



**Dynamic**Strategies  
*Innovations for Social Change*

**The District of Columbia Sexual Assault Response Team (SART)  
and  
The System of Care for Sexual Assault Survivors**

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## **Executive Summary**

The Sexual Assault Victim's Rights Amendment Act of 2013 (SAVRAA) requires the Independent Expert Consultant to formally evaluate the Sexual Assault Response Team (SART) with a particular focus on the new statutorily enacted case review process. The Sexual Assault Response Team (SART) and its case review process is inextricable from the SART's overarching goal of coordinating a victim-centered system of care for survivors of sexual assault in the District, particularly as it is defined by SAVRAA. Therefore, this evaluation necessarily included robust discussions of that system and includes findings and recommendations from those conversations with survivors, service providers, and other peripheral community stakeholders. These findings are particularly relevant given the lack of a unified, functional sexual assault coalition in the District for sexual assault services providers and survivors alike, and the SART's role as the current de facto coalition forum.

The information gathered about the continuum of services also bears discussing because the requirements of SAVRAA and the system of care it mandates represent a departure from the manner in which advocacy services were provided in the past. Therefore, illuminating those services as much as possible, i.e. what those services are, and who is being served, how and by whom, is necessary. Further, based on interviews and observations both with survivors and service providers, these changes have had consequences within the service provider community that need to be resolved to maintain and expand the high quality city-wide services envisioned by SAVRAA.

The methodology used to evaluate the SART, the case review process, and the system of care to then arrive at these recommendations included interviews with 26 survivors of sexual assault who utilized the services discussed, all service providers and SART members, as well as other community stakeholders such as multi-faceted social service organizations who make referrals to the sexual assault system of care in some way or have reason encounter the issue of sexual assault among their service population. All available aggregate data and specific documentation of services provided, policies and procedures manuals, handbooks and written complaints were reviewed and compared. The SAVRAA Independent Expert Consultant also attended four meetings of the full SART and three Case Review Meetings over the course of one year to observe discussions and information sharing, details and process of the case review itself, as well as group dynamics as a whole.

This report covered many disparate topics, from the statutory requirements of the SART to specific case review process to the broad issue of coalition representation for SAVRAA's system of care to gaps in services. Ultimately the SART is well on its way to being a highly

effective SART even by national standards, and the case review process is functioning beyond its mere legal requirements to identify patterns and find solutions to systemic problems. However, as discussed in the section about the system of care, there are gaps in services such as the mobility and overall capacity of the DC SANE Program to meet geographically scattered and non-hospital based requests for services as well as the current capacity of DCRCC's much needed hotline. In order for survivors to receive clear and correct information about where to go to receive the services they seek and to have knowledge of all of the available choices, transparency and coordination across the entire system of care is imperative. Ultimately, the SART is burdened by coalition activities and conflicts that should be undertaken by a more functional and inclusive coalition separate from direct service provision. By making this change, the SART can focus on its more formal system response while the badly needed rape crisis center model and philosophy embodied by DCRCC can continue to thrive as well.

### **Recommendations**

1. Implement the Step-by-Step Practitioner Toolkit for Evaluating the Work of Sexual Assault Nurse Examiner (SANE) Programs in the Criminal Justice System written by Megan R. Greeson, Rebecca Campbell and Shannon Kobes<sup>1</sup>. This toolkit is disseminated by the National Institutes of Justice to establish clear and mutually agreed upon measurable outcomes for the SART. The SART Case Review Subcommittee has agreed to implement the toolkit, and it should begin immediately.
2. Establish a method of information entry for members using the SART website portal so that complete statistical information is provided in a way that can be recorded and disseminated prior to SART meetings. Entering data in this manner increases members' ability to participate fully in the Toolkit and allows for considered discussion at SART meetings. The SART has developed its own website and is creating a method by which members can enter data into the website prior to meetings.
3. Area colleges and universities should be represented by one representative on the SART as is currently the case. However, that representative should be the explicit link between the University Leadership Initiative and any other advocacy groups or regular forums for campus advocates rather than just representing their institution.
4. OVS should provide funding for a full time staff person for the SART. This individual should have higher-level knowledge of sexual assault services and answer to the SART as a whole through the SART Chair.
5. An FTE for an additional staff person at OVS should be provided and fully funded to work with the SART, continue to work with any aspect of the DC SANE Program, both of which OVS is also statutorily responsible, and to continue to manage ongoing work with all area colleges and universities, as well as the ASK and UASK Apps that OVS has so successfully

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<sup>1</sup> Greeson, M, Campbell, R and Kobes, S (2008). Step-by-Step Practitioner Toolkit for Evaluating the Work of Sexual Assault Nurse Examiner (SANE) Programs in the Criminal Justice System. <https://www.ncjrs.gov/pdffiles1/nij/grants/240917.pdf>.

developed and launched. This person would also be OVS' designee on the SART representing the office's director.

6. The SART should undertake either an annual retreat or other organized member cross training that occurs *at the staff level* annually to ensure that each member is fully acquainted with the services provided by their partners.
7. A public SART presentation should be agreed upon by the entire group to describe access points, the DC SANE Process and the law enforcement reporting process including the option of converting a non-report case later into a report to law enforcement. Education about sexual assault and consent generally can be included in this presentation to address misconceptions about what is and is not considered sexual assault or abuse. This presentation and locating opportunities for providing it should be a priority to mitigate existing misperceptions, particularly given the changes brought by SAVRAA.
8. Cases to be reviewed bi-monthly should be provided to case review participants two weeks in advance of each Case Review Subcommittee meeting to allow participating organizations and agencies time to research the cases and arrive prepared to have a deeper discussion. Ultimately a full-time SART Coordinator should be hired as described in the recommendation on page 8, and this would be one of the duties assigned to that staff person.
9. MPD and/or the USAO should present cases that did not entail a SANE Program response to allow the group to identify resources to help those who did not need or wish to engage a hospital-based response. These cases can be made anonymous because those survivors did not sign the SART release of information for case review. Alternatively, MPD or the USAO could obtain that release as part of their initial meeting with a survivor.
10. Non-report cases, i.e. those for which no police involvement was requested but the DCSANE Program was engaged in some way and an evidence kit was collected, should also be presented and reviewed at case review meetings to identify resource gaps for this population. Anecdotal information should be provided by mental health service providers and other long-term service providers about survivors they serve who did not engage the DC SANE Program or report to law enforcement at all.
11. When cases are chosen that involve college or university students, advocates and department of public safety officials and/or Title IX coordinators from that university should be invited as guests for that particular case's discussion to the case review to provide crucial information about the interaction between the campus response and the District-level response.
12. The DC SANE Program should undertake a three year strategic plan for expansion to determine whether a more mobile model, a 24-hour presence at one hospital, or a combination of the two can be integrated with a broader non-hospital case response over a period of time.
13. The Network for Victim Recovery of DC (NVRDC), the Victim Witness Unit at the US Attorney's Office and the Victim Services Unit at MPD should engage in cross training and strategic coordination meetings facilitated by the Independent Expert Consultant to bridge the significant gap in communication, information sharing and services referrals.

14. Training for all staff as described above should be provided annually about the different confidentiality laws that govern the roles of each, as well as updated information and training regarding the federal Crime Victims' Rights Act, and the DC Crime Victim Bill of Rights.
15. DCRCC's hotline should be improved upon to provide referrals to other organizations for both acute and longer-term services, including but not limited to the DC SANE hotline for acute care and advocacy, a clear description of the DC SANE Program and process and reporting options as approved and provided by the SART, mental health resources, and support groups and individuals counseling for adult survivors of childhood sexual abuse and others.
16. Mental health services should be funded and built out by the Office of Victim Services to establish a wider network of trauma-informed providers than currently exists, with a specific focus on increasing the capacity to serve adult survivors of childhood sexual abuse, the severely and persistently mentally ill, and marginalized populations who may be more reluctant to report sexual assault through more formalized processes.
17. Establish a functional sexual assault coalition for the District that includes all organizations whose primary mission explicitly includes serving sexual assault survivors and therefore the survivors those organizations serve. Any sexual assault coalition that is created or altered should contain a strong survivor advisory board or council, and contain survivor representation at all levels from the board of directors to staff and volunteers.
18. This coalition, however ultimately configured, should be entirely separate from any direct service provision for sexual assault survivors to facilitate transparency and avoid any apparent conflict of interest in funding and legislative advocacy efforts as well as overall philosophical orientation.

Each section of this report discusses any statutory requirements and related compliance, describes the current state of the issue and any findings, and then provides recommendations for improvement. The vocabulary used in this report is also worthy of note. While the term "survivor" is viewed by many as preferable to "victim" because it connotes empowerment, this report uses the terms interchangeably because the term "victim" is used in the DC Code and in accompanying policies and procedures.

## **I. Introduction**

The Sexual Assault Victim's Rights Amendment Act of 2013 (SAVRAA) requires the Independent Expert Consultant to formally evaluate the Sexual Assault Response Team (SART) with a particular focus on the new statutorily enacted case review process. The Sexual Assault Response Team (SART) and its case review process is inextricable from the SART's overarching goal of coordinating a victim-centered system of care for survivors of sexual assault in the District, particularly as it is defined by SAVRAA. Therefore, this evaluation necessarily included robust discussions of that system and includes findings and recommendations from those conversations with survivors, service providers, and other peripheral community stakeholders. These findings are particularly relevant given the lack of a unified, functional sexual assault coalition in the District for sexual assault services providers and survivors alike, and the SART's role as the current de facto coalition forum.

The information gathered about the continuum of services also bears discussing because the requirements of SAVRAA and the system of care it mandates represent a departure from the manner in which advocacy services were provided in the past. Therefore, illuminating those services as much as possible, i.e. what those services are, and who is being served, how and by whom, is necessary. Further, based on interviews and observations both with survivors and service providers, these changes have had consequences within the service provider community that need to be resolved to maintain and expand the high quality city-wide services envisioned by SAVRAA.

The methodology used to evaluate the SART, the case review process, and the system of care to then arrive at these recommendations included interviews with 26 survivors of sexual assault who utilized the services discussed, all service providers and SART members, as well as other community stakeholders such as multi-faceted social service organizations who make referrals to the sexual assault system of care in some way or have reason encounter the issue of sexual assault among their service population. All available aggregate data and specific documentation of services provided, policies and procedures manuals, handbooks and written complaints were reviewed and compared. The SAVRAA Independent Expert Consultant also attended four meetings of the full SART and three Case Review Meetings over the course of one year to observe discussions and information sharing, details and process of the case review itself, as well as group dynamics as a whole.

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“survivor” is viewed by many as preferable to “victim” because it connotes empowerment, this report uses the terms interchangeably because the term “victim” is used in the DC Code and in accompanying policies and procedures.

## II. **The SART Model**

The Sexual Assault Response Team (SART) model is a nationally recognized multidisciplinary approach to coordinating services for survivors of sexual assault that combines a victim-centered approach with the needs of the criminal justice system.<sup>1</sup> While there is often an inherent tension between being victim-centered and the less flexible requirements of the criminal justice system’s adversarial process for holding offenders accountable, the SART model seeks to overcome this gap through coordination and collaboration, and ultimately by keeping the needs of survivors at the center of its mission and actions.<sup>2</sup> SARTs are typically comprised of victim advocates, police, prosecutors, forensic nurse examiners, and forensic scientists who meet regularly to formalize processes, discuss issues that have arisen with particular cases, or and improve the system as a whole.<sup>3</sup> Successful SARTs promote honest feedback and member accountability and increase the system’s capacity as a whole. SARTs can also tackle broader systemic gaps and issues in acute service provision, reconcile issues regarding the prosecutability of criminal cases, as well as guide and contribute to general public education about sexual assault, consent and how and where to get respectful and effective assistance when needed.<sup>4</sup>

## III. **The District of Columbia Sexual Assault Response Team (SART)**

### A. **Statutory Requirements**

Although the District’s SART existed in some form prior to the Sexual Assault Victims’ Rights Amendment Act (SAVRAA) of 2013, the new law formally established the District of Columbia Sexual Assault Response Team (SART) as the coordinating body for the District’s coordinated response to sexual assault, and also clarified the system and standard of care required by the District for survivors. Specifically, SAVRAA established required membership,

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<sup>1</sup> National Sexual Violence Resource Center, *Sexual Assault Response Team Development: A Guide for Victim Service Providers*, 2011, page 1.

<sup>2</sup> Campbell, R and Raja, S (1999). *Secondary Victimization of Rape Victims: insights from Mental Health Professionals Who Treat Survivors of Violence*. *Violence and Victims*, Vol. 14, No 3, 1999 and 70 Patterson, D. and Campbell, R. (2010). *Why rape survivors participate in the criminal justice system*. *Journal of Community Psychology*, 38(2), 191-205.

<sup>3</sup> National Sexual Violence Resource Center, *Sexual Assault Response Team Development: A Guide for Victim Service Providers*, 2011, page 1.

<sup>4</sup> Campbell, R, Greeson, M, Bybee, D, and Watling Neal (2011). *Sexual Assault Response Team (SART) Implementation and Collaborative Process: What Works Best for the Criminal Justice System?* Pg. vii. <https://www.ncjrs.gov/pdffiles1/nij/grants/243829.pdf>.



staffing, meetings, and specific duties for the full SART as well as the SART Case Review Subcommittee.

Required members of the SART are as follows: the Director of the DC Office of Victim Service (OVS) or his or her designee; the SART Coordinator; the Chief of Police for the Metropolitan Police Department (MPD) or his or her designee provided that the designee is a member of the Sexual Assault Unit with the rank of Captain or above; a representative from MPD's Victim Services Unit; the United States Attorney for the District of Columbia (USAO) or his or her designee provided that the designee is an attorney assigned to the Sex Offense and Domestic Violence Unit; a representative from the USAO Victim Witness Assistance Unit; a representative from the US Park Police; the director or his or her designee of a private non-profit entity providing medical forensic care through the DCSANE Program provided that the designee is a forensic nurse; the director or his or her designee of a community-based advocacy organization providing services through the DC SANE Program; a representative selected by OVS from a community-based organization that is providing post-assault mental health services; the District's designated sexual assault coalition; the director of the Department of Forensic Sciences (DFS) or his or her designee provided that the designee is a qualified forensic scientist; the Chief Medical Examiner (OCME) or his or her designee; and a representative from a District area college or university.<sup>5</sup>

A SART Chair is required to be elected by a simple majority of the membership. That chair can only be from a non-profit member rather than from any of the government agency members. The SART is also mandated to meet at least 6 times per year after its initial meeting.<sup>6</sup>

As described in SAVRAA, the SART's functions are to improve the coordination and functioning of victim services, medical forensic care, investigations and prosecutions available to survivors of sexual assault; and to conduct regular case reviews of all parties involved in sexual assault responses including a review of sexual assault reports and investigations by MPD and cases reported to any member of the SART through the Case Review Subcommittee also established by SAVRAA.<sup>7</sup> As part of incorporating feedback from the Case Review Subcommittee, the SART was also required through SAVRAA to develop a protocol to ensure feedback and recommendations from the SART Case Review Subcommittee are incorporated

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<sup>5</sup> DC Code § 4-561.12(c).

<sup>6</sup> DC Code § 4-561.12(d) and § 4-561.12 (e).

<sup>7</sup> DC Code § 4-561.13.

into SART member agencies' policies and procedures, practices, training and decisions to re-examine investigations when applicable.<sup>8</sup>

**B. Current State and Findings**

*i. Statutory Compliance*

The current membership and attendance of the SART is statutorily compliant, with one required seat temporarily vacant. The SART members are: MPD's Chief of Police represented by the Captain of the Criminal Investigation Division that contains the Sexual Assault Unit (SAU); the Chief of the Sex Offense and Domestic Violence Unit at the United States Attorney's Office; the Executive Director of the DC Forensic Nurse Examiners (DCFNE) under the DC SANE Program; the Executive Director of the Network for Victim Recovery (NVRDC) representing the advocates under the DC SANE Program; the DC Rape Crisis Center (DCRCC) as the District's designated sexual assault coalition; the director or deputy director of the USAO Victim Witness Unit; the director of MPD's Victim Services Unit; the executive director of the Wendt Center for Loss and Healing as the OVS-designated community-based organization providing post-assault mental health services; the Chief Toxicologist for the Office of the Chief Medical Examiner; the Victim Witness Coordinator for the US Park Police; a representative from an area college or university (currently vacant); and the SART Coordinator provided by OVS.

Given its previous sometimes contentious history and the enormous changes the system of care has experienced in the last two years, the SART's functionality should be evaluated as a work in progress. The first necessary step in that progression is trust and relationship building among the SART members to solidify a more collegial culture, and the establishment of agreed upon internal governing processes. The second step involves clarifying roles and vocabulary among the members and uniform information sharing, leading to a third step of actual strategic planning to address broader systemic issues, differing perspectives, and gaps in services. These steps can certainly overlap, but it is important to lay a solid foundation so that the mission and vision can be clearly implemented over time regardless of the individuals at the table.

Overall, the SART is extremely well organized and is adhering to the duties assigned by SAVRAA. The SART is organized through a Memorandum of Agreement that outlines the mission and vision of the SART, as well as its guiding principles to enact that mission to which all members must agree and adhere. All SART members except for MPD's Chief of Police have signed the MOA, though changes in member leadership will require new signatures at the beginning of 2016.<sup>9</sup>

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<sup>8</sup> DC Code § 4-561.13.

<sup>9</sup> District of Columbia Sexual Assault Response Team Memorandum of Agreement, 2015.

The SART's mission statement is clear and encompasses the duties described by SAVRAA and listed above. That mission is: "to ensure consistent, sensitive services for adults who have been sexually assaulted; identify and remedy gaps in services; increase engagement in the criminal justice system; improve forensic evidence collection and processing of results; and improve investigations and the prosecutability of cases." The Sexual Assault Response Team Handbook, developed in the past year by the SART Chair and agreed to by the members, also details the SART's mission, vision and goals as well as operating processes and bylaws. The Handbook also contains a detailed DC SANE Program response protocol for all cases presenting to a hospital with or without a report to law enforcement, and for those that originate with law enforcement but also require a DC SANE Program response. At each meeting information is exchanged about aggregate data and member activities as a way to approach analyzing the efficacy of the system and adherence to the protocols described in the Handbook. Issues encountered with any portion of this response are addressed, as are more benign issues such as outreach opportunities or ongoing education and training. Other issues regarding accessibility, survivor satisfaction with services, and the perceptions or needs expressed by various groups and individuals are also discussed as they arise. The full SART meets at least bi-monthly and case review meetings are held bi-monthly alternating with full SART meetings.

*ii. Information Sharing*

Currently, an extremely high value is being placed on relationship building among SART members and, where possible, overcoming previous tensions exacerbated by the changes mandated by SAVRAA. As mentioned above, the SART appropriately shares aggregate data at each meeting through member updates. This information sharing is still in an early stage and requires increased transparency both of the definition of terms and what services were provided. Thus far, this data and the way it is presented are very confusing because it does not illustrate a continuous or connected system of care or speak to specific issues with a common vocabulary. For example, what population a member agency or organization is reporting on is not clear, and the services provided or referenced are not entirely clear. Therefore, when a member says they did 45 "intakes" in a particular month, what that intake functionally contains or to whom the services were provided is not clear to the group and therefore gaps in services are not yet clear. Some organizations and agencies also do not have staffing or time to gather this information in advance of every SART meeting. Important metrics that agencies do actually keep, such as response times to the hospital by advocates or whether warrants were approved or declined, are also being glossed over or not provided at all because agencies are providing general statistics rather than those that would speak to a particular more pointed issue.

Improving prosecutability and survivors' experiences of the response itself requires defining terms and outcome measures very clearly and being thorough about what is reported.

#### *Information Sharing Recommendations*

1. Implement the Step-by-Step Practitioner Toolkit for Evaluating the Work of Sexual Assault Nurse Examiner (SANE) Programs in the Criminal Justice System written by Megan R. Greeson, Rebecca Campbell and Shannon Kobes<sup>10</sup>. This toolkit is disseminated by the National Institutes of Justice to establish clear and mutually agreed upon measurable outcomes for the SART. The toolkit provides a standard process for determining the data the SART will track, and will also provide a neutral structure that everyone can adhere to rather than having to agree with one member or another in determining process or methodology. The SART Case Review Subcommittee has agreed to implement the toolkit, and it should begin immediately.
2. Establish a method of information entry for members using the SART website portal so that complete statistical information is provided in a way that can be recorded and disseminated prior to SART meetings. Entering data in this manner increases members' ability to participate fully in the Toolkit and allows for considered discussion at SART meetings. The SART has developed its own website and is creating a method by which members can enter data into the website prior to meetings. This method of data entry will allow any metrics that are decided upon via the toolkit to be reported as a normal part of SART participation, and a report can be provided at each meeting to facilitate deeper discussion of that data rather than the oral report that is provided currently and reflected in the meeting minutes later.
3. Amend the SART Handbook to reflect the statistics that are to be entered by each member and any definitions needed to ensure a common vocabulary among SART members.
4. A distinction should be made in all reporting between number of survivor contacts and unduplicated individual survivors served within any given time period so that the SART, and ultimately the District, can determine how many people the system is serving and what they are choosing to access, and what they are receiving as a result.

#### *iii. Campus Sexual Assault Representation on the SART*

The designated representative for an area college or university is now open and the SART is actively seeking a replacement, which provides an opportunity for a structural change. It is notable that of 450 survivors seeking services at the DC SANE Program in 2015, 23% (102) were college or university students at the time of the assault.<sup>11</sup> The current SART structure and expectation for this representation is lacking. Interviews with college and university students and their advocates indicated a huge variety of understanding levels and, in two instances, outright

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<sup>10</sup> Greeson, M, Campbell, R and Kobes, S (2008). Step-by-Step Practitioner Toolkit for Evaluating the Work of Sexual Assault Nurse Examiner (SANE) Programs in the Criminal Justice System. <https://www.ncjrs.gov/pdffiles1/nij/grants/240917.pdf>.

<sup>11</sup> DC SANE Program Annual Report, 2015, pg. 12. While the single largest category of colleges and universities where these students are enrolled is listed as "other," meaning that they are not from one of the eight District-area colleges and universities but were students visiting the District for a variety of reasons, students from George Washington (17), American (15), Howard (10), Georgetown (10), Catholic (5), Gallaudet (4), UDC (4), and from other universities outside the DC area (36) received services through the DC SANE Program in 2015.

misinformation received about the DC SANE Program. Similarly, there are vast differences in how each campus responds to sexual assault for various reasons, some of them cultural. The District is also in an unusual position compared to other jurisdictions due to the sheer number of colleges and universities in the city in addition to the large number of students that travel to the District both for entertainment, vacation and educational purposes. These factors may inflate the percentage of the total reported cases that are reported by college students, but they also speak to the urgent need for coordination and transparency in the efforts surrounding sexual assault on college campuses and how they interact with the SART system of services.

Additionally, the DC Coalition Against Domestic Violence coordinates the University Leadership Initiative (ULI), which is a forum for monthly campus advocates to meet and discuss issues related to sexual assault, dating violence and stalking on campus, and quarterly meets with university presidents to discuss policies and reporting of crime statistics. The DC Rape Crisis Center participates in the ULI as an advisor, but little is brought back to the SART. The other direct service providers on the SART are also not privy to the ULI, though the advocates meeting to discuss issues are necessarily interacting with the DC SANE Program at a minimum by referring students. These loops of information and coordination can be chaotic and contradictory based on campus representatives various perceptions and understandings of the SANE process.

#### *Campus Sexual Assault Representation Recommendations*

1. Area colleges and universities should be represented by one representative on the SART as is currently the case. However, that representative should be the explicit link between the University Leadership Initiative and any other advocacy groups or regular forums for campus advocates rather than just representing their institution.
2. MPD should also report to the SART about its monthly meetings with campus departments of public safety attended by the supervising sergeant of the Sexual Assault Unit, and convey any needs or concerns expressed by that group regarding sexual assault investigations on campus.
3. Alternatively, a campus public safety representative should be directly added to the SART's membership to speak to this separate need and function on college campuses. That public safety representative would have to coordinate with his or her peers on other campuses to ensure they're speaking to issues more broadly than those on their own campus.

*iv. Staffing*

Dr. Heather DeVore, Executive Director of DCFNE and Medical Director of the DC SANE Program, was elected Chair of the SART in 2014 and is serving the first of two possible three-year terms under the bylaws of the SART.<sup>12</sup> As Chair, Dr. DeVore guides meetings, sets the agenda, and ensures that member organizations and agencies follow the bylaws and other agreed upon regulations. She also selects the cases to be reviewed in case reviews. The Office of Victim Services also provides a SART Coordinator as required by SAVRAA. The SART Coordinator attends SART and Case Review Subcommittee meetings and provides logistical support including keeping SART records and minutes, as well as speaking for the Director of the Office of Victim Services on the SART when needed. While the SART Chair and the SART Coordinator make every attempt to provide what is currently needed and do an excellent job, the SART is not their full time job by any means.<sup>13</sup>

This capacity limitation has a large impact on how the SART functions. For example, case review names are provided sometimes the day before case review meetings, and statistics and other required research for meeting discussion is almost impossible to provide in a timely way. The requirements of the SART both through SAVRAA and as proposed in the SAVRAA Task Force Recommendations which include a robust complaint process located within the SART as well as added reporting requirements and coordination with other systems such as the Multidisciplinary Team which serves minor survivors of sexual assault, and increased opportunities for public outreach and education will require a full time staff person for the SART. OVS is appropriately statutorily responsible for providing a coordinator and for participating in the SART, but some members have expressed concerns about regarding the *potential* ramifications of OVS' dual role as a funder, as well as concerns about the potential for ongoing changes as the office has recently experienced two leadership changes in a short period of time.

Similarly, the work surrounding sexual assault policy and monitoring within the victim services community has been appropriately assigned to the Office of Victim Services. This workload is significant and will continue to increase. This includes working with colleges and universities to address campus sexual assault, requests for additional program development and funding related to sexual assault, tracking and updating the ASK and UASK apps recently

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<sup>12</sup> District of Columbia Sexual Assault Response Team Handbook 2015, page 8.

<sup>13</sup> Dr. Heather DeVore is physician at Washington Hospital Center's Emergency Department working the night shift three nights a week, and is the unpaid Executive Director of the DC Forensic Nurse Examiners (DCFNE). Kelley Dillon, the current SART Coordinator, is a grant manager to OVS who has a full assignment of grantees to oversee in addition to the SART and the SAVRAA Task Force.

re-launched by OVS, and most significantly, partially managing the DC SANE Program.

#### *Staffing Recommendations*

1. OVS should provide funding for a full time staff person for the SART. This individual should have higher-level knowledge of sexual assault services and answer to the SART as a whole through the SART Chair, rather than as an employee of the Office of Victim Services. Insulating this position in this way, as a nonprofit or for-profit contractor using a fiscal sponsorship model, answering to the SART itself preserves the SART's sustainability insofar as funding for this position allows.
2. An FTE for an additional staff person at OVS should be provided and fully funded to work with the SART, continue to work with any aspect of the DC SANE Program, both of which OVS is also statutorily responsible, and to continue to manage ongoing work with all area colleges and universities, as well as the ASK and UASK Apps that OVS has so successfully developed and launched. This person would also be OVS' designee on the SART representing the office's director.

#### *v. Outreach and Education*

One of the SART's explicit goals is to engage in outreach and education to encourage reporting and help seeking by the affected public and to increase public awareness of sexual assault generally. These outreach goals and activities are detailed on page 28 of the SART Handbook and are extremely detailed, appropriate and clear. However, conducting outreach for services prior to ensuring that all SART members are willing and able to represent the actual continuum of services accurately and clearly may create a situation where survivors receive conflicting information. Based on complaints about incorrect referrals and misconceptions, as well as incorrect information provided to certain populations such as sex workers and advocates working with college students about how the DCSANE Program works, reporting requirements to law enforcement, and accessibility issues for survivors with disabilities and those with limited English proficiency, the SART's outreach and training process should include adhering to the following recommendations.

#### *Outreach and Education Recommendations*

1. The SART should undertake either an annual retreat or other organized member cross training that occurs *at the staff level* annually to ensure that each member is fully acquainted with the services provided by their partners, how to utilize the DCSANE Program, reporting requirements and limits to confidentiality, accessibility issues, and how to refer survivors to other providers in the system. Staff level cross training also increases relationship building across sectors, which benefits the survivors receiving those services.
2. A public SART presentation should be agreed upon by the entire group to describe access points, the DC SANE Process and the law enforcement reporting process including the option of converting a non-report case later into a report to law enforcement. Education about sexual assault and consent generally can be included in this presentation to address misconceptions about what is and is not considered sexual assault or abuse. This

presentation and locating opportunities for providing it should be a priority to mitigate existing misperceptions, particularly given the changes brought by SAVRAA.

3. Create boilerplate referral instructions agreed upon by the SART for receiving help with any sexual assault issue with an explanation of available services to distribute to the general public. This language or small presentation can also provide to organizations that may serve sexual assault survivors as part of their service population, and the SART can encourage them to include this information in their public outreach and education presentations or on their websites. This information can then be tailored to specific populations that an organization serves.

Additional recommendations for the full SART are included in the section entitled "Additional Issues: Gaps in Services and the Role of the SART" beginning on page 16.

#### **IV. The SART Case Review Subcommittee**

Much like the larger SART, SAVRAA also established statutory requirements for the Case Review Subcommittee including membership, meeting frequency, and duties. Specifically, SAVRAA requires that Case Review Subcommittee consist of the following: the director or his or her designee of a private non-profit entity providing medical forensic care through the DCSANE Program provided that the designee is a forensic nurse (currently the DC Forensic Nurse Examiners, DCFNE); the director or his or her designee of a community-based advocacy organization providing services through the DC SANE Program (currently the Network for Victim Recovery of DC, NVRDC); a representative selected by OVS from a community-based organization that is providing post-assault mental health services; the SART Coordinator; the Commander of MPD's Sexual Assault Unit or his or her designee provided that person is at a level of Captain or above; the director of DFS or his or her designee provided that person is a qualified forensic scientist.<sup>14</sup>

The subcommittee is statutorily charged with reviewing cases randomly selected from investigations involving sexual assault, specific cases as requested by members of the SART or the Case Review Subcommittee, and as requested by the Independent Expert Consultant.<sup>15</sup> To perform these reviews, the subcommittee was also required develop a protocol including a standard review form and adequate protections for survivor confidentiality under federal and District law. Further, the Subcommittee has to examine at a minimum whether each agency and service provider involved in the response followed current best practices for each case reviewed, including but not limited to whether police waited at least 48 hours before conducting a follow up interview, whether the victim's request for information about toxicology and/or DNA results was accommodated as required under SAVRAA, any prosecutorial actions taken, and

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<sup>14</sup> D.C. Code § 4-561.14(b) (2015)

<sup>15</sup> D.C. Code § 4-561.14(c) (2015)



whether evidence testing complied with timing requirements of SAVRAA. The Subcommittee is also expected to track and discuss the use of forensic evidence in the investigation and prosecution of the case. The subcommittee is then required to submit any feedback or recommendations to the larger SART for their consideration and action when concerns or problems are identified.<sup>16</sup>

#### **A. Findings**

The Independent Expert Consultant observed four case review meetings from December 2014 until October 2015, and was able to determine that the Case Review Subcommittee is statutorily compliant and that the process, while a work in progress, is occurring as intended. The Case Review Subcommittee membership is compliant with SAVRAA and comprised of the following: the executive directors of NVRDC and DCFNE representing the DC SANE Program advocates and forensic nurses respectively; the Commander of the Criminal Investigation Division and thus also the Sexual Assault Unit at MPD; the Division Chief of the USAO's Sexual Offenses and Domestic Violence Unit; and the Executive Director of the Wendt Center for Loss and Healing. An addition has also been made to the core group of Subcommittee members. At the last SART meeting, the Director of the Toxicology Unit at OCME was also invited to participate on the Case Review Subcommittee and will be attending beginning in December 2015.

The only discrepancy in membership that currently exists is that of the Department of Forensic Sciences (DFS). DFS' General Counsel had been attending Case Review meetings as DFS' Interim Director and continued to do so during DFS' recent reorganization. Although he was extremely helpful, informed and engaged, either the current Director of DFS or a qualified forensic scientist should be present. As DFS Forensic Biology Unit returns to full functionality, this problem will likely be remedied quickly.

Policies and forms have been created which adequately protect survivor confidentiality and the Subcommittee is following those policies routinely. Case review participants sign a confidentiality form at the beginning of each meeting indicating that no case specific information will leave the room or be communicated beyond the case review in any way. The SART Coordinator keeps a copy on file with participants' signatures for each case review meeting. A time-limited informed consent and release of information form explaining the SART and the case review process is offered to each patient to sign as part of the intake forms for the DC SANE Program. The survivor can then consent to their case information being released to the Subcommittee and sign the form, or simply not sign the form to opt out. Survivors may also opt

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<sup>16</sup> D.C. Code § 4-561.14(d) (2015).

out after signing the form at any point, orally or in writing, by contacting their advocate at NVRDC or the follow up nurse at DCFNE and requesting to change their form. The survivor chooses the time limitation for the release of information as well, which is consistent with best practices nationally and the requirements of the Violence Against Women Act.<sup>17</sup>

As of its October 2015 meeting, the SART has reviewed 23 cases randomly chosen by the SART Chair from among the cases that originated in the DC SANE Program and were reported to police. Case review is conducted based on a detailed list of questions tailored to each member agency's function in the process. The case review questions provide information about each of the survivor's rights provided by SAVRAA as well as tracking forensic evidence processing times, and asks detailed questions about what was helpful and what may have gone wrong within the process for each agency. The SART Chair maintains a spreadsheet of reviewed cases and the information provided about each so that aggregate data can be reported as required of the SART's annual report to the DC City Council, and so that patterns can be seen in the cases reviewed and action recommended. The spreadsheet also allows the Subcommittee to follow up on cases previously reviewed to accommodate the fact that cases are in fact constantly progressing and changing as time goes on, and to also allow tracking of noted issues retroactively.

In spite of being a work in progress making continual adjustments, the Subcommittee is working extremely well, and has already begun to systematically address patterns apparent in the cases reviewed thus far. One issue that became extremely clear to the Case Review Subcommittee is the prevalence of survivors presenting with severe and persistent mental illnesses. Although the obvious response would be to simply refer these survivors back to their community service agency for help with their mental health concerns, this solution did not address what the group identified as a real and immediate need at the hospital on a 24-hour basis for more crisis intervention level mental health care. Upon identifying this need from among the pool of cases at that time, the subcommittee agreed to track the issue for another two months and reported back to the full SART. As a result, a subcommittee of the SART has

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<sup>17</sup> Section 3 of the U.S. Violence Against Women and Department of Justice Reauthorization Act of 2005 (VAWA 2005) provides, in relevant part: (A) IN GENERAL. In order to ensure the safety of adult, youth, and child victims of domestic violence, dating violence, sexual assault, or stalking, and their families, grantees and subgrantees under this title shall protect the confidentiality and privacy of persons receiving services. (B) NONDISCLOSURE.—Subject to subparagraphs (C) and (D), grantees and subgrantees shall not (i) disclose any personally identifying information or individual information collected in connection with services requested, utilized, or denied through grantees' and subgrantees' programs; or (ii) reveal individual client information without the informed, written, reasonably time-limited consent of the person (or in the case of an unemancipated minor, the minor and the parent or guardian or in the case of persons with disabilities, the guardian) about whom information is sought, whether for this program or any other Federal, State, tribal, or territorial grant program, except that consent for release may not be given by the abuser of the minor, person with disabilities, or the abuser of the other parent of the minor.

been formed to address this issue and partner with the DC Behavioral Health Association, a group that has devoted two members to pursuing a solution with the SART for this vulnerable subpopulation of clients. This would not have been possible without a systematic case review and is an example of how this process should proceed.

The Subcommittee also correctly identified the extreme delays in forensic results from DFS, albeit in a less direct manner. Unlike the mental health issue, this issue was harder to pinpoint and identify due to lack of initial focus on the timeline for specific cases as well as a lack of information about those cases from DFS as a representative was rarely sent to case review. Another factor in this conversation may have also been the fact that it is a strict accountability point with a SART partner, making it awkward to address directly in an environment currently focused on relationship-building. In fact, when questions were asked in a case review meeting, the Independent Expert Consultant had to pointedly state that the Subcommittee's perceptions of delayed results were verifiable and not merely a result of missing information in spite of the fact that some at the table clearly knew the extent of the problem. While this may be an advantage of temporarily having an Independent Expert Consultant to state uncomfortable facts directly without fear of damaging a relationship, the use of clear data points and a review of the aggregate information on a regular basis by the Case Review Subcommittee will remove this sort of relationship based conflict because the group will already have agreed on the information shared and what it may reveal about any one of them at any given time. That kind of data sharing is a second phase of the development of this group and not a failing thus far, and the group has done well with the first necessary step of creating a collegial and therefore functional environment. It is also worth noting that the Subcommittee members are explicitly people from the agencies and organizations who do not directly handle cases themselves to reduce any defensiveness that may otherwise create.

As described above, cases to be reviewed are chosen from those that go directly through the DC SANE or SART process, from a forensic exam with an advocate assigned and present with a police report that may or may not result in a warrant and prosecution. They may also have been referred for counseling at the Wendt Center for Loss and Healing. This means that all of the Case Review Subcommittee partners are engaged in the discussion, and therefore creates an easier starting point for the Subcommittee. However, restricting case review to this particular pool of cases leaves out approximately 60% of cases reported to MPD<sup>18</sup> as well as 31% of those served by the DC SANE Program who do not make a report to law enforcement.

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<sup>18</sup>Metropolitan Police Department, Sexual Assault Unit, 2014.

For example, MPD received 1102 reports of sexual assault in 2014, and the DC SANE Program provided care for 415 survivors in 2014, of which 283 (68%) made a report to MPD.<sup>19</sup> This means that in 2014, out of 1102 cases reported to police, the Case Review Subcommittee would only be choosing cases from a pool of 283, all of whom had a forensic exam, the benefit of an advocate, and were at least comfortable enough with law enforcement to report. There is a great deal we can learn from those who choose not to report to law enforcement and from cases in which a forensic exam or hospital response was either deliberately refused or not appropriate due to the nature of the assault.

Similarly, the Case Review Subcommittee is also lacking the perspective of those who chose not to engage the system that has been set up even if their assault was acute enough to trigger that response.<sup>20</sup> Individuals who do not engage any formal assistance other than counseling or perhaps a church or community group after an assault may be more marginalized than those who do seek help, or they may have inaccurate ideas or have actively been given incorrect information about resources and reporting. Often conversations about highly marginalized groups and those who may refuse the more formal part of the system of care are framed as a report to the SART without adequate detail as to how this problem arose or even presented itself and without constructive solutions thus leaving the SART with little way to actually address the source of the barrier or the misinformation being provided.

The pool of case review eligible cases have been chosen thus far based on those for which a release of information is possible for the entire group. For non-report cases served by the DC SANE Program, law enforcement and prosecution should not know their identity or the details of their assault by virtue of the survivor's initial decision not to report to police. Similarly, cases only reported to MPD could not be shared with the rest of the group. Cases that were reported to no one but a hotline or a mental health professional would face the same confidentiality barriers. There may be ways around these hurdles both by using de-identified survivors' cases to review where this is a concern, and by implementing a broader informed consent and release of information process for the SART. However, to change this focus the SART will have to explicitly determine whether its mission is limited to those cases that availed themselves of the hospital response and engaged law enforcement, or if the group sees itself as actively working on the entire system of care for survivors of sexual assault regardless of what part of the system they engaged.

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<sup>19</sup> DCSANE Annual Report, 2014, pages 2-3.

<sup>20</sup> Acute cases are those that have occurred within the previous 96 hours making a forensic exam appropriate, and triggering crisis intervention level response. It is not intended to indicate that other assaults are less traumatizing or less in need of a response.

While the process and case review questions are extremely helpful and case reviews are occurring regularly and with the full intention of the group to engage in the process, the process itself remains relatively perfunctory, sometimes leaving out key pieces due to the absence of one or more parties such as the Department of Forensic Science. This surface-level discussion is less a shortcoming than it is the result of an evolving process that the Subcommittee is now learning as well as the resources currently available to the group. The primary reason the discussion is not as in-depth as it should be or could be is the fact that cases are distributed a day or two before the meeting, and participants are too busy with the rest of their respective jobs to do in-depth case research at the last minute. This lack of preparation is understandable given that the SART is something conducted as an addition to the Chair and to the SART Coordinator's full time jobs, and can be remedied by the staffing recommendations for the full SART. The recommendations below specifically address these issues.

## **B. Recommendations**

1. Cases to be reviewed bi-monthly should be provided to case review participants two weeks in advance of each Case Review Subcommittee meeting to allow participating organizations and agencies time to research the cases and arrive prepared to have a deeper discussion. Ultimately a full-time SART Coordinator should be hired as described in the recommendation on page 8, and this would be one of the duties assigned to that staff person.
2. A recommendations log should be maintained as part of case review and presented to the larger SART at each meeting. The log should capture recommendations such as the need to follow up on a particular data point, or to educate the community in a particular way so that problems with referrals are resolved, develop strategies to help a particular population, or to simply document a particular issue to facilitate program development and advocacy efforts in the future. This will help the Subcommittee ensure that they are following up on each issue and communicating that to the full SART.
3. MPD and/or the USAO should present cases that did not entail a SANE Program response to allow the group to identify resources to help those who did not need or wish to engage a hospital-based response. These cases can be made anonymous because those survivors did not sign the SART release of information for case review. Alternatively, MPD or the USAO could obtain that release as part of their initial meeting with a survivor. This pool of cases in particular may help identify access issues, including misinformation among the general public and on college campuses, for the DCSANE Program to tailor program development and outreach efforts.
4. Non-report cases, i.e. those for which no police involvement was requested but the DCSANE Program was engaged in some way and an evidence kit was collected, should also be presented and reviewed at case review meetings to identify resource gaps for this population, any myths or real access issues related to law enforcement reporting, should they exist, as well as mistakes made by MedStar that result in law enforcement responding to cases in which the survivor has already indicated that they do not want police involvement.

5. Anecdotal information should be provided by mental health service providers and other long-term service providers about survivors they serve who did not engage the DC SANE Program or report to law enforcement at all. This information from other service providers on an anonymous but case-specific basis, rather than as a report about a population as a whole in general terms, will help SART members identify any barriers to services experienced by survivors in underserved or marginalized populations as well as any misconceptions about the reporting process.
6. When cases are chosen that involve college or university students, advocates and department of public safety officials and/or Title IX coordinators from that university should be invited as guests for that particular case's discussion to the case review to provide crucial information about the interaction between the campus response and the District-level response.
7. A representative from OCME's toxicology unit should be assigned to participate in case review and a series of relevant case review questions should be devised for OCME's report to the group on each case.
8. Case review questions should be followed more closely during each case review, and amended as follows:
  - a. MedStar's dispatch response should be routinely included in case review reports. Specifically, the case review should ask and track any problems that occurred in the dispatch of a nurse, detective or an advocate through MedStar.
  - b. The NVRDC advocate should report specifically about language access issues. While they do report on this as needed, it should be specifically reflected in the questions so that this continues regardless of NVRDC's Subcommittee representation.
  - c. NVRDC should report whether an advocate accompanied the survivor for the law enforcement interview, and if not, whether the survivor declined an advocate in the interview with them.
  - d. MPD should report the reason that an advocate was not present for the law enforcement interview, i.e. what exigent circumstances, survivor request, etc., existed from their perspective which prevented them from conducting the interview with the advocate present. Pursuant to a legislative and policy change, for any survivors who opted out of the advocacy process, MPD should provide verification of the required signed form.
  - e. DCFNE should report on the total time the patient was at the hospital rather than only reporting on any significant delays, which is an extremely subjective measure.
  - f. The US Attorney's Office should report on whether a grand jury was convened and if the grand jury was polled for a decision, or if the Assistant US Attorney declined to request an indictment.
  - g. Whether the survivor started their request for assistance at a hospital other than MedStar Washington Hospital Center and were then transported or referred to WHC for a forensic exam, and which hospital that was and if there were any logistical issues reported.

## **V. Additional Issues: Gaps in Services and the Role of the SART**

The newly formalized system of care described by SAVRAA necessarily focuses on the DC SANE Program as it relates to the right to an advocate during a medical examination and/or a law enforcement interview. However, because the SART is currently serving as the de facto coalition for the District, and because its membership contains far more members than just those involved in the acute hospital response, the system of care itself became a topic of discussion in interviews for this evaluation, regardless of whether that information was explicitly requested. The information provided illuminated a system still in need of dialogue, but one that was becoming highly organized and effective in terms of providing acute services and referrals to longer-term care. Gaps in services also became clear as survivors and service providers asked questions and shared complaints about existing services. Specific problem areas exist around role confusion within the current system, ongoing pressure to change the current DC SANE Program response beyond its existing model and capacity and/or back to the pre-SAVRAA model, lack of transparency and inclusivity in official sexual assault coalition activities, distinct gaps in services, as well as outreach and messaging discrepancies. In some instances these conflicts have prevented appropriate referrals and progress for survivors that have been reported as complaints to the Independent Expert Consultant.

A note about this section of the report is warranted. The District is a very small community in many ways, and therefore the discussion of and recommendations to remedy these issues will maintain the confidentiality of the interview sources where at all possible, though maintaining that confidentiality may require vagueness or assertion of fact without explicit attribution more often than is normally advisable. Further, while there are many parts of any continuum of services, organizations, and issues within it, the issues discussed in this report are limited to those that have a direct impact on victim services and therefore on how survivors understand and experience the options available to them.

### **A. The DC SANE Program**

Under SAVRAA, the DC SANE Program is comprised of the DC Forensic Nurses Examiners (DCFNE), and the Network for Victim Recovery of DC (NVRDC) to provide a forensic nurse examiner and a victim advocate to support survivors seeking medical and forensic care up to 96 hours after an assault.<sup>21</sup> If police involvement is desired by the survivor, law enforcement will be notified by MedStar's dispatch service as well and meet the survivor, the forensic nurse, and the

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<sup>21</sup> Ninety-six hours, or four days, is the maximum time after an assault that forensic evidence can reliably be gathered.

advocate at Washington Hospital Center. Sexual Assault Unit Detectives also may transport a survivor from a crime scene to the hospital for an exam and to meet with an advocate as well. Forensic exams are performed almost exclusively at MedStar Washington Hospital Center. NVRDC Advocates respond to the hospital 24-hours a day, 7 days a week to work with survivors to provide information about their legal options, emotional support, and social services referrals as well as ongoing case management and advocacy for the duration of their case regardless of its legal outcome or status. Survivors also have the legal right to have an advocate present during the medical forensic exam and any interviews with law enforcement at any point in the process. The DC SANE Program also provides a 24-hour call center for survivors to speak with an on-call victim advocate and obtain information and transportation to MedStar Washington Hospital Center for purposes of obtaining a medical forensic examination and can also link survivors to a forensic nurse to answer medically-related questions.

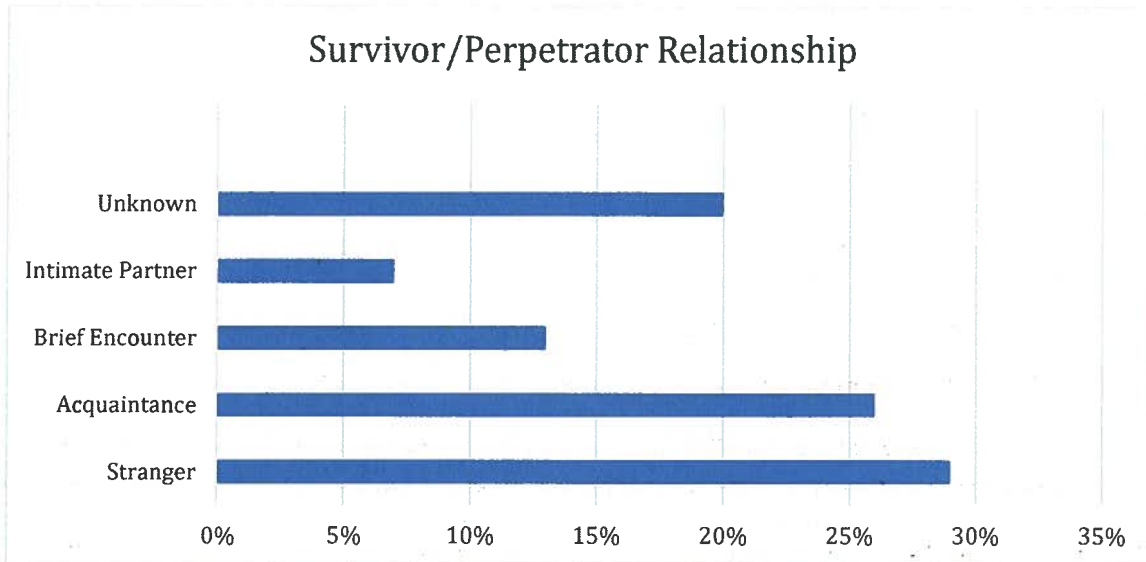
In Fiscal Year 2015, the DC SANE Program conducted medical forensic exams and provided advocacy services for 450 cases, an 8% increase in the number of examinations conducted in 2014 and a 19% increase in the average number of cases presenting over the previous five years.<sup>22</sup> Of those 450 cases, 274 (61%) were reported to law enforcement and 174 (39%) were non-reports.<sup>23</sup> In both report and non-report cases, toxicology specimens are tested for potential drug facilitated sexual assault by the Office of the Chief Medical Examiner. Results for non-report cases are provided to DCFNE to convey to the survivor as with any other medical test result. In cases reported to law enforcement, those results become part of the evidence in the case, and under SAVRAA, the survivor has a right to know the results upon request as well.<sup>24</sup> NVRDC provided 265 safe rides for survivors to MedStar Washington Hospital Center and to a safe location after their exam through a contract with Uber in FY15.

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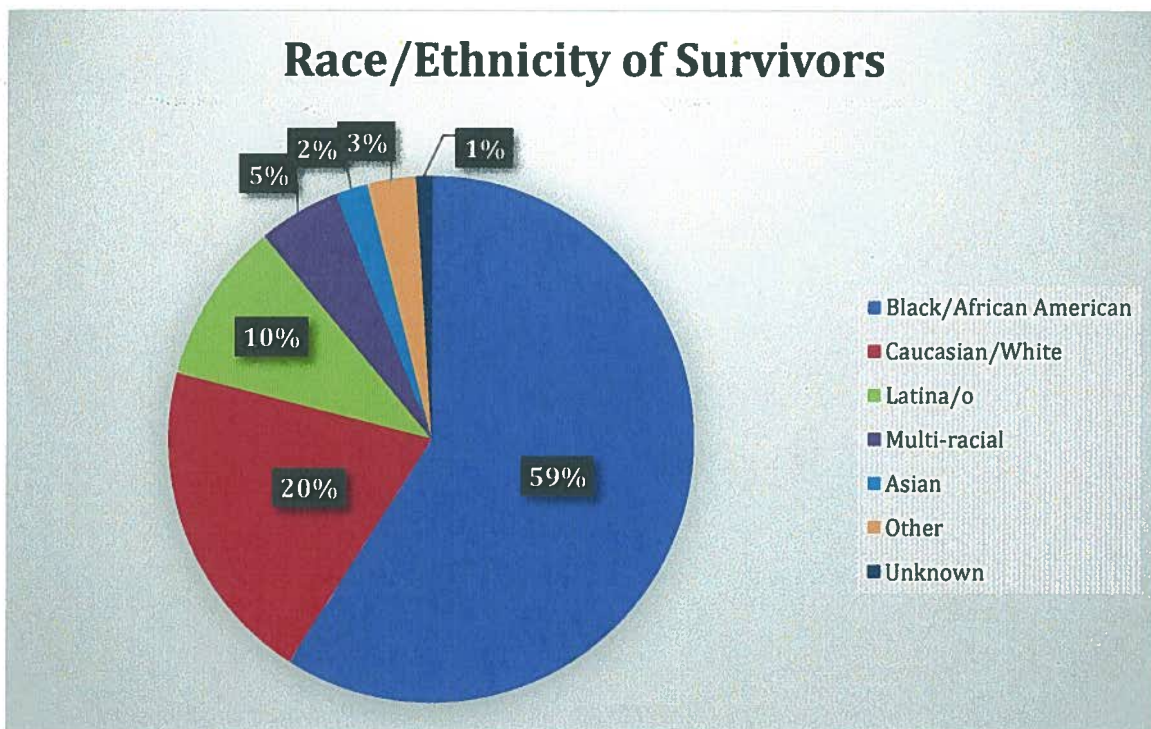
<sup>22</sup> DC SANE Program Annual Report 2015, pages 1-2.

<sup>23</sup> Non-reports means that the Physical Evidence Recovery Kit (PERK) is stored by DCFNE for one year and then destroyed by MedStar Washington Hospital Center as biological waste unless the survivor wishes to make a report to law enforcement during that time.





In FY15, the self-identified gender of patients entering the DC SANE Program was 91% female, 8% male and 1% transgender (male to female). The relationship between the survivor and the perpetrator of the assault was as follows: stranger (29%), acquaintance (26%), brief encounter (13%), intimate partner (7%), and unknown (20%).



The self-identified race and ethnicity of DC SANE Program clients are: African-American (59%), Caucasian/white (20%), Latina/o (10%), Multi-racial (5%), Asian (2%), Other (3%), and

unknown (1%). The interpreter bank was utilized for foreign language interpretation services for 13 survivors with limited English proficiency: Spanish (7); American Sign Language (3); and Amharic (3).

*i. Growth and Expansion of DC SANE and Community-Based Advocacy Services*

The process for obtaining a SANE exam and advocacy services requires that the survivor be willing to go to MedStar Washington Hospital Center either themselves, or brought in by the police or ambulance, or via transportation provided by NVRDC, usually an Uber driver. The DC SANE Program forensic nurse and the advocate will respond to other area hospitals only if the patient is not medically or psychologically stable enough to be transported to MedStar. In FY2015, of the 450 cases, the DC SANE Program responded to the following area hospitals other than MedStar Washington Hospital Center: Providence Hospital (2), Georgetown University Medical Center (2), United Medical Center (1), Howard University Hospital (1), and George Washington University Hospital (3) for a total of nine mobile responses.

Inquiries have been made repeatedly as to why there are not more mobile responses. This inquiry has been made specifically in reference to historically underserved populations who may not feel welcome or comfortable at MedStar for any reason, as well as college students who may not want to venture too far from their zone of familiarity on campus. Similarly, inquiries have been made from advocates at Howard University and George Washington University as to why their respective universities do not have their own SANE Programs as they have their own hospitals. DCFNE and NVRDC met with George Washington University advocates to discuss this issue and OVS, DCFNE and NVRDC met in 2014 with Howard University advocates as well, but these issues have not necessarily been resolved and similar requests continue.

Another area of expansion requested is for the advocacy response to become more mobile and respond to cases where a report has been made to law enforcement but no hospital response was required. In 2014, MPD received 1102 reports of sexual assault and approximately one third of those survivors also had a SANE exam and therefore received advocacy services from NVRDC. The SAVRAA Task Force has undertaken this question as part of one of its statutorily assigned inquiries into whether there is a need for additional advocates and under what qualifications and circumstances should those be provided. To determine the need for additional advocates, the Task Force has recommended that NVRDC and MPD gather data for one year regarding the survivors presenting outside of the DC SANE Program response. Once this needs assessment is complete, a more targeted and effective

response program can be created to provide credentialed community-based advocates for survivors reporting to police without contact with the hospital response.

Logistical issues have also been reported regarding MedStar's dispatch system. Detectives have been dispatched to respond to the hospital for survivors who have already stated they do not wish to report to law enforcement. Additionally, MedStar sometimes gets information about survivors wrong, or provides the wrong name to the responding nurse or advocate. None of these errors are due to the DC SANE Program or MPD, but rather are located with MedStar. Similarly, area hospitals receive training to refer survivors presenting at their emergency departments to MedStar Washington Hospital Center, but this is not without delay or occasional error, and can be vastly different depending on the hospital.

The pressures on the program to grow beyond its current capacity are many, and speak well to the quality of and need for the services provided. Rather than responding to these concerns repeatedly or individually, which takes time away from providing needed services, the DC SANE Program and the SART should address these issues systematically with needs assessments to document the issues and then issue a strategic plan. This plan will help with obtaining sustainable and diversified funding as well.

### **Recommendations**

1. Area hospitals should receive clear instructions and regular training from the DCSANE Program to ensure that survivors presenting at hospitals other than MedStar Washington Hospital Center receive a swift and clear response.
2. MedStar should receive clear instructions and regular training from the DCSANE Program to address problems with the dispatch process. Any such problems should be documented and presented at each SART meeting as well as any case-specific information presented at case review meetings. This compiled information should be used for both training purposes and to ensure accountability to the Office of Victim Services for MedStar's annual funding.
3. The needs assessment recommended by the SAVRAA Task Force to assess the specific need for community-based advocacy for survivors who do not engage the DCSANE Program is a sound recommendation and should be implemented as soon as possible so that this population of survivors receives equal access to resources as ultimately found and directed by the upcoming needs assessment.
4. A needs assessment should also be conducted by the DCSANE Program and the Independent Expert Consultant to determine the need for a more mobile advocacy response, SANE nurse response, or both in response to patients who present at other area hospital locations and would prefer to remain at those locations for care.
5. The DC SANE Program should undertake a three year strategic plan for expansion to determine whether a more mobile model, a 24-hour presence at one hospital, or a combination of the two can be integrated with a broader non-hospital case response over a period of time.

*ii. Role Confusion*

The current services provided by NVRDC advocates and those provided by MPD's Victim Services Unit and the USAO's Victim Witness Unit suffer from significant role confusion with one another, something that is currently creating confusion for survivors who may have more than four or five individuals attempting to interact with them and providing differing pieces of information, while other survivors have no support at all based on how they entered the system. The distinctions in services provided by each are very real and clear, though a survivor can get some of the same resources and referrals from any of the three as they move through the legal process. NVRDC is a community based organization that has a confidential relationship with each survivor they serve, almost exactly like that of an attorney with their client.<sup>25</sup> They also provide advocacy services using a model of vertical advocacy, meaning that once the NVRDC advocate begins working with a survivor, they work with that person throughout all of their expressed needs from the beginning to the end of a criminal case and well beyond that point if the survivor so desires. Even if a criminal case is dropped early on, advocacy can continue indefinitely as needed.

System-based victim services, i.e. those coordinators and victim services personnel employed within the criminal justice system by either law enforcement or prosecutors provide extremely valuable support, some of which cannot be duplicated by non-system actors, but under different terms. MPD's Victim Services Unit provides support in terms of crisis intervention, referrals to needed resources, and act as a link to detectives to provide information about the status of their case. They begin working with a survivor when a police report is filed, and that relationship ends for the most part when the case ends or it is handed off to the USAO for prosecution.

Similarly, the USAO's Victim Witness Unit provides crisis intervention, referrals to other resources with special attention paid to mental health needs, support surrounding the prosecution process, support during a trial, and act as a link to the prosecutor in the case. They also sit in on interviews with prosecutors to provide support to the survivor. Neither MPD nor USAO victim services has a confidential relationship with the survivor, meaning that they are legally required to inform the detective or the prosecutor of any information they learn about or from the survivor. Their mandate also involves ensuring that victim participation in a case is facilitated by empowering the victim with the services, support and information they provide,

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<sup>25</sup> D.C. Code §14-312 (2015).

which is an entirely laudable and needed function to ensure that the criminal justice system is more victim centered overall.

This tension between community-based advocates and system-based victim witness coordinators is not unique to the District at all. In fact, such is the pervasiveness of the divide that there are conference seminars provided at the national level about how to get these two types of service providers to work together. A tremendous amount of the tension comes from the system-based providers feeling as though they are being disrespected or even entirely duplicated by community-based advocates, while community-based advocates allege that system-based service providers do not recognize the limits of their roles in terms of confidentiality and their obligation to the criminal justice system in addition to the survivor. The reality is that the two have distinct and equally valuable and crucial roles in the system of care for survivors.

In interviews with MPD detectives, survivors who had reported to MPD, and Victim Services Coordinators themselves, it became apparent that a large disconnect clearly exists between MPD's Victim Services Unit and NVRDC's advocates and attorneys. NVRDC advocates and case managers indicate that they are unclear as to precisely what the Victim Services Unit provides and has very little interaction with them. However, the survivor's experience may be very different, possibly receiving various communications from both. This isn't to say that survivors are dissatisfied with one over the other, but rather that there is a gulf that needs to be bridged with each performing their specific roles appropriately and in coordination with the other.

Conversely, the relationship between the USAO Victim Witness Unit and NVRDC's advocates and attorneys involves a great deal more contact, particularly in meetings with survivors at which both are present. This month, an NVRDC client indicated to her advocate that the hostility from the USAO Victim Witness staff was palpable and awkward, while the Victim Witness Coordinator reported the NVRDC advocate to her supervisor. The client reported that she did not witness anything untoward from NVRDC's advocate but that there was any issue that had to be discussed at all is beyond what should be happening in these meetings. With the upcoming SAVRAA Task Force recommendation to include of prosecutorial interviews in the mandate for a community-based advocate as a right for all survivors, this contact and likely the tension that exists will only increase without intervention.

#### **Recommendations:**

1. The Network for Victim Recovery of DC (NVRDC), the Victim Witness Unit at the US Attorney's Office and the Victim Services Unit at MPD should engage in cross training and strategic coordination meetings facilitated by the Independent Expert Consultant to bridge the significant gap in communication, information sharing and services referrals.

2. Training for all staff as described above should be provided annually about the different confidentiality laws that govern the roles of each, as well as updated information and training regarding the federal Crime Victims Rights Act, and the DC Crime Victim Bill of Rights.
3. SAVRAA should be amended to clarify confidentiality language related to the provision of a community-based advocate and their presence in meetings with prosecutors and system-based victim witness coordinators. This is necessary to ensure that there is maximum confidentiality provided to the survivor regardless of who they do or do not wish to have in their meetings with prosecutors or law enforcement, and so that everyone can be reassured regarding their presence and the integrity of a criminal case.

**B. The DCRCC Hotline**

Perhaps the broadest access point for service delivery for individuals who do not contact the DC SANE Program or report to police is the DC Rape Crisis Center's anonymous 24-hour hotline. The hotline receives approximately 300 calls per month, though these are anonymous callers and therefore there is no way to know how many of those callers are unduplicated individuals rather than repeat calls. In 2015, DCRCC referred 9 callers to the DC SANE Program Call Center for acute services. Though this number is shockingly low, according to DCRCC's Executive Director, callers to DCRCC's hotline are typically individuals who do not have an acute assault to report but rather were assaulted either as children, or in the recent or distant past and may not wish to report the assault or engage with anyone other than the hotline call taker or eventually a counselor or support group. According to DCRCC, this hotline has shifted recently from a counseling line on which callers could expect to talk for up to several hours to one that is geared more towards crisis intervention and referrals.

The hotline is not without significant problems and warrants vast improvement to serve as a primary entry point to the system of services. The most significant issue noted through interviews with survivors who have utilized the hotline as well as other service providers and DCRCC leadership is the distinct separation and apparent lack of coordination with other service providers in the continuum of care, though this may be due to the hotline's recent transition noted above. The Independent Expert Consultant also received three complaints about DCRCC's hotline's inappropriate information or lack of referrals to the DC SANE Program within the past year, two of which were instances in which the DC SANE Program was entirely appropriate for the caller and the callers were told that the forensic exam the caller was requesting was not an option for them. In one of those two instances, the caller was incorrectly told that because her assault, which had occurred less than 24 hours prior, did not involve actual penetration, there was no reason to engage the SANE Program. Further, the Independent Expert Consultant has received 13 complaints from survivors directly and via

sexual assault as well as domestic violence advocates because the hotline went unanswered, in one instance for nearly three days, and in another a woman who had been assaulted within the previous two to three hours seeking acute services found the DC SANE Program Call Center through her insurance company help line after attempting to get help from the DCRCC hotline for three hours. As of September 2015, the hotline only had one line. If the call taker is speaking with someone, other callers get a busy signal or a recorded message that says the call taker is busy helping another survivor and to call back later. The line then hangs up on the caller. Survivors calling after a recent assault or survivors having an acute crisis related to a past assault receiving this response may experience extreme distress at being disconnected in this manner.

DCRCC also reports that their callers are from more marginalized portions of the District's population such as sex workers, transgendered survivors, immigrant survivors and teens. As such, they may not wish to go to a hospital or engage in a more formal system for fear of being turned in themselves, or otherwise not treated respectfully, as the response they receive from formal systems may have done more harm than good in the past. While this is entirely plausible and should be taken at face value, it is also the case that when specific numbers were requested for these populations to verify DCRCC's assertions about the enormous needs they presented, as well as the number of adult survivors of child sexual abuse to verify the hotline's population, DCRCC cited the fact that callers are anonymous and therefore they don't have any way to know who is calling. This lack of specific information about what about the response is inadequate or about what the gaps are in a case-by-case manner makes it difficult for the SART to address them constructively. The hotline is a vital resource for very vulnerable populations and its capacity should only increase in the ways described below.

### **Recommendations**

1. A functional crisis-level hotline should be established or improved upon that provides robust referrals to other organizations for both acute and longer-term services, including but not limited to the DC SANE hotline for acute care and advocacy, a clear description of the DC SANE Program and process and reporting options as approved and provided by the SART, mental health resources, and support groups and individuals counseling for adult survivors of childhood sexual abuse. This hotline should be the primary entry point to the system of care.
2. Though acute cases are numerically rare among hotline callers according to DCRCC, cross training for hotline staff with the DC SANE Program should occur regularly so that correct referrals are made, and so that any programmatic changes in the DC SANE Program and accessibility issues encountered by hotline callers can be shared.

### **C. *Mental Health Services for Survivors of Sexual Assault***

There are three primary mental health service providers for sexual assault survivors: The Wendt Center for Loss and Healing, The Women's Center and The DC Rape Crisis Center (DCRCC), all of whom provide trauma-informed counseling services free of charge. The need for these services cannot be overstated; the Wendt Center often has a wait list for counseling services, as does the Women's Center, though DCRCC generally does not. The specific remedy to this problem involves increasing the capacity of these three organizations to address this need, while at the same time bringing in other service providers who focus on sexual assault and trauma informed care as portions of their service provision and educating other service providers in both issues of sexual assault and practicing trauma informed mental healthcare to expand the District's city-wide capacity and give survivors additional choices.

Through interviews with survivors and service providers, as well as analyzing MPD's data and observing case review subcommittee meetings, two gaps in mental health services became apparent. First, adult survivors of childhood sexual abuse are without a clearly designated service provider capable of providing ongoing support. This population often has acute lifelong needs and requires ongoing support. Three survivors interviewed indicated that, while they had been attending groups at DCRCC in prior years, they had been told that there were no groups for them as an ongoing matter. As of this writing, DCRCC does currently have a group for African American women who were victimized as children and may be starting more groups for adult survivors of child sexual abuse. This represents excellent progress in filling this gap, but the need is vast. The Wendt Center does not currently have a support group for this population, but the Women's Center does hold one periodically in Vienna, Virginia.

The second issue, discussed in the Case Review Subcommittee section on page X, is the high percentage of survivors with severe and persistent mental illnesses. The SART is currently working on increasing not only their capacity to serve this population more appropriate to the need expressed, but also to ensure that the capacity of mental health service providers engaged in this process outside of the SART are better equipped to work with sexual assault survivors overall.

### **Recommendations**

1. Mental health services should be funded and built out by the Office of Victim Services and the SART to establish a wider network of trauma-informed providers than currently exists, with a specific focus on increasing the capacity to serve adult survivors of childhood sexual abuse, the severely and persistently mentally ill, and marginalized populations who may be more reluctant to report sexual assault through more formalized processes.
2. Proof of current licenses for counselors, psychologists, social workers, etc. should be required by OVS as a condition of grant funding for any counseling activities. This includes appropriate supervision of interns by a licensed professional.



3. Services for adult survivors of child sexual abuse should be prioritized so that this unfortunately large population can receive the services they desperately need and want. This includes support groups such as those provided by DCRCC currently as well as individual counseling with an emphasis on clear information about accessing these services.

**D. Sexual Assault Coalition Activities and the SART**

After careful review and interviewing of all parties concerned, including a total of 5 hours of interviews with DCRCC leadership, it is clearly apparent that there is no functioning sexual assault coalition in the District that encompasses both the more radical grassroots history of the DC Rape Crisis Center and the more formal SAVRAA mandated service providers for sexual assault embodied by the DC SANE Program and the majority of the SART. As mentioned in the discussion about the SART's statutorily required membership, DCRCC is the District's designated sexual assault coalition.<sup>26</sup> As discussed above, it is also a direct services provider serving survivors via the above-discussed hotline and counseling services.

The definition of a sexual assault coalition used by the CDC as defined in the Public Health Services Act is nearly limitless,<sup>27</sup> and therefore the structure and composition of each state's coalition can be designed to suit each state or each community's specific needs. The narrower definition provided by the Office on Violence Against Women (OVW) which provides specific funding for CDC-designated state sexual assault and domestic violence coalitions is: "Statewide sexual assault coalitions provide direct support to member rape crisis centers through funding, training and technical assistance, public awareness activities, and public policy advocacy (e.g. state coalitions might work with law enforcement, prosecution, and community organizations to enhance their responses to victims of sexual assault)."<sup>28</sup> Regardless of which definition one applies – the CDC's which leaves it to community defined needs or OVW's narrower one – the District is currently without an inclusive functional coalition to speak for and benefit all sexual assault survivors and the service providers working with them every day.

Based on community need and strong advocacy by DCRCC and other related community activists and survivors, SAVRAA was created to address not only the way police handled sexual assault reports and investigations, but to alter and formalize the advocacy and forensic evidence collection process associated with those investigations. The SAVRAA Task

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<sup>26</sup> State sexual assault coalitions are designated by the Centers for Disease Control and are not assigned by local or state entities.

<sup>27</sup> 42 U.S.C. 208(b).

<sup>28</sup> United States Department of Justice, Office on Violence Against Women, Fiscal Year 2015, State and Territorial Sexual Assault and Domestic Violence Coalitions Program, 2015, page 6. April 3, 2016. OMB Number: 1122-0020 [http://www.justice.gov/sites/default/files/ovw/pages/attachments/2015/04/08/finals\\_coalitions\\_fy2015\\_4\\_2\\_15.pdf](http://www.justice.gov/sites/default/files/ovw/pages/attachments/2015/04/08/finals_coalitions_fy2015_4_2_15.pdf).

Force was established to explore expanding that mandate beyond law enforcement investigations and the adult survivor population. The system of care and the advocacy model endorsed by SAVRAA, though always a work in progress, was and is a reflection of a dire community need for more formalized and highly organized community-based organizations to advocate for survivors within the legal system, other formal systems and beyond.

Based on OVW's definition as the funder of sexual assault coalitions, the support and coordination of services is not forthcoming as of this writing, and in fact a philosophical discomfort with the coordination required by the community through SAVRAA has been apparent in multiple meetings and interviews. While it should go without saying that this more grassroots perspective – that the history of the anti-rape movement requires that rape crisis centers, and in this instance DC's state coalition because it is one and the same with DC's rape crisis center, act in opposition to system actors and formal organizations who are viewed as needed but also part of an inherently oppressive culture badly in need of broad-based change<sup>29</sup> – is of course valid and desperately needed in a community with many historically marginalized communities, populations and even subgroups with specific needs and perspectives within those populations. However, is also not a philosophy that allows this particular state coalition to work well with the system that the community indicated it needed through SAVRAA and its mandate of highly coordinated and formalized services. The two perspectives are not mutually exclusive by any means, but based on interviews and observations of interactions, as well as review of written materials indicate strongly that these two portions of the anti-rape movement cannot coexist constructively in the current configuration where the city's rape crisis center is also serving as the state coalition while also providing direct services.

A wealth was brought to the attention of the Independent Expert Consultant by survivors who noticed strained relationships between DCRCC and the other service providers, DCRCC leadership who defined coalition work very differently and exclusively of the other service providers, other service providers very concerned about a lack of coordinated voice for their organizations and the survivors they serve in policy matters. Throughout this evaluation, the Independent Expert Consultant also noted the highly chaotic and sometimes entirely

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<sup>29</sup> See generally Byington DB, Martin PY, DiNitto DM, Maxwell MS (1991). Organizational affiliation and effectiveness: the case of rape crisis centers. *Administration in Social Work* 15(3): 83-103; Campbell R, Baker CK, Mazurek TL (1998) Remaining radical? Organizational predictors of rape crisis centers' social change initiatives. *American Journal of Community Psychology* 26(3): 457-83; and Poskin, P, "A Brief History of the Anti-Rape Movement," September 2006 (presented by DCRCC's executive director at a public meeting on December 14, 2015).

contradictory outreach messages given to other, more peripheral service providers and the general public about how the DC SANE Program works and where to get help if one needs it. It is precisely these contradictions and their impact on survivors seeking care that prompt the inclusion of this highly divisive and controversial issue in this report.

Relevant Information related to the determination that the District is in need of a new configuration for its sexual assault coalition work is as follows:

- While outreach and technical assistance may have been occurring with other service providers, the only reports received by the SART from DCRCC were related to direct services even when questions about policy or coalition activities were asked.
- Coordination of services has been left entirely to the SART. The idea of a coordinated continuum of services and what it might contain had to be clarified by the SAVRAA Independent Expert Consultant to DCRCC's leadership on August 31, 2015 and again on October 20, 2015.
- On both occasions, DCRCC's leadership indicated that they spoke for survivors of sexual assault, and that their organizational agenda could not be shifted or diluted by other service providers who, in DCRCC's view as it was understood at those meetings, either did not speak on behalf of the survivors they served, or spoke on behalf of a privileged group of survivors who received the assistance of formal service providers.
- Unbeknownst to the service providers whose primary missions are to serve sexual assault survivors directly<sup>30</sup> and in some instances exclusively, policy advocacy and organization was outsourced to the DC Coalition Against Domestic Violence (DCCADV) at the request of the Office of Victim Services previous leadership through a Memorandum of Understanding between DCCADV and DCRCC. In spite of multiple direct requests, that MOU remained confidential until it was requested from OVS by the Independent Expert Consultant. Though this confidentiality is often a matter of courtesy between organizations, and DCCADV did appropriately view it as a courtesy to DCRCC that the MOU not be provided to others,<sup>31</sup> it was a private arrangement made regarding the public policy agenda of the providers requesting illumination of who was actually representing them and under what terms that representation was taking place.
- A policy meeting was held at DCCADV in February 2015, that included the members of the DC SANE Program and others on the SART, but there was no explanation given of why this was taking place or what the terms of their contribution were relative to representation with policy makers.
- When the Independent Expert Consultant inquired about who was representing the other service providers and the survivors they served in policy matters, DCRCC indicated on two occasions that they were representing DCRCC only, and that any other organizations would be represented by DCCADV because theirs was a broader coalition, and that this representational structure would continue for the foreseeable future, however informally. DCCADV's leadership confirmed this description in an interview as well.
- DCCADV also, quite rightly, is engaged in work around sexual violence as described in their 2016 request and award for funding from OVS as sexual violence is an all too integral part of domestic violence. However, these activities are not communicated or coordinated with the remaining service providers leading to the potential again for the confusion encountered when interviewing survivors, service providers and college campus advocates.

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<sup>30</sup> Some of these organizations also serve other victims of crime and trauma, but have specific and primary programming to serve survivors of sexual assault.

<sup>31</sup> Telephone interview with DCCADV Executive Director, Karma Cottman, October 2, 2015.

This discord and separation could be considered as nothing more than the normal institutional competition or philosophical differences working themselves out were it not for the consequences for survivors attempting to receive services. The palpable distrust expressed by DCRCC towards NVRDC was reported by two survivors of the 26 interviewed, though it should be noted that this issue was raised by the survivors themselves without any prompting. One indicated that she requested a referral, and her request was met with an awkward level of resistance. Both indicated that this was why they were no longer seeking or receiving services at DCRCC. As recently as December 2015, DCRCC prohibited its staff from collaborating with NVRDC to help a mutual client who had been referred by the Office of Victim Services, in spite of releases of information, and a staff member told an NVRDC client who had come to the Lighthouse to drop off receipts for her advocate that she could not take the envelope and that the client would have to mail it to NVRDC. Two college campuses indicated a completely incorrect understanding of the DC SANE Program and indicated that they received their information from DCRCC and DCCADV. Valid criticism should always be welcome, such as the need to be more mobile, reconfigure access, etc., but incorrect information and a refusal to collaborate even for individual clients speaks to a deeper problem.

The weight this lack of a functional coalition places on the SART is enormous. Many of the recommendations listed above could be carried out by a coalition, but currently cannot be because an enormous part of the puzzle is missing. DCRCC necessarily works with more marginalized populations who may have no desire to contact a medical professional or report to police, and the DC SANE Program's clients may not see a need to interact with DCRCC directly, but the two should be working in tandem regardless. The SART could theoretically be the coalition itself but for the fact that they have government agency members who are prohibited from commenting on policy initiatives or even coordination efforts that require a legislative remedy, and because SARTs are typically and rightly very focused on the medical forensic and criminal justice response to sexual assault thus precluding much of DCRCC's service population. That focus may also validate DCRCC's contention and concern that the inclusion of more system-oriented actors such as legal services providers might dilute the organization's core mission and agenda.

The lack of a functional and transparent coalition is overburdening the SART, creating conflicting outreach messaging, as well as tension that is noticeable to the individual survivor as well as anyone engaging with the parties in a group setting. Although the state coalition designation and funding streams are federal, OVS has previously also funded coalition activity

at the local level. Based on the ongoing issues described above, the Office of Victim Services has indicated that they will not fund any coalition activity that does not explicitly include all service providers whose core mission includes that of providing sexual assault services. All of these factors speak to the need for a different configuration for the District's state coalition to the entire system of care and all survivors, to speak publicly on survivors' and service providers' behalf both with policy makers and the general public.

### **Recommendations**

1. Establish a functional sexual assault coalition for the District that includes all organizations whose primary mission explicitly includes serving sexual assault survivors and therefore the survivors those organizations serve.
2. This coalition, however ultimately configured, should be entirely separate from any direct service provision for sexual assault survivors to facilitate transparency and avoid any apparent conflict of interest in funding and legislative advocacy efforts as well as overall philosophical orientation.
3. Any sexual assault coalition that is created or altered should contain a strong survivor advisory board or council, and contain survivor representation at all levels from the board of directors to staff and volunteers.
4. Clarify the role of the DC Coalition Against Domestic Violence (DCCADV) within sexual assault work in the District such that projects are not in conflict with one another and so that outreach and education messaging can be appropriately coordinated.

### **VI. Conclusion**

This report covered many disparate topics, from the specific case review process to the broad issue of coalition representation for SAVRAA's system of care to gaps in services. Ultimately the SART is well on its way to being a highly effective SART even by national standards, and the case review process is functioning beyond its mere legal requirements to identify patterns and find solutions to systemic problems. However, as discussed in the section about the system of care, there are gaps in services such as the mobility and overall capacity of the DC SANE Program to meet geographically scattered and non-hospital based requests for services as well as the current capacity of DCRCC's much needed hotline. In order for survivors to receive clear and correct information about where to go to receive the services they seek and to have knowledge of all of the available choices, transparency and coordination across the entire system of care is imperative. Ultimately, the SART is burdened by coalition activities and conflicts that should be undertaken by a more functional and inclusive coalition separate from direct service provision. By making this change, the SART can focus on its more formal system response while the badly needed rape crisis center model and philosophy embodied by DCRCC can continue to thrive as well.