital staff or SANE that the patient has declined advocacy services. The opportunity to leave the information packet for the SANE to give to the patient for follow up contact and the opportunity to assist support systems in the waiting area are still there and it is simply "a hazard of the job."

The Crime Victim and Sexual Assault Center sexual assault hotline is called when the SANE is called; the victim is not and should not be asked (NYS DOH). We service 3 hospitals in Albany County. We are told the age and gender of the assault victim, no names. The individual can refuse to work with us after we arrive, but that rarely happens. The SANE introduces us and asks the victim then if they want an advocate. If the person does refuse, we ask to leave our flyer and related information. People don't want to "bother" anyone, especially in the early hours after midnight but most, over 95%, appreciate the accompaniment.

We have tried it both ways...calling an advocate with the request of the patient and calling immediately. I also have had only one patient decline if the advocate is readily available. Many decline if they are asked if they want to wait for yet another person/process to be put in place. If the SANE waits to consult the victim, the patient is asked and consents, the arrival of the advocate either delays the exam process or she arrives mid-exam. We now always call an advocate immediately, give the hospital name, the patient gender and age and it has worked very well for a dozen years.

Here in Hood River, Oregon once a patient presents to the ED, we call dispatch who calls the advocate who is on call. We let dispatch know that we have a rape case. HIPAA has not been a problem for us. We do not give the patient the opportunity to say no as they will most of the time always do so. We let the advocate introduce themselves and at that time the patient may refuse. All of our patients so far have accepted the advocate and they hear the same story that we are told.

I was an Advocate for our local Sexual Assault Center for several years and that was always an issue we had with the hospital not the victim. The issue we ran into was the victims were not being given the choice to speak with an advocate at times. We had a Memorandum agreement with the ER that we would be called once a victim presents. A good nurse would let the victim know that an advocate was on the way and give the a little insight on what an advocate is. That helped allot because then at least the victim knew you were coming. once I was there I was able to explain more about who I was and what serviced I provided. That then allowed them to make a decision if they wanted the service or not. Honestly, I have never been turned away from a hospital called. The one who was most shocked that I was an advocate was certain doctors who did not know me. Victims understand that there are doctors, nurses and other people they will see at the hospital. Just letting them know that the Advocate sole purpose is to support them and not the system is very important to them.

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For a number of years we have had an agreement with our local hospitals that an advocate would be called as soon as a victim presents at the hospital. Since the inception of our SANE program five years ago, we have had the protocol of dispatching an advocate and a SANE at the same time. The victim is informed that an advocate and SANE are coming and what their roles are – the victim always has the option of refusing an advocate if that is their desire. When calls come in from the hospitals, we are informed of the victim's age (if it is a pediatric SANE call) and which hospital the call is from. We receive no other identifying information so it is not a HIPAA concern. It has been extremely rare that a victim has asked that an advocate leave – our SANEs feel that advocates are able to offer support to the victim that allows them to do their job better. In the past, when we asked victims before calling advocates, we felt that victims sometimes didn't want to "bother" someone by asking them to come to the hospital. With advocates being automatically available, victims rarely decline their presence. Our SANE program is a community-based program which runs through our advocacy agency which is a little different than most communities. We have agreements with both of our local hospitals for the SANE and advocate presence when victims present to the ER.

Generally, in Vermont and, specifically, at the hospital where I work the advocate is called automatically when a patient presents to the ED for care after sexual assault. The Triage nurse calls the advocate immediately. The advocate is told there is a patient in need of services but gives no information about the patient. Once the advocate arrives, we introduce the advocate to the patient whereupon the advocate offers services and outlines their role if wanted. Our reasoning for doing this has been that we do not want to offer first/then call because we worry that the patient might feel they are inconveniencing someone. We want them to feel like the service is automatic, something like when we have our social worker come in when there is a death or a social service need in any other situation. The advocate offers to keep the patient company both in the exam room and out of the exam room, offers to wait for them while they are in the exam, provides information about the services they can provide. Also, HIPPA does not preclude the sharing of information in order to provide continuing care to a patient. I would say 90% of the time, the patient accepts the advocates presence, either to be in the room or to wait for them while they are having their exam. The other 10% of the time, they decline and the advocate leaves contact information with the patient and then leaves.

We often hear from victims that they don't want to bother an advocate with the hassle of coming out to the hospital, if the advocate is not already there. So best practice would be for the hospital to call the advocate out, then once there the victim is given the choice. The advocate does not meet the victim or get any other identifying info (other than age and gender) until the victim agrees to accept the service. Age is important b/c not all of our centers respond to child victims.

My advice and the way I work around HIPPA in the state of WI is to work with Hospital administration. I will use literature, the WI SART Protocol and national research Rebecca Campbell. I will not move forward with program development without the understanding of using the SART Protocol. In ending I would like to say that the biggest challenges I have seen in this work has been the understanding and value of advocacy. There are a lot of therapy models in WI. My work as the Statewide SANE Coordinator has been to ensure that the SANE in WI understand, respect and value the work of advocacy. And then to ensure it is practiced in our communities.

An Advocate's Responsibilities

- Informing of rights
 - The victim has the right to deny any service or procedure at the hospital. She does not have to give an explanation if she does not want to. Victims should also be made aware of the potential consequences, ultimately, there is nothing the victim HAS to do. In order to obtain a forensic exam, she will need to cooperate with police and be subject to an interview before the police will authorize evidence collection. If the victim does not want to cooperate with police, then the costs of her medical treatment will be her responsibility.
- Serving as a liaison between agencies
 - While responding as an advocate, you will have the opportunity to network and educate other systems. Your ability to serve as a bridge will help to improve relations in the future.
- Offering crisis intervention
 - **Validate and Ventilate:** Victim advocates support and encourage the victim as the victim ventilates and then validates the experience. Acknowledging the victim's words and feelings is a way to confirm that the reactions are normal responses to an abnormal situation. The victim's feelings can be validated as normal reactions, while not being confirmed as reality.
- Explaining the medical process
- Explaining the legal process
- Accompanying or staying with the victim
 - This should always be the victim's decision. If you are asked to leave by either medical or law enforcement personnel and you've already asked and confirmed with the victim that they want you to stay, briefly explain to that person the victim's desire for you to remain as their support person. If medical/law enforcement insists that you have to leave, ask to speak with them further in the hallway/another room. It is important you do not have power struggles in front of the victim. If in the end, you are still not allowed to remain with the victim during a period, document your conversation and inform your supervisor. In all cases, advocates should get the name of the responding law enforcement officer and medical person. It will be the role of the supervisor to work with other systems in this regard.
- Facilitate decision making
 - **Prepare and predict** for the victim the unfolding chain of events in the criminal justice system. Advocates provide the victim with a sense of what will happen next, a "roadmap" of what will unfold. The victim determines how much information is given. Advocates also attempt to help the victim understand typical emotional, cognitive, physical, and behavioral reactions to trauma. Providing the opportunity for victims to learn more about the whole experience of "victimization" allows them to take a greater role in managing their own healing.

- Conducting safety planning
 - **Safety and Security:** Victim advocates must take the victim feelings of safety (or lack of safety) seriously. Advocates assess the victim's feelings of safety at the moment and validate the victim's fears as well as prepare a safety plan.
- Documentation
 - As required per agency. Advocate documentation should not contain any judgment and details of the assault should not be required. More explicit documentation will be conducted if the victim seeks follow up services within the agency. Advocacy programs should also consider data collection for their statistics regarding demographic and overall assault information.
 - Advocates should not take notes during the call and again, only a brief summary is needed for documentation. This limits what the defense can use in court if subpoenaed. The brief synopsis should focus on the victim's emotional response and not on the aspects of the assault.

[http://www.suffolkcac.org/assets/pdf/From the Life to My Life Suffolk Countys Response to CSEC June 2012.pdf](http://www.suffolkcac.org/assets/pdf/From%20the%20Life%20to%20My%20Life%20Suffolk%20Countys%20Response%20to%20CSEC%20June%202012.pdf)

The SEEN advisory group- think tank of providers. Using subcommittees or task groups, the Advisory Group developed the elements of a

comprehensive, cross-system CSEC response, including: offender accountability; interagency communication/confidentiality; interview/intervention guidelines; service provision; data/evaluation; housing/placement; and training/public awareness.

SEEN Case Coordinator: The Case Coordinator position was created to manage and coordinate the MDT response to CSEC... The SEEN Case Coordinator is the one professional in the Coalition with full-time responsibility for the day-to-day operation of SEEN and SEEN's multidisciplinary response to CSEC victims. Interviewees described the SEEN Case Coordinator as the epicenter of the collaborative efforts to address CSEC in Suffolk County. This role is critical for ensuring that the system responds quickly and comprehensively to girls involved in CSEC.

Susan Goldfarb: Director at a Children's Advocacy Center- SEEN Program . Similar to safe shores- in a family justice center. Co located with LE and a RCC. Forensic interviews done in house. Serve a range of children- exposure to violence, abuse, etc. SEEN is for children who experience or are at risk for sexual exploitation.

Several kinds of advocates- victim witness advocates that are systems based. Become involved with kids and family pre-complaint. Get involved at the initial concern, not once a case has been launched.

As soon as a report of suspected abuse is made, everyone immediately coordinates. The CAC has a position called a family advocate. They help when prosecution is unlikely. They are CAC non-governmental employees.

In the context of exploitation work, - SEEN drafted human trafficking legislation in 2011, safe harbor provision for youth under 18.- provides an advocate, but doesn't say who. Since the law was passed, there hasn't been discussion about whether or not a child has gotten an advocate since there are so many in different roles involved. There is almost never a situation in which there is not an advocate available to the child.

The human trafficking legislation includes language around self-identifying. (It is in the legislation, we can read it.) It comes with privilege and confidentiality so it required definition. I don't think that there

has been much discussion or movement- no one has come forward and said that they couldn't be an advocate.

Different entities provide support- RCC is providing medical advocacy and some civil legal services along with a civil only legal organization. There just isn't the same jockeying that there is here in DC.

There are some circumstances where it can be really hard for a family to have so many different advocates involved in their life. In the absence of coordination that can be really tricky.

It's possibly more complicated on the adult front. On the youth side, they are able to share information and it is statutorily allowed. Certain notifications are required: Once child welfare is notified they must report to LE and DA. The victim is entitled to a multidisciplinary team. Then, information is shared with team members.

Is there a difference between the way you handle custodial abuse vs. peer to peer?

One difference is that both would be reported to child welfare, but child welfare wouldn't be involved with peer to peer. All will be sent to LE. Peer to peer must be very mindful. Even if it was a crime on the books, not everyone will be wanting to approach it as a crime. Others might approach it statutorily, but this isn't held standard across the state.

The big question: If you are given the right to an advocate, do you have the right to engage the system on your terms? Does the kid get the same confidential communication privilege as the adult here in DC?

(5) If so, is the advocate there to tell the survivor that he or she is able to get a kit without cooperating with the police, even if the police need to be notified?

There needs to be a report filed with child welfare if a PD kit is done. Then LE decides what to do. But a child still needs to give consent to cooperate with the process. 'not in the business of forcing anyone to do things they don't want to do'