

**Evaluation of the Sexual Assault Victims' Rights
Amendment Act (SAVRAA) Task Force
Recommendations for DC Youth**

**Presented to the City Council of the District of Columbia and the
Executive Office of the Mayor**

By

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I. Introduction

The Sexual Assault Victims' Rights Amendment Act (SAVRAA) of 2014 established important rights for adult survivors of sexual assault, including the right to have a confidential, independent community-based advocate present during a medical and forensic exam and law enforcement interviews,¹ to have their sexual assault evidence kits processed within 90 days of submission to the lab,² and to be informed of the results of toxicology and DNA testing.³ While these rights were extended to adults in the new law, the issues raised by youth who experienced sexual assault and their parents about their experiences reporting those crimes were ultimately delegated to the statutorily created SAVRAA Task Force to research further and provide policy recommendations for future action by the City Council of the District of Columbia.

The SAVRAA Task Force was established on October 8, 2014, and was tasked with researching nationally recognized best practices and developing recommendations regarding the following: (1) The development and implementation of an effective complaint mechanism regarding the handling of, or response to, a sexual assault reports or investigations; (2) Whether a need exists for additional sexual assault victim advocates; (3) Whether a need exists to expand the right to a sexual assault victim advocate beyond the hospital and law enforcement interview settings, such as meetings and conversations with prosecutors; and, (4) Whether a need exists to expand the right to juvenile sexual assault victims, and if so, to identify the nature and extent of the need and make recommendations on how best to meet it.⁴

The SAVRAA Task Force was made up of local victim service providers, law enforcement, attorneys, and various experts in the field of victim services from the DC Metro Area. They reported their findings and recommendations on January 30, 2016, after a three-month extension on its September 30, 2015 deadline was specifically requested to more fully investigate the issue of whether juveniles should have the right to an advocate. The purpose of this report is to evaluate those recommendations in light of both the work of the Task Force Itself, in which the SAVRAA Independent Expert Consultant participated as an observer/member, and the additional investigation conducted by the Independent Expert Consultant. This report details those recommendations and explains their reasoning, the

¹ DC Code §23-1909.

² DC Code §4-561.02.

³ DC Code §23-1910 (1).

⁴ Sexual Assault Victims' Rights Amendment Act of 2014, Sec. 215.

findings related to those investigations, as well as recommendations from the SAVRAA Independent Consultant about the Task Force recommendations. The Independent Expert Consultant had broader latitude to investigate independent of any DC government agency, and also was at liberty to disagree with the Task Force when warranted.

The SAVRAA Task Force recommended that minors between the ages of 12 and 17 who experience peer to peer sexual assault or sexual assault by a stranger no more than four years older than the victim should have the right to an independent confidential victim advocate, and that that advocate should be exempt from mandated reporting of child abuse and neglect for purposes of maintaining the confidential relationship with their client. There has been an enormous amount of controversy about this issue as well as heated emotional exchanges due to fears about our own children, the children of the District in general, and our steadfast belief that as adults, as parents and as professionals each of us knows exactly what is best for them. We also often approach issues regarding an entire diverse population of children as though every child were our own specific child. In some ways that impulse is useful in terms of maintaining a commitment to every child's safety and well-being. However, in some ways it clouds our ability to see that each child is different and may come from a perspective and experiences about which we know very little.

The debate around the issue of whether minors should have the right to an advocate eventually arrived at a fine point that involved parenting, professional ethics, and philosophies behind entire systems of care. Broadly, that central issue is whether it is harmful or even dangerous to youth to allow them to make choices about their care and about their interaction with the criminal justice system, to whatever degree, and to also possibly make decisions that may conflict with what we as adults believe is in their best interests, whether through our knowledge as parents, professionals, former children ourselves with our own life experiences, or all of the above. This is a particularly difficult discussion to have when we are talking about a choice as consequential and frightening as whether to report sexual assault. While the Task Force had a very specific assignment – to determine whether an advocate was warranted for minors in the same way that advocates are now provided for adults under SAVRAA – this evaluation also takes into consideration not only whether there are problems that the right to an advocate could ameliorate, but also explicitly addresses how current services intersect with choices minors are already making in terms of help seeking.

A. Methods

The SAVRAA Task Force spent six months researching these issues and discovered that there were intense feelings raised by these issues, much of which was driven by a desire

to protect children, polarized professional opinions about what is best for children from an adult perspective, and concerns about parental rights. The group vigorously debated the issues from all possible angles, consulted with more than 15 experts in the field, held three focus groups with youth and two well-attended listening sessions open to the general public which included parents, service providers from a host of different perspectives, and other interested community members and activists. To open the debate to any interested person or organization not necessarily on the Task Force, the Task Force created a Minors Work Group that was open to the public. The Work Group met monthly for five months and communicated frequently between meetings as well to share information, ask questions, and suggest experts to be consulted. Work Group meetings were well attended and it created vigorous discussion that allowed the Task Force to arrive at the recommendations in their current form.

The Independent Expert Consultant also spent approximately six months in addition to the work of the Task Force, and conducted two additional focus groups with minors as well as two focus groups with parents to further investigate the wisdom and practical utility of the Task Force's recommendations, and what improvements might be recommended to further the Council's original legislative assignment. In total, 82 minors and 14 parents were interviewed to inform this evaluation, and interviews with parents are ongoing.

In addition to interviews and focus groups, the available data from District agencies and service providers was reviewed, as well as basic demographic data in the District. Research was conducted into evidence-based best practices in the field, practices and legal frameworks employed by other jurisdictions and interviews with practitioners in other jurisdictions, as well as local and federal laws giving certain rights to minors and to minors who are victims of crime more specifically. Although the research and work done by the Task Force as a whole is combined where possible with that of the Independent Expert Consultant, the analysis and recommendations contained herein are solely those of the Independent Expert Consultant.

The District's mandatory reporting laws required that even in focus groups and interviews with individual youth or parents, interview subjects had to be advised to bear in mind that identifying information about abuse might trigger a mandated report by the SAVRAA Independent Expert Consultant to DC's Child Abuse Hotline. This requirement created a lack of specificity in conversations and made follow up questions problematic, even when clear concerns were raised. In two interviews that were mediated by other service providers, the subjects did not provide their real names or any identifying information. A third interviewee interviewed by a member of the SAVRAA Task Force Minors Work Group preferred to maintain her anonymity from the interviewer even though the prosecution of her child's case was closed.

All interviewees and focus group participants, whether they were law enforcement members, survivors, parents or service provider/professionals were guaranteed anonymity in this report. Therefore, most direct quotes are not attributed and responses are highly aggregated and anonymized to avoid identifying any one person or organization.

B. Definitions

Because so much of this report involves specific terms specific to victim services and because we are talking about the SAVRAA Task Force Recommendations in great detail, it is important that we are using the same terms and definitions. The needed definitions utilized in the SAVRAA Task Force Report⁵ and in this report are as follows:

- (1) “DC SART” means the District of Columbia Sexual Assault Response Team (DC SART), a multidisciplinary collaboration, exists to provide a coordinated response to sexual assault in the community.
- (2) “DC SANE” means the collaborative program administered by the Office of Victim Services and Justice Grants that consists of specially trained nurses who conduct medical forensic exams for evidence collection following a sexual assault (as staffed by the DC Forensic Nurse Examiners), professional vertical advocacy (as provided by the Network for Victim Recovery of DC), and hospital care (as provided by MedStar Washington Hospital Emergency Department.)
- (3) “Multidisciplinary Team” means the agencies and organizations that coordinate to care for a minor victim following a sexual assault. In the District the MDT consists of the Metropolitan Police Department (MPD), Office of the Attorney General for the District of Columbia (OAG), United States Attorney’s Office for the District of Columbia (USAO), Child and Family Services Agency (CFSA), Children’s National Medical Center (CNMC), and Safe Shores – The DC Children’s Advocacy Center (DCCAC).
- (4) “System-based advocate” means a professional working with victims of crime advocate who is employed by a state or local government agency or department. System-based advocates typically work during the regular work day/week, are not on call and do not have confidentiality privileges with victims.
- (5) “Community-based advocate” means a professional who is employed by a not for profit, non-government organization and whose primary purpose is to represent the needs and interests of the crime victims they are serving. Community-based advocates are often crisis-oriented and have confidentiality privileges with the victim or survivor.
- (6) “Minimal facts interview” means an interview used by first responders to determine the basic

⁵ Sexual Assault Victim’s Rights Amendment Act of 2013 SAVRAA Task Force Report 2016, pgs. 6-8.

facts of the complaint from a victim or witness. A minimal facts interview is narrative in nature and is used to determine the basic facts of “who”, “what”, “where”, and “when” that will allow the first responder to take immediate action to protect life or property.

(7) “Confidential communication” means a communication between a victim and their independent advocate wherein the advocate is not bound by any law, regulation, or ethical standards to disclose the information received to a third party.

(8) “Privilege” means a right held by a client with regard to information that the client discloses to a professional (often an attorney, doctor, social worker, therapist, or advocate) that is statutorily protected from disclosure by that professional to a third party.

(9) “*Maryland vs. Brady*” means the United States Supreme Court case, 373 US 83 (1963). In *Brady*, the defendant challenged his conviction after alleging that the prosecutor had withheld certain evidence from the defense that would have been exculpatory and material to the case. The Supreme Court reversed the defendant’s conviction, setting forth the rule that any member of the prosecutorial or law enforcement team disclose material and exculpatory evidence to the defense. Exculpatory evidence is “material” if “there is a reasonable probability that his conviction or sentence would have been different had these materials been disclosed.” Brady evidence includes statements of witnesses or physical evidence that conflicts with the prosecution’s witnesses and evidence that could allow the defense to impeach the credibility of a prosecution witness.

(10) “Independent Expert Consultant” means the consultant hired in accordance with the requirements of the Sexual Assault Victims’ Rights Amendment Act of 2013. The consultant works independently of any government agency or community-based organization and is tasked with investigating practices, reviewing files and interviewing parties in order to provide an informed independent report to the Council of the District of Columbia on the policies and procedures used to investigate sexual assault and serve victims and survivors.

(11) “Mandatory reporting” means the legal requirement that certain people are mandated to report suspected allegations of child abuse or neglect to the relevant law enforcement or child protection agency.

(12) “Violence Against Women Act” means United States federal law (Title IV, sec. 40001-40703 of the Violent Crime Control and Law Enforcement Act of 1994, H.R. 3355) signed as Pub.L. 103–322 by President Bill Clinton on September 13, 1994 (codified in part at 42 U.S.C. sections 13701 through 14040). The Act provides \$1.6 billion toward investigation and prosecution of violent crimes against women, imposes automatic and mandatory restitution on

those convicted, and allows civil redress in cases prosecutors chose to leave un-prosecuted. The Act also establishes the Office on Violence Against Women within the Department of Justice, and has been reauthorized in 2000, 2005, and 2013.

(13) “Warm hand-off” means a victim-centered approach in which a primary care provider or first provider does a personal introduction of a victim or survivor to a referral or longer-term source of assistance.

(14) “Physical Evidence Recovery Kit (PERK)” means the physical package of evidence that is collected by medical forensic personnel in the aftermath of a crime or, more specifically, a sexual assault.

(15) “Minor victims’ working group” means a sub-group of the SAVRAA Task Force which was convened to work specifically on issues related to minor victims of sexual assault and make recommendations to Legislative Question #4 of this Report. The Minor victims’ working group invited non-Task Force members to participate in the meetings and cultivated public input from service providers, as well as teenagers and adolescents in the District

(16) “Minor” in this report refers to a person aged 12 years to 17 years of age.

(17) Person with a significant relationship includes: a) A parent, sibling, aunt, uncle or grandparent, whether related by blood, marriage, domestic partnership or adoption; b) A legal or de facto guardian or any person, more than 4 years older than the victim, who resides intermittently or permanently in the same dwelling as the victim; c) The person or the spouse, domestic partner, or paramour of the person who is charged with any duty or responsibility for the health, welfare, or supervision of the victim at the time of the act; and, d) Any employee or volunteer of a school, church, synagogue, mosque, or other religious institution, or an educational, social, recreational, athletic, musical, charitable, or youth facility, organization, or program, including a teacher, coach, counselor, clergy, youth leader, chorus director, bus driver, administrator, support staff, or any other person in a position of trust with or authority over a child or a minor.

A final but significant note about terminology is warranted. The Sexual Assault Victim’s Rights Amendment Act (SAVRAA) of 2014 refers to juveniles when referring to anyone under age 18. While this is a technically correct designation, the term *juvenile* is more commonly used to refer to youth in the juvenile justice system and therefore has a specific meaning not representative of our target population. Referring to youth as *minors* is also technically correct, but it is a legal term referring to any person from age zero to age 21 in the District of Columbia⁶.

⁶ DC Code §16-2301(4) The term “minor” means an individual who is under the age of twenty-one years.

Adolescence or the term *adolescent* is a medical and psychological designation indicating that a youth has reached puberty but does not yet possess an adult identity or behaviors, and is defined by the World Health Organization as being potentially between the ages of 10 and 19.⁷ There is some debate regarding when adolescence actually ends, and some practitioners define adolescence as a period extending beyond legal adulthood to an average age of 25 when brain structures become fully adult,⁸ a topic we will address more fully below. The term *child* is sometimes used to refer to anyone under the age of 18, but as a medical and psychological definition it refers to someone between the infancy/toddler stage and the onset of puberty, while the legal definition has multiple exceptions the older a minor becomes and those exceptions and ages differ by state with the District of Columbia legally defining any minor under the age of 18, except those charged with certain crimes or a traffic offense.⁹ Because these terms mean specific things to various professionals and to youth themselves, and can overlap with each other, this report will refer to our target population as minors or youth with the understanding that this term refers to people between the ages of 12 and 17 as described above in the Task Force definition. This report will focus exclusively on the needs and concerns related to this age group for reasons that will be described below.

II. Background

A. National Prevalence, Reporting and Disclosure of Sexual Assault Among Minors
Minors between the ages of 12 and 17 are twice as likely as adults to be sexually victimized in some way, from first degree sexual assault to sexual harassment.¹⁰ According to the 2014 National Juvenile Crime Survey, 6% of all youth, both male and female, ages 0 to 17 stated they have been sexually abused at some point in their lives,¹¹ and when the age of these

⁷ World Health Organization: http://www.who.int/topics/adolescent_health/en/.

⁸ Jay N. Giedd, "The Amazing Teen Brain," *Scientific American*, June 2015, pg.32; and Laurence Steinberg, *Age of Opportunity: Lessons from the New Science of Adolescence*. Houghton Mifflin Harcourt, 2014 and Michelle K. Jetha and Sidney J. Segalowitz, *Adolescent Brain Development: Implications for Behavior*. Academic Press, 2012.

⁹ DC Code §16-2301(3) The term "child" means an individual who is under 18 years of age, except that the term "child" does not include an individual who is sixteen years of age or older and — (A) charged by the United States attorney with (i) murder, first degree sexual abuse, burglary in the first degree, robbery while armed, or assault with intent to commit any such offense, or (ii) an offense listed in clause (i) and any other offense properly joinable with such an offense; (B) charged with an offense referred to in subparagraph (A)(i) and convicted by plea or verdict of a lesser included offense; or (C) charged with a traffic offense. For purposes of this subchapter the term "child" also includes a person under the age of twenty-one who is charged with an offense referred to in subparagraph (A)(i) or (C) committed before he attained the age of sixteen, or a delinquent act committed before he attained the age of eighteen.

¹⁰ Fehler-Cabral, G, and Campbell, R. Adolescent Sexual Assault Disclosure: The Impact of Peers, Families and Schools. *American Journal of Community Psychology*, 2013. 52:73-83, pg. 73.

¹¹ Sickmund, M., and Puzanchara, C. (eds.) (2014). *Juvenile Offenders and Victims: 2014 National Report*. Pittsburgh, PA: National Center for Juvenile Justice. Pg. 37.

youth is restricted to those ages 14 to 17, that number increases to a staggering 16% over the course of their short lifetimes.¹² When asked about recent victimization, 6.1% of youth ages 0 to 17 experienced sexual abuse in the past year (4.8% boys; and 7.4% girls). When the definition is restricted to sexual assault rather than broadly any sexual victimization, the overall percentage shrinks to 1.8%, 1.3% of boys assaulted in a given year and 2.3% of girls. If we restrict the age group to the target population for the SAVRAA Task Force Recommendations, the rates are far more alarming with 7.7% of 10 to 13 year olds and 16.3% of 14-17 year olds reporting being sexually victimized in the past year. If the definition is restricted to sexual assault rather than all sexual victimizations, 1.4% of 10 to 13 year olds and 5.3% of 14 to 17 year olds have been sexually assaulted in the last year nationally.¹³

The older a minor is, the more likely that the perpetrator of the assault is a peer or stranger, and the likelihood of intra-familial assault declines. For minors age 12 to 17, parents and caregivers account for approximately 20% of offenders, with other minors and to a far lesser extent, strangers making up the remaining 80%.¹⁴ In the 2014 National Juvenile Crime Survey, for youth ages 12 to 14, 28% of perpetrators were family members, 68% were acquaintances, and 5% were strangers, and for older youth ages 15-17, those perpetrating their assaults were family members or caretakers only 21% of time, 73% were acquaintances and 6% were strangers.

In spite of the shockingly high prevalence of sexual assault in the lives of minors, assaults committed against minors in this age range are rarely reported to the criminal justice system. Reasons minor survivors may not wish to disclose or report to authorities include shame, self-blame for the assault, fear of being blamed particularly if they were doing something illegal or against parental rules at the time of the assault, fear that they will bring disruption by child protective services or law enforcement to their families particularly if those families are struggling already in some way, concern that they will unduly upset their parents, and concern that they will be ostracized from their peer group which is of paramount importance to them at this age.¹⁵ An estimated 8-13% of sexual assaults against minors are ever reported to the criminal justice system, as compared to an adult reporting rate that ranges from 15-39% in

¹² Ibid pg. 38.

¹³ Ibid pg. 37.

¹⁴ Stein, R and Nofzinger, S. Adolescent Sexual Victimization: Choice of Confidants and the Failure of Authorities. *Youth Violence and Juvenile Justice*, Vol. 6, No. 2, April 2008, pg. 159; and Young, A., Grey, M., and Boyd, C. (2009). Adolescents' Experiences of Sexual Assault by Peers: Prevalence and Nature of Victimization Occurring Within and Outside of School. *Journal of Youth & Adolescence* 38:1072–1083. DOI 10.1007/s10964-008-9363-y.

¹⁵ Hanson, R., Kievit, L., et al. Correlates of Adolescent Reports of Sexual Assault: Findings from the National Survey of Adolescents Child Maltreatment, Vol. 8, No. 4, November 2003. 261-272, pg. 261.

various studies.¹⁶ However, as many as 85% of minor survivors within this age range do initially disclose to peers and, though far less often, to parents or other family members.¹⁷ African American girls were found to be significantly less likely to disclose their assault than their European American counterparts, and male victims of all races and ethnicities are especially unlikely to disclose sexual abuse to anyone.¹⁸ Once a minor does disclose to a peer or an adult, authorities – meaning child protection or law enforcement - are only notified between 10 to 33% of the time.¹⁹ One study found that minors only initially disclose to mandatory reporters, i.e., teachers, social workers and police, in less than 7% of cases.²⁰

The pattern of disclosure to others such as friends and acquaintances, family members and other trusted adults mirrors that of adult women insofar as minors in this age range disclose to their friends first in almost all cases, and use the reaction of those friends as a litmus test for how others, including the authorities, might react to a disclosure. If the reaction is negative, they will persevere to find validation from others in their peer group if at all possible.²¹ Research into the pathways of reporting indicates that, much like adults, once a minor survivor has told a peer, that peer will often encourage that survivor to disclose to an adult who can then help them with an official report.²² Although it is true that disclosure to adults increases the likelihood that authorities will be notified, research also indicates that minors whose choices are respected and can participate voluntarily in the process actually follow through with prosecution more readily

¹⁶ Campbell, Greeson, et. al. (2012) pg. 142.; Campbell, et. al. (2011) Adolescent Sexual Assault Victims' Experiences with SANE SARTs and the Criminal Justice System, pg. 11. <https://www.ncjrs.gov/pdffiles1/nij/grants/234466.pdf>

¹⁷ Fehler-Cabral, G., and Campbell, R., Adolescent Sexual Assault Disclosure: The Impact of Peers, Families and Schools, *American Journal of Community Psychology* (2013), 52: 73-83. pg. 73., Hanson pg. 261.

¹⁸ Hanson pg. 263 stating that characteristics of abuse, the relationship between the victim and the perpetrator, and whether the victim was using drugs or alcohol at the time of the assault have also been found to have an impact on disclosure of sexual abuse and reporting to authorities. See also Lane MA, McCright J, Garrett K, Millstein SG, Bolan G *et al.* Features of sexually transmitted disease services important to African American adolescents. *Archives of Pediatrics & Adolescent Medicine* 1999; 153:829-833, and van Ryn M, Fu SS. Paved with good intentions: do public health and human service providers contribute to racial/ethnic disparities in health? *American Journal of Public Health* 2003; 93:248-255.

¹⁹ Hanson (2003) pg. 269.

²⁰ Stein and Nofzinger (2008); and Fehler-Cabral and Campbell, pg. 73.

²¹ Campbell, R., Greeson, M.R., Bybee, D., and Fehler-Cabral, G. Adolescent Sexual Assault Victims and the Legal System: Building Community Relationships to Improve Prosecution Rates, *American Journal of Community Psychology* (2011) Volume: 50, Issue 1-2, 141-154; and Archambault, J. and Lonsway, K. (2013). "Start by Believing: A Public Awareness Campaign Designed to Change the Way We Respond to Victims of Sexual Assault." *Sexual Assault Report*, July-August, 2013, Vol 16 No. 6, pp. 81-84, 88-92. Published by Civil Research Institute.

²² Fehler-Cabral, G., and Campbell, R. Adolescent Sexual Assault Disclosure: The Impact of Peers, Families and Schools, *American Journal of Community Psychology* (2013) 52:73-83. Pg. 77.

than those who did not voluntarily disclose or were coerced into participating in the system.²³ That said, a majority of youth who were forced into the system in some way or felt that their disclosure was not voluntary but were subsequently met with a respectful and positive response within the system also reported to researchers that they were ultimately satisfied with the process. Minor survivors who were not in control of their own disclosure or report to authorities and were also *not* met with a respectful response either refused to participate in the end, or deliberately withheld pieces of information from investigators to ensure the case would end or to protect themselves or others from some perceived negative consequence.²⁴ Maintaining Victim choice and control is essential for both adults and adolescents in recovery from an assault. In fact, trauma is reduced when choice and control are returned to the victim and can be maintained by them, while forcing a victim to comply with requirements that they feel are against their best interest or produce results they find unacceptable can re-traumatize and re-victimize a victim.²⁵

B. Prevalence and the Current System of Care in the District of Columbia

Using this data and applying it to this age group in the District can give us a better sense of the possible size of the problem locally, and gauge what our service population might be based on estimated reporting levels. As of 2016, the District had 41,535 youth ages 10-17.²⁶ Using national statistics for this age group broken into two groups, ages 10-13 and ages 14-17, brings us to the following conclusions regarding sexual assault among youth in the District:

- Approximately 3,463 District youth, ages 14-17, have likely experienced sexual assault, understood as a felony level sexual assault, at some point in their lives.
- When we change the question from whether the youth experienced sexual assault at some point in their lives, to whether they have experienced sexual assault in the past year, we get closer to an estimate, however rough, of what our target population might be. An estimated 278 youth ages 10 to 13 may have experienced sexual assault in the last year, while 1,147 youth ages 14 to 17 may have experienced sexual assault in the last year.

²³ Campbell, R., Greeson, M.R., Bybee, D., and Fehler-Cabral, G. (2012). Adolescent Sexual Assault Victims and the Legal System: Building Community Relationships to Improve Prosecution Rates, *American Journal of Community Psychology*, 50:141-154, pg.

²⁴ Stein and Nofziger, 2008; and Campbell and Greeson, et. al. (2011).

²⁵ Campbell, R., and Raja, S. *Secondary Victimization of Rape Victims: Insights from Mental Health Professionals Who Treat Survivors of Violence*. *Violence and Victims*, V. (1999) 14 (3).

²⁶ The population figures for these calculations were taken from Suburban Stats, which distills US Census Bureau information into a multitude of categories including age, race, and household composition and also provides up to date numbers rather than Census year numbers only.

<https://suburbanstats.org/population/how-many-people-live-in-washington-dc>.

- When we expand that definition to include any sexual victimization, not limited to sexual assault, the numbers increase dramatically to 1,531 youth ages 10-13 having experienced sexual victimization of some kind in the past year, and 3,528 youth ages 14-17 having experienced the same.
- While a very rough estimate, the number of assaults reported should be in the range of 300 cases per year assuming the lowest reporting rate quoted in the research at 8%. Broadened to all categories of sexual violence, approximately 500 cases should be reported total. To be clear, these numbers are *not* intended to be used as a benchmark, per se, but are provided here to give some indication of scope of reporting possible given the low likelihood that minors will report at all.

The current system of response to child sexual abuse in the District is established by statute and vested in DC's Multidisciplinary Team (MDT) consisting of Children's National Medical Center (CNMC), Safe Shores – The DC Children's Advocacy Center (CAC), MPD's Youth Division, the Office of the Attorney General for the District of Columbia (OAG), Child and Family Services Agency (CFSA), and the US Attorney's Office for the District of Columbia (USAO).²⁷ The MDT agencies provide services and investigate cases in a coordinated and collaborative manner that incorporates the District's Memorandum of Understanding and Inter-Agency Agreement on Child Maltreatment Investigations between CFSA and MPD using a "case management approach that is focused first on the child victim's needs, second on the law enforcement, prosecution and civil proceedings involved, and third on the family members who are supportive of the child and whose interests are consistent with the best interests of the child."²⁸

Services for families and children are primarily provided at the DC Children's Advocacy Center, which is a well-equipped, child-friendly, secure one-stop location housing personnel from all MDT agencies. Services include trauma-focused counseling, emergency services such as clothing, food, and other household items, and victim advocacy services for the family. The Children's Advocacy Center also contains forensic interviewing rooms equipped to record interviews conducted by trained forensic interviewers so that a child ideally only has to recount their sexual assault once for the criminal justice process. Forensic interviews also may reduce the likelihood of a defense attorney's claim that the child was coached. This CAC model is nationally recognized as a best-practice in the field of services for child victims of sexual and

²⁷ DC Code §4-1301.

²⁸ District of Columbia Memorandum of Agreement on the Multidisciplinary Response to Child Sexual Abuse, January 2016.

physical abuse.²⁹

The MDT and the Children's Advocacy Center receive referrals from cases reported to Child Protective Services through the Child Abuse Hotline or to MPD. If a case is made known to CFSA through CFSA's Child Abuse Hotline, they will screen that case to determine if it warrants further action, which may also include forwarding to MPD for criminal investigation. When a case is initiated, the victim may also be referred to Children's National Medical Center for a medical care. If the assault occurred less than 72 hours prior to the referral, a forensic exam may also be conducted to be submitted to the Department of Forensic Sciences for analysis as evidence in the criminal case. MPD provides the forensic exam kit to the hospital for the exam and a police report or report to CFSA is a precursor to receiving an exam regardless of the age of the minor survivor. If a minor presents at Children's National Medical Center on their own or before a report is made to CFSA or MPD, mandated reporters at CNMC will notify the child abuse hotline as required by DC law and appropriate parental notification will be made by CNMC, CFSA or MPD according to their respective agency policies and legal constraints when they begin their investigation. Similar to the process for a minor presenting at CNMC on their own, if a minor seeks services from The DC Children's Advocacy Center without a referral from CFSA or MPD, a report to CFSA is made as a precursor to receiving services.

In 2014, CFSA's Child Abuse Hotline received 220 calls for youth ages 12-17 indicating that they had been sexually abused, but these cases were not broken down by relationship to the perpetrator in CFSA's data. In 2015, Safe Shores provided services to 119 new clients in this age group who were primary victims of sexual abuse, and Children's National Medical Center's Child and Adolescent Protection Center conducted 35 acute forensic exams, . The Metropolitan Police Department received 155 reports of sexual abuse in which youth ages 12-17 were the victim. Of those 155 reports, 86 of those reports (55%) were cases in which non-familial perpetrators, i.e., peers as defined above, were listed as suspects, and 69 reports (45%) were filed in which a family member, caregiver or someone in a trusted relationship with the minor had allegedly committed the abuse. Of these reports, the USAO filed charges in 32

²⁹ More information about the Children's Advocacy Center model can be found at the National Children's Advocacy Center's website at <http://www.nationalcac.org>. See also, Nwogu, NN, Agrawal, L, Chambers, S, et. al. Effectiveness of Child Advocacy Centers and the multidisciplinary team approach on prosecution rates of alleged sex offenders and satisfaction of non-offending caregivers with allegations of child sexual abuse: a systematic review. JBI Database System Rev Implement Rep. 2016 Jan 15;13(12):93-129.

cases against adult defendants,³⁰ and the Office of the Attorney General filed the remainder of the prosecuted cases against juvenile defendants. The District's Office of the Attorney General is willing to provide information as to the exact number of cases they prosecuted in 2015 upon the provision of a court order providing an exemption under DC Code §16-2331.³¹

III. SAVRAA Task Force Recommendations for Minors

The SAVRAA Task Force was legislatively required to study nationally recognized best practices and develop recommendations regarding whether a need exists to expand the right to an advocate to minor survivors of sexual assault. If a need was identified, the Task Force was required to identify where that need exists and to what extent, and to make recommendations on how best to fill that need. In addition to the inherent complexity of the issue itself, the Task Force's mandate was further complicated by the fact that there is a highly developed and statutorily defined system of services for victims of child sexual and physical abuse in the District provided by the Multidisciplinary Team (MDT), as described above. The concerns about the experiences of minor survivors raised at the December 2013 hearing about the proposed SAVRAA legislation focused primarily on the Metropolitan Police Department's approach to sexual assault in youth cases, but the possible solutions to these problems necessarily involve the entire MDT system of care. The Executive Director of Safe Shores - DC Children's Advocacy Center (DCCAC) was invited to serve as the representative of the MDT on the Task Force and as a representative of Safe Shores as an individual organization with significant expertise in the field.

After six months of vigorous debate, interviewing and extensive research, the SAVRAA Task Force Recommended the following in their report issued January 30, 2016:³²

- Minor victims should have a right to an independent, community based advocate and ~~that~~ the advocate should be provided within a protocol tailored to the role of the perpetrator in the victim's life as well as the age of the victim;
- The population served by this advocate should be restricted to minors ages 12-17, who have been sexually assaulted by a peer, as defined above, and for minors, ages 12-17, who

³⁰ See Appendix A for a full description of this data. The 32 cases that were filed may not be the extent of the prosecutions stemming from those cases as the USAO could pursue a case years later, and MPD may still be investigating.

³¹ A motion was filed with DC Superior Court on November 1, 2016 under DC Code 16-2331 Juvenile Case Records; Confidentiality; Inspection and Disclosure to request aggregate data regarding prosecution of sexual abuse offenses perpetrated against youth ages 12-17 by other minors. This data will be shared immediately upon receipt.

³² SAVRAA Task Force Report 2016, pg. 31. The Task Force recommendations are copied nearly verbatim with edits for efficiency provided only so that nothing is lost or confused in attempted to paraphrase them

experience sexual violence committed by a stranger or by someone who does not have a significant relationship to the minor victim survivor and is no more than 4 years older than the victim.

- This advocacy shall be provided by an independent, community-based advocate using a model of vertical advocacy established by SAVRAA. Vertical advocacy means that the advocate with whom the youth survivor meets initially remains their advocate throughout the process, if the survivor wishes.
- The advocate shall be provided to the minor victim prior to any substantive, investigatory conversation with hospital-based personnel, law enforcement, Child and Family Services Agency, or prosecutorial authority, but this provision is not intended to limit hospital-based personnel or law enforcement from gathering information for purposes of time-sensitive, emergency or triage care to the victim.
- A youth-oriented hotline be established, or included in an existing hotline, to provide information anonymously to minors ages 12-17 about their legal rights, mandatory reporting requirements of various system actors, the details of the law enforcement reporting process, age appropriate and Violence Against Women Act-compliant access points for medical care, counseling, and law enforcement assistance, as well as the details of parental notification laws in the District.
- The hotline must provide a “warm” hand off, i.e., a direct and personally introduced link to a community-based advocate who is available to meet in-person with the minor victim or survivor to provide the following information, regardless of the status of the case or report to law enforcement: information about the system of care available to the minor victim or survivor and the youth victim’s or survivor’s rights under the Violence Against Women Act; a general outline of the civil and criminal legal remedies available to youth victims and survivors; the minor victim’s or survivor’s right of accompaniment to a medical forensic exam and any other portion of the process as desired by the minor victim or survivor; Information and assistance regarding the minor victim’s or survivor’s ability to inform or speak with parents or other adults in the minor victim’s or survivor’s life, if desired by the minor victim or survivor; information about creating and periodically amending a safety plan with the minor victim or survivor; information about the minor victim’s or survivor’s rights in the school system; referrals to counseling services that are appropriate to the minor victim or survivor; information about logistical challenges that the minor victim or survivor may face, such as transportation, school attendance, and other safety planning issues; advocacy in, and assistance with, any benefits or financial supports available; any other

advocacy needs identified by the sexual assault victim advocate and the minor.

- The youth advocate should be exempt from the District's mandatory reporting requirements which state that any person in the District aware of abuse or neglect of a child must report that abuse or neglect to Child and Family Services or to law enforcement. However, the exemption to mandatory reporting for this sub-group of victims should not include situations in which there is an immediate or exigent risk of harm to the minor victim or survivor if the report to law enforcement is not made.
- Physical Evidence and Recovery Kits (PERKs) should be made available to healthcare providers at Children's National Medical Center, independent of a report to police so that the minor's right provided by the Violence Against Women Act which states that any survivor age 13 or older must be able to obtain a forensic exam and medical care free of charge and without requiring a report to law enforcement can be exercised.

IV. Findings

The findings in this report are the cumulative result of both the SAVRAA Task Force process which includes the SAVRAA Task Force Minors Work Group, as well as the Independent Expert Consultant's investigation and evaluation. Rather than deconstruct or solely evaluate the system of services for all minors ages 0 to 18 in the District in isolation, findings discuss this issue through the narrower lens of the SAVRAA Task Force recommendations themselves, and address broader issues where needed to ensure that optimal results for minors are achieved. Although they rely in part on work conducted while a member of the SAVRAA Task Force and Minors Work Group, these findings are solely those of the Independent Expert Consultant.

Overarching findings that inform the findings and recommendations below are:

- The current system of care is well-organized, lead and staffed by professionals truly committed to the District's youth. However, the system as currently configured contains barriers that are off-putting to youth between the ages of 12 and 17, and that ultimately discourage reporting.
- When minors this age do report assault by a peer, they may not be receiving services in the most age-appropriate way despite the very carefully thought out and well-delivered services within the system because it is currently largely designed, both in terms of policies and philosophy, for younger children and youth affected by intrafamilial abuse.

A. Gap in Services for Minors, Age 12-17 Assaulted by a Peer or Stranger

The MDT collaborative process for investigating and providing services at the DCCAC to minors who have experienced sexual abuse is available to children up to 17 years of age

for cases involving intra-familial abuse, meaning abuse perpetrated by a family member, caregiver or someone in a relationship of trust to the minor victim, otherwise known as intra-familial assault. However, as a matter of policy, minors age 12 to 17 who are not assaulted by a family member, caregiver or someone in a relationship of trust with the minor are automatically screened out of CFSA's caseload and may be sent to MPD's Youth Division for criminal investigation. MPD then pursues the case according to their investigative protocols. Under the Memorandum of Agreement on the Multidisciplinary Response to Child Sexual Abuse (MOA) signed in 2016, minors whose cases fall into this category can receive a forensic interview if the detective believes it is necessary and beneficial to the process, if the minor survivor has developmental, emotional, learning or other disabilities, or if they were non-communicative on the scene. In January 2016, after the Task Force identified this gap, the MDT revised the MOA to include a provision that allows MPD and CFSA to refer any minor age 13 to 17 regardless of the relationship between the victim and the offender for a forensic interview should they deem it necessary. However, this addition still leaves a significant gap in services and a lack of advocacy for minors age 13 to 17 who are assaulted by a peer or a stranger as defined above and do not necessarily need a forensic interview, or do not wish to cooperate with law enforcement or are strongly motivated to keep details and information from their parent or guardian. The processes and pathways for referral to receive advocacy services therefore leave a gap in services and support for minors ages 13 to 17 who have experienced peer to peer sexual assault rather than interfamilial assault, though MPD may investigate their case and the USAO or OAG may prosecute the offender. That this gap exists at all in CFSA's screening protocol and in the MDT's MOA and process indicates that they both acknowledge that this category of crime among minors is in fact distinct from intra-familial assault in both dynamics and in terms of the needs of minors this age who have experienced it.

Update: Since this report was initially published, MPD has changed the structure of the Youth Investigation Division to include detectives who work solely with teenagers, and those detectives are increasingly bringing teenagers who have experienced peer to peer sexual assault to the Children's Advocacy Center for a forensic interview when appropriate.

1. *Choice of Age*

The Task Force debated the issue of age extensively and was very careful to create an advocacy right tailored to the group who needed it most, specifically the group who was not consistently receiving services and who therefore would be reporting to law enforcement on their own or with the help of an adult, and were also more reluctant to disclose to a parent. The

gap identified in the MDT's model of services is actually from ages 13 to 17, and not from ages 12 to 17 as the Task Force Recommendations indicate. By choosing ages 12 to 17, the Task Force attempted to mirror other related rights in District law, specifically that of the statute allowing minors age 12 to 17 to obtain a temporary protection order against an intimate partner

without parental notification under certain circumstances.³³ The group discussed at length over several months the possibility of only applying these rights to those ages 14-17 but determined that the more inconsistencies were thrown in front of youth attempting to obtain services and understand their rights, the more likely it was that they would feel alienated and not want to follow through with seeking help.

2. *Type of Crime Covered*

Similarly, the Task Force recommended right to a confidential advocate is appropriately restricted to peer to peer sexual assault, and to assault committed by a stranger that is no more than four years older than the victim. This type of assault more closely follows patterns seen in adult sexual assault in that they rarely involve the exploitation and abuse of power involved in assaults carried out by parents, caregivers or persons in a relationship of trust with the victim. This distinction was also made because peer to peer assault does not typically involve the “grooming” or manipulation of the victim to obtain access, compliance and silence required for ongoing sexual abuse to occur.³⁴ This type of assault is often the result of activity initiated or consented to by the victim initially like sexual activity in which consent is withdrawn, going to a party or other location, and/or consuming drugs or alcohol. Peer to peer assaults may be committed a situational acquaintance, or more likely as part of a violent intimate partner relationship.³⁵ Intimate partner violence is of course dangerous and poses safety risks, but these relationships are handled in the domestic violence arena with a measured degree of autonomy for minors currently in the District as well. In fact, this recommendation is structured to precludes intimate partner relationships in which the perpetrator is more than four years older than the victim so that the power relationship that that kind of age difference creates cannot be exploited. Peer to peer assault, while still difficult to report from a minor’s perspective, does not typically involve a relationship in which the minor survivor would otherwise be required to have ongoing contact with the perpetrator of their assault, though school and peer situations always have to be negotiated. These factors were all appropriately considered at great length to ensure that in their attempt to create access, the Task Force was not opening this group of minors up to a vulnerability created by someone upon whom they depended or by whom they were unduly influenced.

B. Reporting Choices of District Youth

³³ DC Code §16-1003 Petition for Civil Protection Order.

³⁴ Smalls, S. A., & Kerns, D. Unwanted sexual activity among peers during early and middle adolescence: Incidence and risk factors. *Journal of Marriage and the Family*, (1993) 44, 941–952.

³⁵ Young, Grey and Boyd, pg. 1072-1083.

Minors in the District in the five focus groups with youth ages 14-17 mimicked available research in the field regarding barriers to reporting and parental disclosure among minors. Of the 82 minors asked whether they know someone who had been sexually assaulted, 37 participants (45%) raised their hands.³⁶ When asked if those people they knew had been assaulted had told an adult or a parent, all hands went down, meaning 100% said no. The paraphrased/condensed reasons they gave were as follows:

- Fear that their parents will think they're lying;
- 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.
- Religious implications if your parents are highly religious and think that you're 'ruined' now;
- Fear that parents would go to the police and the person's reputation would be ruined among their peer group and then the reporting victim would be ostracized;
- "Self-pity" or blaming themselves for the incident.
- Intersections of marginalization and exploitation such as homelessness, LGBT, runaways, sex workers, etc., are discouraged from saying anything to avoid having to reveal the rest of what they're hiding from their parents or law enforcement;
- Embarrassment and shame;
- Lack of familial support in general, might tell them and find that they don't care or worse be abusive because of it; and
- Fear that someone will call CFSA and that agency will disrupt their family or find something out about their family; stated that they would feel like they did something bad to their family.

C. Hotline and Advocacy Response

1. Anonymous Hotline

The recommendation that an anonymous hotline be provided for youth that would provide a warm hand-off to an advocate for that minor survivor to provide more in-depth services was almost unanimously and enthusiastically supported by the Task Force, the Task Force Minors Work Group, parents, youth and other service providers.

Focus group participants were specifically asked for their reaction to these specific proposed recommendations to provide an anonymous hotline and a confidential advocate. The most surprising response to focus group facilitators was the immediate lack of trust in the offer of an anonymous hotline, or more accurately, the suspicion that confidentiality and anonymity

³⁶ While it is possible that those responding in each group were part of the same peer group and were thus all responding with the same person in mind, it is more likely that they were talking about different acquaintances and friends given how these focus groups were assembled.

would be retracted in the end after the youth disclosed abuse and enough identifying information to locate them. Approximately 30 of the 82 youth interviewed expressed extreme concern that their phone numbers and Internet Protocol (IP) addresses would be tracked even if the hotline claimed to be anonymous and wanted assurances that technology would be employed that would not log this information at all. They provided extremely useful feedback about how to build a hotline that was truly anonymous that they and their peers would therefore trust to use. These suggestions included a recording prior to the live call taker answering the call in which the confidentiality terms could be provided thus allowing the caller to hang up before they spoke with a hotline call taker if they didn't feel comfortable. The need for confidentiality and the expectation that adults will deceive them spoke volumes about the importance of finding a confidential avenue for youth to receive information and make decisions about disclosure and reporting. That said, if properly set up, the idea of having somewhere to call for themselves and to find out how to help a friend if they should they disclose sexual assault to them, was very enthusiastically received.

Parents also overwhelmingly approved of the idea of an anonymous hotline for their children to call, and similar to the minors interviewed, said that they would very much like somewhere to call themselves to find out what the reporting process looked like, how to go about it, and how to get help for their children when they did disclose to them. Three parents specifically liked the idea of having somewhere to call that would not necessarily lead to an official report at that moment.

2. Community-Based Advocate

The idea of a community-based advocate was also enthusiastically received by minors in focus groups, specifically that survivors need to be given an advocate separate from their parent, or at least the choice to have one. In spite of this enthusiasm for their own advocate, a majority, though not all by any means, indicated that they would want their parents to be very involved. During this discussion in three of the focus groups, one or more participants agreed that just because they can tell their parents does not mean that everyone is so lucky. They specifically cited youth who identified as LGBT. When asked if they would prefer to have an advocate as described in the recommendation advocating for them or their parent, participants responded as follows. Direct quotes and generalized statements encapsulate longer discussions and each side of those discussions.

- “I would want my mom to know, and to help me, but I'd want the advocate to advocate for me because they know the system. My mom wouldn't know more than I did at the start.”

- “Parents may have an agenda or be so angry that they can’t help you or listen.”
- Advocates should be independent liaisons and not part of any system other than helping the get resources and information about their rights and how the system works.
- It’s important for survivors to understand exactly what is going to happen. This process often leads to feelings of betrayal mistrust of the system. It’s important for survivor healing that they can direct their own process. [Answer given by an 18-year-old survivor].
- If they don’t want an advocate for their child, they’re likely to be unsupportive themselves.
- “I would want my mom to advocate for me because I don’t want a stranger knowing my business...to have to tell all kinds of things to a stranger.”
- “A lot of people will need help telling their parents and then dealing with whatever that brings up.”
- “I’d want someone I knew was going to be totally honest with me.”

Regardless of which side they agreed with, minors indicated that they wanted to be able to have the choice as to whether to involve their parents, to what degree, including ceding all decisions to them, and whether they wanted an advocate because, as one participant put it, “you never know how it’s gonna be or how you’ll feel until it’s you.”

Conversations with youth were the most inspiring and illuminating part of this process. It should be noted prominently that the minors in focus groups did as well or outperformed the many adults participating directly in the Task Force Juvenile Work Group Listening Sessions and other forums in terms of having rational discussions, being able to respectfully debate and considering all of the relevant points surrounding these issues from multiple perspectives, including that of their parents, without any prior knowledge of the topic. In one focus group of 14-17-year-old girls, two girls engaged in a spirited but respectful debate about the pros and cons of having an advocate versus a parent acting as their advocate and within that brief exchange managed to identify nearly all issues and argue them well.

Parents were asked similar questions about the possibility of an advocate, specifically how they would feel if their child could get an advocate or an advocate was offered to their child and not to both of them, as well as how they would feel/what they thought about the idea that their child might have an advocate who was not allowed to talk to them. Of the 14 parents in the focus group, none had a problem with their child having an advocate by themselves, but they did raise questions about who the advocate might be, how they were trained, and whether the advocate had to tell someone if their child was going to harm themselves or was going to be or

was immediately in harm's way. Five parents total indicated that they would like an advocate as well, separate from their child's advocate, to help them. The groups were more divided in terms of whether they would object to or be troubled by their child having a confidential advocate. Reactions were categorized as follows. These statements summarize two wide-ranging discussions of 20 to 30 minutes each:

- Would rather their child simply get help rather than not get help because the minor felt like they couldn't go to their parent;
- Would be ok with it because the advocate knows the system, can help everyone by helping the minor themselves;
- Would prefer that their child come to them for advice about anything, but said that they want them to have someone looking out for their interests if they choose not to do so.
- The system is intimidating/indicated that they didn't trust it (meaning the criminal justice system) and would feel better if their child had an advocate;
- Would be ok with it because sometimes there are things teenagers especially don't want to tell their parents;
- Would rather their child tell them everything but their priority is to make sure they're getting all the help they possibly can;
- Concern that they were out of the loop or not helping their child enough or wouldn't know if their child was ok if they weren't part of those conversations in some way;
- Would feel rejected and anxious about why their child felt the need to hide things.

B. Confidentiality, Parental Notification and Mandatory Reporting

The Task Force recommended that the community-based advocate provided to minors have a confidential relationship with the minor and that as such the advocate be exempt from mandatory reporting requirements, and therefore exempt from parental notification as well. The role of parents and the issues of parental notification and mandatory reporting were all vigorously debated due to concerns that an advocate would displace or overrule a parent's guidance, that a youth would be receiving advice or medical care that a parent knew nothing about, or that the minor survivor's case would simply never be reported to anyone but the advocate and therefore no action would be taken by any adult or investigative professional who could keep the minor safe.

While ideally, a parent would be a minor's first point of disclosure based on a positive and trusting relationship that would then lead to a report to authorities, when youth make a decision to disclose to others instead and seek services entirely without an adult's help, they

have already made a decision based on their own life factors, including their relationship with their parents, and are asking service providers for help based on those decisions. The issue at hand is not what we would ideally like the parent-child relationship to be, but what a minor perceives their needs to be when they seek help, and whether a parent or guardian can be notified without the minor victim's consent.

The District has already enacted legislation that allows minors certain rights to access services without parental notification or consent. These rights include:

- the right to obtain a temporary or civil protection order without parental consent or notification in cases of intimate partner violence with the permission of the court through a court appointed attorney at age 12 and without an attorney at age 16;³⁷
- access reproductive health services including contraception and abortion, prenatal care, HIV testing and treatment at age 13;³⁸
- the ability to seek out mental health support without parental notification based on a mature minor standard, with psychotropic drugs provided to minors age 16 and up under certain circumstances, including where parental notification/consent would be harmful to the minor patient.³⁹

In fact, if a minor decided to keep the sexual assault component of their service needs to themselves, they could access all of these services without informing anyone else, whether a parent or guardian or CFSA. However, if the sexual assault is known to the service provider, under current DC law a mandatory report would have to be made to Child Protective Services Child Abuse Hotline, thus triggering parental notification in most cases either by CFSA or MPD, and nullifying the minor's rights enumerated above.

Attorneys who represent teens in dating violence cases reported in interviews that the conflict between a parent's wishes and expectations of the legal system sometimes do differ from those of their youth clients or sometimes even from what is legally feasible given the facts of a case. Some youth interviewed also expressed the concern that parents would have their own agenda driven by fear, rage, shame or guilt and not be capable of listening to the survivor. Others said that they would want their parents to know but might need help talking to them about it, while still others said their parent would be their primary support with no help or intervention needed from the advocate to bridge that gap.

³⁷ DC Code §16-1003.

³⁸ DC Code §13-2803.

³⁹ DC Code 7-1231.14 Consent of youth receiving mental health services or mental health supports.

Youth advocates and medical professionals who regularly work with unaccompanied teens, i.e., teens who seek services without a parent or guardian's knowledge or permission, attempt to engage parents with their clients or patients as a standard practice. This may include helping the youth talk to their parent, or talking to the parent with the youth or even prior to but on behalf of the youth in order to preclude inappropriate or harmful responses such as victim blaming, punishment for rule breaking co-occurring with the assault itself, etc., rather than the crime or other tangible harm that has occurred. This process also allows advocates to assess for the potential for abuse and/or neglect and report those appropriately. This step is assumed within the recommendation for an advocate's support.

One of the objections raised by several service providers within the current system for minors discussed above is the possibility that African-American parents will view an advocate as an attempt to diminish their role or separate them from their children as has historically been the case. This is obviously an important point that speaks not only to parental notification but also to the model of services currently provided for minors in intrafamilial cases where the minor does not get an advocate but the family does with an emphasis on the non-offending caregiver acting as the point of contact and service provision. The goal is to increase support rather than create an additional issue for the minor to deal with or to subject parents to a system that they feel is disrespectful of their role. A youth focus group member spoke eloquently about the different needs of marginalized populations and the anxieties of African American, immigrant and LGBT youth and parents when interacting with official systems. She stated that mothers know what their children go through in the system, and would want their child to have an advocate. The other youth in her focus group agreed that in these instances the most supportive and culturally appropriate model would be to provide an advocate for the youth and an advocate for the parent, particularly in instances where a report was made to law enforcement, but that those advocates should be separate to avoid conflating the support the parent might need with that needed by the youth, and so that the parent can become as knowledgeable about the system itself as possible and be presented with ways to support their teenager in their own confidential space without feeling separated from the process itself or their teenager. This provides support without removing the possibility that a minor who needs an advocate separate from their family could get one. As mentioned above, some parents in the focus groups indicated that they would like their own advocate or support of some kind as well with five out of the 14 members saying as much. Eleven of the participants in the parents' focus groups were African- American mothers and three were Latina mothers.

The current model for providing access to contraception and reproductive healthcare is instructive in terms of what motivates minors to seek help and what would keep them from taking steps to ensure their health and well-being to avoid parental notification. A study of statewide survey data indicated that 86% of adolescents *would use* a health clinic if the services were entirely confidential, and 83% indicated that they *would stop* going to that clinic entirely if their parents were notified. Confidentiality is recommended as a best practice by all major medical associations for minors over the age of 13.⁴⁰

Mandatory reporting of child abuse and neglect is required by DC law for almost all DC residents except for attorneys and advocates for adult victims of sexual assault.⁴¹ Based on all available research about barriers to help seeking among adolescents, as well as the responses from three focus groups conducted with teens themselves, the Task Force as a whole, though not unanimously, determined that mandatory reporting was a significant barrier to minors seeking help for sexual assault.

Having determined that this was a significant barrier to minors seeking help, the Work Group had two choices: either (1) exempt this entire population and/or category of crime (ages 12-17 assaulted by a peer) from mandated reporting requirements across the system, or (2) carve out an exemption for the advocate only. The group was far more comfortable with the latter because it meant that the likelihood of mandated reporting occurring for that particular incident would still remain high, but not act as such an absolute barrier to voluntary help seeking by the minor. This way, the youth and the advocate are surrounded by mandated reporters whether at school, at a hospital or clinic, or via law enforcement, but safe space still exists to give and get information and support with the whole array of circumstances out on the table with the advocate.

A related point was made that if the advocate finds a situation of caregiver abuse or neglect, that would be a mandated report regardless of the proposed exemption for the advocate, thus creating two parallel tracks or categories of cases. Similarly, the Task Force recommendation includes language that allows for what is normally called a Tarasoff warning or report, meaning that confidentiality can be breached if immediate or ongoing harm to the minor is suspected by the advocate.⁴²

⁴⁰ Reddy, DM, Fleming, R., Swain, C. Effect of mandatory parental notification of adolescent girls' use of sexual healthcare services. JAMA 2002; 288: 710-714.

⁴¹ 22-3020.52 Any person who knows, or has reasonable cause to believe, that a child is a victim of sexual abuse shall immediately report such knowledge or belief to the police. For the purposes of this subchapter, a call to 911, or a report to the Child and Family Services Agency, shall be deemed a report to the police.

⁴² Tarasoff v. Regents of the University of California, 551 P.2d 334 (Cal. 1976).

Other jurisdictions function with a model similar to the one recommended by the Task Force. Alaska, California, and Massachusetts exempt advocates for sexual assault survivors (minors and adults) from mandated reporting requirements. Colorado exempts advocates if no other child is still being harmed, and Maryland does not require reporting for peer to peer assault of a minor.

Minors employ multiple strategies to get the information and help they need and avoid the requirements placed in their way, from lying about their age to remaining anonymous when possible, to keeping their help-seeking at the peer level, sometimes with highly negative results. The DC Crime Victim's Hotline receives instant messages and the DC Rape Crisis Center receives phone calls from minors who simply keep their personal information to themselves upon being told that the call taker is a mandated reporter. The DC Crime Victim's Hotline has received 26 instant message hotline contacts from individuals who revealed their age to be under 18 to get information about sexual assault and intimate partner violence since January 2016. DCRCC does not track the number of callers who are minors but has indicated that minors are a regular population on their hotline.

The trust that a hotline call taker establishes or an advocate would need to build with a minor client in order to help them can be undermined entirely by a mandated report being made. A physician working with pregnant teens stated, "The mandatory reporting system stinks and often has the potential to be disruptive to the relationship that I have with the patients.... Don't get me wrong; people have to be held accountable, but I don't think it results in the best outcomes for the young person." She indicated that the problem arises because she needs them to buy into the decisions made as a partner if they are going to follow through, and the mandatory reporting system means things are then happening without the minor's consent.

Minors who participated in the focus groups were acutely aware of mandatory reporting. As stated above about the hotline, reporting to CFSA or having CFSA involved in their families' lives was viewed almost entirely as something to be avoided. Because of the group nature of the exercise, facilitators did not follow up and ask if CFSA was involved in anyone's life or if they were speaking from prior personal experience. In one focus group with males only, the primary reason given for not disclosing sexual assault was to avoid CFSA and to a lesser extent, police involvement.

C. Medical and Forensic Exams: Forensic Compliance

The Task Force recommended that PERKs, i.e., evidence kits, be provided and available at CNMC without initially alerting law enforcement and that youth be given the option afforded under VAWA to obtain the forensic exam without necessarily cooperating with law

enforcement. The overwhelming majority of medical and forensic exams for minors have historically been provided by Children's National Medical Center's Children and Adolescent Protection Center (CAPC), which provides exceptional pediatric care and mental health services for children who have been abused. CAPC employs SANE nurse examiners and has nurse examiners on call who are certified to perform pediatric exams. This program performs between 30 and 40 acute exams per year, approximately 35% of which are for youth ages 12 to 17.⁴³ In 2015, 35 acute forensic exams were conducted, meaning that the assault had taken place in the previous 72 hours. Through interviews for this report the following additional findings were made:

- Beginning in October 2016, CNMC keeps kits in their clinic and has changed their protocol to nominally allow survivors to obtain an exam without cooperating with law enforcement, though a mandated report to CFSA must be made under DC law, triggering a law enforcement response. CNMC has provided hospital and CAPC staff with written information and training about the rights of teenagers under VAWA, and provides a one-page information sheet to parents and patients informing them that they can get an exam free of charge and without necessarily cooperating with law enforcement, though a report will have to be made.
- Prior to 2016, CNMC was not providing forensic exams for this age group compliant with the forensic provisions of the Violence Against Women Act that requires all sexual assault survivors who wish to receive a medical and forensic exam be provided with one free of charge and without requiring a report to law enforcement as a condition of receiving the exam.⁴⁴ CNMC's protocol was for MPD to bring a new evidence kit to the hospital at the time the report was made, and therefore an exam could not be had without encountering law enforcement first.
- CNMC's CAPC staff has expressed strong concerns about granting minors greater choice in the process due to limitations in decision making capacity created by the developmental stage of the adolescent brain, though they also acknowledged that high barrier systems discourage reporting. In interviews with CNMC personnel *outside* of CAPC but also treating adolescents there, a significant philosophical resistance to minors of this age making autonomous decisions emerged. Two interviewees questioned the veracity of existing rights of minors provided under DC law separate from their parents, and they were dismissive of a teenager's ability to functionally exercise these rights and access services on their own.
- CNMC does see minors who are unaccompanied by an adult and contacts CFSA to act as their

guardian in those instances. They also will not force a minor to reveal information that would lead to the ability to identify a perpetrator if the minor refuses to do so.

- Also in compliance with VAWA, DC Forensic Nurse Examiners (DCFNE) also provides medical and forensic exams for youth ages 12 to 17 at MedStar Washington Hospital Center. They have served fewer than 10 minors in the past two years according to their Executive Director. Their protocol in these instances is for the nurse to advise minor patients that they are mandated reporters and must contact CFSA after the exam is finished. The nurse also offers to contact a supportive adult for them or with them before the exam begins.
- The Network for Victim Recovery of DC (NVRDC) provides advocacy, casemanagement and legal representation for minors age 12 and older, but not as a specific program tailored to that population, according to a June 14, 2016 interview with Co-Executive Director Nikki Charles. However, until a youth services organization finalizes a protocol with the DC SANE Program to provide this type of advocacy in these instances, NVRDC will provide that advocacy and make appropriate referrals in conjunction with DCFNE as they would for any survivor served through the DC SANE Program. DCFNE will refer teens to CAPC at CNMC, or they can also be referred to Whitman Walker Clinic if they would prefer to receive follow up services there.
- In a review of evidence kits and meetings with the Department of Forensic Sciences, problems with PERKs from CNMC became apparent. When problems were raised with CNMC by DFS staff, CNMC was reportedly not receptive to their feedback.

Update: Since this report was published, CNMC has met with DFS to discuss these issues and resolved the majority. They are now meeting quarterly to ensure that any questions or problems can be addressed in a timely way.

D. Hospital/Medical Focus and Location of Advocacy Services

The Task Force recommendations frame the right to an advocate as attaching both from the hotline call referral and warm handoff at that point, and also at the point where a minor would request a forensic exam at a hospital. The youth service providers working at community-based organizations and other health clinics, as well as some minors interviewed for this project strongly indicated that there was an over-emphasis within the Task Force Report on a medical or hospital initiated protocols. They indicated that minors generally attempt to avoid hospital settings and experience significant barriers when trying to access them on their own such as requests for identification, proof of insurance, and the chance that a triage nurse will contact police or CFSA before the minor has had the opportunity to meet with an advocate. They each made suggestions that advocacy services be provided in more youth-

friendly locations and that even forensic exam locations should be provided in clinic settings that were easier to access for minors such as Whitman Walker Clinic, Planned Parenthood, and La Clinica del Pueblo.

E. Cross-Training and Community Response with Youth Services Organizations

Youth Service providers at five non-MDT organizations indicated that a large number of their service population do disclose sexual assault or violence to them long after it has occurred, sometimes many years, and the minor survivor has determined that the service provider can be trusted with the information. Service providers indicated that when that happens, the system for serving youth is designed more for acute reports and becomes difficult to access if a report is delayed because simply contacting CFSA does not seem productive, particularly for older minors who will likely be screened out of CFSA services as previously described. Each person interviewed indicated a need for cross-training and cross-referrals so that warm hand-offs are possible beyond just making a mandatory report to CFSA to trigger a process largely designed for acute cases.

F. Awareness of and Practical Accessibility of the Rights of Youth

This evaluation process revealed that many people working within the criminal justice system, the youth services system and the community at large are partially or entirely unaware of the extent to which minors have gradually increasing autonomous rights from the ages of 12 to 17. Minors in focus groups indicated that this type of confusion is alienating and feels like a trap because adults communicate this information with such certainty even when they're wrong.

G. MPD's Youth Investigative Division (YID)

By all accounts the Metropolitan Police Department's Youth Investigative Division (YID) has experienced vast improvement in the past three years, including some detectives receiving the intensive training about child sexual abuse provided by Safe Shores. The work that YID does with children who have suffered abuse is commendable, and requires a particularly empathetic but collected personality. A complete, case-by-case review of Youth Investigative Division (YID) cases was not possible because SAVRAA does not statutorily mandate a review of youth cases in the way it does for adults, making these findings purely anecdotal.

Update: Additional information about this unit's work will be provided in an addendum to this report after reviewing specific cases and speaking with detectives.

- MPD's Youth Investigative Division was extremely forthcoming with data and other information about their investigative process.

- When asked about minors, ages 12 to 17 who experienced peer to peer sexual assault, MPD indicated that the number of reports that fit this description was extremely small in both absolute terms, and compared to the rest of YID's caseload which totals approximately 2,500 cases per year.
- Information about interactions with detectives was vastly inconsistent, with some survivors and youth service providers expressing high admiration and appreciation for the detectives who investigated their cases or with whom they work. However, some interviews with survivors, their case managers, attorneys and advocates provided anecdotal evidence of an overt concern by some detectives with projecting authority over youth of this age.
- Four reports were provided of threats to arrest youth if they did not cooperate or provide information upon request. Two of these reports were corroborated by the youths' attorneys who indicated that the threat of arrest was repeated to them about their client and had no legal basis. YID supervisors attested that no charges for false reporting nor any related to impeding an investigation or lack of cooperation have been filed in the past three years, which indicates that these threats may be tactics to gain compliance rather than something the detective intends to follow through on. Regardless, the minor survivor has no way to know that it is an empty threat.
- One survivor indicated that she would never report again without an attorney even though her case was resolved in way she deemed positive, though not with a prosecution.
- Other points of tension existed around attempts to hold a minor's phone for evidence. While sometimes a legitimate evidentiary need, a phone is a lifeline for some youth and seizing it can create a reason to stop cooperating with the case.
- Of the two focus groups with parents held with 14 parents total, five parents indicated that their children did not think the detective believed them. In three instances, parents described their child's response as ranging from becoming reluctant to participate to totally refusing to continue the process.
- Additionally, during a training with community-based service providers about trauma informed care and youth, some detectives emphatically expressed the view that youth of this age could not be trusted, and some detectives indicated they did not understand the dynamics of sexual assault and intimate partner violence as experienced by youth. One detective indicated that a youth who had initiated a sexual encounter couldn't then claim to have been raped later on. Another indicated that youth brought these things on

themselves by the way they behaved sexually. As incendiary as these things may sound within the context of this report, these views were not expressed by the majority and were not reflective of their views about young children but seemed specifically targeted toward minors over age 12. A larger percentage of the trainees reportedly did strongly resist the idea of giving these youth choices and working with them in a more trauma-informed way that would necessarily require a more egalitarian approach.

- MPD has indicated that they are very open to additional training to resolve these issues and has begun the process of forming the specialized unit for minors within this age range who experience sexual assault.
- Update: MPD has restructured the Youth Division workload such that five detectives who specifically want to work with minors, ages 12-17, and either already have or are willing to acquire the skill set required to do so appropriately have been assigned to work solely with this age group. An addendum will be provided regarding these improvements.

H. Language and Services Access

One parent interviewed indicated that while the police were good, meaning YID detectives, and her daughter's case was prosecuted, she was never offered an interpreter despite clearly needing one. Instead, her aunt had to interpret for her and did not share everything said in interviews with police and prosecutors because she was uncomfortable repeating certain things. To her knowledge, she and her daughter also did not receive an advocate until she was assigned one by the USAO's Victim Witness Unit in spite of being under age 12 and assaulted by someone in an intra-familial relationship. She reported that her USAO Victim Witness Specialist was very helpful. Ordinarily this level of detail about one case would be glossed over, but this case stands out insofar as not receiving the resources that are indicated as normally provided in this process.

I. Youth Empowerment Approach vs. Child Protection Philosophy

There is a clear divide in the approach and philosophical orientations of those serving minors in the District, with community-based youth service providers outside of the MDT system approaching these issues from a youth empowerment perspective that affords youth greater autonomy, and the MDT member organizations and agencies approaching these issues from a child protection standpoint that often views youth autonomy as unsafe even for older minors. While each perspective has its place, this tension had a severe impact on the group's ability to discuss accessibility, appropriate safeguards and informed decision making for minors. This divide is not unique to the District of Columbia. In a survey of Sexual Assault Response Teams (SARTs) in jurisdictions where there are also Children's Advocacy Centers,

those jurisdictions report a high degree of tension between advocates and advocacy oriented organizations like rape crisis centers and children's advocacy centers.⁴⁶

A physician who works with minors and adults providing reproductive health services indicated that, in her experience, this schism exists in the medical field as well. She indicated that due to their training, pediatricians are uncomfortable with adolescent decision making generally, and may view them solely as children and therefore discount their decisions as invalid. She also indicated that physicians for adults are often not trained to work with adolescents, leaving this group of minors with no appropriate option to get their needs met.

I. Adolescent brain development and research indicating that brain structure maturity does not occur until one's mid-20's have been cited as a reason that autonomy for minors is not safe or in their best interest. That research is based on MRI studies coupled with behavioral research that indicates that adolescents go through enormous changes to brain structure and functioning on their way to full maturity. The behavioral implications this brain development is that adolescents are far less likely to modify risky behavior or consider the long-term consequences of their behavior, and that they are more likely to misconstrue social cues and act on impulse. Research does not necessarily indicate that adolescents are incapable of making decisions as a result, only that the way they do so is different than a mature adult.⁴⁷ Part of this brain development is a process where, because of heightened emotions, they also need greater peer validation than before and are also individuating from their parents and home life. This leaves them vulnerable to a number of problems, but it also means they are less likely to go to their parents or want their parent's involvement and more likely to turn to peers, as the research about sexual assault disclosure indicates.⁴⁸

IV. Recommendations

1. Youth ages 12-17 in the District should be provided with an anonymous hotline to call for crisis support, information about the various systems of services available to them, legal information regarding their rights both as youth and as victims of crime in the District, referrals to community organizations and government agencies appropriate to their age and the issue they present, and a warm hand off to an independent community-based advocate. The hotline could

⁴⁷ The American Academy of Child and Adolescent Psychiatry, Teen Brain: Teen Brain: Behavior, Problem Solving, and Decision Making, No. 95, September 2016. Steinberg, L. Should the Science of Adolescent Brain Development Inform Public Policy? American Psychologist, November 2009, 739-750

⁴⁸ Jay N. Giedd, "The Amazing Teen Brain," Scientific American, June 2015, pg.32 and Laurence Steinberg, Age of Opportunity: Lessons from the New Science of Adolescence. Houghton Mifflin Harcourt, 2014 and Michelle K. Jetha and Sidney J. Segalowitz, Adolescent Brain Development: Implications for Behavior. Academic Press, 2012.

also be accessed by parents or friends of youth who have questions about the process and/or need information about the best way to support youth who have disclosed to them.

This hotline should be marketed to youth, parents, teachers, and service providers in a culturally appropriate manner and in languages most commonly utilized in the District. Materials should specifically reach out to marginalized youth in a culturally appropriate manner. The SART and Multidisciplinary Team should create this marketing jointly as described in the recommendation below regarding a broader public awareness campaign about sexual assault.

2. The advocate recommended by the Task Force should be provided as a legal right to the youth themselves, and should be provided as, recommended, by an organization with a history of providing services to youth of this age and an approach working with minors from a youth empowerment perspective rather than solely a child protection perspective. To be clear, an organization can hold both perspectives, but youth of this age who have been sexually assaulted by a peer have distinct needs that do not necessarily mirror those of a child victim of abuse perpetrated by a family member or caregiver and also have needs distinct from those of younger children. Advocates should be youth service providers first and sexual assault advocates second in terms of methods, outlook and training, but their perspective in approaching this population must be one of youth empowerment. They should receive training on adolescent brain development, trauma-informed care, youth-friendly clinical and advocacy practices and be adept at working with law enforcement and prosecutorial entities. They should also be credentialed through the advocate credentialing process being developed as a result of other Task Force Recommendations.

Advocates for parents, or some other form of similar support could be extremely helpful in terms of providing support to a family when needed without abrogating the minor's right to a confidential advocate. A program in Colorado utilizes this model successfully, and was interviewed for this report.

3. Advocates should employ the standards of parental or supportive adult involvement recommended by Advocates for Youth and the Guttmacher Institute as employed by Title X,⁴⁹ organizations providing confidential healthcare to minors age 13 and older. These standards emphasize the need for parental involvement whenever possible, and encourage a team

⁴⁹ 42 C.F.R. § 59.11.

approach with the minor patient in speaking with parents, guardians or other supportive adults, but ultimately leave this choice in the hands of the patient/client.⁵⁰

4. To increase accessibility to services, the Task Force's focus on providing advocacy solely in conjunction with a forensic exam should be broadened to include youth who contact the hotline, indicate that they are survivors of sexual assault, are between the ages of 12 and 17, and simply wish to meet with an advocate. In addition, based on interviews detailed in the findings in this report, even if youth do wish to receive a forensic exam and get medical care, that medical care should be accessible at a non-hospital location such as Whitman Walker Clinic, the District's new Planned Parenthood facility, and the DC Children's Advocacy Center clinic. Both CAPC and DCFNE's forensic response have been located solely within hospital settings, making access to care difficult for adults and youth who are not in need of care for acute injuries that would warrant an emergency room visit. While the need for acute care is a subjective determination that can be professionally made by medical professionals, both youth and adult survivors do make that very determination for themselves, just as we all do, when deciding where to first request care. The barriers for unaccompanied youth walking into a hospital emergency department have been detailed in the report and are markedly higher than those encountered by an adult. These barriers are compounded still more if the youth is part of a marginalized and/or underserved population, culture or community.

5. Youth seeking services for a sexual assault exam on their own or with a parent or guardian must have the option to access those services at a location other than Children's National Medical Center, and to choose to access services from an adult/adolescent program rather than a pediatric one. This does not preclude CNMC from conducting exams for minors of this age range who seek those services there, but the option to access a program and a facility that promotes a youth empowerment model as opposed to a child protection model must be provided.

6. CAPC should meet periodically with DFS staff, specifically forensic biology unit staff, to address issues presented with the kits submitted from this program, and to implement training and/or policy changes to address those issues as needed. Update:

⁵⁰ 42 U.S.C. § 300(a) (1991), and also Advocates for Youth, (2014) Best Practices for Youth Friendly Clinical Services. <http://www.advocatesforyouth.org/publications/publications-a-z/1347--best-practices-for-youth-friendly-clinical-services>.

7. All professionals working with District youth should receive training regarding parental notification laws in the District and the various rights afforded to teens, including the right to access reproductive healthcare including birth control and pregnancy termination, the right to be tested for HIV and receive treatment in the event of a positive diagnosis at age 13.

8. The program providing advocacy for youth should be added to the Sexual Assault Response Team (SART) by statute, and be required to share aggregate information with the SART regarding their services. A representative from the adolescent sexual assault team within the Youth Division at MPD should also attend SART meetings and participate in case review when an adolescent case is reviewed.

9. Advocacy should be provided to youth ages 12-17 in a confidential manner exempting the advocate from mandated reporting, with the clear statement and understanding that exigent or imminent harm to the youth, specifically defined as a situation of ongoing or immediate bodily harm, would have to be reported to CFSA's hotline. This exemption from mandated reporting is recommended with the additional understanding that under DC law nearly all other providers and individuals with whom the youth would interact in this process remains a mandated reporter. The far more expensive, and in some ways more limiting, alternative to this provision that would still achieve the same goals would be to provide attorneys for youth so that they can still obtain information and support in a confidential space before or while interacting with other system providers.

10. The SART and the Multidisciplinary Team should work jointly to develop a city-wide public awareness campaign about sexual assault for both adults, youth and children to dispel the misunderstandings about access and eligibility for services. This campaign should be highly informed by the Start by Believing Campaign and should attempt to increase public education about consent, as well as what counts as sexual assault. By devising this campaign jointly, hopefully communication and trust between the two groups will increase and improve. This campaign will also require deciding on simple, accurate and easily understood explanations for the public about system access points.

11. MPD's Youth Investigative Division should create and maintain a specialized unit to work with youth of this age who have experienced sexual assault and dating violence. Those assigned to this unit should be selected for their willingness to engage with their work using the Start by Believing, victim-centered philosophy employed by the Sexual Assault Unit for adults. They should also receive specialized training in working with adolescents to include adolescent brain development, youth culture(s), sexual assault and intimate partner violence dynamics and related issues, as well as the laws related to youth and victims' rights in the District of Columbia including any newly provided SAVRAA rights. Ultimately, these should be detectives who *want* to work with this population and relate well to them.

12. Advocates provided under this right should be allowed to accompany the youth in any way the youth deems helpful, including to interviews with law enforcement and prosecutors. The confidentiality extended to advocates under these circumstances should be enumerated clearly in the statute change to include provisions for the presence of third parties, and the similar adult confidentiality provisions clarified and strengthened to include the same features as previously recommended to remove any doubt as to the role of the advocate in those meetings and the impact their presence might have on prosecution. These advocates may also be present during a forensic exam as a supportive person for the youth should they so desire.

13. The screening process at CFSA's Child Abuse Hotline should be examined to ensure that cases involving this age group who have experienced peer to peer sexual assault are in fact being consistently screened out of CFSA's case load and forwarded to MPD's Youth Division instead. CFSA staff should be trained regarding the rights of youth with regard to parental notification and with regard to SAVRAA once those are established, and be prepared to make appropriate referrals to the youth hotline depending on how the situation is reported to them, i.e., by another mandated reporter or a parent or caregiver calling to report a case. This policy should be in place whether the case is reported by them to MPD or not and does not have to impact the course of action they take.

14. Youth service providing organizations in the District, particularly those focusing exclusively on this age group, i.e., youth between the ages of 12-17, should be included not only in training about this process, but in an active network that facilitates robust cross-training, relationship building for staff and volunteers as well as cross-referrals for the youth they serve. This training should also include training about the new hotline and advocacy services and

discussions about ways to collaborate on cases such that the independent community-based advocate and the existing youth service provider with whom a youth may already be working can work together with the youth so as to avoid duplication of services and conflicting information about confidentiality and roles with the youth themselves which may prove alienating.

15. According to VAWA, unaccompanied youth who seek medical and forensic care should receive this care free of charge. Billing departments, intake staff at hospitals, and any other administrative personnel should be engaged at any hospital or clinic where forensic exams are offered to youth to ensure that bills will not be sent to the youth's address or billed to parent's insurance inadvertently. Should the youth require additional medical care beyond that provided through the forensic exam, the youth needs to understand that their parents may be required to consent to this care on their behalf and that it may not be free of charge. The District should also strongly consider ways to ameliorate or remove these requirements and barriers to youth seeking forensic care in tandem with the implementation of any changes.

16. Barriers such as requests for identification, requests for proof of insurance or Medicaid of any kind should be investigated at each proposed location, and the administrative or intake staff at those locations should be trained to exempt youth from the requirement to show any particular type of identification to receive forensic and medical services.

17. Logistical issues such as payment for HIV prophylaxis for minors, insurance billing, and the hurdles described in the previous recommendation should be addressed by the MDT and the SART jointly as soon as possible to ensure that access can be a reality for any minor seeking services for sexual assault.

V. Conclusion

These findings are by no means intended to indicate that services provided at any one organization or government agency should be changed or discontinued, or that there is an inherent flaw of some sort with the MDT. In fact, everyone engaged in this process is deeply committed to the welfare of minor survivors of sexual assault, and based on this investigation the Children's Advocacy Center provides an incredibly needed service for the District's Children in a way that is both sensitive and legally meaningful in terms of facilitating prosecutions. However, the findings indicated as a whole that minors feel comfortable disclosing and reporting once they have adequate information about what will happen if they do tell an adult or seek

services, but that they want confidentiality guaranteed before they reach out. Conversely, they want parental involvement most of the time, but also want to maintain their autonomy in a very self-aware but age-appropriate manner given the normal developmental needs that adolescents have to individuate and bond more closely with their peer group. The findings also indicate that the more protective stance with less confidentiality and choice for minors of this age range has to be balanced against the need to meet minors where they are willing to seek help. The dichotomy between child protection and youth autonomy is dangerous if we err on the side of conditions that prohibit minors from reaching out at all.

Concerns about parental involvement and mandatory reporting are, of course, valid and should not be dismissed out of hand. However, CFSA currently is not taking these cases on as a matter of policy, and MPD has indicated that they receive few reports from this cohort of minors with only 86 reports in 2015. Minors whose relationships with their parents are good or even fair, will still disclose and seek parental support as evidenced focus group responses. The options opened up by meeting minors where they truly are developmentally while taking the reality of their still-developing brains into account will only increase parental involvement where it can be facilitated by an advocate. By providing an anonymous hotline to inform survivors of their rights, the process for reporting, and where and how to get help, coupled with access to a confidential, community-based advocate positioned in such a way that appropriate limits and safeguards are in place, community members can create a system in which not only is this gap in services closed, but minors will feel more empowered to seek help transparently and report sexual assault.

References

- Advocates for Youth (2014). Best Practices for Youth Friendly Clinical Services. <http://www.advocatesforyouth.org/publications/publications-a-z/1347--best-practices-for-youth-friendly-clinical-services>.
- Archambault, Joanne and Kimberly Lonsway, "Start by Believing: A Public Awareness Campaign Designed to Change the Way We Respond to Victims of Sexual Assault." Sexual Assault Report, July-August, 2013, Vol 16 No. 6, pp. 81-84, 88-92. Published by Civil Research Institute.
- Blakemore, S.-J. and Choudhury, S. Development of the adolescent brain: implications for executive function and social cognition. *Journal of Child Psychology and Psychiatry*, (2006) 47: 296–312.
- Bolen, R. and Gergely, K. A meta-Analytic Review of the Relationship between non-offending caregiver support and post-disclosure functioning in sexually abused children. *Trauma, Violence & Abuse* 2015, (2015) Vol. 16(3). 258-279.
- Campbell, R., Greeson, M.R., Bybee, D., and Fehler-Cabral, G. (2011). Adolescent Sexual Assault Victims and the Legal System: Building Community Relationships to Improve Prosecution Rates, *American Journal of Community Psychology*, Volume: 50, Issue 1-2, 141-154.
- Campbell, R., Do Rape Survivors' Experiences with the Legal and Medical Systems: Do Rape Victim Advocates Make a Difference? Vol. 12, No. 1. January 2006. 30-45.
- DC Children and Youth Investment Trust Corporation (2011) Needs and Assets Assessment of Washington, DC Youth, December 2011.
- Fehler-Cabral, G., Campbell, R., (2013) Adolescent Sexual Assault Disclosure: The Impact of Peers, Families, and Schools, *American Journal of Community Psychology*, Volume 52, Issue 1, pp 73–83.
- Ford CA, Thomsen SL, Compton B. Adolescents' interpretations of conditional confidentiality assurances. *Journal of Adolescent Health* 2001; 29:156-159.
- Hanson, R., Kievit, L, Saunders, B, Smith, D, Kilpatrick, D, Resnick, H., Ruggiero, K. (2003). Correlates of Adolescent Reports of Sexual Assault: Findings from the National Survey of Adolescents. *Child Maltreatment*, Vol. 8, No. 4, November 2003. 261-272.
- Jones RK. Do U.S. family planning clinics encourage parent-child communication? Findings from an exploratory survey. *Perspectives on Sexual & Reproductive Health* 2006; 38:155-161.
- Kapshahn CJ, Wilson KM, Klein JD. Adolescent girls' and boys' preferences for provider gender and confidentiality in their health care. *Journal of Adolescent Health* 1999; 25(2):131-142.
- Kogan, S. Disclosing unwanted sexual experiences: results from a national sample of adolescent women, *Child Abuse & Neglect* 28 (2004) 147-165.

Lane MA, McCright J, Garrett K, Millstein SG, Bolan G *et al.* Features of sexually transmitted disease services important to African American adolescents. *Archives of Pediatrics & Adolescent Medicine* 1999; 153:829-833.

Munzer, A., Fegert, J., Ganser, H., Loos, S., Witt, A., and Goldbeck, L. Please Tell! Barriers to Disclosing Sexual Victimization and Subsequent Social Support Perceived by Children and Adolescents. *Journal of Interpersonal Violence* (2016) Vol. 31(2) 355-377.

Nwogu, NN, Agrawal L, Chambers S, Buagas AB, Daniele RM, Singleton JK. Effectiveness of Child Advocacy Centers and the multidisciplinary team approach on prosecution rates of alleged sex offenders and satisfaction of non-offending caregivers with allegations of child sexual abuse: a systematic review. *JBIS Database System Rev Implement Rep.* 2016 Jan 15;13(12):93-129. doi: 10.11124/jbisrir-2015-2113.

McElvaney, R., Greene, S., and Hogan, D. To Tell or Not to Tell? Factors Influencing Young People's Informal Disclosures of Child Sexual Abuse. *Journal of Interpersonal Violence* (2014) Vol 29 (5), 928-947.

Stein, R. and Nofziger, S. Adolescent Sexual Victimization: Choice of Confidant and the Failure of Authorities. *Youth Violence and Juvenile Justice* (2008) Vol. 6, No 2, April 2008. 158-177.

Reddy DM, Fleming R, Swain C. Effect of mandatory parental notification on adolescent girls' use of sexual health care services. *JAMA* 2002; 288:710-714.

Jones RK, Boonstra H. Confidential reproductive health services for minors: the potential impact of mandated parental involvement for contraception. *Perspectives on Sexual & Reproductive Health* 2004; 36:182-191.

Smalls, S. A., & Kerns, D. (1993). Unwanted sexual activity among peers during early and middle adolescence: Incidence and risk factors. *Journal of Marriage and the Family*, 44, 941–952. doi: [10.2307/352774](https://doi.org/10.2307/352774).

Steinberg, L., Commentary: A Behavioral Scientist Looks at the Science of Adolescent Brain Development *Brain Cogn.* 2010 Feb; 72(1): 160–164.

Steinberg, L. Should the Science of Adolescent Brain Development Inform Public Policy? *American Psychologist*, November 2009, 739-750.

Tarasoff v. Regents of the University of California, 551 P.2d 334 (Cal. 1976).

US Department of Justice, Office on Violence Against Women, "National Protocol for Sexual Assault and Medical Forensic Examinations (Adult/Adolescent)", April 2013. <https://www.ncjrs.gov/pdffiles1/ovw/241903.pdf>.

Young, A M., Grey, M., and Boyd, C. Adolescents' Experiences of Sexual Assault by Peers: Prevalence and Nature of Victimization Occurring Within and Outside of School. *J Youth Adolescence* (2009) 38:1072–1083.

Appendix A: Prosecution Data

The USAO is responsible for prosecuting cases in which the victim may be a minor but the defendant is an adult or is being tried as an adult. In the District, someone over the age of 16 can be considered an adult for purposes of criminal prosecution. However, they may still be sentenced and remanded to the Department of Youth Rehabilitative Services. According to DC Superior Court records, the total number of cases prosecuted in 2015 by the US Attorney's Office in which the victim was a minor and the charge was related to any category of sexual abuse was 32 cases, of which 13 (40%) were originally charged with a felony, either 1st Degree Sexual Abuse of a Child, 2nd Degree Sexual Abuse of a Child, or Sexual Performance Using Minors. Other misdemeanor charges were filed as well in those cases, but the felony charge initially dictated the path of the case and also indicated the severity of the abuse alleged. No felony cases from 2015 were dismissed before adjudication. The remaining 19 cases (60%) were originally charged as Misdemeanor Sexual Abuse of a Child or Minor. Six cases were dismissed for want of prosecution, 6 are undisposed as of this writing, five went to trial leading to three guilty verdicts and two not-guilty verdicts, and 21 were disposed with a plea bargain. It should be noted that for cases in which a plea bargain was accepted for cases that began as felonies, only three cases included a guilty plea to a felony charge. The remaining four plead down to either Misdemeanor Sexual Abuse of a Child or Minor or Simple Assault, which was a lesser included charge.

Cases with Adult Defendants

■ Guilty at Trial ■ Not Guilty at Trial ■ Plea Bargain ■ Dismissed ■ Undisposed

