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ROBERT L. COWLES
Wisconsin State Senator
2nd Senate District

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Justice for Children Package Testimony

November 5, 2015

Senator Rob Cowles

Over the past year, the Department of Justice, the Attorney General's office, advocacy groups, Senator Cowles, our office, and Assembly authors have collaborated to address some major crimes against children and victims of sexual assault to create a collaborative approach to protect them and provide them with an opportunity for better outcomes. We are very pleased today to have the "Justice for Children package" heard.

These bills are aimed to reform major crimes against children and victims of sexual assault, but ultimately keep kids safe. In researching these crimes and collaborating with the Department of Justice, it was clear that something needed to be done to address cases of abuse, neglect, and sexual assault and again, and most importantly, to keep kids safe.

In this package we have put together four bills to aid in the fight against these crimes.

Assembly Bill 430 allows victim advocates to play a larger role in cases of sexual assault and human trafficking, both against adults and children. Through research, we have found that survivors of sexual crimes who have received services from a victim advocate have experienced better outcomes and are in less distress through such a difficult and trying time. National statistics estimate nearly 23 million women in the United States have experienced sexual violence, while child sexual assault remains a grossly under reported crime. We needed to address the needs of our victims in this state.

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This bill, specifically, gives victims greater access to victim advocates during examinations and consultations performed at a hospital, as well as, during preliminary law enforcement interviews. This bill gives victims, free of charge to them, someone who is there, solely, for their needs. Additionally, we have introduced an amendment to address concerns raised by some of the interested parties on this legislation to try provide better and less traumatic experiences for children who have been victimized by such a horrible crime. I want to thank all of those involved to help strengthen this bill and provide better advocacy for Victims of sexual assault.

Assembly Bill 431 reforms the neglect statutes and adds substance and clarity. Under current law, you have to prove intent to neglect, in addition to, a felony schedule that is inflexible and leaves out many instances that certainly constitute neglect that are happening in our communities. This bill redefines neglect as the negligent failure to provide necessary care. The bill further defines necessary care, as amended, as now adequate food, clothing, medical and dental care, shelter, supervision, the opportunity for education, and protection from the exposure to the distribution, manufacture or use of controlled substances; modeled after the statutes governing jurisdiction over children alleged to be in need of protective services (§48.13(10m)). This bill also creates a new felony schedule, while the ceiling and floor remain that same, we have included instances where children are at unreasonable and substantial risk of harm, great bodily harm, or death, as well as accounting for emotional harm, and if the child neglected becomes the victim of a child sex offense. The new schedule clearly provides greater detail and flexibility to identify neglect while maintaining the discretion District Attorneys and jurors currently have.

Assembly Bill 431 also creates the crime of repeated acts of neglect of the same child. This is modeled after the crime of repeated acts of sexual assault of the same child (§948.025). This gives prosecutors a new tool to identify situations in which a very young or non-verbal child has been neglected. For very young or non-verbal children, dates and specific instances maybe challenging to identify. This new crime does not change any of the elements necessary to convict someone of neglect. Furthermore, we have introduced an amendment to provide even greater clarity and substance to address a number of concerns raised in the Senate hearing. I again want to thank all those involved to help strengthen this legislation.

Assembly Bill 428 is similar to Assembly Bill 431 in that it too creates a new crime. The bill creates repeated acts of physical abuse of the same child. Again, modeled after repeated acts of sexual assault of the same child (§948.025) this crime helps prosecutors convict the more grievous cases of physical abuse against children, many of whom are very young or possibly non-verbal. Through our research, the children who are victims of these crimes are very young. In the State of Wisconsin, from 2008-2012, 61% of physical abuse deaths of children were aged 3 or younger, with 35% of the deaths were children under the age of one. We hope that the two new crimes created in this package will save such young children who are victims to these horrible crimes.

Assembly Bill 429 expands referral of all reports of suspected or threatened child abuse or neglect to law enforcement. Under current law, suspected cases of child abuse and neglect are referred by mandated reporters to Child Protective Services and not law enforcement. Child abuse and Neglect are the only two felonies not referred to law enforcement. This bill requires that Child Protective Services refer all suspected or threatened cases to law enforcement and coordinate a response if necessary. This legislation lets law enforcement decide if law enforcement needs to be involved, and changes the model to allow early-intervention of law enforcement, if necessary. We feel that having law enforcement involved and aware from the beginning can, at an absolute minimum, reduce duplicate investigations and provide fewer interviews where the victim will have to relive their traumatic experience. Unfortunately, we have amassed several examples from all over the state where law enforcement was not involved in an investigation of neglect or abuse and the child/children suffered continued maltreatment and, in the saddest cases, death. Law enforcement has different tools available for investigating, such as the ability to obtain search warrants and subpoenas. Through collaboration with stakeholder groups, we have introduced an amendment to help provide greater flexibility for County Human Services to refer cases, along a sliding timeline schedule, for referral ranging from 12 to 48 hours to reach law enforcement. We feel that referring all cases to law enforcement will be a vastly improved approach to identifying cases of abuse and neglect and help to keep kids out of harm's way.

Additionally, The Wisconsin Police Chiefs Association, Sheriffs and Deputy Sheriffs Association, and Wisconsin Professional Police Association all are publicly supporting this legislation. Their position is that these calls are potential felonies and they want to be involved sooner rather than later, or at least aware of referrals that have happened in their communities, because the consequence could be that a children will continue to suffer. The State Prosecutors Association and Wisconsin District Attorneys Association are also supporting this legislation.

It is so important to ensure that victims of such terrible crimes are protected in Wisconsin and receive justice from those who have wronged them. By aligning our District Attorneys, Law Enforcement, Victim Advocates, Child Protective Services and our communities together we can create a proven environment to protect the victims of these crimes and aim towards achieving greater outcomes for these victims.

I want to thank all those involved with these bills especially Attorney General Schimel, and Representatives Heaton, Macco, Murtha and Tranel for their work on this package of bills.

With these bills, I hope we can strive to give kids a violence-free and safe childhood and deter acts of abuse neglect and sexual assault in our communities. I hope that these bills can bring criminals to justice and of course, keep kids safe.

JOHN MURTHA

STATE REPRESENTATIVE • 29th ASSEMBLY DISTRICT

November 5th, 2015

Dear Chairman Kleefisch and Members,

This past spring, I held a meeting with a group from my district called The Bridge to Hope, which serves survivors of domestic and sexual abuse, stalking, and human trafficking. They brought to my attention the need for legislation providing survivors of certain crimes the right to be accompanied by a trained advocate throughout all stages of the medical and criminal justice processes.

Along with the support of Senator Cowles and Attorney General Brad Schimel, I am happy to be a part of advancing this sort of legislation. It has been shown that survivors with access to victim advocates have experienced reduced mental and physical distress as well as less physical health challenges, self-blame, guilt, and depression. It has also been found that when victim advocates are present in the process, there has been increased offender accountability.

The University of Wisconsin-Stout is a valued and important part of the 29th Assembly District. There is an ongoing national dialogue about sexual violence and assault on college campuses, but this problem permeates well beyond campus life. According to the U.S. Department of Justice's National Crime Victimization Survey, there are about 293,066 victims of sexual assault every year in the United States. If you do the math, that comes out to one sexual assault every 107 seconds.

I cannot imagine the mental and physical toll an entire sexual assault investigation takes on a victim. They shouldn't have to go through it alone. They deserve the right to a victim advocate.

I appreciate you taking the time to read my testimony. Should any of you have any questions, please feel free to contact my office at (608) 266-7683.

Sincerely,

J. Murtha

Representative John Murtha
Wisconsin State Assembly
29th Assembly District

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PREPARED TESTIMONY OF ATTORNEY GENERAL BRAD D. SCHIMEL

Support for Assembly Bill 428, Assembly Bill 429,
Assembly Bill 430, and Assembly Bill 431
Assembly Committee on Criminal Justice and Public Safety
Thursday, November 5, 2015

Good morning Mr. Chairman and members of the Assembly Committee on Criminal Justice and Public Safety. Thank you for this opportunity to testify on these four important bills: AB 428, AB 429, AB 430, and AB 431.

I would first like to thank Senator Cowles; Representatives Tranel, Macco, Murtha, and Heaton; and legislative leaders for sponsoring the "Justice for Children" legislation and addressing a need to change the way we protect children who are victims of abuse and neglect.

In my former lives as an Assistant District Attorney and District Attorney, I spent the largest part of my 25 year career prosecuting Sensitive Crimes cases. That experience included countless child abuse and neglect cases.

In that work, I saw firsthand how child abuse and neglect often do irreparable harm to children and families. Worse, the fallout from that abuse and neglect often is passed from generation to generation. Children usually learn their sense of "normal" from what they see in their own home. Unfortunately, when they grow up in an environment of physical abuse, sexual abuse, neglect, domestic abuse or drug abuse, they very often grow up to perpetuate that same conduct in their own adult relationships.

We have no higher responsibility in government than to protect our children. It is time for us to provide stronger tools to address physical abuse and neglect of children to break this cycle. These four bills will help Wisconsin better protect our children.

Assembly Bill 428
provides the ability to charge repeated acts of physical abuse and neglect when multiple abusive or neglectful acts are committed against the same child. For many years, Wisconsin law has given prosecutors the ability to charge repeated acts of sexual assault of a child as a single continuing offense. That tool has been critical to

our finding the truth in cases involving ongoing, repetitive sexual abuse.

Children often are not able to identify the specific date on which acts of sexual abuse were committed against them. This is just as true with acts of physical abuse and neglect as it is with sexual abuse.

Physical abuse and neglect can, also, be every bit as damaging to a child as sexual abuse. It is long overdue for Wisconsin to give prosecutors the ability to charge long-term physical abuse and neglect as an ongoing course of conduct so that we can achieve justice for these child victims and prevent offenders from committing future crimes against children.

It can be very difficult for a child to identify specific dates of violation sufficiently to support charges when there are multiple acts of physical abuse or neglect committed against them. Assembly Bill 428 provides an important tool to prosecutors that will enable them to address this challenge.

Assembly Bill 429 requires notification to law enforcement of allegations of physical abuse and neglect of a child.

The criminal justice system works best for victims when there is a collaborative approach that brings together a multi-disciplinary team made up of prosecutors, law enforcement, victim advocates, and social services. We learned this years ago when we first mandated that law enforcement be notified of allegations of sexual assault of a child. At about that same time, some jurisdictions started utilizing Child Advocacy Centers and Multi-Disciplinary Teams to address offenses committed against children. There was resistance to those kinds of collaborative approaches at that time, but they are now accepted as the gold standard and we serve survivors of child sexual assault much better than we did just 15 years ago.

Under current law, mandatory reporters must report sexual abuse, physical abuse and neglect of a child to the county social service agency. Only as to sexual abuse of child, however, are social service agencies required to share the report with law enforcement. Wisconsin law does not require that law enforcement be notified when physical abuse or neglect of a child is suspected.

Social services and law enforcement have complementary, but not always identical interests relative to child abuse and neglect. Law enforcement also has tools available to it, such as subpoenas and search warrants, that are not typically available to social services agencies working alone.

I have been around long enough to remember when collaborative investigations were not the norm. We ran into many situations in which children were interviewed multiple times about the abuse, forcing them to relive the circumstances over and

over again.

AB 429 makes sure that the two systems both work together to investigate child abuse and neglect. AB 429 will be a force multiplier in our effort to keep our children safe. In Waukesha County where I was a prosecutor, we began conducting collaborative investigations between law enforcement and social services years ago, and I saw firsthand the benefits of this multi-disciplinary approach.

Law enforcement and prosecutors do not lose any of their discretion to make determinations as to when a child protection service response is adequate and when there should also be a criminal justice response.

Assembly Bill 430 provides the right to assistance of a victim advocate to crime victims. During a police investigation, a suspect has the right to be represented by an attorney. In fact, if the suspect is in custody, police must inform them that they have the right to legal representation before law enforcement can interview them about the crime. Further, if the suspect cannot afford an attorney, they are told they will get one for free. No reasonable person can dispute that these rights are appropriate and in the best interests of justice.

Current law gives victims the right to accompaniment by an advocate once charges are filed, but current law does not address the investigative stages. The investigation phase can be the most stressful part of the entire process for a child victim, since that will often be the first time they talk with a stranger about what happened.

Assembly Bill 430 makes sure that victims have rights to support similar to the ones already granted to an accused suspect. Why would we not afford a crime victim, especially a child, who is being interviewed the right to have an advocate present to help them?

Further, unlike the attorney representing a suspect as part of an adversarial process, the presence of a trained victim advocate can actually assist law enforcement in doing their job. Advocates do not have a responsibility to be adversarial to the efforts of child protection workers, medical professionals or law enforcement officers. In fact, the presence of a victim advocate will make the system work better and more compassionately.

Assembly Bill 431 proposes several changes to the neglect of a child statute.

Current Wisconsin law requires that the State prove that a person who neglected a child did so intentionally. This is an oxymoron. By its nature, neglect is not intentional. Assembly Bill 431 would remedy this confusion in our law by setting a criminal negligence standard.

Assembly Bill 431 also creates graduated penalties for varying degrees of child neglect. Under current law, a prosecutor has only two options when addressing allegations of child neglect: 1. Charge a misdemeanor if the child does not die from the neglect; and 2. Charge a felony if the child does die as a result of the neglect. This bill provides graduated penalties for neglect based upon the severity of the injury to the child. Thus, more severe neglect can be punished more severely than less severe neglect. Right now, in almost every case, neglect is only a misdemeanor offense, no matter the consequences, as long as they are short of death.

Conclusion

AB 428, AB 429, AB 430, and AB 431 will enable us to give children the resources they need to navigate the criminal justice system and begin the long process of healing. These tools will enable us to do the very best we can to keep our children safe.

It is important to note, once again, that these bills propose the same things we have already utilized with great success in child sexual assault investigations and prosecutions. They simply provide to investigations and prosecutions for physical abuse and neglect the same tools and methods that have long been in place for child sexual assault cases.

The Wisconsin Department of Justice, state prosecutors who specialize in child abuse and neglect prosecutions, as well as representatives from partner organizations like the WCASA and CHW have worked tirelessly with legislators to develop this comprehensive solution to some of society's worst problems. I am confident the "Justice for Children" package of laws will be a great asset to prosecutors statewide and hold offenders more accountable than current law allows.

Thank you for allowing me the time today to address this body. I am happy to take questions.

Children's Hospital of Wisconsin | Marshfield Clinic HEALTH SYSTEM | UW Health

TO: Assembly Committee on Criminal Justice and Public Safety
FROM: Barbara Knox, MD, UW Health and American Family Children's Hospital Medical Director of Child Protection Program
Lynn Sheets, MD, Children's Hospital Wisconsin, Medical Director of Child Advocacy and Protection Services
Dr. Nash and Dr. Iniguez, Marshfield Clinic
DATE: November 5, 2015
RE: AB 430 – Victim's Advocate

Good afternoon Chairman Kleefisch and members of the Committee. Thank you for the opportunity to provide this testimony on AB 430 relating to victim advocacy. We want to thank Senator Cowles and Representative Murtha for their work on this bill and for bringing several interested stakeholders together for discussions on ways to make the bill even stronger. It is because of our joint experience with child victims in our emergency room and child advocacy centers, we offer the following recommendations for this legislation as it relates to child victims.

My name is Lynn Sheets and I am the Medical Director of the Child Advocacy and Protection Services program at Children's Hospital of Wisconsin. In this role I oversee programs that serve more than 7,000 children seen each year through Children's seven Child Advocacy Centers (CAC) throughout the state (those CACs are Milwaukee, Racine, Kenosha, Fox Valley, Walworth, Eau Claire and Wausau). We also provide medical care to children served at the CAC in Green Bay. The CAC model is a collaboration between medical, law enforcement, district attorneys, advocates and social services coming together to minimize trauma for a child victim, break the cycle of abuse and, importantly, increase prosecution rates for perpetrators. It is nationally recognized as the model for best practice in the evaluation of children suspected of being physically or sexually abused. Along with other organizations around the state and the Wisconsin Department of Justice, Children's collaborates on providing child victims with the care and services they require including advocates when appropriate.

My name is Barbara Knox and I am the Medical Director for UW Health and the American Family Children's Hospital Child Protection Program, whose mission is to ensure the safety and well-being of infants, children and adolescents. I oversee our programs that treat children who have been or are suspected of being victims of physical abuse, sexual abuse, neglect and factitious illness by proxy. I also provide medical review of child abuse cases for social services agencies, law enforcement and prosecutors.

This testimony also comes from our counterparts at Marshfield Clinic, Drs Nash and Inigue, who couldn't be here today.

Together we have served on numerous councils and committees, written extensively on the subject of child abuse and have worked with the Department of Justice and other partners on these topics.

We applaud the authors and organizations who worked so diligently on putting together this legislation. As it relates to adult victims, this legislation is spot on and well crafted to address the critical issues they face. We are here today because we believe an amendment addressing victim advocacy as it relates to children will strengthen the bill and resolve unintended consequences.

As you know, AB 430 provides a victim the right to an advocate. For child victims, it provides the parent of the child the ability to raise this right on behalf of their child. This is problematic for child victims in many circumstances and would harm child safety. The sad truth is that often the parent is the perpetrator of the abuse or is aware of the abuse and unable or unwilling to protect the child.

In physical abuse cases involving verbal young children, the child is often asked about the cause of the skin injuries during the medical examination. The presence of an advocate in the room makes such disclosures less likely. Since the proposed legislation even includes physical abuse of preverbal children, an advocate who is present at the behest of the parent could act as a conduit of information about injuries as they are found on exam, photographed or found on testing, thus compromising the investigation.

For these reasons, we are appreciative of recent discussions with the authors and other interested stakeholders which resulted in agreement to amend the bill to clarify that for child victims under the age of ten, it is the treating medical provider that could invoke the right for the child victim to have an advocate.

We also suggest that an advocate would also not be appropriate during a forensic interview under the direction of a child advocacy center forensic interviewer. CAC interviews are critically important in assessing if a child has been sexually abused or assaulted. CAC forensic interviewers are highly trained in the science of interviewing children on sensitive topics. The forensic interviewer who is responsible for the quality of how the interview is conducted should have the discretion to allow an advocate to be present in pediatric cases, but should not be required to do so as the quality of the interview could be negatively impacted inadvertently through verbal and nonverbal cues from an advocate's presence. This is uniquely a risk for child victims who are vulnerable to cues from adults and influence they perceive coming from their parents or other adults. Even a perception of influence from an advocate in the forensic interview of a child could affect the legal outcome of a case. Forensic interviews discuss some very sensitive topics. Another unfamiliar person in the room is likely to make it more difficult for a child to disclose critical information. While in general, CACs are very supportive of the advocate role, we believe the presence of an advocate in a CAC forensic interview situation would be more detrimental than beneficial.

For these reasons, we are appreciative of discussions with the authors and other interested stakeholders that results in a collective recommendation to clarify this bill does not apply to forensic interviews performed under the direction of a Child Advocacy Center.

Chairman Kleefisch and committee members, we thank you again for the opportunity to submit testimony. If you have any questions, comments or concerns please feel free to contact us via email at lsheets@chw.org or phone Dr. Lynn Sheets at 414-266-2090.

To:	Members of the Assembly Committee on Criminal Justice and and Public Safety
From:	Vicki H. Biehn
Subject:	Assembly Bill 430: Victim Accompaniment Bill
Position:	Support
Date:	November 5, 2015

Dear Chairman Kleefisch and Members of the Committee,

Hello and thank you for taking the time to listen to my testimony today about the Sexual Assault Victim Accompaniment legislation, Assembly Bill 430. My name is Vicki Biehn and I have worked with sexual assault survivors and their allies as a sexual assault advocate for the last 23 years in the state of Wisconsin. It has been a privilege and honor to work with sexual assault survivors and their allies.

As a trained advocate, my sole role or concern is to provide emotional support and information /resources to the victim/survivor as they proceed through the system. This support is vitally important because this support helps to alleviate some of the trauma, anxiety, fear, confusion, pain, anger, and frustration associated with the sexual assault as well as the medical and legal proceedings. I have seen first-hand how scary, intimidating, painful, and frustrating it is for survivors to proceed through these systems. It takes tremendous amounts of courage to seek out medical care and to report a sexual assault to law enforcement and these survivors deserve the support that an advocate provides. When an advocate is able to provide this emotional support and information about how the system works, the survivor is prepared, informed, able to cope, and therefore is more likely to stay involved with the system. I believe that every report of sexual assault is an act of courage and an opportunity. This active engagement of survivors in the system is what ultimately holds offenders accountable and creates a safer community for us all!

I want to strongly encourage you to support the Sexual Assault Victim Accompaniment bill because I know that it is extremely beneficial for the survivor and the system to have an advocate with the survivor as they proceed through the system. Not only do I know this but there was a study done by Rebecca Campbell in 2006 that showed that rape victim advocates provide numerous benefits for the survivor and the system. I believe that you already have this information in your packets. For me, the most important reason to support this bill is that it is crucially important for these survivors and their families to have this support so we can hold these offenders accountable. If survivors have this support, they will stay engaged in the system and more survivors will come forward to report these crimes if they are supported. I want to live in a safer world. I want my children and grandchildren and so on to live in a safer world and I know that this bill would increase the safety of all of our communities because the survivors will be supported and the offenders will be held accountable.

I would like to end my testimony with some quotes from sexual assault survivors about how the advocate was helpful to them as they proceeded through the medical and criminal justice systems. These quotes are from survivors who received services from my agency, Sexual Assault Services of LSS (SAS). SAS is located in Racine County.

She was amazing! I don't know what I would have done without her.

Wonderful care, made me wonder why more people don't report

They provided answers in a time when all I had was questions. They helped slow down my mind and let me know that it was going to get better.

Reminded me that it was about "me" and gave me room to cry and talk

Calming demeanor, supportive, compassionate, wonderful relief

Having someone there with me through the process who tell you they understand was helpful

Good listener, understanding

Information on what to do next, Crime Victim Compensation, distracting in a good way

Shared info about resources, informed about the process

Everything was helpful. Such good advocates for me and felt really taken care of.

Resources were helpful-good to be believed and taken seriously

She made me feel comfortable

Understanding, explained resources, was supportive through exam

Made things more comfortable to have someone there for support and information

The way she took time to explain

Very caring, made me feel comfortable, very patient

Walked me through the process

She was there the whole time

Very professional

Thank you for your time and serious consideration of supporting the Wisconsin Sexual Assault Victim Accompaniment legislation, Assembly Bill 430! Do you have any questions for me at this time? If not, please feel free to contact me vbiehn@lsswis.org.

Sincerely,

Vicki H. Biehn, MA, LPC

Vicki H. Biehn, MA, LPC

Testimony for Victim Accompaniment Bill AB430
November 5, 2015

Lisa Marie Penterman

Committee: Assembly Committee on Criminal Justice and Public Safety

Good Morning Committee Members. My Name is Lisa Marie Penterman. November 3, 2007 I *was* a victim of an acquaintance Sexual Assault. However, today (8 years and 2 days later) is a different story, I am extremely proud not only to be here as a Sexual Assault Survivor but foremost as a Victim Advocate for other Sexual Abuse survivors. I am here as a *voice* for all survivors out there that are in great need of advocacy to help guide and assist them through their journey during this horrific and most difficult time in their lives. I am here testifying today to help pass this Bill so Sexual Assault Survivors have a fair chance and redeem their hope and empowerment back that someone dreadfully took away from them.

My story: The night of November 3, 2007 my perpetrator, an acquaintance, stole that trust away from me the night he sexually assaulted me. I was out at a retirement party with friends; my headlight was out on my car so an acquaintance offered to give me a ride home. I knew this person for years and I trusted him. We were on our way home and he did not go to my house, he went to his place. He said I could sleep in his bed and he would take the couch. That did not happen. As I had fallen asleep, he came in the bed and took off my pants. I remember perfectly the grossly and unwantedly a large drool of spit coming out of his mouth to get me wet. I laid there and cried and cried, asking him why, why, why me? He said "this is what friends do". I told him "no they don't". I told him to "STOP". He kept on until he fell to the side of the bed. I laid there sobbing in hopes he was passed out, he wasn't. He got up and raped me again and again fell over to the side of the bed. This time, as I was sobbing, I got up, got my clothes on, ran outside and called a friend to pick me up. Hysterically crying, I told my friend what happened and he wanted to go in the apartment and hurt him, I told him "No, he is not worth you going to jail, I just want to go home and be in my own bed". My friend took me home to my house.

I was hurt, embarrassed and ashamed about the rape. I felt it was my fault. I did a lot of driving around, secluding myself from the world and crying immensely for days before telling my family. My Brother, Tony, noticed a difference in me and had me come to his work. I ended up telling him and his co-worker (a retired Appleton Police Officer) about the rape. I knew, the night of the rape, my life was never going to be the same.

The day Tony and I stepped foot at the Sexual Assault Crisis Center, I felt safe and knew I was not alone, there were good people to help me and give me hope. My Advocate Sally was there for me through thick and thin. She was there for me from day one and was an advocate between the courts, victim

witness, law enforcement, DA Andrew Meier and me. My advocate kept me informed of all hearings and proceedings with my case.

For 13 months I leaved in constant fear, hopelessness and hardship and spent many endless and sleepless nights, terribly worried and wondering if and when he was going to kill me because I told on him. During this time, waiting day after day wondering when jury trial would be, I had weekly and sometimes bi-weekly counseling appointments with Sally, attended group therapy with other survivors, and was on many of different medications for anxiety, depression and sleep issues, I had PTSD. I was a crazy wreck! My Advocate, Sally, greatly helped me realize that I was not crazy and he was not going to kill me. Sally would redirect my focus elsewhere and focus on me and my positive attributes. Along with my family, my advocate knew how to talk me down. She was my angel and cheerleader.

During that year, November 3, 2007-December 17, 2008, again, I was a wreck; *cried a lot*, couldn't work, overdosed on my prescription medication because of the agony he and his lawyer put me through cancelling and rescheduling the court date and then of course thoughts of suicide had entered my mind- I knew I wouldn't do it but the thought was there-wanted to be with my parents in heaven where I would be safe. Every time I had outrageous thoughts, My Advocate was always readily available for me and would talk me down out of my (as I say) "manic state of mind". The jury trial was December 16 and 17, 2008, Sally tactfully prepared me for both the best and worst outcomes. I did not attend the verdict, my advocate and I sat in a small room outside the court room. The verdict was read and my Sister came in the room by us and said he was acquitted. I sobbed, I was in disbelief, I felt my heart sink and that I had nothing left to fight for. At that point, Sally, My Advocate, looked at me and never gave up on me, she continued to see me continuously week after week, continued group therapy and also my meds.

I do have to say that the wonderful and much needed advocacy I received from My Advocate and Sexual Assault Crisis Center helped me *stand up for myself and other survivors.* Even though my perpetrator was acquitted, he and I both know what he did to me. However, from the assault and throughout the process I have gained great strength and confidence to help other survivors of Sexual Abuse.

Being a Victim Advocate: During this whole process I learned that I wanted to be just like Sally My Advocate, I wanted to be the one guiding a survivor through their journey and beyond. During the time I attended College, I volunteered as a Victim Advocate at Sexual Assault Crisis Center and once I graduated I was the Centers Victim Advocate and I also trained volunteer Victim Advocates. I say it is a full circle, I received the wonderful help and guidance from my Advocate Sally and the Center , court did not turn out as planned but **I stood up for myself and other sexual abuse survivors** and became that Victim Advocate. Also during this time I started on the WCASA Board of Directors as a Survivor, which has greatly empowered me to continue being a Victim Advocate for Survivors.

Once you are a victim of Sexual Abuse, one feels alone and afraid, loses hope and security. As a survivor myself, knowing there is an advocate to listen and be and voice is instrumental to the survivor's well-being and the feeling of empowerment.

I kindly ask you all too *please* think of your loved ones, if they were sexually assaulted, you would want them to have a Victim Advocate present. I know my family is very thankful for Sally as she Advocated for me along with the rest of the team on my behalf.

Passing this Bill AB 430 will allow all survivors the right to have a Victim Advocate present during SANE (Sexual Assault Nurse Exam's) examinations, meeting and appointments with law enforcement and also during court proceedings. However, most of all by passing this Bill it will give survivors a sense of hope, healing and empowerment that they *will* survive, not only by themselves but also the help and guidance of a Victim Advocate. Be a voice to all survivors out there, we all need you.

I want to graciously thank each and everyone here in this room today for listening to my testimony. It has been 8 years and 2 days since my assault and Sally, My Victim Advocate, is still only a phone call away if I need assistance. I still have my moments where I cry but I cry knowing that I am a *voice* for survivors and I am helping them on their healing journey. Along with my family and friends we are all *very thankful* for the care and compassion My Victim Advocate has given me.

Victim Advocacy gives strength to Survivors.

Sincerely,

Lisa Marie Penterman

Victim Accompaniment

My name is Angel Gilbertson and I live in the village of WI. I have been employed as the Client Advocate at ASTOP Sexual Abuse Center, a non-profit organization, located in Fond du Lac, WI for the past 8 years. ASTOP is a Sexual Assault Service Provider dedicated to offering treatment, outreach, prevention, case management, and advocacy, emphasizing hope and connection to self and others. ASTOP provides a link between crisis and recovery. The trained professional staff offers supportive services to survivors of sexual abuse, rape, or incest. These services are also offered to their affected family members and friends.

Today, I am here in Madison, to discuss the "victim accompaniment" legislation before you that I very strongly support as both an advocate and also as the chair of the Fond du Lac County Sexual Assault Response Team (SART).

As a community-based advocate in Fond du Lac, WI, I provide advocacy services in several capacities. This includes and is not limited to medical advocacy, law enforcement advocacy, and court accompaniment advocacy.

ASTOP Medical Advocacy: medical advocacy services are available 24 hours per day, 365 days per year. St. Agnes Hospital Emergency Room Department has a signed Memorandum of Understanding to contact ASTOP and request an advocate to respond and provide supportive services to all individuals entering the department to have a sexual assault nurse examination. Advocates that respond to the Emergency Department are ASTOP professional staff and ASTOP trained volunteers. Advocates provide emotional safety, support, and information to the victim. Advocates are present during the interview conducted by both the sexual assault nurse examiner and the law enforcement officer. Advocates will provide support in the exam room during the physical examination and collection of evidence. When the exam is completed advocates provide replacement clothing for clothing that has been collected as evidence. They also provide the patient with a blanket and self-care bag containing personal care products and a journal. These items are donated to ASTOP by the Fond du Lac Community Church. The advocate will assist the patient with filling out the Crime Victim Compensation application. The original copy is put into the hospital mail and a copy is provided to the patient. The advocate will give the patient an ASTOP folder. The folder contains ASTOP brochures, sexual assault information, and community resource information. Advocates ask the patient if ASTOP can contact them to follow up. With the patient's consent the ASTOP Case Manager calls the patient to see how they are doing and to again offer all ASTOP free resources.

ASTOP Law Enforcement Advocacy: law enforcement advocacy services are available 24 hours per day, 365 days per year. In past history, City of Fond du Lac Police Department, City of Ripon Police Department, and Green Lake County departments had a signed Memorandum of Understanding to contact ASTOP and request an advocate to respond and provide supportive services to all individuals presenting at the department to make a sexual assault report. In most recent of times, May, 2015, Fond du Lac County Executive members signed a Memorandum of Understanding with ASTOP. Memorandum of Understanding Executive signatures include Fond du Lac Sheriff's Department, Fond du Lac City Police Department, North Fond du Lac Police Department, Brandon-Fairwater Police Department, Campbellsport Police Department, Oakfield Police Department, Ripon Police Department, Rosendale Police Department, Town of Ripon

Police Department, Waupun Police Department, Fond du Lac County District Attorney, and ASTOP Executive Director. As the ASTOP Client Advocate, I presented the Fond du Lac County Law Enforcement ASTOP Advocacy MOU procedures to an estimated 50 City of Fond du Lac police officer at their scheduled briefings in September 2015. I am scheduled to present at the Fond du Lac County law enforcement in-service training in January 2016. All Fond du Lac County Jurisdictions will be present on the several days of training. I am scheduled to present the Fond du Lac County Law Enforcement and ASTOP Advocacy MOU procedures on the three scheduled dates.
Advocates that respond to the Police Department are ASTOP professional staff and ASTOP trained volunteers. Advocates provide support and information to the victim throughout the interview process. Advocates are present during the victim interview and written statement. They provide support and information during this process. Advocates do not speak on behalf of the victim, do not interrupt the interview, hinder, or impede the investigation in any way. When the reporting process has been completed the advocate will give the victim an ASTOP folder of information to take with them ask them if ASTOP can contact them with a follow up call.

ASTOP Law Enforcement Advocacy for Juvenile Victims, Victim Sensitive Interviewing Protocol, VSIP Interviews: advocacy is provided for Fond du Lac County VSIPs. The Fond du Lac County Victim Witness Coordinator from the District Attorney's Office contacts ASTOP to request an advocate. Myself, and other ASTOP professional staff respond to VSIP advocacy requests. Trained volunteers do not respond to these requests. The advocate provides support and information to the parent/and or caregiver while the child is being interviewed. The advocate will provide the parent and or/caregiver an ASTOP folder of information and ask them if ASTOP can contact them with a follow up call.

ASTOP Court Accompaniment Advocacy: Myself, and other ASTOP professional staff provide court accompaniment to sexual assault victims in both Fond du Lac County and Green Lake County Courts. ASTOP trained volunteers do not provide court accompaniment advocacy. Court accompaniment advocacy is requested directly from survivors in these cases. ASTOP also receives court accompaniment advocacy requests from an Assistant District Attorney in the Fond du Lac County District Attorney's Office. This Assistant District Attorney prosecutes the majority of all sexual assault and domestic violence cases in the county. It is her only caseload. Court accompaniment advocacy is assisting and supporting victims as they interact with the justice system. Advocates accompany the survivor to court proceedings, all stages of the court process, prosecutor appointments, and or any additional interviews. They can explain trial language, courtroom procedure, and courtroom etiquette in ways survivors can more easily understand. The courtroom can be confusing and frightening to survivors. Court procedures can be difficult for many survivors to understand. Advocates provide assistance in filing for crime victim compensation, preparing victim impact statements for the courts to be used for sentencing, and assisting with restraining order applications. Advocates do not act as attorneys for survivors.

ASTOP Volunteer Training: perspective volunteers must pass a background check, go through interview process, and complete 16 hours of volunteer training. If all requirements have been successfully completed they can volunteer as an ASTOP advocate to answer calls on the 24 hour crisis line and/or to respond as an advocate to the Emergency Room or Police Department.

ASTOP Team Training: cross-training between various professional disciplines involved in sexual assault response. During ASTOP Team training newly trained volunteer advocates, St. Agnes Hospital SANE nurses, and local law enforcement actively role-play 2 SANE case scenarios. This has provided a new learning opportunity for several each time this has been done. ASTOP Team Training gets scheduled in the St. Agnes Hospital Emergency Room Department 3-4 times per year. Each training, new advocates, law enforcement, and SANE participate. Positive feedback has been provided by all professionals involved in these past trainings. ASTOP Team Training is next scheduled for the end of January 2016.

I have been blessed to have met some very brave and amazing individuals in my 8 years as a Client Advocate in Fond du Lac, WI. Individuals that will forever leave an impact on my heart and soul. I have witnessed countless survivor testimonies on how beneficial advocacy services were to them. I did bring along with me today, two beautifully written statements from a primary survivor and also a secondary survivor of sexual assault. Both survivors share their personal experience with ASTOP advocacy and how it greatly assisted them on this long and traumatic journey. Often, survivors feel empowered continuing through the judicial process because of the support and information they have received on a continuous basis from the advocate.

Sadly, I can also tell you today how many countless times I have had to hear that an offender has more rights than a victim. Victims of crimes should not be made to feel that way. By supporting victim accompaniment we are demonstrating we support victim rights, including their right to be supported by a trained advocate during medical and criminal justice processes. Similar laws already exist in eleven other states and have been proven effective.

Please don't deny victims this right any longer.

Thank you for your time and consideration today.

Sincerely,

Angel Gilbertson

Angel Gilbertson
ASTOP Client Advocate

To: Members of the State Senate Committee on Judiciary and Public Safety
From: Roberta Last
Subject: Senate Bill 323: Victim Accompaniment Bill
Position: Support
Date: October 22, 2015

Dear Chairman Wanggaard and Members of the Committee,

My name is Roberta Last and I live in , WI. Today I ask you to cosponsor the "victim accompaniment" legislation strongly supported by the Wisconsin Coalition Against Sexual Assault (WCASA). This bill will ensure that survivors of sexual assault are given the right to a trained victim advocate during the medical and criminal justice processes, such as during the forensic exam, law enforcement interviews, and court proceedings. I would like you to consider the following experiences of my daughter and me in looking at the Senate Bill 323: Victim Accompaniment Bill.

On January 2nd, 2014, my daughter woke me up to disclose sexual abuse at the hands of her father. My daughter was 18 at the time of disclosure, but was victimized from the ages of 5-13 years old. I had knowledge of the Sexual Assault Victim Advocates at ASTOP in Fond du Lac and when I accompanied my daughter to the police station to make a report, the advocates were contacted to provide immediate support to my daughter.

Her advocate provided emotional support to each of us throughout the 18 month court process and ongoing as needed. The advocate was with my daughter when I could not be for her initial statement to police and for the subsequent police initiate phone call she made to her father which resulted in his arrest. The advocate accompanied us to nearly every hearing and every meeting with the Prosecutor. She met with my daughter frequently throughout the court proceedings and is continuing to follow up with her as my daughter feels she needs and has greatly assisted the healing process. The advocate also assisted us with information gathering about different steps of the process along the way. The advocate was available for me to vent to, complain to, ask questions, and most importantly focus on my daughter and healing myself. She was able to validate all of our feelings and assist us to continue to move on in our lives as we went down the path of healing. Having the Advocate available from the very beginning started the healing process and provided the support we needed along the way. During hearings, I knew that the advocate's primary focus was my daughter, the victim, and this allowed me to focus on what was going on during the hearings, knowing that my daughter was well taken care of. My daughter's offender took a plea deal just shy of a week before the trial was scheduled for. We were already thoroughly prepped for trial. The advocate was with us throughout trial prep. My daughter wanted me to be in the courtroom during her testimony for support, but there was a very real possibility that I would not be allowed in during her testimony. As much as that concerned me, I knew her advocate would be with her every step of the way during her testimony. That was also reassuring to my daughter.

Each hearing was difficult as people who used to love and support my daughter turned against her. Having the advocate present and supportive was huge during this time. Each meeting with the Prosecutor was intimidating and the advocate assisted us to understand and proceed with what we needed to do. The advocate hooked my daughter up with Equine therapy, which was very beneficial to my daughter. The advocate also connected us with WCASA and we have benefitted greatly from their Survivors and Allies Task Force meetings. The advocate further empowered us to stand tall and tell my daughter's story. To date, I know for sure of one

additional victim who felt able to come forward with her own abuse due to my daughter's story of her abuse.

An advocate is the only person whose sole concern is the victim's well-being and who has no other obligation to any other agency or individual. Not all victims have support in their mother or other family members or friends like my daughter had. Without the assistance of our Advocate, my daughter and I would have been more vulnerable to her offender and the system in general. The Court process is extremely intimidating. After an assault, legal and medical proceedings can leave survivors feeling lost, confused, overwhelmed, and powerless. The more victims that are well supported, the more that will feel comfortable coming forward and possibly less offenses will occur as more victims come forward and offenders are able to be held accountable. Our communities are safer and better able to hold perpetrators accountable when victims feel supported in reporting sensitive crimes and participating in their prosecution.

Similar laws already exist in eleven other states and Washington, DC, and have proven effective. Existing Crime Victim Rights laws ensure that all crime victims are treated with "fairness, dignity and respect for their privacy." The presence of a victim advocate helps make good on that promise. Current law offers victims of certain crimes, including sexual assault and domestic abuse, the right to be accompanied by a victim advocate at a limited number of court proceedings if the alleged crime is a factor in a child custody case or is a factor in the victim's ability to represent him or herself. By contrast, victim accompaniment allows the victim, if they so choose, to be accompanied by a trained advocate at all stages of the criminal justice process. Law enforcement and medical professionals in states with similar laws state that providing assistance to sexual assault victims has a positive impact on those individuals and increases the likelihood that crimes are reported and that offenders are charged.

Victims of sexual assault have been violated in the vilest way possible. Their belief in humanity, justice and good in the world has been corrupted. Their sense of feeling safe is often non-existent. An advocate accompanying them along the way of this difficult process is a necessary step to provide them with the support they so need and deserve. Please consider this example of my daughter's experience with a victim advocate and co-sponsor this Bill.

Thank you for your consideration. If you have any questions, you can contact me at

Sincerely,

Roberta Last

Victim Accompaniment Bill

My name is Amanda Ebben, and I believe that the Victim Accompaniment Bill would be beneficial to all victims, and this is why.

On October 30th, 2011 I was the victim of a brutal sexual assault and domestic violence. After being beaten for 5 hours, my then boyfriend, decided that to appease me, he would rape me. After being ignored by people who came into contact with me that night, I felt like I would never get away. I felt that I was going to die there. I even went so far as to tell a man I loved, and who I thought loved me to "just end it, just kill me." So many women, myself included at that point, are not aware that even in a relationship, even after being brutally beaten, no doesn't have to be said for sex to be unwarranted.
My case, was difficult, because I reside in a completely different community from where my assault took place. After filing a restraining order against my assailant in my county, I was informed that I should see someone about the sexual assault.
That is when my life changed for the better. I met Angel Gilbertson, a client advocate through A-STOP. Being so overwhelmed, she did her best to give me the information and resources I needed that night. She offered the services of A-STOP as well. I don't think I could ever put in words just how much of a blessing her presence was in that room. Just how important is was for me that she was there. She gave me a little care package, that the local church had put together, since many women have nowhere to go. I didn't really require it, as I had everything I needed, but the level of comfort you feel, knowing that your every need can be met. In that package was a small, red, fleece blanket with snowmen on it. Four years later, I still have this blanket. I slept with this blanket for weeks after my attack. Angel gave me this comfort, Angel was my care package. I may not have known it that night, but four years later I do know this.
Angel knew, before I did, all the things I needed to move forward, she was present for every stride forward, for every hearing, and offered any assistance she could. I just figured she was expected to be there at the hospital that night. I would have never have thought to ASK for someone to advocate me through the darkest night of my life. No abused person should ever have to ask for this level of help, no person should ever have to ask for their Angel.
I know that night would have gone very differently had Angel not been there. After being ignored by so many people, I finally had people who were not just listening but understanding, and giving me the compassion I needed.
This Accompaniment NEEDS to be required. Advocates are a pillar of strength, even for the scared women who have everything they need already. Just think of what they mean to the women who truly leave with nothing.
Many Thanks,

Amanda Ebben

POSITION DESCRIPTION
CLIENT/VICTIM ADVOCATE
ASTOP, INC.

ACCOUNTABILITY
Accountable to ASTOP Executive Director

POSITION STATUS
This is a full time position, approximately 40 hours per week responsible to coordinate and direct client support services. Provides input for the collection, compilation and interpretive analysis of complex client related statistical data. Responsible for providing coordination and oversee ongoing and special direct services designed to assist victims. Provide comprehensive assistance and liaison to and for victims and referrals to appropriate follow up services.

PRIMARY RESPONSIBILITIES
Within the programs, policies, procedures and budget, the Client/Victim Advocate is responsible for the duties below:

1. Committed to the philosophy and vision of the agency.

2. Complete in-service training for crisis intervention and continue with further client or services training when appropriate.

3. Uphold the standards and methodology of the prevention education program of Protective Behaviors including the Agency environment and all aspects there in.

4. Attend regularly scheduled staff meetings, client service meetings and meet with the Director as defined by the Director.

5. Prepare and organize volunteer training and quarterly trainings; attend volunteer meetings; organize volunteer recognition; create and maintain volunteer manuals to keep information up to date. Maintain emergency room supplies and folders.

6. Actively seek and establish opportunities for ASTOP programming, regarding issue related working groups. Make site visits, attend meetings, committees or conferences with regard to client services related research and conduct literature and field research as appropriate.

7. Provide direct services for victims and their families to include crisis intervention; emotional support and assistance as needed/requested; information on victim's rights and the availability of therapy/counseling and shelter; legal and medical services; education; restraining order assistance; Crime Victim Compensation Applications; pre-trial and post-trial support and appropriate referrals.

8. Provide follow-up contact to all identified victims.

9. Coordinate and conduct Inpatient Behavioral Health education groups.

10. Understand and anticipate the nature of the position requiring some flexibility and off-duty hours.

11. Oversee, coordinate and chair the Sexual Assault Response Team (SART) and be actively involved in the Fond du Lac County Coordinated Community Response (CCR).

12. Maintain client files and statistics as needed. Perform other administrative operations as dictated by funding opportunities.

13. Maintain, update and utilize as a resource the ASTOP website.

14. Participate in goal setting and long term and short term service program planning that are congruent with the strategic plan.

15. Participate in and assist with grant proposal development and fundraising.

16. Participate in continuing education opportunities that promote personal and professional growth.

17. Perform all other duties as deemed necessary by the Director.

QUALIFICATIONS

A. Education/Training: Criminal justice, social work or other human service industry. Knowledge of statistics, records management, information and data processing or business administration. Practical knowledge of crisis intervention and of community resources and services.

Licenses: Valid Wisconsin Driver's License and appropriately insured vehicle.

B. Experience: At least two years experience in a business, budget, and planning or development office in a non-profit setting. At least two years experience in crisis intervention services, preferably in the area of sexual abuse.

C. Personal: Excellent organizational, communication and interpersonal skills; ability to analyze, interpret and communicate client/service goals; ability to maintain accurate and detailed program records; reasoning and problem solving skills. Ability to maintain an atmosphere of trust, fairness and respect and be mutually supportive with clients, volunteers, co-workers and the public. Ability to listen to other's concerns, interact with external agencies and be receptive to change in the spirit of collaboration for strengthening ASTOP services. Knowledge of the issues surrounding sexual violence. Ability to maintain client confidentiality.

Memorandum of Understanding

By Fond du Lac County Law Enforcement and ASTOP (Sexual Assault Advocacy Center)

I. PURPOSE

Fond du Lac law enforcement agencies recognize the responsibility it has to respond to the needs of citizens requiring its services. This responsibility is not limited to the investigation of criminal acts; rather it extends to providing assistance to citizens in need. Victims of violent crime, especially sexual assault victims, require services from Fond du Lac County law enforcement agencies on multiple levels. Providing this assistance can be difficult as the need for information sometimes competes with the needs of the victim. Recognizing this fact, the Fond du Lac County law enforcement agencies have partnered with an outside agency better suited to meeting the special needs of those victims. In doing so, the emotional needs of the victim may be met while the criminal investigation moves forward.

This procedure has been developed to provide guidelines to officers and deputies investigating sexual assault complaints. Its intent is to inform officers and deputies on how to access ASTOP as an assisting agency and what ASTOP's role is in aiding the criminal investigation.

II. ASSIST SURVIVORS TREATMENT OUTREACH PREVENTION (ASTOP)

ASTOP is a sexual assault advocacy program located in the City of Fond du Lac. ASTOP specializes in educational and awareness programs, medical and legal advocacy, and victim/family support in relation to sexual assaults. More information about ASTOP can be located via their website at www.astop.org. ASTOP does support the mission of Fond du Lac County law enforcement agencies and wishes to be a strong partner in addressing the problem of sexual assault in Fond du Lac County.

III. ROLE OF ASTOP ADVOCATES

The role of an ASTOP advocate is to provide support and services to the victims of sexual assault and their families. Their partnership with Fond du Lac County law enforcement agencies provides a way to reach more victims in a timely manner while assisting the law enforcement agency in meeting the needs of victims. Advocates are not present to hinder the criminal investigation, rather they are available to offer support to victims at a time when they need it most. Through a collaborative effort, an ASTOP advocate can assist a victim of sexual assault in understanding the process of the criminal investigation and support them so they can provide the law enforcement agency with necessary information.

IV. SUPPLEMENTAL INFORMATION PACKETS

A. ASTOP has agreed to provide Fond du Lac County law enforcement agencies with information packets regarding services for victims of sexual assault.

B. These information packets will be stored at each of the Fond du Lac County law enforcement agencies for distribution to sexual assault victims.

C. ASTOP advocates will retrieve these information packets upon arrival. They will insure the information is distributed and explained to sexual assault victims as appropriate.

V. ADULT OR JUVENILE VICTIMS

A. An ASTOP advocate should be called out for assistance in meeting the needs of sexual assault victims with the exception of when a VSIP interview is used. Officers and deputies should not ask the victim if they would like an advocate to respond. Many times a victim of sex assault does not want to burden/bother anyone else because of the many emotions they are experiencing at the time. If the victim does not want the ASTOP advocate present when the interview begins, the advocate will leave after providing the information packet to the victim. An advocate will not be notified if an officer or deputy feels the advocate's presence will be detrimental to the investigation; however, ASTOP should still be notified as soon as possible for follow up with the victim at a later time.

1. Juvenile Victims (Victim Sensitive Interviewing Protocol, VSIP interviews)

   a. Juvenile victims of sexual assault are particularly sensitive. In many cases, the Department of Social Services (DSS) and the District Attorney's office are present during the interviews of these victims. Officers and deputies should follow the Fond du Lac County MOU for VSIP.

   b. Officers should not call out ASTOP advocates during these types of investigations without consulting representatives from the Department of Social Services and/or the District Attorney's office.

   c. If a VSIP interview is not used for the juvenile victim, ASTOP should be contacted directly.

B. In lieu of the presence of an ASTOP advocate, officers may provide the ASTOP information packet to the adult victim or family of juvenile victims where the family members are not the suspected violator.

VI. CALL OUT PROCEDURES

A. Initial Response

1. An officer receiving the initial complaint of a sexual assault should, request an ASTOP advocate respond and provide officer contact information. The officer or deputy will meet with the victim to determine the following preliminary information:

   i. Jurisdiction of the crime,

ii. Age of the victim (juvenile or adult),
iii. Amount of time passed since the assault, and
iv. Need for evidence collection including the sexual assault kit.

2. After the preliminary interview, the officer or deputy should then determine whether to continue the investigation at the hospital or at the law enforcement agency.

B. Advocate Response

1. The ASTOP advocate should respond to the appropriate location as provided by the Fond du Lac County Communications Center.

2. The ASTOP advocate should provide support and assistance to the victim of the sexual assault as needed.

3. The ASTOP advocate should be present to assist in the investigation by providing the victim with support. The advocate should not hinder or impede the investigation in any way.

2. An officer witnessing an ASTOP advocate obstructing an investigation in any way should notify the officer's immediate supervisor.

VII. PROGRAM EVALUATION AND TRAINING

A. As with any partnership, open communication is paramount in maintaining a good working relationship with all parties involved.

B. Fond du Lac law enforcement agencies will keep an open dialog with ASTOP and its representatives to insure services provided meet the needs of the victim, ASTOP and the law enforcement agencies.

C. Input from both department employees and ASTOP representatives will be considered during the continued evaluation of this partnership to insure the best service available is provided to the victims of sexual assault.

D. Fond du Lac law enforcement agencies will provide periodic training to its employees regarding the services provided by ASTOP and the ongoing partnership between both entities.

VIII. EXECUTIVE SIGNATURES

Fond du Lac Sheriff's Office Designee

Date: 5-6-15

Fond du Lac City Police Department Designee

Date: 5-06-15

North Fond du Lac Police Department Designee

Date: 5-6-15

Brandon-Fairwater Police Department Designee

Date: 05-06-15

Campbellsport Police Department Designee

Date: 05-06-15

Oakfield Police Department Designee

Date: 05-06-15

Ripon Police Department Designee

Date: 5-6-15

Rosendale Police Department Designee

Date: 05-15-15

Town of Ripon Police Departmant Designee

Date: 5-6-15

Waupun Police Department Designee

Date: 05-06-15

Fond du Lac County District Attorney Designee

Date: 5/6/15

ASTOP Designee

Date: 5/7/15

ASTOP Sexual Abuse Center
Impact on the Community

Assist Survivors

Since 1992, 681 victims of sexual violence have presented themselves in the Emergency Department of St. Agnes Hospital where, in collaboration with Agnesian Healthcare, a Sexual Assault Nurse Examiner (SANE) gathers forensic evidence and completes an examination for injuries. In 2014, 56 individuals reported directly to the Fond du Lac city police station. In either situation, one of ASTOP's trained advocates accompanies these individuals and acts as a support person for the survivors and their family members. ASTOP's client advocate then assists the victim as their cases move through the legal system and makes referrals to other resources as necessary. Since 1992, our Client Advocate/Volunteer Coordinator has served 1,345 clients in this capacity.

Treatment

Since April 6, 1992, ASTOP's counselors have provided cost-free counseling to over 3,720 clients dealing with issues of sexual violence in Fond du Lac and Green Lake County. Seventy percent of these clients are at or below poverty level. Sixteen percent of these individuals are elementary age; eleven percent are teens; eleven percent are clients with developmental disabilities and the remaining are adult males and females. Twenty-two percent of the adults are affected family members. Education groups are provided for women in correctional residential treatment, females who are in recovery for substance abuse, and males and females who are patients in the Inpatient Behavioral Health Unit of St. Agnes Hospital. Adult, teen, and non-offending parent therapy groups are also offered. ASTOP provides two other locations on a part-time basis in Ripon and Green Lake, Wisconsin.

Outreach

Since July 6, 1992, ASTOP received over 3,339 calls on its 24-hour crisis line. ASTOP's trained volunteers give 25 to 30 hours per month. Their role is to provide medical and law enforcement advocacy and answer any crisis calls.

Prevention

Since August 1991, ASTOP has taught prevention education to over 105,268 children, adolescents, adults, and professionals using the Protective Behavior's curriculum. The program teaches specific strategies to help them confidently address personal safety issues.

ASTOP, Inc.

A not-for-profit organization, ASTOP recognizes and is thankful for our individual and corporate supporters, and for collaborative community involvement. St. Agnes Hospital continues to support ASTOP by donating office space because they believe in our mission of working toward creating a safer environment from sexual violence. ASTOP is proud to be a member of the Fond du Lac Area United Way and Ripon United Way.

ASTOP Prevention Education Programs

We can't take away all of the risks that children face. We can give them the skills to feel safe. Prevention education is not only about decreasing the incidence of sexual abuse, it is also intervening when abuse has or is occurring. In 2014, ASTOP's goal was to collaborate and transfer our professional knowledge, skills, and materials to parents, teachers, administrators, community, adolescents, and children. It also included helping society to understand that there needs to be zero tolerance when it comes to sexual violence and that each individual person is responsible to stand up and be a voice, not just a bystander. At all levels of education, -- of the students could identify two to three of their Early Warning Signs, and name at least one person on their personal network that they could talk with when not feeling safe. In 2014, 540 participants in attendance disclosed sexual abuse, and 125 of those disclosures were from children and teens, pre-K thru freshman.

Protective Behaviors

Specifically, ASTOP's prevention education program, Protective Behaviors (PB), is appropriate for all ages and can be used throughout a person's life. The Protective Behaviors concepts and strategies can be taught to promote anti-victimization and enhance empowerment for all people. It has two themes, which are:

Theme One: "We all have the right to feel safe all of the time... and others have the right to feel safe with us."

Theme Two: "We can talk with someone (we trust) about anything, no matter how awful or small.

ASTOP conducts workshops to train educators, social workers, service providers, and law enforcement personnel in the Protective Behavior's process to use with their individual clientele. The following is a brief description of the "K-Through-Life" program.

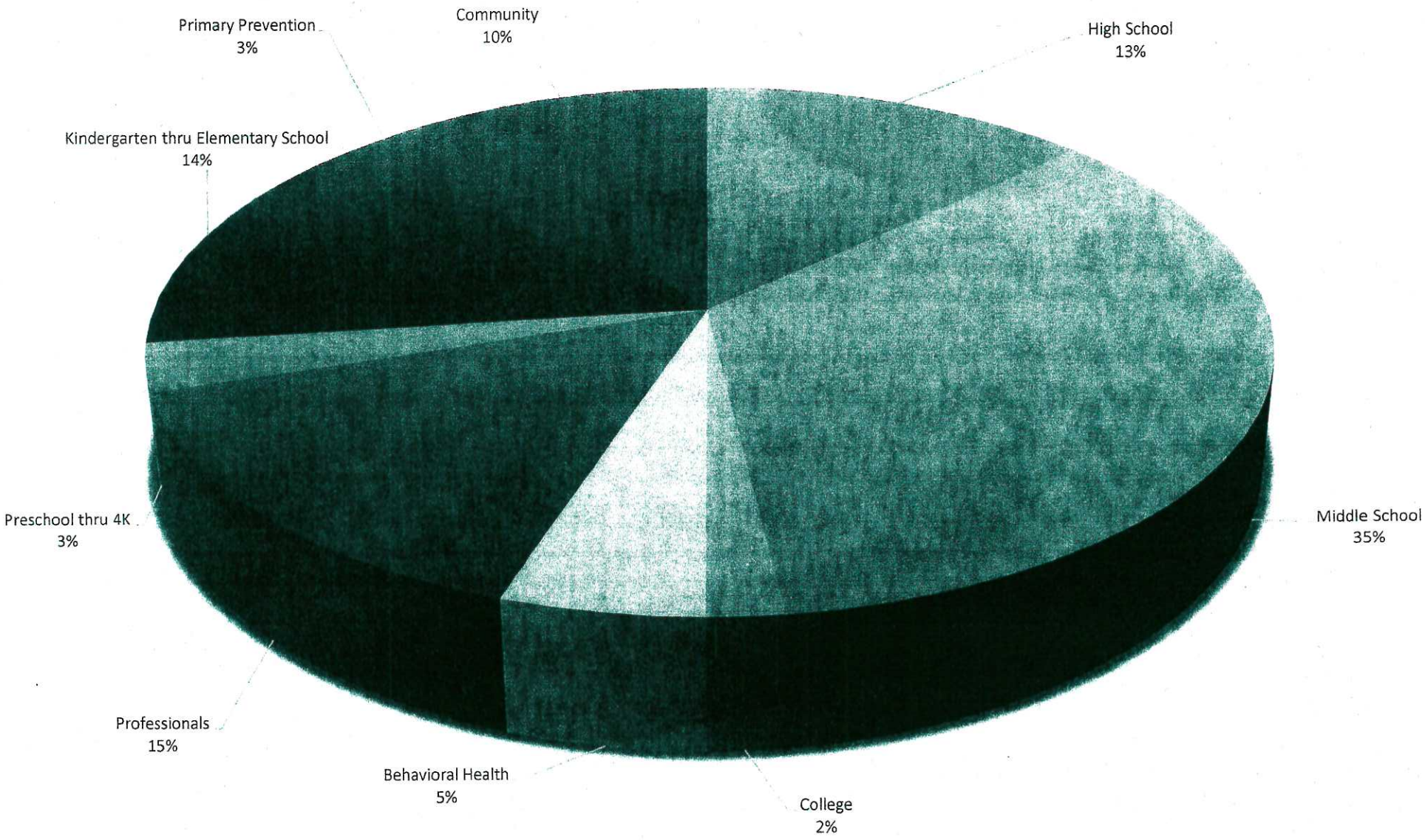
Elementary Education

Safety is a concept that applies to everyday life and yet all too often we are taught to be careful, don't take drugs, don't talk to strangers, "good touch/bad touch" – which in some instances creates paranoid individuals. Protective Behavior's education for the elementary level is an empowerment process, which encourages us to say YES by teaching specific strategies to face challenges confidently without sacrificing the right to feel safe.

Secondary Education

ASTOP specifically wrote a secondary curriculum for teaching Protective Behaviors titled *Feeling Safe and Standing Strong.* This curriculum works toward creating nonviolent individuals, families, and communities and is being used across Wisconsin, the United States, Australia, Canada, and the United Kingdom. Violence has become an increasing concern in our personal lives. Feeling Safe and Standing Strong enables the participants to explore the influence that values and attitudes have on the amount of violence we see in our schools, communities, and society.

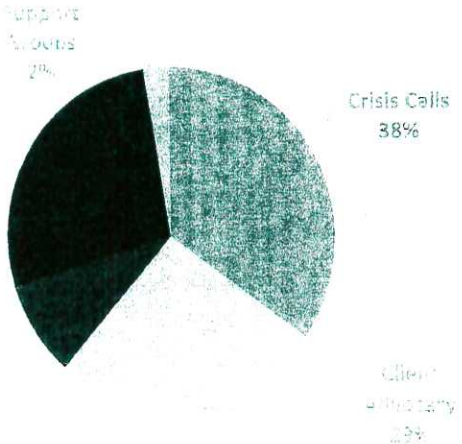
Estimated 2014 Presentations



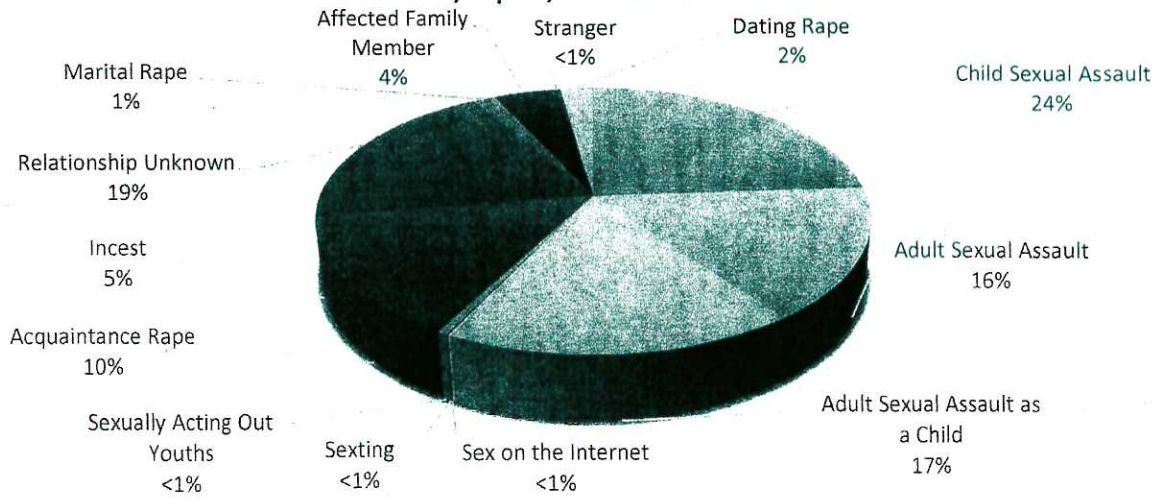
ASTOP, Inc. Summary of Services – All Locations

Service	4/92-2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	Total
Continuing Clients			47	89	63	50	76	97	100	109	173	172	77	108	N/A
New Counseling Clients	1,334	248	170	194	168	94	154	187	185	214	242	173	244	232	**3,720**
Females	919	132	77	92	99	64	110	127	124	134	153	100	149	128	**2,408**
Males	93	38	30	38	16	8	9	12	12	10	17	12	24	26	**345**
Adolescents	117	22	18	24	24	13	17	15	17	30	32	24	20	34	**407**
Child	126	56	45	40	29	9	18	33	32	40	40	37	51	44	**600**
Clients w/ Special Needs	0	54	49	25	10	7	39	41	18	16	18	25	51	41	**394**
Client Advocacy	19	78	80	92	34	16	29	51	60	115	151	130	202	288	**1,345**
Crisis Contacts, Information, and Referral					34	55	114	87	81	97	26	68	34	32	**628**
24 HR Crisis Line Calls	1,669	73	109	99	96	85	95	105	88	117	143	147	278	235	**3,339**
Medical/Law Enforcement Advocacy	187	28	20	24	29	36	27	19	23	55	48	35	75	95	**701**
Presentations (# of participants)	17,238	2,704	2,056	4,155	4,792	5,269	6,679	6,835	8,008	8,181	8,507	11,820	7,754	11,270	**105,268**

ESTIMATED ASTOP SERVICES ACCESSED 2014



Estimated Reasons Why Therapy Clients Accessed Services in 2014 in Fond du Lac, Ripon, & Green Lake Locations



ASTOP Volunteer Application

Please send completed application to:
ASTOP, Inc. 430 E. Division Street, Fond du Lac, WI 54935

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email address: _____

Employer: _____ Phone: _____

Occupation: _____ Hours: _____

Why are you interested in volunteering with ASTOP?

Please check all areas in which you are interested in being a volunteer.

___ Crisis Line ___Special One-Time Projects ___ Medical Advocacy
___ Fund Raising ___ Office Assistance ___ Other_____

Are you willing to complete an inservice training in crisis intervention, interviewing, client support and resources? ___Yes ___ No

What is your educational background?

List any jobs, course, or experiences, which you feel would assist you in being a sexual assault volunteer?

Tell us a little about yourself in terms of interests, activities, and social involvement.

Are you a survivor of sexual assault/abuse/incest or domestic violence? ___ Yes ___ No

If yes, briefly describe your healing process and present understanding.

Are you experiencing any significant emotional problems at present or have you experienced them in the past five years? ___ Yes ___ No

If yes, please describe.

Have you ever been convicted of a felony? ___Yes ___No

Please indicate with a check mark (only one per line) your comfort level in discussing the following issues.

	Very Comfortable	Somewhat Comfortable	Somewhat Uncomfortable	Very Uncomfortable
Sexual Assault				
Incest				
Child Abuse				
Birth Control				
Anger/Revenge				
Abortion				
Venereal Disease				
Depression				
Suicide				
AIDS				

Please list three references whom we may contact (not a relative or spouse).

1. Name_____ Relationship_____

   Address_____ Telephone_____

   City/State/Zip_____

2. Name_____ Relationship_____

   Address_____ Telephone_____

   City/State/Zip_____

3. Name_____ Relationship_____

   Address_____ Telephone_____

   City/State/Zip_____

I hereby declare that the above information is accurate and factual and give my permission for ASTOP to contact the references listed above.

_____ _____

Signature Date

ASTOP Sexual Abuse Center
Crisis Line Advocate and Medical Advocate Volunteer Description

Purpose
To help survivors of sexual assault/incest in meeting their emotional and medical needs.

Qualifications
1. 18 years of age or over.
2. Experience working with people or desire to work with people.
3. Sensitivity to issues of sexual violence, including child sexual abuse and sexual assault.
4. Work with other community agencies in assisting the clients.
5. Have respect for and have ability to maintain confidentiality.
6. Commit one's self to the program for at least one year after training completed.

Coverage
Crisis Line – flexible scheduling, volunteer will be utilized 24- 30 hours per month, (4-5) 6-hour shifts (week day and weekend hours).

Emergency Room/Police Departments Advocacy – flexible scheduling, volunteer will be on call 5 shifts p month, 3 weekday shifts, 2 (12 hour) weekend shifts.

Responsible to
ASTOP Sexual Abuse Center Staff: Lindsey Speitz, Office/Intake/Volunteer Facilitator
Jan McDonough, ASTOP Executive Director

Responsibilities
1. Attend training sessions and volunteer meetings.
2. Sign a confidentiality statement.
3. Abide by the policies and procedures of ASTOP.
4. Understand, support, and respect clients with whom you work.
5. Supply relevant information and support when requested.
6. Provide staff with pertinent client information and forms.

Duties
Crisis Line – Volunteer will respond to calls in their homes from the answering service. Volunteer will offer emotional support to the survivor as well as any needed information, including referrals and will encourage the caller to seek necessary assistance. Volunteers are required to call in a crisis line report as soon as possible following the format set by ASTOP. Using this information, ASTOP staff can follow-up as necessary.

Emergency Room/Police Department Advocate – Advocate will be involved in supporting the survivor in any phase of the crisis or during the investigative or medical proceedings that may follow. An advocate will provide direction, support, guidance and nurturing to the person in crisis. An advocate may accompany the survivor to the emergency room and Police Department(s). Advocates are required to complete an ER/PD intake and contact ASTOP office immediately and leave a message on ASTOP's voice mail with the information so Case Management can follow-up.

Special note - If sexual abuse has been an issue in the past, the volunteer must have worked through those issues successfully at least 2 years before volunteering for ASTOP.

ASTOP Sexual Abuse Center
Volunteer Policy and Procedures

1. All ASTOP crisis line and emergency room advocates must complete volunteer training. All training sessions required in attendance.

2. All volunteers are required to sign a confidentiality statement and keep confidential all information learned while volunteering for ASTOP.

3. All volunteers are required to commit to one year of service after volunteer training is completed.

4. Crisis line volunteers are required to commit to 5 shifts per month on the crisis line – 2 of the 5 shifts being scheduled on the weekends.

5. ASTOP volunteer advocates are required to commit to 5 shifts per month on the advocacy calendar – 2 of the 5 shifts being scheduled on the weekends. Volunteer advocates are to meet clients/survivors in the ER/PD only.

6. Volunteers are to enter their availability/shifts into the ASTOP crisis line and advocacy calendars by the 20th of each and every month.

7. Volunteers are to schedule one holiday shift per year.

8. Volunteers who are unable to cover an assigned shift should find their own replacements for that shift. Once a replacement is found, the volunteer must call the ASTOP office to make them aware of the switch. If the call is made during business hours, Monday through Friday from 8 a.m. to 4:30 p.m., the office staff will inform the answering service about the change. If the change is made on a weekend for that same weekend, the volunteer is responsible for contacting the answering service to make them aware of the change. The ASTOP office must also be called and a message can be left on voice mail about the schedule change.

9. Volunteers are required to attend at least 2 volunteer meetings per year after training completed.

CONFIDENTIALITY AGREEMENT
VOLUNTEER
ASTOP INC.

The term "client" as stated in this agreement refers to any individual that accesses any service of ASTOP including referral services but excluding participants of educational presentations.

I, as a volunteer of ASTOP, agree to uphold the importance of client confidentiality in the operation of ASTOP. Any client information obtained in the course of service, whether written, verbal or communicated electronically is confidential, including identification of anyone as a client of ASTOP.

I understand that client names and any personally identifiable information regarding a client or that client's situation shall not be used and/or communicated to anyone other than an ASTOP paid staff member in the course of service operation. I agree that I will hold in strict confidence and not use or disclose, except in connection with my duties as a volunteer of ASTOP, all information marked or designated as confidential by ASTOP. This may include any information relating to the identity of clients seeking advocacy, medical records, client records or police records and reports, as long as others do not generally know such information outside the ASTOP organization. This confidentiality policy applies to ASTOP volunteers whether on duty or off.

I agree that home addresses and telephone number of ASTOP volunteers or staff are confidential and shall not be given out without specific permission from the volunteer or staff person in question in each instance that an inquiry is made.

Therefore, I hereby agree to maintain confidentiality as an ASTOP volunteer in accordance with the aforementioned policy. Intentional, reckless or negligent violation of this confidentiality policy may result in my termination of my association with ASTOP. I agree to abide by this policy upon termination or resignation.

I have read and understand my responsibilities as stated in this policy, and by my signature given below hereby agree to abide by its terms.

_____
Name (Please Print)

_____
SIGNATURE Date

_____
ASTOP Representative Date

cc: Volunteer

ASTOP Volunteer Training Outline

Day 1 – October 10, 2015 @ Journeys Health Resource Center

Time/Presenter	Topic(s)
8:00 a.m. – 9:00 a.m. Angel Gilbertson, Client Advocate Lindsey Spietz, Volunteer Coordinator	* Introductions * ASTOP Services * Confidentiality
9:00 a.m. – 10:00 a.m. Meredith Birmingham, Prevention Educator	* Sexual Assault 101
10:00 a.m. – 10:15 a.m.	* Break
10:15 a.m. – 10:45 a.m.	* E.R./SANE Tour
10:45 a.m. – 12:00 p.m. Lindsey Spietz, Volunteer Coordinator	* Move: *It Was Rape* * Discussion
12:00 p.m. – 12:30 p.m.	* Lunch
12:30 p.m. – 2:00 p.m. Angel Gilbertson, Client Advocate	* Boundaries * Advocacy
2:00 p.m. – 2:15 p.m.	* Break
2:15 p.m. – 3:00 p.m. Jan McDonough, Executive Director	* Trauma Response * Grounding
3:00 p.m. – 3:30 p.m. Jan McDonough, Executive Director	* Self-Harm * Wellness Check
3:30 p.m. – 3:45 p.m. Angel Gilbertson, Client Advocate	* Wisconsin Sexual Assault
3:45 p.m. – 4:00 p.m. Lindsey Spietz, Volunteer Coordinator	* Self-Care * Homework
4:00 p.m.	* Day One Complete! ☺

Day 2 – October 12, 2015 @ Plaza Level Fitness Conference Room

Time/Presenter	Topic(s)
5:00 p.m. – 5:15 p.m. Lindsey Spietz, Volunteer Coordinator	* Questions * Homework Discussion
5:15 p.m. – 5:30 p.m. Angel Gilbertson, Client Advocate	* Resources * Services Providers in WI
5:30 p.m. – 7:00 p.m. Angel Gilbertson, Client Advocate Lindsey Spietz, Volunteer Coordinator	* Crisis Line Scenarios * Questions
7:00 p.m. – 7:15 p.m.	* Break
7:15 p.m. – 8:00 p.m. Lindsey Spietz, Volunteer Coordinator	* Scheduling

Day 3 – October 14, 2015 @ St. Agnes E.R. Conference Room

Time/Presenter	Topic(s)
4:30 p.m. – 6:30 p.m.	* Scenarios
6:45 p.m. – 7:15 p.m.	* FDL P.D. Tour

ASTOP Volunteer Manual

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Chapter 6: Wisconsin Sexual Assault Laws

Chapter 7: Resources & Service Providers in Wisconsin

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Greeting – Hi, my name is April Eckdahl and I am a special education teacher for the Milwaukee Public School system. I'm here today because not only do I have experience with the Bureau of Milwaukee Child Welfare for the past 8 years as a teacher, but because for the past two years I have seen monumental errors that have and could continue to affect a child's life.

AB 431 - LRB-1942/6- This bill changes the current statutes to better define what the intent of neglect is and makes it easier for District Attorneys to explain to a jury. This bill also creates a crime of repeated acts of neglect of the same child. This change was modeled after repeated acts of sexual abuse to allow prosecutors the tools necessary to address those who have neglected the same child in numerous instances.

- I know this bill is of great debate. Neglect is such a broad area it is really hard to know what is considered "neglect" under the law or not. In the proposed changes to better define neglect and to make the punishments on a level, not just a misdemeanor or felony, I am hopeful that it will create a much more explanatory way of informing mandated reporters of what constitutes neglect. I know it is a case of "critical" neglect, but isn't that very subjective?
- For example, as a teacher I have seen what I think are many cases of neglect, only to call 220-SAFE and they say it is not, or question why I think it would be neglect. I have seen students walk to school in below freezing temperatures with a light jacket or a sweatshirt but that is not neglect. Or students have lice for weeks or continuous bed bug bites still sent to school. I have worked with a student (8 yr. old) who wore the same underwear for weeks, switched clothes with a sibling without them being washed, smelling, etc. I think most of these things ARE neglect. Not ridding your child's head of lice or not having a different pair of underwear to the point of smelling, to me is neglect. It is not necessarily seen that way by the BMCW and that is a problem. Worse is that the situation seems to be based on what intake worker you get on the phone. One may think it is horrible, one may not.
- In the case of a girl having a seizure disorder and not being taken for required dr check ups, especially when adults begin to notice her walking differently, speaking slower, and having frequent bloody noses, but is STILL not taken in, even when offered by a school worker. It was screened out. That should be a clear case of neglect right there! Therefore, this statute, as the authors said, needs to BETTER DEFINE neglect is long past overdue (and repeated acts - there should be a record, and it should be MONITORED, of both substantiated or unsubstantiated – that should be considered numerous instances as well).
- This bill, all bills, should also address the needs of children with disabilities. The "typical" kind of neglect can look very different than what is neglect for children with disabilities. Children with disabilities being neglected can look very different than neglect for children without disabilities.

AB 429 - LRB-2015/1-While child abuse and child neglect are both felonies in the State of Wisconsin, neither of these crimes are referred to law enforcement. This legislation requires that any suspected or threatened child abuse or neglect instances be referred to law enforcement. This bill aligns law enforcement and Child Protective Services to work as partners to substantiate allegations of abuse and neglect by using greater investigative power and experience to help Wisconsin's children.

- While this bill is of extreme importance, I believe there should be a measure put in place to monitor that all suspected instances are actually being referred to law enforcement. As it stands now, all suspected sexual assault instances of children are to be referred to law enforcement within 12 hours and through anonymous law enforcement sources I have learned that this is not always followed. This NEEDS to be followed with documented guidelines for calling. Does the child have to be pregnant? Knowing that calls of SEXUAL abuse are being dismissed and not even sent to law enforcement should make us all question if the same thing will happen with physical abuse or neglect.
- I think this bill is extremely important but it needs to be followed and implemented with great fidelity. There also needs to be someone to overlook this to make sure it is always followed and that it can be verified that each allegation was worked in coordination with law enforcement.
- I made numerous calls alleging of sexual assault for one of my students over the course of two years, as did co-workers, and not once was this ever referred to Sensitive Crimes or any other sort of law enforcement as is REQUIRED, according to my source. To make this situation worse was that this student was a young girl with autism.
- A call of any kind of abuse for a child with disabilities is different than for disabled children. Children with disabilities are taken less seriously – why?

AB 430 - LRB- 1327/2- Research has shown that sexual assault survivors who received services from sexual assault advocates had more positive outcomes and experienced less distress. This legislation works to partner with victim advocates by giving them closer access to survivors and make them a more important part of the treatment for sexual violence survivors to work towards better outcomes for survivors.

- Since I have worked with children for nearly ten years with varying types of disability, I can attest that any and all of my students would have benefited from having an advocate with them. It increases their feelings of confidence, reduces their fear, and doesn't feel alone in what is or could be a very scary time.
- A child is allowed to have a trusted adult with them in the room when they speak to an initial assessment worker. This should be put in place so that an interview doesn't start without an advocate, maybe even of their own choice. Of course not every student or teacher knows that is an option, which makes having victim advocates known much more important. Once this bill is passed, giving victim advocates closer access to survivors and more a part of the treatment for victims needs to be made aware on a

massive level. It should be made known that these advocates are out there and are available and can be utilized if needed.

AB 428 - LRB- 2516/1-This bill creates the crime of repeated acts of physical abuse of the same child. As children are often not the best with times and dates, this legislation gives District Attorneys the ability to set time periods for when instances of abuse have occurred and levy the crime of repeated acts of physical abuse of the same child.

- I also agree with this bill as part of the Justice for Children Package. It is extremely hard for children to set time periods in their heads and adults in all capacities need to understand that most likely, the child will not be able to give an exact date, or give a time period for how long abuse occurred. It is one more thing that can and has caused a problem when attempting to prosecute child abuse cases.
- This gives the children more of a voice. Having someone understand that it's okay if they aren't sure of the day, the month, if it was raining or cold is okay because that is not what is important. What's important is what HAPPENED and a general time frame. Any person working with children that is worth anything, that cares about kids at all, knows how children's minds work and will work with them, not AGAINST them.
- Physical abuse is rarely a one-time thing and rarely will it stop simply because one was arrested. The abuser needs to know that it can happen again, they can be arrested again, and with further consequences. More importantly, the victim needs to know that they do not need to be subjected to continuous abuse because the law only allowed prosecution for one offense.

At this point, I want to strongly urge you as power-holders of the law to deeply think about children with special needs; I'll primarily focus on autism. Children with disabilities are experiencing an injustice because they cannot express abuse verbally. They are a much more vulnerable population and much more likely to keep the abuse to themselves for many different reasons. In my experience, they have been treated much differently in the child protective services system than their neurotypical peers.

I have experienced this past year and a half a heart-breaking situation that has opened my eyes wide to the injustice for those with disabilities who cannot express the abuse they're subjected to in the way that the Bureau considers "disclosing". The summary of this situation is that one of my students began to exhibit behavior changes after a family member said something may have happened to her by a parent. I began to notice many changes that I soon learned from research were classic signs of sexual abuse. I call the BMCW over a dozen, maybe 2 dozen, times with new and important information. Another teacher called in as well. This little girl was telling us in her own way, in her own time, and when case workers came out to talk with her, she used avoidance as her tactic. She did not open up to anyone, and that is not how she is. She requires a close relationship with them, building trust over a long period of time before she will start to disclose. But she was disclosing to me and the other teacher in drawings, writings, acting things out with dolls (including laying the boy doll next to the girl doll after the abuse and saying the boy then says "I'm sorry". Any "normal" 8-year-old girl would not know that that comment is a classic of what pedophiles say, followed by presents and trips to McDonald's.

She also tried to disclose with her own physical actions, comments, etc. In the end, she did disclose to both a school social worker and a Bureau social worker. Instead of even realizing that children with disabilities will express things different, need patience, need different tactics, they closed the case because she didn't SAY what they wanted. With her mouth. And when she did, it was questioned. I was questioned. My motives were questioned.

A thorough check and understanding of the way her disability affects her thinking, her communication, her vulnerability, was not done. If any training or research has been done, or had been done, workers would see how communication is difficult even for a highly verbal student with autism. They need to stop to think of how that disability affected her judgment or reaction or regard toward her abuser. Autism is even more of a reason to investigate thoroughly. They should be thinking that her teachers perhaps DO know her very well and can see many behavior changes and can see and hear disturbing, sad things that are happening in her life.

Workers have always warned her guardians that they were coming for a "surprise" visit, in more than one case. Am I missing the definition of surprise? Do the guardians automatically get believed or is more research done? Is any relevance put at all on the fact that a child with disabilities may feel alone, closed off and only safe at the place they spend 6 hours a day at? BMCW "experts" need more training about how disabilities can affect a child – patience, commitment, and understanding are just a few very important skills to have.

I have story after story after and during this situation that made me see how differently children with disabilities are treated in the child welfare system. They are dismissed, screened out, tossed aside. They are the least cared for because they are the easiest to be pushed aside. They can't verbally state what happened? Case closed. They are the losers in this because it takes time, it takes commitment, to get to know a child and gain their trust not even just because of abuse but because of their disability in the first place! They need to be taken more seriously and with patience and with time because of their differing ways of communicating, etc. I can understand that caseloads are high but something needs to be done. Perhaps a new section of the BMCW should be created specifically for workers that work only with children with disabilities. Case workers that can recognize and accommodate children with disabilities, or at least supply a generous amount of training, continuously. Perhaps a case worker should have a disability "expert" or advocate accompany them on any visit involving a child with disabilities. They are losers because it is so much easier to close their cases and the workers will not get in any trouble or be thought less of because they followed each step and "no abuse" was found.

WISCONSIN COALITION AGAINST SEXUAL ASSAULT

Testimony

To:	Members of the State Assembly Committee on Criminal Justice and Public Safety
From:	Wisconsin Coalition Against Sexual Assault (WCASA)
Date:	November 5, 2015
Re:	Assembly Bill 430: Sexual Assault Victim Accompaniment Bill
Position:	Support

Good morning, my name is Dominic Holt, public policy and communications coordinator with the Wisconsin Coalition Against Sexual Assault (WCASA). WCASA is a statewide membership agency comprised of organizations and individuals working to end sexual violence in Wisconsin. Among these are the 51 sexual assault service provider agencies throughout the state that offer support, advocacy and information to survivors of sexual assault and their families.

WCASA thanks Chairman Kleefisch and Vice Chairman Kremer for bringing this important legislation forward for a hearing today. We also thank Senator Cowles, Representative Murtha, and their staff for spearheading this legislation. Additionally, WCASA thanks the 36 cosponsors of Assembly Bill 430 and Attorney General Brad Schimel for their support of this bill and continued commitment to issues related to sexual assault and human trafficking. We feel this bill is a vital step the Legislature can take to help reduce the trauma survivors often experience after these crimes, and to help ensure that these crimes are reported and prosecuted.

This bill allows, with some exceptions, survivors of sexual assault and human trafficking to be accompanied, if they so choose, by a victim advocate during critical medical and criminal justice proceedings. These include the medical forensic exam, law enforcement interviews, and court proceedings. Eleven (11) other states and the District of Columbia currently have victim accompaniment laws of some kind. The laws vary widely, but generally allow for an advocate to be present at some or all of the proceedings contained in AB 430.

Victim accompaniment is widely supported as a best practice. The International Association of Forensic Nurses' National Protocol for Sexual Assault Medical Forensic Examinations states that upon initial contact with a survivor, medical personnel should immediately request a victim advocate to assist the survivor.[i] The Wisconsin Sexual Assault Response Team Protocol states that it is best practice to allow a survivor to have an advocate present during law enforcement interviews, medical forensic exams, and meetings with prosecutors.[ii]

Additionally, the International Association of Chiefs of Police recommends providing sexual assault survivors with the option of having an advocate present during law enforcement interviews.[iii] This bill provides the Legislature with the opportunity to codify this best practice.

The rest of our testimony answers two very important questions about this issue: what is the purpose of victim accompaniment, and how do advocates support survivors.

What Is the Purpose of Victim Accompaniment?

The initial response sexual assault survivors receive when reporting the crime or seeking services can have a profound impact on their ability to recover from the assault. This proposal would give survivors a sense of security during a very vulnerable time and can help prevent additional psychological trauma as they navigate complex medical and legal systems. Furthermore, survivors who are supported by a victim advocate are more effective participants in the criminal justice system, which leads to increased reporting of crimes and increased convictions of offenders.

A 2006 study found that sexual assault survivors who had an advocate present during the criminal justice process had better outcomes – they were more likely to have a law enforcement report taken and the case was more likely

to be investigated further when an advocate accompanied a survivor.[iv] Sexual assault survivors interviewed for this study also reported less distress after their contacts with the legal and medical systems.

Additionally, guaranteeing the presence of a victim advocate ensures that survivors will be treated with fairness, dignity, and respect for their privacy. This is very important because treating survivors in such a manner not only is required under Wisconsin's Crime Victim Rights laws, but also helps other survivors feel safer to report these drastically underreported crimes. In fact, approximately 65% of sexual assaults go unreported annually.[v]

Finally, this bill extends these rights to human trafficking survivors, who are often extremely isolated and vulnerable. As a result, WCASA believes AB 430 is an important component in enhancing Wisconsin's response to human trafficking, something which is obviously of concern to this Legislature.

How Do Advocates Support Sexual Assault Survivors?

While the word "advocate" is used in many ways in public policy discussions, in this case "victim advocate" has a very specific meaning as defined in AB 430. Victim advocates work or volunteer at local organizations that provide counseling, assistance, or support services free of charge to sexual assault survivors and their families. Advocates provide critical services to survivors, like explaining various procedures, providing basic information about the medical and legal systems, and offering emotional support.

Survivors report that the presence of an advocate is critical to navigate the complex legal and medical systems. With respect to these systems, there is no other discipline whose primary function is to advocate for the interests and wants of the survivor. As stated by the International Association of Forensic Nurses' National Protocol, "Community-based advocates … have the sole purpose of supporting victims' needs and wishes."[vi] Additionally, advocates are trained to develop relationships with key personnel in the medical and criminal justice systems, whether it be Sexual Assault Nurse Examiners, law enforcement officers, or prosecutors. These relationships are instrumental in assisting survivors engaging with these systems.

Advocates also play an integral role in multi-disciplinary teams responding to sexual assault across the state. They are a key discipline in local Sexual Assault Response Teams that exist in many communities in Wisconsin.

Victim advocates are highly trained before they ever assist survivors. It is best practice for community-based sexual assault victim advocates to obtain 40 hours of crisis intervention training from their sexual assault service provider agency. In addition, it is best practice for advocates to obtain another 40 hours of training through WCASA's Sexual Assault Victim Advocacy School. As part of our membership organization, advocates also receive a variety of ongoing trainings and other resources that enable them to remain up-to-date on changes in the field.

Conclusion

WCASA believes AB 430 provides a measure of security and assistance for survivors of these crimes. This will help survivors personally as they recover, as well as our society in general as we work to ensure that offenders are brought to justice and that future assaults are prevented.

We thank you for your attention to this matter and for your continued efforts to reduce the prevalence of sexual assault and human trafficking in Wisconsin. If you have any questions, you can reach me at dominich@wcasa.org or at the phone number above.

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[i] International Association of Forensic Nurses. A National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents, Second Edition. April 2013.

[ii] Wisconsin Department of Justice. Wisconsin SART Protocol. 2011.

[iii] International Association of Chiefs of Police. National Law Enforcement Policy Center. Investigating Sexual Assaults. Revised 2005.

[iv] Rebecca Campbell. Rape Survivors Experiences with the Legal and Medical Systems. Do Rape Victim Advocates Make a Difference? Violence Against Women. 2006.

[v] U.S. Bureau of Justice. National Crime Victimization Survey. Victimizations Not Reported to the Police (2006-2010). August 2012.

[vi] International Association of Forensic Nurses. Page 39.

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Rape Survivors' Experiences With the Legal and Medical Systems

Do Rape Victim Advocates Make a Difference?

Rebecca Campbell
Michigan State University

This study used a naturalistic quasi-experimental design to examine whether rape survivors who had the assistance of rape victim advocates had more positive experiences with the legal and medical systems compared to those who did not work with advocates. Eighty-one survivors were interviewed in two urban hospitals about what services they received from legal and medical system personnel and how they were treated during these interactions. Survivors who had the assistance of an advocate were significantly more likely to have police reports taken and were less likely to be treated negatively by police officers. These women also reported less distress after their contact with the legal system. Similarly, survivors who worked with an advocate during their emergency department care received more medical services, including emergency contraception and sexually transmitted disease prophylaxis, reported significantly fewer negative interpersonal interactions with medical system personnel, and reported less distress from their medical contact experiences.

Keywords: *rape; rape crisis centers; rape victim advocates; sexual assault*

One of the enduring legacies of the 1970s feminist social movement was the creation of community-based rape crisis centers (RCCs). There are now more than 1,200 RCCs in the United States, and their staff and volunteers provide numerous services to survivors of rape, such as crisis intervention, medical and legal advocacy, and counseling (Campbell & Martin, 2001; Martin, 2005). Of these three basic services, social system advocacy is perhaps the most challenging for RCC staff (Campbell, 1996; Martin, 1997, 2005). Rape victim advocates assist survivors in hospital emergency departments (ERs) and police departments by guiding them through the process of medical forensic evidence collection and legal prosecution. At the same time, rape victim advocates are trying to prevent "the second rape" or "secondary victimiza-

Author's Note: I thank Shelley Mendel and Cherise Watkins-Jones for their assistance with data collection, Deb Bybee and Neal Schmitt for their advice regarding data analysis, and Cris Sullivan and Marisa Sturza for helpful comments on previous drafts of this article.

tion"—insensitive, victim-blaming treatment from social system personnel that exacerbates the trauma of the rape (Campbell et al., 1999; Campbell & Raja, 1999, 2005; Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Madigan & Gamble, 1991; Martin & Powell, 1994; Williams, 1984). The job of the rape victim advocate, therefore, is not only to improve service delivery but also to stop secondary victimization. Although RCCs have been providing legal and medical advocacy services for decades, there is little research evaluating the effectiveness of rape victim advocates. The purpose of the current study was to address this gap in the literature by comparing rates of service delivery and secondary victimization for rape survivors who did and did not work with rape victim advocates.

The work of rape victim advocates is challenging as existing research suggests that most rape survivors do not receive needed services and are often treated insensitively by social system personnel. Within the legal system, studies of rape case processing suggest that approximately 50% of the time law enforcement personnel either do not take victims' reports or never forward their reports for investigation, and only 22% to 25% of reported rapes are prosecuted, 10% to 12% of which result in some type of conviction (Campbell, 1998a; Campbell et al., 2001; Frazier & Haney, 1996). Case attrition is widespread and problematic; however, prior research has also found that postassault contact with the legal system can be revictimizing. For example, rape survivors report that they are asked about their prior sexual histories, questioned about how they were dressed or behaving at the time of the assault, and are encouraged not to report or prosecute the assault. Victims consistently report that these kinds of behaviors are highly distressing and revictimizing (Campbell et al., 1999; Campbell & Raja, 2005). Similarly, prior research has found that most survivors of rape report feeling guilty, depressed, anxious, distrustful of others, and reluctant to seek further help after their interactions with legal system personnel (Campbell et al. 1999; Campbell et al., 2001; Campbell & Raja, 2005).

Experiences of rape survivors with the medical system can also be difficult. When rape victims seek postassault emergency medical care, most receive a medical exam and forensic evidence collection kit (70%; Campbell et al., 2001), less than one half receive information on the risk of pregnancy (40% to 49%) (Campbell et al., 2001; National Victim Center, 1992), and between 20% and 43% are able to obtain emergency contraception to prevent pregnancy (Amey & Bishai, 2002; Campbell et al., 2001). Approximately one third of survivors of rape receive information about the risk of sexually transmitted diseases (STDs) and HIV from the assault (Amey & Bishai, 2002; Campbell et al., 2001; National Victim Center, 1992), and between 34% and 57% receive medication to treat and/or prevent STDs (Amey & Bishai, 2002; Campbell et al., 2001). In addition to these gaps in service delivery, secondary victimization from the medical system may also be a problem for survivors of rape (Martin, 2005; Martin & DiNitto, 1987). Campbell and Raja (2005) found that 58% of survivors in their sample reported that they were distressed by doctors' and nurses' questions about their sexual histories, behavior before the assault, and how they were treated during the exam process. Most women reported feeling violated, depressed, and anxious after their contact with medical professionals (see also Campbell et al., 2001).

These rates of legal case attrition and medical service delivery and secondary victimization come from studies of rape survivors who did not work with rape victim advocates, which raises the question: Can advocates make a difference? Are the experiences of rape survivors who have advocates any better? Few studies have explicitly tested this question. For example, in a statewide evaluation of RCC services, Wasco et al. (2004) found that survivors consistently rated advocates as supportive and informative. Yet being positively perceived does not necessarily mean that advocates are effective in promoting service delivery and preventing secondary victimization. More direct evidence of effectiveness comes from Campbell and Bybee's (1997) study of survivors of rape who had the assistance of an advocate during their hospital emergency department (ED) care. This study found higher rates of medical service delivery than what is typical in the literature: 82% received an exam, 70% information on pregnancy, 38% emergency contraception, 67% information on STDs, and 79% STD preventive antibiotic treatment. However, this study did not include a comparison group of survivors who did not work with advocates, which would have provided a more powerful test of advocates' effectiveness regarding service delivery. In a study of secondary victimization, Wasco, Campbell, Barnes, and Ahrens (1999) examined the relationship between social system contact and posttraumatic stress symptoms of rape survivors as a function of whether the victims had the assistance of an advocate. Although the number of victims in this study who had an advocate was quite small (21 in a sample of 102), they found that survivors who worked with advocates reported less distress after contacting the legal and medical systems. Taken together, the results of these studies suggest that rape victim advocates are beneficial; however, more direct comparison studies are warranted.

The purpose of the current study was to compare the service delivery and secondary victimization experiences of rape survivors who did and did not work with rape victim advocates to determine if survivors who worked with advocates received more services and had fewer negative interactions with social system personnel. Participants were recruited from hospital ERs because this is where most rape survivors receive immediate postrape medical care (Resnick et al., 2000). In addition, Resnick et al. (2000) found that victims who obtained medical care often did so after they had reported to the police and that law enforcement served as a conduit to medical care. Therefore, sampling in hospital EDs increases the likelihood that study participants would have contact with the legal and medical systems, which is consistent with the primary goal of the current study.

Two large, urban hospitals were selected for sampling that had several common characteristics. First, both were the primary hospital in their respective police precincts where law enforcement took rape victims for treatment (if the victim first presented to the police). Second, if a rape victim came to the hospital ED without prior contact with the police, both hospitals had policies to call the police, and then the survivor was given the choice of whether to talk to the police. These two features suggest that the sites sampled for the current study are typical with respect to how communities in other national studies respond to rape victims. Third, the hospitals were comparable with respect to (a) number of rape victims served per year, (b) having doctors

perform the rape exam and forensic evidence collection procedures (rather than sexual assault nurse examiner [SANE] nurses), and (c) serving a racially mixed population with high concentrations of patients who were Medicaid eligible. The primary difference between the two hospitals was that one had a policy to page rape victim advocates from a local RCC to come assist survivors of rape throughout their ER visit (Site #1) and the other did not (Site #2). This naturalistic quasi-experimental design allows for direct comparisons between the rape survivors who worked with a rape victim advocate (Site #1) and those who did not (Site #2).

The advocates serving the Site #1 hospital were paid staff and volunteers from an urban RCC. They had completed a 40-hour training program that included instruction on the psychological and physical health impact of sexual assault, victims' legal rights, the steps of legal prosecution, and the process of medical forensic evidence collection. In this training, the advocates also learned how to assess the survivors' needs for services and work on their behalf to obtain those resources if they were not forthcoming during the exam process. RCC staff also instructed the advocates to intercede when social system personnel engaged in behaviors or pursued lines of questioning that could be distressing to the survivors. The hospital ED staff at Site #1 paged the RCC as soon as they knew they had a victim seeking treatment and would typically wait until the advocate arrived before performing the rape exam. The advocates were usually present for the exam to support the survivor and clarify the information presented by the doctors and nurses. Survivors usually talked with the police after the exam and, hence, had the support of an advocate for that process as well.

To assess how advocates may influence the experiences of rape survivors with the legal and medical systems, victims in each hospital were interviewed right before their discharge about what had just happened in their contact with the medical and law enforcement personnel. Three domains were assessed: (a) service delivery: what services the survivors did or did not receive from legal and/or medical personnel. It is important to note that the use of the term *service delivery* in the context of victims' experiences with the legal system does not imply that all victims want complete trial process. Rather, the term refers to the actions taken by legal system personnel to process reported rape cases; (b) secondary victimization behaviors: whether victims encountered specific behaviors and/or actions from service providers that were distressing; and (c) secondary victimization emotions: whether survivors felt various forms of distress (e.g., self-blame, depressed, violated) after their contact with social system personnel. Rates of service delivery and secondary victimization were compared across sites to assess the effectiveness of rape victim advocates.

Method

Sample

In Site #1 (the hospital that worked with rape victim advocates), 38 rape survivors sought treatment during the 6-month period of time the current study was conducted, and 36 agreed to participate in the study (95% response rate). All 36 survivors from

Site #1 worked with a rape victim advocate. Of these victims, 17 also talked with police either before arriving at or during their hospital care. In Site #2 (the hospital that did not work with rape victim advocates), 46 victims sought treatment during the time of the current study, and 45 agreed to participate (98%). Of these 45 victims, 28 had contact with police. In sum, 45 survivors had contact with the legal system (17 from Site #1 and 28 from Site #2), and 81 had contact with the medical system (36 from Site #1 and 45 from Site #2). All 81 rape survivors in the current study were female, and more than one half were African American (52%), 37% were White, 8% were Latina, and 3% were multiracial. The average age was 26.12 years ($SD = 3.45$). Most of the women had a high school education (51%). Consistent with prior research, most of the assaults were committed by someone known to the victim (acquaintance, date, marital), did not involve the use of a weapon (74%), and did not result in physical injuries to the victim (62%). Of the women, 22% had been using alcohol at the time of the assault.

Procedure

The principal investigator (PI) worked collaboratively with the staff of both hospitals to develop uniform recruitment and data collection procedures that would ensure reliable access to rape survivors without interfering with their medical care. Consistent with the sites' normal protocols for responding to rape survivors, hospital staff would first call the police (if the police were not already accompanying the victim to the ER), then page a rape victim advocate (Site #1 only), and then page the research team. While the victim was receiving medical care and/or reporting to the police, the research team member who had been paged to the hospital waited at the nurses' station and did not have contact with the survivor or witness her interactions with system personnel. While the survivor was waiting for her discharge papers from the hospital, a nurse approached her and asked her if she would be willing to participate in a brief interview about her experiences in the ED. She was told the interview would be conducted by a female researcher who was not affiliated with the hospital or the police. If she agreed, only then was the researcher allowed to have contact with the victim. The interview was conducted with the rape survivor during the waiting time before discharge.

Measures

An orally administered checklist was used for data collection, and its administration was tape-recorded with the permission of the participants (100% agreed to tape recording). In addition to collecting basic demographic and assault characteristics, the checklist was designed to capture three kinds of information. First, service delivery was assessed: What services were provided to the rape survivors in their contact with the legal and/or medical systems? The PI reviewed police and hospital protocols and consulted with officers, doctors, nurses, and rape victim advocates to find out what services could be offered to rape survivors. In the current study, three steps in legal case processing were studied: whether a police report was taken, whether an investiga-

tion was or would be conducted, and whether law enforcement personnel provided referrals to survivors of rape for other community resources. There are other actions that could be taken by the legal system (e.g., arrest, prosecution); however, the informant groups reported that the three previously mentioned services were the only services that could be provided by the time data were collected. For the medical system, 16 services were examined (see Table 2 for a complete list). For each service (legal or medical), the survivors were asked, "Did (service) occur? Did you receive (service)?" and the respondents' answers were coded yes or no. If the participants responded no to a particular service, the interviewers were trained to probe further to find out whether the victim did not want the service (hence, not receiving it was consistent with the victim's wishes) or whether the victim wanted the service, but it was not provided. In the current study, when services were not provided, it was usually instances of the victim's wanting the service, but it was not provided (93% to 97% of the time, across all services).

Second, secondary victimization behaviors were assessed. Because current definitions of *secondary victimization* emphasize the behaviors of social system personnel, participants were asked whether they encountered specific actions. To generate this list of secondary victimization behaviors, formative research was conducted with multiple informant groups (Campbell, 1996, 1998b). Interviews and focus groups were conducted with police officers, prosecutors, doctors, nurses, RCC staff, rape victim advocate volunteers, and rape survivors to find out what specific behaviors of social system personnel might be upsetting to survivors of rape. In the current study, 14 behaviors were assessed for the legal system, 12 for the medical system. The questions were not the same across systems because the formative research revealed that assessment needed to be tailored to each system because of the inherent differences in the roles and functions of the legal and medical systems (see Tables 1 and 2 for a complete list). Consistent with prior studies on this topic (Campbell et al., 2001; Campbell & Raja, 2005), these behaviors were not labeled as secondary victimization during assessment; participants were simply asked whether the actions occurred. For each behavior, rape survivors were asked, "Did you experience (behavior)? Did this (behavior/action/comment) happen?" Answers were coded yes or no. To check whether it was reasonable to conceptualize these behaviors as secondary victimization, distress ratings were also collected from the survivors of rape. If a survivor reported that she encountered one of these behaviors, she was also asked to rate how distressing it was to encounter that behavior on a 1 to 5 scale (1 = not distressed, 2 = a little distressed, 3 = some distress, 4 = quite a bit of distress, 5 = a great deal of distress). All behaviors were rated as 3 or higher by all survivors who encountered them ($M = 4.22$, $SD = .47$).

Finally, secondary victimization emotions were assessed. Secondary victimization has been defined as insensitive and victim-blaming treatment by social system personnel that leaves victims feeling distressed. In the current study, eight secondary victimization emotions were assessed for the legal and medical systems, including feeling guilty, depressed, anxious and/or nervous, distrustful of others, and reluctant to seek further help as a result of contact with either the legal or medical systems. Rape survi-

vors were asked, "Did you feel (emotion) after your contact with the police officer/ hospital staff? Did you feel this as a result of your contact with the police/hospital staff?" The participants' answers were coded yes or no.

Results

Legal Case Processing and Secondary Victimization

Differences in proportions tests, with Bonferroni corrections to control Type I error, were used to compare the endorsement rates of rape survivors for each service across the two sites (Downie & Heath, 1983). The differences in proportions test is quite conservative with sample sizes less than 100 (Downie & Heath, 1983), and coupled with a Bonferroni correction, Type I error may be adequately controlled, but at the risk of a Type II error. To balance these competing risks, the Bonferroni tests were grouped by substantive focus (Tabachnick & Fidell, 2001) (see Table 1). As Table 1 shows, police reports were significantly more likely to be taken in Site #1 where victims had the assistance of an advocate (59%) as compared to Site #2 (41%) (z [44] = 2.43, $p < .02$). Most reported cases were not investigated further or were not likely to be investigated (24% in Site #1, 8% in Site #2). A trend emerged suggesting that investigations were slightly more common in Site #1 than in Site #2 (z [44] = 2.02, $p < .05$). Most rape survivors were not given referrals by police officers to other community services: 6% in Site #1, 11% in Site #2 (no significant differences across sites).

Consistent with prior research on legal secondary victimization, some behaviors were commonly encountered, others were infrequent. Most rape survivors in both sites stated that they were discouraged from filing a police report; however, this was significantly more likely to happen in Site #2 (where rape victim advocates were not present): 81% in Site #2, 59% in Site #1 (z [44] = 2.42, $p < .01$). Similarly, many rape survivors reported that police officers were reluctant to take their report (although they did so); however, this was significantly more likely to happen in Site #2 as compared to Site #1: 79% vs. 35% (z [44] = 3.11, $p < .01$). It was less common for officers to refuse to take the report (e.g., officers stating that they would not take a report because they thought the victim was lying); however, again, this occurred more frequently in Site #2 where rape victim advocates were not involved: 43% versus 18% (z [44] = 2.39, $p < .01$). Most rape survivors who did not work with rape victim advocates (57%) were told by police officers that their cases were not serious enough to pursue further in the criminal justice system; the women who had the assistance of an advocate were significantly less likely to encounter this response (29%) (z [44] = 2.47, $p < .01$). In Site #2, it was typical for police officers to ask rape survivors if they had a prior relationship with the perpetrator (86%); however, this was less commonly asked in Site #1 (47%) (z [44] = 2.13, $p < .02$). Slightly less than one half of the rape survivors in Site #2 were asked about their prior sexual history by the police officers (46%), and this was significantly less common in Site #1 (12%) (z [44] = 2.83, $p < .008$). Finally, 31% of the women in Site #2 were asked by police officers if they had responded sexually to

the assault (e.g., asked whether they had an orgasm from the assault); this line of questioning was significantly less likely to occur in Site #1 (6%) (z [44] = 2.73, $p < .008$).

After their contact with the legal system, most rape survivors reported experiencing multiple kinds of distress. As can be seen in Table 1, almost all secondary victimization emotions had endorsement rates of more than 50%. Some emotions were nearly ubiquitous: 82% of the rape survivors in Site #1 and 93% of the victims in Site #2 stated that they felt violated after their contact with the legal system. Most also said that they felt disappointed (88% in Site #1 and 93% in Site #2). Some emotions, though still typical, were more likely to be reported by the women who did not work with a rape victim advocate. For instance, 83% of the survivors in Site #2 reported that they felt bad about themselves after their contact with the legal system. This was also common in Site #1 (60%) but was more typical in Site #2 (z [44] = 2.41, $p < .01$). Similarly, women in Site #2, who did not have the assistance of an advocate, were more likely to report feeling guilty (86%) or depressed (88%) than the survivors in Site #1 (59% and 53%, respectively) (z [44] = 2.36, $p < .01$; z [44] = 2.40, $p < .01$). Finally, most women in Site #2 stated that they were reluctant to seek further help after their experiences with the legal system (89%), which was significantly higher than those who reported this sentiment in Site #1 (61%) (z [44] = 2.33, $p < .01$).

Medical Service Delivery and Secondary Victimization

Differences in proportions tests with Bonferroni corrections were used to compare survivors' experiences with the medical system across the two sites. As can be seen in Table 2, some medical services were consistently provided to survivors, such as the rape exam, forensic evidence collection, and STD prophylaxis (medication for any treatable STDs that may have been contracted in the assault). However, several services were offered to less than one half of the rape survivors, including information on the risk of HIV from the assault, pregnancy testing, emergency oral contraception, testing for STDs and/or HIV, HIV prophylaxis, information on the health effects of rape, information on follow-up care, and community referrals. Some services were consistently more likely to be provided by medical professionals to survivors in Site #1, who had the assistance of a rape victim advocate. These women were significantly more likely to receive information on STDs (72% vs. 36%; z [80] = 2.67, $p < .008$), were somewhat more likely to receive information on the risk of HIV specifically (47% vs. 24%; z [80] = 2.09, $p < .05$), and were significantly more likely to receive STD prophylaxis (86% vs. 56%; z [80] = 2.50, $p < .008$) than were the women in Site #2 (who did not have an advocate). The victims who worked with advocates received more pregnancy-related services than the survivors who did not have the assistance of an advocate. Specifically, they were somewhat more likely to be tested for pregnancy (42% vs. 22%; z [80] = 2.01, $p < .05$) and were significantly more likely to receive emergency contraception to prevent pregnancy (33% vs. 14%; z [80] = 2.20, $p < .02$).

The rates of endorsement for the secondary victimization behaviors were generally low (most under 50%, see Table 2). For example, in only 24% of the cases in Site #1 and 36% of the cases in Site #2 did hospital staff refuse to conduct the medical exam

and/or forensic evidence collection. These refusals were not because of the medical provider's training and/or expertise (e.g., one provider refused so that someone with more or less training could do the exam) or his or her gender (e.g., one provider refused because the victim wanted a provider of the opposite sex). Exams and evidence collection were refused when hospital staff said that the assault occurred "too long ago," even though by the victims' accounts all sought services within 96 hours, which is within the time frame for forensic work (International Association of Forensic Nursing, 2005). During the exam process, the victims seen in Site #2 often reported that they were treated impersonally or coldly (69%), which was less commonly reported by the survivors treated in Site #1 (36%; z [80] = 2.51, $p < .01$). The women at Site #2 were somewhat more likely to be asked about how they were dressed at the time of the assault compared with the survivors treated at Site #1 (48% vs. 28%; z [80] = 2.24, $p < .05$). Most of the survivors in Site #2 were asked about their prior sexual histories (73%), which was also common, though statistically less likely in Site #1 (44%; z [80] = 2.47, $p < .008$). Of the survivors in Site #2, where no advocate was present, 20% were asked if they had responded sexually to the assault; this question was significantly less likely to be asked by the medical staff in Site #1 (3%; z [80] = 2.53, $p < .008$). The survivors' rates of endorsement for the secondary victimization emotions were quite high (72% or higher). The women treated in Site #2, without the assistance of a rape victim advocate, were more likely to report blaming themselves for the assault post-contact (82% vs. 54%; z [80] = 2.33, $p < .01$) and were significantly more likely to state that they were reluctant to seek further help (91% vs. 67%; z [80] = 2.40, $p < .01$) than were the women in Site #1.

Discussion

RCC staff and volunteers have been providing legal and medical advocacy for rape survivors for decades. However, there have been few empirical studies evaluating the effectiveness of the advocates' intervention. The current study used a naturalistic quasiexperimental design to compare the outcomes of victims who worked with rape victim advocates with those who did not. Rape survivors who worked with advocates reported receiving more services from the legal and medical systems. Previous research suggested that police officers take reports of rape survivors only 50% of the time (Campbell et al., 2001); however, the victims who worked with advocates had reports taken 59% of the time. Rates of medical care service delivery in this research were consistent with Campbell and Bybee's (1997) study of rape survivors who had the assistance of an advocate during their hospital ED care: Approximately 70% received an exam, information on pregnancy, information on STDs, and STD preventive antibiotic treatment. Most survivors did not receive emergency contraception (about one third); however, this rate is common for advocate-assisted cases and is significantly higher than for women who did not work with an advocate. Beyond service delivery, most survivors who worked with advocates reported less secondary victimization from legal and medical system personnel, and less post-system-contact dis-

Table 1
Rates of Legal Service Delivery and Secondary Victimization as a Function of Whether the Rape Survivor Worked With a Rape Victim Advocate (in percentages)

	Rape Survivors Who Worked With a Rape Victim Advocate	Rape Survivors Who Did Not Work With a Rape Victim Advocate
Legal—Services (3)		
Police report	59*	41
Investigation	24[a]	8
Referrals	6	11
Legal—Secondary victimization behaviors (14)		
Discouraged filing a report	59	81[b]
Reluctant to take a report	35	79[b]
Refused to take a report	18	43[b]
Told case was not serious enough to pursue	29	57[b]
Did not explain steps of reporting/prosecuting	18	21
Asked why with perpetrator	47	61
Asked if had prior relationship with perpetrator	47	86[b]
Questioned the way dressed	41	46
Questioned behaviors/choices	35	43
Questioned about prior sexual history	12	46[b]
Questioned why memories were vague or scattered	12	21
Questioned if resisted perpetrator	82	86
Questioned if responded sexually to the assault	6	31[b]
Asked if willing to take a lie detector test	6	18
Legal—Secondary victimization emotions (8)		
Felt bad about self	60	83[b]
Guilty and/or blame self	59	86[b]
Depressed	53	88[b]
Nervous and/or anxious	47	47
Violated	82	93
Disappointed	88	93
Distrustful of others	47	57
Reluctant to seek further help	61	89[b]

Note: For the three legal service delivery tests, only alpha levels $p < .02$ are considered statistically significant. For the legal secondary victimization tests, the five behaviors pertaining to the process of reporting and prosecuting a rape were grouped and alphas $p < .01$ are significant; the six behaviors relating to the survivors' behaviors at the time of the assault were grouped, alphas $p < .008$ are significant; and the three questions regarding the survivors' prior relationship with the assailant were grouped, alphas $p < .01$ are significant. For the legal secondary victimization emotions tests, the four emotions pertaining to guilt, depression, and anxiety were grouped, alphas $p < .01$ are significant; the four emotions relating to violation and reluctance to seek further help were grouped, alphas $p < .01$ are significant.

a. Denotes a trend difference.

b. Denotes a statistically significant difference.

tress than those who did not have the assistance of advocates. Secondary victimization has been linked with a variety of negative health outcomes, such as increased psychological distress, physical health symptomatology, and sexual health risk-taking behaviors (Campbell et al., 1999; Campbell et al, 2001; Campbell, Sefl, & Ahrens, 2004). Thus, a reduction in secondary victimization may have important long-term benefits for rape survivors. These findings regarding service delivery and secondary victimization provide some of the strongest evidence to date that RCC services are beneficial to rape survivors.

Whereas the design of the current study allowed for a direct comparison of victims' legal and medical system experiences as a function of whether they had an advocate, random assignment was not possible in this research. In the process of planning the current study, the PI met with staff from multiple hospitals in a major metropolitan city to explore design options. None would allow random assignment of advocates. Those that had policies to work with advocates felt it would be unethical to randomly assign victims in the ED to have the assistance of the advocate. Their perception was that advocates were tremendously helpful to survivors and that not providing this assistance would be a disservice to their patients. Hospitals that did not work with advocates were not interested in bringing them in to work with some patients, but not others. Without random assignment, either across sites or within sites, a quasi-experimental design was needed. It was also not possible to conduct a within-site quasi-experimental study as none of the hospitals used advocates only some of the time (they either consistently worked with advocates or did not). Yet it was discovered that two hospitals in this city were very similar on multiple characteristics (both were located in racially mixed neighborhoods, both served high concentrations of patients who were Medicaid eligible, and both had similar protocols for responding to victims of rape), except for their policies and practices regarding rape victim advocates: One routinely worked with rape victim advocates, the other did not. These similarities provided a solid methodological foundation for the current study; however, without random assignment, cross-site differences may be because of multiple factors, advocate involvement only one among many.

Therefore, it is important to explore what other factors, besides advocate involvement, could explain the differences in service delivery and secondary victimization rates across the sites (see Cook & Campbell, 1979). Four alternative explanations were examined. First, service providers' demographics, such as age, race and/or ethnicity, and education level, may influence how they respond to rape survivors, and if the hospitals varied significantly in provider demographics, this could account for site differences. To test this possibility, all social system personnel with whom the survivor interacted were also interviewed (see Campbell, in press), and there were no significant differences between sites with respect to their service providers' demographic characteristics. Thus, if providers' demographics influence their work with rape survivors, it appears that such effects would be consistent across sites.

Second, the degree of training legal and medical system personnel have had about sexual assault may influence their responses, as would their levels of experience working with rape survivors. In the interviews with system personnel, all participants were

asked to rate their perceived awareness of the issue of sexual assault and their experience working with rape survivors (Campbell, in press). Again, there were no significant differences across sites. To further explore the possible impact of training and experience, the directors of both hospital ERs were contacted to find out when their staff had last been trained on sexual assault and how many rape cases their staff had responded to within the past year. Both hospitals had not had training on sexual assault within the past 5 years, and there were no significant differences between the two sites with regard to the number of rape cases processed each year. Similar data were collected from the deputy chief of police who oversaw the two police precincts that served these hospitals. Again, there were no differences across sites with respect to police training or number of reported rapes the officers had responded to within the past year.

Third, it is possible that the policies and procedures for each hospital and each police precinct were fundamentally different, which would account for the varied experiences rape survivors had in each site. This issue was more difficult to examine as neither hospital nor police precinct had good written documentation explaining their response protocol for rape cases. Both hospitals' protocols stated that they followed state law regarding forensic evidence collection. As noted previously, Site #1 had a policy, unwritten but consistently followed, to page rape victim advocates to assist survivors in the ED, and this was the only identifiable difference between the sites. Both police precincts' operations manuals outlined a standard procedure for responding to victims of violent crime, and there was no other written evidence that suggested differential policies. Yet previous research has found that the decision-making processes of legal personnel are cultural and quite specific to their units (Frohmann, 1991, 1997, 1998; Kerstetter & Van Winkle, 1990; Martin & Powell, 1994), which may not be reflected in written policies, even if detailed versions existed. However, something was undoubtedly different between the two sites because one had a standing relationship with an RCC and engaged in what Martin and Powell (1994) termed *responsive processing* by providing victim-assistance resources. Previous research has shown that RCCs can create institutional change (Martin, DiNitto, Byington, & Maxwell, 1993; Schmitt & Martin, 1999), so it is possible that the rape victim advocates in Site #1 are representative of an ongoing institutional social cultural dynamic, rather than a force for change in individual encounters between victims and social system personnel.

Finally, it is possible that the victims themselves and/or the characteristics of the sexual assaults may have been different across the two sites. Perhaps one hospital treated more of some kinds of survivors or types of rape than the other, and such differences prompted alternative system responses. Demographic and assault characteristics were collected in the survivors' interviews, and cross-site comparisons yielded no significant differences. Taken together, these findings suggest that individual demographics, assault characteristics, system personnel's training and experience, and site policies and procedures were consistent across data collection sites and, thus, may not explain the differences in service delivery and secondary victimization rates across sites. However, one key alternative interpretation cannot be ruled out: The service pro-

Table 2
Rates of Medical Service Delivery and Secondary Victimization as a Function of Whether the Rape Survivor Worked With a Rape Victim Advocate (in percentages)

	Rape Survivors Who Worked With a Rape Victim Advocate	Rape Survivors Who Did Not Work With a Rape Victim Advocate
Medical—Services (16)		
Rape exam	89	76
Forensic evidence collection	89	76
Detection and/or treatment of injuries	61	56
Information on risk of pregnancy	72	56
Information on risk of STDs	72[b]	36
Information on HIV specifically	47[a]	24
Tested for pregnancy	42[a]	22
Emergency oral contraception	33[b]	14
Tested for STDs	14	13
Tested for HIV	8	13
STD prophylaxis	86[b]	56
HIV prophylaxis	19	16
Information on psychological effects of rape	6	4
Information on physical health effects of rape	6	4
Information on follow-up treatment	11	4
Referrals	14	7
Medical—Secondary victimization behaviors (12)		
Refused to conduct exam	24	36
Refused to do forensic evidence collection	24	36
Did not explain rape exam procedures	17	22
Impersonal and/or detached interpersonal style	36	69[b]
Asked why with perpetrator	44	58
Asked if had prior relationship with perpetrator	56	53
Questioned the way dressed	28	48[a]
Questioned behavior and/or choices	36	44
Questioned about prior sexual history	44	73[b]
Questioned why memories were vague or scattered	8	7

(continued)

viders in Site #1 simply told victims what they wanted to hear because of the presence of the rape victim advocate but did not actually follow through with more complete service. For example, law enforcement personnel may have said that a case would be investigated in the presence of the advocate; however, in fact, they did not pursue the case. Given the scope of the current study, it was not feasible to conduct follow-up assessments through police records, and this remains a limitation of the current work. In addition, it was not possible to identify the specific actions taken by the advocates

Table 2 (continued)

	Rape Survivors Who Worked With a Rape Victim Advocate	Rape Survivors Who Did Not Work With a Rape Victim Advocate
Questioned if resisted perpetrator	83	87
Questioned if responded sexually to assault	3	20[b]
Medical—Secondary victimization emotions (8)		
Felt bad about self	72	89
Guilty and/or blame self	54	82[b]
Depressed	81	93
Nervous and/or anxious	86	96
Violated	92	96
Disappointed	78	93
Distrustful of others	69	78
Reluctant to seek further help	67	91[b]

Note: For the Bonferroni corrections of the medical service delivery tests, the three services pertaining to the rape exam and injury treatment were grouped, alphas $p < .02$ are statistically significant; the three items related to pregnancy were grouped, alphas $p < .02$ are significant; the six questions regarding HIV/STDs were grouped, alphas $p < .008$ are significant; and the four items regarding health effects and follow-up treatment were grouped, alphas $p < .01$ are significant. For the medical secondary victimization tests, the four behaviors pertaining to rape exam were grouped and alphas $p < .01$ are significant; the six behaviors relating to the survivors' behaviors at the time of the assault were grouped, alphas $p < .008$ are significant; and the two questions regarding the survivors' prior relationship with the assailant were grouped, alphas $p < .03$ are significant. For the medical secondary victimization emotions tests, the four emotions pertaining to guilt, depression, and anxiety were grouped, alphas $p < .01$ are significant; the four emotions relating to violation and reluctance to seek further help were grouped, alphas $p < .01$ are significant. STDs = sexually transmitted diseases.

a. Denotes a trend difference.

b. Denotes a statistically significant difference.

that may have contributed to higher rates of service delivery and lower rates of secondary victimization across the sites. Nevertheless, the comparative data collected in the current study suggest that rape victim advocates and the RCCs they represent have had a positive impact on the experiences of rape survivors with the legal and medical systems.

In light of these findings, RCCs should continue to work toward widespread availability of rape victim advocates' services. Presenting evaluation data—either internal evaluations conducted by individual agencies or academic research studies—that speak to the effectiveness of rape victim advocates might help strengthen ties between RCCs and the legal and medical systems. It may also be useful to reexamine commonly used protocols for bringing advocates into hospital EDs to assist rape survivors. Several of the hospital ED directors contacted for participation in the current study mentioned that the so-called page-and-wait method for requesting an advocate was cumbersome, and this was a major deterrent to using RCC services. In addition to building stronger relationships with community service providers, RCCs may want to

reenergize their efforts to reach out directly to the women in their communities to publicize their services. Other research on postassault community help-seeking experiences of rape survivors has found that many women do not know about RCCs and do not work with rape victim advocates (Campbell et al., 2001; Wasco et al., 1999). Further efforts to advertise RCCs' services and their effectiveness could be beneficial so that survivors (or their family, friends, or significant others) could request advocacy services if they are not forthcoming. Rape victim advocates appear to provide numerous benefits and can prevent serious negative consequences for rape survivors, and it is important that future research and policy efforts continue to find ways to improve the accessibility and availability of advocates' services.

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STRATEGIES in Brief
ÆQUITAS
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Presence of Victim Advocate During Sexual Assault Exam Summary of State Laws

Charlene Whitman, JD[1]

Following a sexual assault report, victims are propelled into the criminal justice system and faced with an array of strangers, each with his or her own role in the response, investigation, or prosecution of the crime. Victims are often interviewed by multiple people, including police officers, doctors, nurses, social workers, and prosecutors. To help victims cope with these challenges, some state legislatures have passed laws providing them with the right to have a victim advocate or personal representative present during such interviews to offer support. This article focuses specifically on the victim's right to have an advocate present during a medical forensic exam. To date, only eight states — California, Florida, Iowa, New Jersey, New York, Oregon, Texas, and Washington — have enacted laws to provide victims with this right.[2] For more information, readers can consult a statutory compilation created by AEquitas: The Prosecutor's Resource for Crimes Against Women. The compilation is current as of December 2012.[3]

RATIONALE

While health care providers are often the point of entry for victims seeking assistance immediately following an assault, advocates play an important role for victims of sexual assault by providing support and guidance, regardless of whether or not they decide to report the crime to police. Therefore, the medical exam offers a good opportunity to provide victims with an advocate for emotional support. Advocates can also answer any questions the victim might have regarding the exam and the victim's continuing role in the investigation and prosecution of the assault, should the victim choose to report.

Another reason to provide an advocate is that many victims experience the exam itself as traumatic. As stated in the Texas law: "Many victims report the exam as a second assault."[4] The legislative history of the Texas statute explains that the presence of an advocate, who is trained to provide comfort and support for a victim, may help minimize the traumatic impact of the medical forensic exam. The remainder of this article will focus on the eight states that specifically provide a victim with the right to have an advocate or personal representative present during the medical forensic exam.

VICTIM NOTIFICATION

Among the eight states that provide for the presence of a victim advocate, there are different approaches to how the law extends this right to a victim. In California, Texas, New Jersey, and New York, state law requires that medical personnel inform sexual assault victims of their right or opportunity to have a victim advocate present during the medical forensic exam. This statutory requirement represents a proactive approach on behalf of the legislature, providing support for victims of sexual assault. By contrast, the laws in Florida, Iowa, Oregon, and Washington provide only that a victim has *the right* to have a victim advocate present. In these states, the burden to request an advocate for the medical forensic exam lies with the victim.

Under California law, the health care provider[5] must inform the victim, either orally or in writing, of their right to have a sexual assault counselor and one other support person present during the exam.[6] Health care providers are required to give victims notice of this right before they begin the exam. The right to have a counselor present may be restricted only if either a law enforcement officer or the health care provider determines that the presence of the person serving in this role would be detrimental to the purpose of the exam.

Texas law requires that a health care provider offer a victim of sexual assault the right to have a sexual assault advocate present during any medical forensic exam to which she has consented.[7] As in California, the health care provider must inform the victim of this right before beginning the exam. Texas law also establishes that the health care provider has the discretion to exclude a sexual assault advocate from an exam if the advocate interferes with or delays emergency medical treatment of a victim.

CONCLUSION

It is critical to offer services to sexual assault victims as soon as possible. Allowing for an advocate to be present during the medical forensic exam provides immediate support and also presents the opportunity for victims to be informed of additional resources that are available to them to assist in their recovery. Therefore, it is considered best practice to offer victims the option of having an advocate present during a medical forensic exam, regardless of whether there is a statutory requirement. This best practice is recommended in the *National Protocol for Sexual Assault Medical Forensic Examinations*[20] as well as many state protocols for sexual assault response. The *National Protocol* calls for victim-centered care during the exam process, and specifically recommends that the nurse examiner "understand the importance of victim services within the exam process [and] involve victim service providers/advocates in the exam process (including the actual exam) to offer support, crisis intervention, and advocacy to victims, their families, and friends."[21]

The legislatures of California, Florida, Iowa, New Jersey, New York, Oregon, Texas, and Washington have provided a valuable legal tool for victim advocates and health care providers to offer guidance and support for victims of sexual assault. For the full text of these state laws and other legal issues faced by advocates and victims of sexual assault please see http://www.aequitasresource.org/library.cfm.

ENDNOTES

[1] Charlene Whitman is an Associate Attorney Advisor at AEquitas: The Prosecutors' Resource on Violence Against Women. This article has been revised, since its original publication, to reflect changes in the law.

[2] These eight states also ensure the right to have a victim advocate present during other proceedings within the criminal context. In fact, this is true for the majority of U.S. states, which provide for sexual assault victims to have an advocate present at any interview with police or prosecutors. However, a review of the laws addressing this right is beyond the scope of this article.

[3] This and other resources are available upon request at http://www.aequitasresource.org/library.cfm.

[4] Commentary in support of Tx. B. An., H.B. 1234, May 2, 2001.

[5] This article uses the term "health care provider." For state-specific terminology (and a definition of which personnel are included in the definition), see the law and practices for your jurisdiction.

[6] CAL. PEN. CODE § 264.2(b).

[7] TEXAS CODE CRIM. PROC. ANN. ART. 56.045

[8] N.J. STAT. ANN. § 52:4B-52(h)(2011); N.Y. PUB. HEALTH LAW § 2805-I(3)(2012).

[9] N.J. STAT. ANN. § 52:4B-52(h)(2011).

[10] N.Y. PUB. HEALTH LAW § 2805-I(3)(2012).

[11] FLA. STAT. ANN. § 960.001(1)(u).

[12] IOWA CODE ANN. § 915.20(1).

[13] IOWA CODE ANN. § 915.20(1)(a).

[14] IOWA CODE ANN. § 915.20(2).

[15] OR. CODE §147.425.

[16] *Id.*

[17] WASH. REV. CODE ANN. § 70-125.060.

[18] WASH. REV. CODE ANN. § 70.125.020.

[19] For more information, AEquitas has created a statutory compilation titled, *Victim Privilege by Practitioner*, which is current as of July 2010 and available, upon request, at http://www.aequitasresource.org/library.cfm.

[20] Office on Violence Against Women, United States Department of Justice (2004, September). *A National Protocol for Sexual Assault Medical Forensic Examinations (Adults/Adolescents)*. Washington DC (NCJ 206554).

[21] *Id.*

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IACP National Law Enforcement Policy Center

Investigating Sexual Assaults

Concepts and Issues Paper

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Revised: July 2005

I. INTRODUCTION

A. Purpose of Document

This paper was developed to accompany the *Model Policy on Investigating Sexual Assaults* developed by the IACP National Law Enforcement Policy Center. The paper provides essential background material and supporting documentation to provide a greater understanding of the developmental philosophy and implementation required for the model policy. It also addresses field investigative procedures and best practices for working with victims of criminal sexual violence.[1] This material is designed to assist law enforcement executives in tailoring the model policy to the requirements and circumstances of their own communities and agencies.

B. Background

Estimates of the prevalence of sexual assault in the United States vary due to differences in data collection, definitions, and calculations. Based on numbers from the National Crime Victimization Survey (NCVS), 150 of every 100,000[2] women ages 12 and older were raped or sexually assaulted in 2003.[3] In 2003, the Federal Bureau of Investigation's (FBI) Uniform Crime Report[4] (UCR) statistics indicated a rate of 63.2 reported forcible rapes per 100,000 adult women. UCR estimates tend to be much lower for three reasons. First, the UCR data only include incidents that are reported to law enforcement. Second, the UCR definition of rape is more restrictive than the NCVS definition. Third, the NCVS definition is broader, including females ages 12 and over, whereas the UCR definition includes only adult women.

The article *Making Sense of Rape in America: Where Do the Numbers Come From and What Do They Mean?* (2004) explains that accurate estimates of rape are difficult to obtain because many rape victims are reluctant to disclose the experience to other people. Additional factors that hinder an accurate estimation include: different ways of defining and measuring rape; different population groups measured; different time frames; and different units of analysis in reporting statistics (i.e., within a given time frame, the number of people raped versus the total incidents of rape).[5]

Many victim advocates, law enforcement administrators, and others have expressed concern about the limited definition of rape used by the UCR, arguing that it does not present an accurate picture of sexual violence in America.[6] Specifically, the definition used by the FBI for the UCR limits rape to "the carnal knowledge of a female, forcibly and against her will." This definition excludes the following types of assaults:

- Those committed through the delivery of drugs or alcohol to the victim
- Those committed against victims who are incapable of consenting
- Those that involve anal intercourse, oral copulation, or penetration with a foreign object
- Those committed by female perpetrators or perpetrated against male victims
- Those committed by a blood relative
- Those perpetrated against child victims

Many argue that such a narrow definition contributes to the stereotype of sexual assault, leaving law enforcement professionals ill prepared to respond to the realistic dynamics of these crimes.

Contrary to the stereotype of "real rape" as an assault by a stranger committed with a weapon and a great deal of physical force, research and law enforcement experience demonstrate that the following represent some of the realistic dynamics of sexual assault crimes:

- Most sexual assault victims are acquainted with the suspect(s) in some way, yet they rarely expected intimacy with the suspect(s).
- Many women are victims of repeated rape and sexual assault.
- Most sexual assaults are not reported to law enforcement authorities.
- Men are even less likely to report their sexual assault to the police than are women.
- Victims rarely report to the police first; usually they go first to a close friend or relative, a health care provider, or a victim advocate.
- Victims often delay reporting a sexual assault for days, weeks, months, or even years, and many never disclose it to anyone, including their closest friends.
- The police are more likely to be notified of sexual assaults that are committed by strangers than by someone the victim

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knows.

- Sexual assault perpetrators rarely use weapons and may not use physical force, relying instead on verbal threats, intimidation, and a victim's vulnerability. Victims' emotional reactions may include confusion, shame, and embarrassment.
- Victims may lie about specifics of the sexual assault because they fear that their actions may have contributed to the sexual assault.
- The trauma of victimization can increase chances for substance abuse, sleeping and/or eating disorders, mental illness, prostitution, suicide, and running away.
- Few victims are injured to the point that emergency medical attention is needed.
- Alcohol and drugs are involved in a high percentage of sexual assaults.
- Individuals who have been previously victimized may be unable to defend themselves due to the past trauma the assault triggers and the fear they experience during the current assault.

Because these realities of sexual assault differ dramatically from the stereotypes held by much of law enforcement and society in general, victims are often unwilling to report sexual assault for fear of not being believed or because they think they will be blamed for the crime. Victims often fear that their sexual assault report will not be believed or taken seriously because: (1) they knew their assailant; (2) they are related to or closely acquainted with the assailant; (3) they are intimidated by the assailant's position, power, or social status; (4) they engaged in drug or alcohol use; (5) they put themselves at risk by actions such as entering a stranger's automobile or apartment; (6) they have an arrest record or an outstanding warrant; or (7) they were engaged in illegal activity at the time of the offense. These same factors that deter victims from reporting have been demonstrated to influence the complaint-filing and charging decisions of police and prosecutors.[7]

In small communities and rural areas, many of these problems are further exacerbated. Victims in these communities often find themselves at great distances from law enforcement agencies, social services, and medical care facilities. Because victims in a smaller community may know law enforcement officers, they may calculate that it is too difficult to report the crime or call for support.[8]

Law enforcement professionals must work to help prosecutors and jurors understand the behavior of sexual assault victims and how it differs from the stereotype. If an attack involved no physical force, police can help explain a victim's submission out of fear by conducting a comprehensive interview in which the victim describes in detail what she was thinking and feeling during the assault. If the victim was incapacitated as a result of voluntary alcohol or drug use, law enforcement officers can help show why this is an issue of increased *vulnerability* rather than *culpability*.

There are a number of improvements that can be made in the investigation and prosecution of sexual assault crimes. Although some of these improvements are technological, most are actually results of a thorough police investigation, comprehensive interview techniques, and diligent work to establish rapport and trust with victims. Law enforcement agencies and investigators need to ensure that sexual assaults involving acquaintances and intimate partners are pursued as vigorously as those perpetrated by strangers.

It is important to remember that one of the most critical responsibilities of the responding officer and investigator is to reassure the victim that he or she will not be judged and that the complaint will be taken seriously. Responding officers and investigators are expected to take a professional, victim-centered approach to sex crimes and to investigate these crimes in a manner that restores the victim's dignity and sense of control, while decreasing the victim's anxiety. Virtually all sexual assault victims want validation from the authorities that the crime occurred, and this may be a more critical element of a successful response and investigation than a criminal prosecution or conviction. Regardless of the investigative results, responding officers and investigators have the power to help a person heal from sexual assault.

II. LEGAL BASIS FOR SEXUAL ASSAULT

For purposes of the policy and this paper, the term "sexual assault" will be used to refer to felony crimes of sexual violence. Although specific statutory definitions of sex crimes vary by state, most are conceptually similar and can be understood by analyzing their elements. This conceptual analysis must thus be supplemented with specific information from local definitions and statutes in the development of a policy for a law enforcement agency.

A. General Elements of Felony Sexual Assault

In addition to the general elements of felony sexual assault (defined in the policy), some state statutes require that the act of sexual assault have an element of sexual gratification to constitute a criminal offense (e.g., the "intent of arousing, appealing to, or gratifying the lust, passions, or sexual desires"). Unfortunately, this element has contributed to a misperception among some law enforcement professionals that ejaculation is a required element of a sexual assault offense. Although investigators and prosecuting attorneys need to question the victim about whether the suspect had an erection, made verbal comments of a sexual nature, ejaculated during the commission of the crime, or penetrated with a foreign object, many state statutes have been changed to recognize that much sexual violence is about humiliation and abuse rather than sexual gratification.

B. Sexual Penetration versus Sexual Contact

Although the specific terminology and definitions vary, most state laws recognize a conceptual distinction between criminal sexual acts of penetration (of any orifice by body part or object) and other forms of criminal sexual activity short of penetration (e.g., fondling, grabbing, pinching). As a result, sex crimes investigators must also recognize this distinction to appropriately identify which type of offense is being reported by the victim in a particular case.

It is important to recognize that the violation of a victim may involve multiple offenses, including some combination of criminal sexual penetration and contact. Each count or charge must be identified independently. For the purposes of this paper, the following discussion will refer to crimes of felony sexual assault involving penetration. The discussion is equally relevant to crimes involving sexual contact.

C. Investigative Strategy: Denial, Identity, and Consent Defenses

The framework provided in this paper is designed to help officers and investigators determine which category of sexual assault case they are handling, predict the defense most likely to be

raised, and guide an investigative strategy toward overcoming that particular defense. A well-thought-out investigative strategy can:

- Define what issues are likely to be raised in court
- Prioritize the probative value of evidence and its impact on the investigation
- Determine the probative value of statements made by the victim, witness, and offender

Investigators must remain flexible because defenses are not entirely predictable and may change—even during the course of a single investigation.

1. Denial Defense. When a suspect is charged with a sex crime, one primary element of the offense will always be the sexual act involved (whether sexual penetration or contact). Because the sexual activity constitutes an element of the offense, it therefore provides the grounds for one particular defense strategy—*denial*. If the suspect denies that the sexual activity took place, and he[9] can create reasonable doubt to that effect, it is likely that he will be acquitted of the charge(s). For this reason, the investigative strategy in every sexual assault case must first focus on establishing whether or not the sexual activity took place. Once the sexual activity is stipulated or proven (and is alleged to have been committed using force or threat), there are two additional defenses available to suspects.

2. Identity Defense. First, the suspect can raise a defense of identity. This defense is primarily used in cases where the suspect is a stranger to the victim. This defense can thus be characterized as, *"You've got the wrong guy. Someone else might have raped her, but it wasn't me."* In these cases, the investigative strategy is not that different from the one used with other crimes (such as burglary or robbery) because it focuses on a complete physical description of the suspect provided by the victim or other witnesses, as well as on any DNA or trace evidence linking the suspect to the victim or the crime scene. In any case where an identity defense might ultimately be raised, it is important for the investigator to first determine whether the suspect denies engaging in sexual activity with the victim. A suspect who initially denies the sexual contact may later switch to an identity defense, and this change should be documented.

3. Consent Defense. Alternatively, the suspect can raise a defense of *consent*. The consent defense has historically been used when the victim and suspect know each other to some degree. This defense usually stipulates that the sexual activity took place but argues that it did not involve force or threat. Because of sophisticated DNA and forensics techniques, the majority of people charged with a sex offense now claim a consent defense because identity can typically be established with a great deal of certainty. This defense can therefore be described as, *"Yeah, I had sex with her, but she wanted it, and it was great. I didn't force her to do anything."*

When a consent defense is raised, the investigation should focus primarily on evidence to establish that consent was absent and force or threat was present, including:

- A detailed account of the victim's thoughts and feelings during the assault
- Information regarding the suspect's size and strength, in comparison with the victim's
- Evidence of physical or verbal resistance on the part of the victim
- Evidence of genital or nongenital injury
- Information regarding the environment in which the assault took place (e.g., an isolated area)
- Information regarding the victim's post-assault behavior, including post-traumatic stress

Evidence of injury or physical resistance on the part of the victim can be useful in establishing that force or threat was present in the situation. On the other hand, **the absence of injury or resistance cannot be used as proof of consent**. In such cases, it can be particularly useful for investigators to document any information about the event that is inconsistent with the character of a consensual sexual act. For example, there are cases where the victim is unable to use a contraceptive or remove her tampon before the suspect forces his penis into her vagina. This type of behavior would not be typical of a consensual sexual encounter.

Although much of the evidence collected in a sexual assault case (such as biological and trace evidence) is traditionally used to identify the assailant, some of it can also be used to establish the presence of force and overcome a consent defense. For example, both the victim's and suspect's clothing should be examined for biological and trace evidence, as well as tears, missing buttons, or other signs of force. Similarly, blood can be analyzed to identify the donor, but it can also be used to corroborate the use of force. Photographs or video are especially critical to establishing the context of force if they depict the crime scene according to the first responding officer, including the condition of the site and the location of recovered evidence.

In a consent case, the issues at trial will likely focus on the victim's and suspect's behavior as well as their perceptions of events. They will also center on challenges to the victim's credibility and how much risk the victim took.[10] Any evidence to corroborate the victim's account can be useful, as well as any information that demonstrates inconsistencies between the victim's and suspect's descriptions of events. Such information can be particularly persuasive in addressing a consent defense, especially when both the victim's and suspect's accounts of events are entirely consistent up to the point of the sexual assault.

4. Investigative Strategy Must Remain Flexible. The defense will sometimes change the primary defense strategy—typically from identity to consent, once forensic evidence has established that the sexual act did take place and the person charged with the crime was involved. Successful sex crimes investigators need to recognize common theories of sexual assault offenses and strategize their investigation around the defense that is most likely to be raised, but they must be flexible in case an alternative charge is proffered or the defense strategy is something other than expected.

D. Forcible Sexual Assault versus No Force Required

To constitute a criminal offense, the investigation must determine that the sexual activity in question was committed using *force or threat*, or identify whether the situation was one in which *no force is required*.

1. Forcible Sexual Assault. If force or threat is used to commit a sexual act, the elements of the offense are: (1) sexual penetration or contact and (2) force or threat. Few states recognize the presence or absence of consent by the victim. Although some states retain language that the sexual offense must be "against the will" of the victim, most have recognized that a lack of consent is implied by the presence of force or threat. In other words, when force or threat is present, it is assumed that the victim does not consent to the sexual activity in question. Consent is therefore generally defined as positive cooperation in act or attitude pursuant to an exercise of free will. The person must act freely and voluntarily and have knowledge of the nature of the act and

transaction involved.[11]

Despite this general recognition that sexual activity is illegal if it involves force or threat, there remains no clear standard as to what exactly constitutes force or threat. Rather, the presence of force or threat must be determined by considering the entire context of the event.

2. *No Force Required.* There are situations in which sexual activity is criminal *in the absence of force or threat.* These include situations where the victim is legally viewed as unable to consent, either due to age or some type of incapacitation (e.g., disability, lack of consciousness, drug use). In these situations, a consent defense is precluded, so the investigative strategy should not focus on issues of force. Rather, the defense is limited to denying the sexual activity, disputing the status of the victim that renders the individual unable to consent, or claiming that the suspect did not know and could not reasonably have known about the status of the victim.

• *Unconscious Victim.* Clearly, a victim who is unconscious cannot legally consent to sexual activity. When a victim is unconscious, the elements of a sexual assault offense are as follows: (1) sexual penetration or contact and (2) an unconscious victim. A suspect can defend against this type of sexual assault charge by denying either that the sexual activity took place or that the victim was unconscious. In either case, the investigative strategy should focus on establishing both of these elements. The investigation does not need to focus on the issue of force, however, because the victim's lack of consciousness renders him or her unable to legally consent to sexual activity.

• *Incapacitated Victim.* Somewhat more difficult is the case in which the victim was incapacitated at the time of the sexual act. Incapacitation in this sense is typically due to alcohol or drug use, whether caused by voluntary consumption or covert administration by the suspect. However, incapacitation could also be a result of some other physical or mental cause. The elements of this type of sexual assault are as follows: (1) sexual penetration or contact and (2) an incapacitated victim. There is no clear legal standard for incapacitation. Many states require that the perpetrator administer the drug himself for the sexual act to constitute forcible rape or aggravated sexual assault.[12] Whether or not this requirement is present, the investigator must show that the perpetrator knew the victim was intoxicated and therefore unable to give informed consent.

In these cases, the defense is likely to focus on denying that the victim was incapacitated to the degree alleged by the prosecution, thereby denying the second element. Based on the victim's account, toxicology evidence, and interviews with witnesses, the investigator must demonstrate that the victim was so incapacitated that he or she could not legally consent to sexual activity. Even in cases where the prosecution has framed the case as one involving an incapacitated victim, the defense is likely to challenge this characterization, raise a more traditional consent defense, and use intoxication to challenge the victim's credibility.[13]

Although many states have added sections to their criminal statutes to clearly state that force is not required as an element of drug-facilitated sexual assault, prosecuting attorneys have argued in some situations that drugging a person is chemical restraint and, therefore, force. In that case, the prosecuting attorney may consider filing complaints on both charges.

• *Victims with a Disability.* As with other forms of incapacitation, there is often no clear legal standard for when a disability affecting cognition or communication renders an individual unable to legally consent to sexual activity. Therefore, a determination must first be made as to whether the individual is capable of understanding and giving consent to sexual activity. As part of this process, the investigating officer will typically need to determine whether the victim has the ability to protect his or her rights to carry out normal activities. If the individual is determined to be *able* to legally consent to sexual activity, the behavior would constitute a criminal offense only if force or threat was present or if the victim was unable to legally consent to sexual activity for some other reason (e.g., incapacitation, age).

If the individual is deemed to be *unable* to legally consent to sexual activity due to a disability affecting cognition or communication, the elements of the sexual assault offense are: (1) sexual penetration or contact, and (2) evidence of disability. As with the incapacitated victim, issues of force and consent are not part of the elements of the offense and should not be part of the defense. Rather, the investigative strategy must focus on establishing that the sexual activity took place and that the individual has a disability affecting cognition or communication to a degree that he or she is unable to legally consent. There is also a possibility that an affirmative defense will be raised asserting that the suspect did not know of the victim's disability. The availability of this defense and the statutes governing its use vary by state.

• *Other Crimes with No Force Required.* Another major category of sexual assault offenses with no force required includes those involving victims who are unable to consent because of their age. All states have established an age before which an individual is recognized as not able to consent to sexual activity. The age of consent varies generally from 15-18 years throughout the United States. Most states also have additional statutes that constitute offenses on the basis of age combinations between the victim and suspect or a position of trust, authority, or supervision held by the suspect (e.g., teachers, coaches, clergy, counselors).

Many states additionally specify a number of situations in which no force is required for sexual activity to constitute criminal behavior. For example, some states prohibit specified sexual activity between patients and their doctors, psychotherapists, and other service providers; between inmates and correctional officers; and between caretakers and their dependents. Other statutes outlaw sexual activity perpetrated using a false representation of identity. Of course, states also prohibit sexual activity between family members, and these relations are typically spelled out in the code of criminal offenses.

III. INVESTIGATIVE PROCEDURES

Officers and emergency communications personnel must use their professional judgment and follow state law and department policies in determining the proper response to a call involving sexual assault. Officer and victim safety must always be the first priority.

When responding to sexual assault calls, officers and communications personnel must make every effort to keep an open mind and refrain from judging the information obtained from the victim or reporting party. Each caller will respond differently, depending on his or her own background, personality, and the circumstances of the assault. For example, most sexual assault victims are female, but assumptions should be avoided if the caller is male.

A. Dispatcher or Call Taker Response

1. *General Protocol.* When a caller reports a sexual assault,

communications personnel need to elicit the initial facts of the situation and determine whether the victim or others are in life-threatening danger or in need of emergency medical attention. The call taker should dispatch emergency medical assistance as necessary.

Once the caller is identified as the victim of a sexual assault, the appropriate priority rating should be applied. Sexual assault reports should be handled as a priority even though it is common for a victim to delay reporting by hours or even days, and injuries at that point may not be life threatening. In addition, potential evidence deteriorates over time and may be intentionally destroyed by the offender. Medical treatment for sexually transmitted infections and pregnancy are also time sensitive and the victim will likely want to clean up (e.g., brush teeth, gargle, shower, or douche) as soon as possible.

Depending on the information obtained from the caller, the call taker and the first responding officer may need to coordinate multiple responses to several different locations (e.g., the location where the sexual assaults took place and any other locations where the victim and offender may have been prior to or following the sexual assault). Crimes may also involve more than one jurisdiction. Officers should follow agency policy concerning multi-jurisdictional case coordination.

2. ***Obtaining Suspect Information.*** If the call is about a crime in progress or a crime that just occurred, the call taker should obtain information from the caller to assist in identifying and apprehending the suspect. The call taker should inquire as to whether there is a relationship between the victim and suspect, if there is a history of violence, whether a weapon was involved, and whether the suspect possesses any weapons.

In order to minimize victim frustration, it is important for the call taker to explain that the questions being asked will not delay the dispatch of an officer to the caller's location.

3. ***Evidence Collection Issues.*** Officers and communication personnel must determine whether a sexual assault victim has bathed, douched, urinated, or made other physical changes (i.e., engaged in any activity that may have contaminated or destroyed probative evidence such as semen, saliva, hair). When doing so they must be mindful that sexual assault victims often feel ashamed or guilty because of something they did or did not do relating to the sexual assault. Victims may evade these questions or answer in the negative, because they are afraid to say that they did something "wrong." If the victim has not engaged in any of these activities, it is important for the dispatcher or call taker to request that the sexual assault victim not do so and to clearly explain the reason for the request. If the victim has taken any of these actions, the call taker must not communicate to the victim that such actions make it futile to report the crime to the police.

Victims of a drug-facilitated sexual assault may report blackouts, gaps in memory, and general uncertainty as to whether or not an assault occurred. Continued, patient questioning by the call taker is encouraged and can help elicit important details.

The call taker should ask the victim about the need to urinate. If the victim does need to urinate and cannot wait for the officers to respond with a urine collection container, the victim should be instructed to urinate in a clean jar or container with a lid. If the victim can wait, it is best for medical or law enforcement personnel to collect a urine specimen whenever possible.

Law enforcement agencies should establish protocols to preserve all sexual assault calls (911 and non-emergency contacts) and computer printouts even if there was a delay in reporting. Tapes should be reviewed as part of the investigation and preserved for use by prosecutors during trial.

B. Initial Officer Response

1. ***Emergency Response.*** After the scene is determined to be safe. The first responding officer on the scene should immediately make contact with the victim to assess whether the person is safe and to assure him or her that safety issues are the first priority. Emergency Medical Services (EMS) can be summoned to assess the victim's medical needs. Additional responding officers should begin a search for the suspect when appropriate.

If emergency medical attention is not needed, the victim can remain at the scene to assist in identifying the crime scene(s), witnesses, evidence, suspect(s), and so forth. Officers should advise the victim of his or her right to obtain a protection order.

2. ***Notifying a Victim Advocate.*** Before contacting the victim advocacy organization, the investigating officer must assess any special needs of the victim (inability to speak English, language difficulties, mental or physical impairment, need for an advocate of the same gender as the victim) and request an advocate accordingly.

As soon as possible, responding officers should notify a victim advocate to provide emotional support and help the victim make informed decisions throughout the investigative process. Victim service providers and advocates work both inside and outside the criminal justice system. As such, their titles and functions vary considerably. Whereas victim service professionals in a prosecutor's office are often referred to as victim or witness assistance coordinators, law enforcement agencies may use the title rape crisis specialist or rape crisis advocate. In community-based organizations, providers may call themselves rape crisis counselors, victim advocates, or service providers. One typical distinguishing difference is whether the advocate has counselor communication privilege. In most cases, advocates within the criminal justice system are not covered under counselor privilege laws because of their connection to the government. In contrast, community-based advocates typically do enjoy counselor communication privilege.

Specifically, privilege laws prevent counselors from testifying or being compelled to testify in court and many even extend that ban to written records. To provide guidance in this area, the Department of Justice (DOJ) has proposed model legislation defining "confidential communications."[14] The investigating officer must understand and respect the privacy of communications between a sexual assault victim and a victim advocate or other service provider. Although the advocate will likely include this in a discussion of rights with the victim, the message can be given by the officer to reassure the victim and communicate that each person responding understands and respects the roles of the other professionals. The victim's comfort and the most effective team approach should be considered priorities when evaluating possible responses and best practice.

Because communications may be privileged, investigating officers must understand that unless there is a written waiver, a victim advocate cannot disclose information from the victim, even if it would significantly impact the investigation or prosecution of the case. The role of the victim advocate in such a situation is to discuss with the victim the consequences of withholding or distorting information regarding the sexual assault and explore with the victim the possibility of discussing with the officer any fears regarding behavior such as drug abuse or giving a false report.

Regardless of how the victim service agencies are structured in a particular community, law enforcement agencies must work collaboratively to establish protocols regarding how and when a victim advocate will be notified when a sexual assault is reported. It is typically in the best interest of the victim that this notification take place as soon as possible so the victim can benefit from the support and information that is offered by an advocate. The presence of an advocate may also be beneficial for the investigative process.

The victim has the option to decline the services of the advocate and this decision must be supported by members of the responding team, including the investigating officer(s). Should the victim request an advocate at any point in the investigation, the investigating officer should facilitate the referral. If the victim declines assistance from an advocate, written referrals for additional avenues of support must be provided.

Absent exigent circumstances, family members and interested parties should not be used as interpreters prior to contacting the victim advocacy organization. Victim advocates should not be used as interpreters, because this places them in the position of assisting with the law enforcement investigation rather than focusing on their victim-support role. It is critical that law enforcement agencies work with victim advocacy organizations and others to explore ways to provide comprehensive services for special populations, including the hearing impaired and those who do not speak English. Because most states have not addressed interpretation needs, law enforcement agencies should develop policies to address this gap.

3. Evidence Collection Issues. Following the emergency response, officers must identify and secure the crime scene(s), making every effort to ensure that potential evidence is not contaminated or destroyed.

Responding officers must ensure that the crime scene is photographed prior to processing. The investigation of every sexual assault should also include a detailed diagram of the crime scene(s). Videotaping can be helpful—especially in the case of a complicated or extensive crime scene.

The process of identifying and collecting evidence is made more difficult by the fact that most victims will have left the location of the sexual assault by the time the crime is reported. All additional crime scene evidence and any clothing that the victim put on following an assault must be identified and collected.

4. Identifying and Locating Witnesses. Responding officers must next identify and isolate any potential witnesses to the sexual assault. If there are numerous potential witnesses (e.g., at a fraternity house, rave party, or nightclub), an officer should be assigned to monitor the witnesses and prevent them from talking to each other.

There may be any number of corroborating witnesses to aspects of the assault, such as a neighbor who heard a scream or a gas station attendant who noticed the victim crying in her car. The officer should identify and record the names of any witnesses who might have left the scene prior to his or her arrival. It is especially important that the victim be questioned about the first person she or he told about the sexual assault. This person must be identified and interviewed because such an "outcry witness" can be used to confirm the credibility of the victim. This can be particularly important in the case of a delayed report or a consent defense raised by the suspect.

5. Additional Resources. Victims should never be left unattended or left in the immediate area where the sexual assault occurred unless the first responding officers are handling a critical threat. The best practice when responding to sexual assault victims is to establish protocols and resources for additional emergency personnel at the crime scene once it is secured and the victim is safe. In small or rural communities, law enforcement agencies are encouraged to utilize the services of firefighters, EMS, police chaplains, and specially trained volunteers to assist the responding officer(s). If additional emergency personnel are responding to the scene, the victim should be notified of this immediately and steps should be taken at all times to protect the victim's privacy and dignity.

C. Preliminary Victim Interview

While the victim interview is one of the key components of a sexual assault investigation, it can also be one of the more challenging tasks for a criminal investigator. Victim advocates or rape crisis counselors can be particularly helpful to both the victim and the investigating officer by providing the victim with the emotional support and information needed to make informed decisions throughout the interview process. Every effort should be made by the investigating officer to contact a victim advocate as soon as possible in the process of responding to a sexual assault. The victim should be offered the option of having the victim advocate or other support person present during the preliminary and follow-up interviews. A spouse, boyfriend or girlfriend, or parent may not be the most appropriate support person to have present during an interview because the victim may hesitate to reveal all the details of the assault in front of someone with whom they are close. Victims may, however, be uncomfortable asking friends or family members to leave the interview. The investigator should privately address this with the victim and take action to support the victim's wishes.

1. Initial Response. Sexual assault investigations should typically include both a preliminary and subsequent in-depth interview with the victim. In the initial response, the responding officer must first establish that a crime has occurred. At this time, only minimal information is needed to confirm that the victim is reporting a crime of sexual assault. However, the responding officer also needs to get enough information to establish the elements of the crime(s) and identify potential witnesses, suspect(s), evidence, and crime scene(s).

During this initial discussion with a sexual assault victim, the officer must determine whether the victim should receive an acute forensic examination and transportation to the designated medical facility if needed. The victim should be advised that the forensic examiner will collect all clothing that was worn during or immediately after the sexual assault and that a change of clothing should be available for after the examination.

2. Preliminary Interview Protocol. Opening remarks represent a critical point at which an officer must gain the victim's confidence and let the victim know that a major part of the officer's function is to provide assistance and protection. It is appropriate for the officer to express sympathy and an interest in the victim's well-being. By doing this, the officer contributes to the immediate and long-term recovery of the victim and lays the foundation for mutual cooperation and respect on which a successful interview is built. The officer should communicate to the victim that a thorough investigation will be conducted using a team approach. It should be explained that other members of the Sexual Assault Response Team (SART) include advocates and medical personnel and that the officer will most likely need to ask the victim additional questions at a later time.

The preliminary interview of a sexual assault victim should

never take place in a public area (such as the waiting room or front counter of a police station), but rather in a private place free of distractions.

At some point during the preliminary interview, the officer must obtain contact information for the victim, especially because those victimized by sexual assault often make arrangements to stay with a friend or family member. The officer should also explain that this first interview is preliminary in nature and that a follow-up interview will be needed during the course of the investigation, either by the same officer or by a detective if the agency has an investigative bureau.

Throughout the interview with the victim, every effort should be made to use simple terminology. It may be necessary to ask the victim to describe the intimate parts of the male and female body and to assess the victim's knowledge of different types of sexual activity. Once this has been established, the victim may experience relief in having a common language to communicate the details of the assault to the investigating officer. When documenting the victim interview, it is especially important for investigating officers to preserve the victim's statements as they are first spoken. They should not be sanitized out of concern that the victim will be misunderstood or misrepresented.

3. *Writing the Report.* The investigating officer must complete a written report in all cases of sexual assault, regardless of whether an arrest is made. The officer should thus clearly document in very specific terms all facts and observations, including the physical and emotional condition of the victim. For example, the report should indicate that the victim was "tearful and trembling," rather than just "upset." Similarly, the officer should report that the victim's shirt was torn and a shoe was missing, rather than just describing the victim's appearance as "disheveled." This report should contain a copy of the forensic examination (if available), including diagrams specifying the nature and location of all injuries, complaint of pain or tenderness, and photographs of nongenital injuries.

4. *Protecting Victim Rights.* Privacy issues concern crime victims throughout the criminal justice process. As a result of highly publicized cases, where information was not kept confidential, many victims either decline to participate in the investigative process or participate only in a guarded way. Law enforcement officers must therefore make every effort to protect the confidentiality of the victim's information to the maximum extent possible by law and policy.

The investigator must ensure that victims are notified of their rights as a crime victim under state law, which may include the right to have their name withheld from public record; be notified of arrests, court dates, and parole or release dates; be present and to make a statement at proceedings; apply for crime victim compensation; and seek an emergency protection order. The victim also has a right to be free from harassment and intimidation by the suspect, and the investigator should explain the process for contacting law enforcement if those laws are violated. (The victim should be advised to call 911 in an emergency.) The victim should be provided with the crime report number, as well as contact information for the reporting officer (including identification or badge number) and lead investigator (or person handling the follow-up).

5. *Drug-Facilitated Sexual Assault.* Call takers, responding officers, and investigators should always ask sexual assault victims about any circumstances that may indicate the use of a drug to facilitate the sexual assault (e.g., whether the victim experienced any loss of memory, disorientation, severe illness, or hallucinations). In doing so, however, investigators must clearly communicate to the victim that substance abuse does not justify the sexual assault. Law enforcement agencies are also encouraged to establish policies and protocols so that the victim's use of illegal drugs will not be referred for prosecution. This issue is discussed in detail in the section on sexual assault forensic examinations.

6. *Arrest and Prosecution Decisions.* In most situations, a sexual assault victim should not be asked during the preliminary investigation whether he or she wants to prosecute the suspect. **Decisions as to whether or not the victim wants to prosecute and whether there is sufficient evidence to warrant criminal charges against a suspect should be made only following a complete investigation.** If a victim is concerned about the issue of prosecution, this can be addressed during the preliminary interview.

In the case of an emergency response that results in an immediate arrest, the prosecuting attorney may have as little as 24-48 hours to present sufficient evidence to keep the suspect in custody. The victim's statement is usually critical in presenting this case. Officers should be discouraged from making an immediate arrest unless there is a reason to believe that the offender may flee the jurisdiction, destroy evidence, or is posing a danger to the victim or other members of the community. This allows the officer time to locate and interview any potential witnesses and to use investigative techniques such as pretext phone calls (where allowed by law). The rationale for the decision regarding arrest should be explained to the victim and any support people present. The investigator and advocate should together address safety issues, including comprehensive safety planning with the victim. They should also inform the victim, in the case of an arrest, that the suspect may be released on bond shortly afterwards.

7. *Delayed Reports.* Most victims of sexual assault postpone reporting the incident to the police or anyone else. The reasons are distinct for each individual and may include the victim's feelings of shame, embarrassment, shock, denial, self-blame, uncertainty regarding whether the event constitutes a sexual assault, fear of not being believed, concern regarding family members and friends finding out what happened, fear of the criminal justice system, and fear of the consequences and how they will affect the victim's life. Because of these many fears and concerns regarding reporting, officers must be patient with any hesitancy on the part of the victim during the preliminary interview.

Officers must remain sensitive to the fact that questions about the delayed report may lead victims to feel the officer does not believe their account of events or blames them for the assault. While the reasons for a delayed report need to be documented, a delay in reporting should be considered normal and not seen as evidence that the victim is lying about the assault. In fact, many state laws allow prosecution many years after the sexual assault. This is determined by the statute of limitations for the specific crime classification and the age of the victim at the time of the assault. Even when the statute of limitations has expired, a prosecutor can use the (previous) victim as a witness to corroborate another case still within the statute of limitations involving the same suspect. A delayed report should, therefore, never deter a thorough investigation.

D. Forensic Examination of Sexual Assault Victims

A timely, well-done forensic examination has the potential of addressing many of the concerns of sexual assault victims and can increase the likelihood that documentation of visible injuries and evidence collected will aid in the investigation and prosecu-

tion of sex offenders. Victim-centered care is paramount to the success of the forensic examination, and it is critical to adapt the examination and the care to the circumstances of each victim as much as possible.

1. Alternative Community Models. There are numerous models for conducting forensic examinations. In some communities, the hospital emergency department performs all sexual assault examinations. This practice can lead to delays and frustration (e.g., examiners not specially trained to work with sexual assault victims, victims triaged with other patients).

Many communities have developed a Sexual Assault Response Team (SART), a multidisciplinary team dedicated to timely, comprehensive attention to the medical and emotional needs of the patient as well as the forensic needs of the criminal justice system. As part of the movement toward SARTs, many communities' forensic examinations are now conducted by specially trained Sexual Assault Forensic Examiners (physicians) or Sexual Assault Nurse Examiners (SANEs) who are on call to respond to sexual assault victims. For more information on SANE or SART tools and resources see the Office on Violence Against Women Web site (http://www.ojp.usdoj.gov/vawo) or the Office for Victims of Crime Web site (http://www.ojp.usdoj.gov/ovc).

If a transfer from one health care facility to a facility designated for forensic examinations is necessary, an established protocol should be in place to minimize delays and loss of evidence while addressing victim needs.

At a minimum, health care facilities have an obligation to provide complete and appropriate services to patients disclosing a sexual assault. If the victim first disclosed the assault to law enforcement, arrangements should be made for the forensic examination to take place as soon as is practical. Although a victim may seek medical care without wanting law enforcement involved, some states have mandated reporting laws requiring that health practitioners notify law enforcement when a patient is treated for injuries resulting from a violent crime, including sexual assault. Victims should be encouraged to at least discuss the options available and what an investigation would entail; however, they cannot and should not be forced to talk to law enforcement.

2. Time Guidelines. Advancing DNA technologies continue to extend time limits for investigations due to the stability of the evidence and the sensitivity of new methods of testing, enabling forensic scientists to analyze evidence that was collected decades earlier. As a result, new guidelines are needed for investigators to determine when a forensic medical examination is appropriate.

Although many jurisdictions currently use 72-96 hours as a standard cutoff for collecting evidence following a sexual assault, evidence collection and the documentation of injury are often possible even beyond that time frame (up to 10 days following a sexual assault)[15] and should be encouraged in order to document injuries or if the victim is complaining of pain or bleeding. In the case of a sexual assault by a stranger, biological evidence and DNA may have a significant impact on the likelihood of holding the assailant accountable. In these cases, a forensic examination may be considered up to three weeks following a vaginal sexual assault, since evidence may still be recoverable.

Decisions to collect evidence should *never* be based on the characteristics of the victim or the assault (e.g., the victim is a drug addict, runaway, or prostitute). Rather they should be made on a case-by-case basis, guided by knowledge that time limits for obtaining evidence vary. If there is a question about the timeliness of a forensic examination, dialogue among forensic examiners, law enforcement representatives, and forensic scientists should be encouraged to determine the potential benefits or limitations of collection. When a forensic examination is not authorized by law enforcement (for those states that require law enforcement to authorize the exam), sexual assault victims should always be encouraged to get medical attention, including testing for pregnancy and sexually transmitted diseases (STDs). Medical attention can address the physical health needs of the victim, and treatment for pregnancy or STDs may even provide evidence to corroborate an assault and support prosecution. The investigator can explore these possibilities, regardless of whether a forensic examination is conducted.

3. Responsibilities of the Forensic Examiner. The forensic examiner should document the victim's medical history, a history of the assault, and all injuries that are observed, and collect biological and trace evidence from the victim's body. Information gained from the history can guide examiners in determining whether and where there may be evidence to collect.

There is no reason for a law enforcement representative (even one of the same gender as the victim) to be present in the exam room. The forensic examiner will testify to the collection of evidence and the chain of custody. When findings from the medical examination are consistent with the account of events given by the victim, the forensic examiner should note in the report that findings are "consistent" or "congruent" with the victim's account. Definitive conclusions about the presence of forensic evidence should be made by a forensic scientist only after analysis in a crime laboratory. For example, the absence of injury or other visible findings should never be used to discredit a victim's account or conclude that a sexual assault did not occur.

4. Addressing Victim Needs. When a forensic examination is to be conducted, the investigating officer should offer to promptly notify a victim advocate and ask the victim if she or he would like anyone else to be called or notified, unless this may be considered harmful in the particular circumstances. The victim should be informed if there is concern that the presence of a particular individual during the medical history may influence the statements that he or she is willing to make or may be *perceived* as influencing the victim's statements. These individuals should not actively participate in the interview or examination process.

The investigator should explain to the victim the general examination procedure and inform the victim of the right to decline any or all parts of the examination. The investigator should also explain that declining part of the examination may negatively affect the thoroughness of the exam, the usefulness of evidence collection, and the effectiveness of the criminal investigation or prosecution of the case. Declining a particular procedure might also be used to discredit a victim if prosecution is pursued. The victim's decision to decline any part of the forensic examination, however, must always be respected.

5. Release of Medical Records. Hospital and medical records are confidential and generally require a subpoena for release. However, the victim has the right to sign a waiver releasing specific information or medical records. Investigators should obtain such a waiver whenever possible.

6. The Team Approach. Communication between the investigating officer and forensic examiners should remain open prior to and following the exam. Notes from before and after the forensic examination should then be compared. In this process, it is not unusual to discover that additional information was revealed during the forensic examination. Many victims will disclose acts to medical personnel that they might not immediately share with

law enforcement because of embarrassment.

If additional information is revealed, the investigating officer must discuss the new information with the victim. It is important for the officer to explain that he or she understands the victim's embarrassment and hesitation in disclosing the information, but that all the facts must be identified so that a thorough investigation can be completed. The examiner should also alert the reporting officer to visible forensic findings such as carpet fibers or other debris that might be connected to the crime scene. The examination findings must then be summarized in the preliminary report, specifically noting all significant information and injury.

7. Drug-Facilitated Sexual Assault. If a drug-facilitated sexual assault is suspected, it is critical that a urine sample be collected. Efforts should be made to add this step to the forensic examination procedure. Not all hospitals and forensic examination facilities have sexual assault evidence kits and even when they do, many such kits do not have urine specimen containers in them. It is critical that law enforcement work with victim advocacy organizations and others to establish protocols to address their response to illegal substance use on the part of the victim (which may come to light as a result of urine or blood testing) so that it does not compromise a sexual assault investigation. It is better to conduct a thorough investigation of a sexual assault crime than to prosecute victims for misdemeanor violations (driving under the influence, underage drinking, being under the influence of a controlled substance).

8. Forensic Examinations without Law Enforcement Involvement. If a victim reports directly to a medical facility or expresses a reluctance to report to law enforcement, it is imperative that the protocol involve meeting with a trained professional (such as a forensic examiner or victim advocate) to explain that the forensic examination is only one part of a thorough criminal investigation. Evidence should be preserved should the victim subsequently desire to proceed with criminal prosecution.

Blind reporting to law enforcement by victims can enable the collection of information about the sexual assault without initiating a full-scale police report and investigation, while preserving the option should the victim desire to proceed with criminal prosecution within the statute of limitations.

9. Reimbursement for the Examination. Some states acknowledge that the forensic sexual assault examination is evidentiary and, as such, law enforcement is required to pay for it. Using this model, law enforcement is generally required to authorize the examination and payment based on the history of the assault, state and local laws, and protocol. Under the Violence Against Women Act, a state is only entitled to funds under the STOP Violence Against Women Formula Grant Program if the state or another governmental entity incurs the full out-of-pocket cost of medical forensic exams for victims of sexual assault.[16] Policies and practices vary from state to state.

E. Follow-Up Victim Interview

1. Interview Protocol. An in-depth follow-up interview should typically be conducted after the victim has been medically examined and treated and personal needs have been met (such as changing clothes, bathing, eating, and sleeping). Efforts should be made to conduct the follow-up interview in a neutral location that is convenient for the victim. When needed, transportation assistance should be provided. Officers can often conduct this follow-up interview at the hospital or other medical facility where the victim is being treated. This is appropriate as long as the physical surroundings provide the necessary level of privacy and an environment of professional care to instill confidence in the victim. The victim may find the police department or the office of the prosecuting attorney very intimidating.

Depending on the circumstances of the assault, it may be best to schedule the follow-up interview for the following day. This is especially true in cases where the victim is still under the influence of drugs or alcohol, is injured, or has not had any sleep. Unless there are exigent circumstances requiring an arrest or identification, delaying the follow-up interview in these cases will generally enhance the investigation and the quality of information obtained. It is important for investigating officers to recognize that victims need time to begin to process the assault. Some victims may initially be unwilling or unable to participate in an investigation; however, with support from friends and family, the victim may be a viable witness at a later time.

Prior to the follow-up interview, the investigator should consult with the initial responding officer(s) and any other agency personnel who responded to the scene. As with the preliminary interview, the investigator should begin the follow-up interview with opening remarks expressing sympathy, updating any contact information for the victim, providing the investigator's contact information, and addressing the questions of any support people present. The investigator should then explain the purpose and scope of the interview and outline the victim's rights, including the right to confidentiality and freedom from harassment by the suspect. The investigator should also describe available resources and support organizations and encourage the victim to contact law enforcement should the suspect violate any existing criminal or court orders or if the suspect contacts the victim in any way.

As with the preliminary interview, the follow-up interview should be conducted avoiding legal jargon and in a nonthreatening manner that encourages conversation rather than resembling an interrogation. To begin, the victim should be allowed to describe what occurred in his or her own words without any interruption by the investigating officer.

During the interview, the investigator must be alert to new information or developments. If the victim's story differs from the originally reported facts or the facts as they were understood by the first responding officer, clarification should be sought. It should be understood that in some cases sexual assault victims may omit details from their initial description of the crime that they find embarrassing or deeply personal. Investigators should therefore expect a certain amount of reluctance on the part of the victim to describe unpleasant facts. The investigator should also explain that certain information must be discussed to establish the legal elements of the crime and pursue the investigation and potential prosecution.

2. Develop an Investigative Strategy. Prior to the interview, the investigator must develop an investigative strategy based on the nature of the assault and the possible defenses available to the suspect (e.g., denial, identity, and consent; *see II C).* Investigators should then seek strategies to address the key issues and consult with the prosecuting attorney, when necessary and appropriate. Because most defenses are based on consent, the victim should always be asked whether and for how long he or she has known the offender. If the two knew each other before the assault, the circumstances of their meeting and the extent of any previous relationship should be explored, particularly with respect to any prior sexual contact. Knowledge of previous sexual acts between the accused and the victim helps to establish the nature of the

relationship with the offender and prepare for prosecutorial obstacles.

The development of an investigative strategy will guide the interview questions and other evidence collection efforts to corroborate the victim, witness, and suspect statements and to note any discrepancies. The investigators should seek to:

- Verify any statements obtained from witnesses by the first responding officer(s).
- Obtain statements from witnesses not interviewed in the preliminary investigation.
- Rephotograph any nongenital injuries in order to document changes.
- Determine whether a search warrant is needed for any aspect of the investigation.
- Identify and contact others who may have been victimized by the suspect.
- Evaluate whether a pretext phone call is appropriate.

The determination of whether a pretext phone call is appropriate is based on the applicable laws of the state where the crime occurred as well as the locations of the victim and suspect, who may reside in different states and jurisdictions at the time of the investigation.

The investigator should also seek to communicate with personnel in other units in the agency as well as in other agencies to identify similarities or fact patterns that are consistent with other crimes (such as voyeurism or indecent exposure). It is important to seek information about other potential crimes by developing relationships with members of communities that are often closed to law enforcement, such as gay, lesbian, and transgendered populations; student bodies or associations; tribes; and other special cultural and religious populations.

3. Evidence Collection and Recovery. The investigating officer should follow department policy for evidence collection and forensic analysis testing by crime labs, and maintain consistent communication with the crime lab. The investigating officer should coordinate the prompt return of the victims' possessions.

4. Referral for Prosecution. Once a thorough follow-up investigation has been completed, it should be presented to the prosecuting attorney's office for review. The investigating officer should give the victim the name and contact information for the prosecutor assigned to the case and facilitate the first meeting between the prosecutor and the victim.

5. Victim Needs and Notification. As previously stated, it is imperative that law enforcement professionals coordinate with other relevant agencies, assistance organizations, service providers, and members of the SART to address the needs of the victim (which may include a follow-up forensic examination, medical testing, counseling, financial assistance, and guidance throughout the criminal justice process). The investigator should therefore work closely with victim advocates throughout the investigation and prosecutorial process to keep the victim informed when an arrest is made, a suspect is released from custody, or the prosecuting attorney decides not to file criminal charges against the defendant.

6. When the Victim Is Unable to Participate. It can be difficult for investigators when a victim is unable to participate in the investigation or the prosecutor declines to file criminal charges. However, it is important to recognize that prosecution may not be a viable option for all victims of sexual assault. Many victims feel that concerns about confidentiality, safety, and emotional well-being outweigh the risk and energy it takes to withstand the stress of an investigation and trial. Law enforcement is encouraged to respect a victim's decision about whether to be involved in criminal justice proceedings and is urged to offer continued assistance and referrals.

Investigators must remember that they can reopen a case within the statute of limitation if necessary. In some cases, an investigation may be warranted even if the statute of limitation has expired, if the prosecutor is able to use the suspect's prior acts to corroborate an offense.

F. Drug-Facilitated Sexual Assault [17]

Sexual assaults have long been linked to the abuse of substances—primarily alcohol—that may decrease inhibitions and render the victim incapacitated or physically helpless. In addition to alcohol, the drugs most often implicated in the commission of drug-facilitated sexual assaults are GHB, Rohypnol, Ketamine, Ecstasy, and Soma, although others are used as well (including benzodiazepines and other sedative hypnotics). To facilitate a sexual assault, a drug is given to the victim surreptitiously by the suspect, or the victim may voluntarily take the drug recreationally (which could cause reluctance to turn to law enforcement). These drugs often render victims unconscious, an effect that is quickened and intensified when the drugs are ingested with alcohol. Because of the sedative properties of these drugs, victims often have no memory of an assault, only an awareness or sense that they were violated.

1. Challenges of the Investigation. Over the last several years, reports of drug-facilitated sexual assaults have increased. These cases present unique challenges to both police and prosecutors, and the responding officer plays a particularly crucial role—especially in the collection, identification, and preservation of critical perishable evidence. A victim of a drug-facilitated sexual assault may display a range of symptoms that could include memory loss, dizziness, confusion, drowsiness, slurred speech, impaired motor skills, impaired judgment, and reduced inhibition. The victim may also appear intoxicated or hung over.

2. Conducting the Victim Interview. When drugs or alcohol are involved, the victim may remember very little, if anything, about the sexual assault itself. The victim's account of the events may have large gaps, which makes it difficult to describe what occurred to the investigating officer. As a result, the victim may be extremely anxious during the course of the interview. Investigating officers must remain patient and maintain an open mind while listening to the events as the victim recalls them. Investigators must also remember that a victim whose memory is impaired due to the pharmacological effect of a drug may innocently and unconsciously seek facts to fill in the blank spots in memory. It is therefore critical that investigators and examiners avoid suggestive questions while conducting the interview.

During the interview, it is very important to have victims articulate how they felt or what they had been doing prior to losing consciousness. It is equally crucial to interview any witnesses who might have seen or spoken with the victim before, during, or after the assault. Often, it is the witness who can establish time frames, confirm unusual behavior, provide critical facts, and identify potential sources of information. Investigators must not wait for laboratory results before beginning an investigation nor should they rely on the drug screening to make the case. Because of frequent delayed reporting in these cases, a negative toxicology report should be expected, increasing the importance of witness interviews.

3. Evidence Collection Issues. When an investigating officer suspects that a sexual assault may have been facilitated with

drugs or alcohol, he or she should immediately determine the time frame of the incident. If it is suspected that the assault occurred within 96 hours (4 days), the investigator should promptly see that a urine sample is collected from the victim. The sooner the sample is collected the stronger the chance that a drug can be successfully detected in a crime laboratory or other laboratory specializing in toxicology. Victims should not be pressured to go to the hospital or to provide a sample for screening for illegal drug use.

Because there could be a need for multiple toxicology tests, it is important to obtain as much urine as possible (100 ml if possible), and the samples should not be combined. Officers or forensic examiners must carefully note the date and exact time each sample is obtained. If the sexual assault is thought to have occurred within 24 hours of the report, officers should obtain a 30 ml blood sample (in gray-top tubes) in addition to a urine sample. Biological specimens such as urine and blood should be refrigerated (not frozen) as soon as possible. They should not be kept at room temperature (e.g., in the trunk or glove compartment of a patrol vehicle or in a desk) for any length of time.

In cases where a victim is transported to the hospital because of needed medical attention, the law enforcement officers, with the victim's consent, should advise the medical staff to obtain additional blood and urine samples or retain samples taken for medical diagnosis.

Additional evidence that may be found in cases of a drug-facilitated sexual assault might be located in the suspect's residence, vehicle, place of employment, locker, and so forth. This evidence may include such items as the drugs themselves, ingredients used to make the drugs, drug or rape-drug literature and recipes, Internet correspondence, drug packaging and bottles, and photographs and videotapes of victims.

4. *Information for the Victim.* A full drug screening should be used to test for any and all drugs and alcohol in the victim's system at the time of the assault. The victim should be informed of the necessity of a full drug screening (to gain complete knowledge of any drugs and alcohol in the victim's body at the time of the assault, including recreational drugs, prescription drugs, and over-the-counter medications). These drugs may often interact with each other and, when taken together, may have an exponential effect on the victim's ability to function.

Investigators, examiners, and advocates must also emphasize to victims the importance of being forthcoming about all drug (prescribed and recreational) use so it is less likely to be used to discredit the victim at trial, and it is critical that this information not be used by law enforcement officers to dismiss the victim's report of the sexual assault.

If victims deny having engaged in recreational drug use, but test positive for a drug like cocaine or methamphetamine, investigators must not assume the victim is lying. Some assailants have administered drugs to victims, surreptitiously or by force, to mask another drug or to discredit victims who may decide to report to authorities. There have even been cases where the assailant applied cocaine or some other drug to the victim's anus or vagina or his own penis before sexually assaulting the victim.

G. Contacting and Interviewing the Suspect

If the crime just occurred and there is a concern that the suspect will flee, destroy evidence, or pose a threat to the victim or the community, every attempt should be made to apprehend the suspect, and a curbstone lineup should be arranged.

1. *Custodial versus Noncustodial Interviews.* Once the suspect has been identified and detained, the investigating officer needs to determine if the suspect is under arrest or free to leave, as in a noncustodial situation. This decision should be based on guidelines from the local prosecuting attorney and agency policies. Noncustodial interviews are useful when investigating sexual assault and can allow more time to locate and interview witnesses and to employ investigative tactics (such as noncustodial interviews and pretext phone calls, where allowed by law and departmental policy), particularly because so many reports are delayed. A number of factors should be considered when determining whether an immediate arrest should be made, including the type of assault, protection of the victim and the public, the possible flight risk of the suspect, and the potential for the destruction of evidence. Factors that should not be considered include past sexual history or behavior of the victim, speculation that the victim will not prosecute, perceived credibility of the victim or the suspect, or the perceived likelihood of conviction.

2. *Conducting the Suspect Interview.* Regardless of whether the initial interview with the suspect is custodial or noncustodial, it is important to obtain an in-depth statement from the suspect in a nonthreatening manner. For example, the first responding officer may be one of the few people who have the opportunity to hear the suspect deny any sexual contact with the victim. With time, after considering the potential charges, however, most suspects quickly resort to a consent defense. Therefore, such a statement of denial is critically important to preserve in the exact wording of the suspect. Decisions about audiotaping or videotaping the interview should be based on state law and the policies of the prosecuting agency and investigating department.

If the suspect invokes the constitutional right to remain silent, investigating officers must still evaluate the circumstances of the assault to anticipate the suspect's defense strategy (e.g., the relationship between the victim and the suspect, whether evidence links the offender to the victim, whether a witness can link the offender to the victim or scene, whether evidence or witnesses can corroborate a lack of consent). These factors can guide the investigative strategy and evidence collection efforts, as well as the interpretation and relative importance placed on various pieces of evidence.

3. *Evidence Collection with the Suspect.* In all sexual assault cases, the investigating officer must evaluate the need for a search warrant to identify and collect evidence from the suspect, including any known photographs or video recordings as well as any of the victim's possessions in the suspect's home or vehicle (which are often overlooked). Law enforcement agencies are advised to work with the prosecuting attorney's office in advance to have templates available for such warrants.

H. The Sexual Assault Forensic Examination of the Suspect

Although the recent trend toward specialized forensic examiners has focused on improving medical care for the *victims* of sexual assault, the issues surrounding the forensic examination of the *suspects* are often overlooked. Law enforcement agencies must therefore work with other agencies and community organizations to establish protocols regarding where the forensic examination of the suspect will take place, who will pay for it, and what steps will be involved. As with the forensic examination of the victim, the forensic examination of the suspect is evidentiary and should be considered an additional expense associated with the investigation.

1. *Protocol for Suspect Examination.* Immediately following the preliminary suspect interview, the investigating officer must

determine whether a forensic sexual assault examination should be conducted with the suspect. Factors to consider in that decision are the length of time since the assault occurred, the nature of the assault, whether the victim believes that he or she injured the suspect, and the likelihood that cells, fluid, or other types of biological or trace evidence were transferred from the victim to the suspect. Depending on the specific acts committed, the suspect could be the best source of probative evidence.

Based on state laws and department policies, a search warrant may be needed to collect evidence from the body of the suspect or even to collect the suspect's clothing. Even without probable cause or a court warrant, most jurisdictions recognize that an officer can obtain consent from a suspect for an examination. If the suspect consents to such evidence collection procedures, documentation of voluntary consent should be captured in the police report. Departments should consider having consent forms available for suspects to sign. Policies need to be developed to address law enforcement's role in the forensic exam of the suspect to include combative or dangerous suspects.

At the beginning of the forensic examination the investigating officer should provide the examiner with a summary of the assault, including the acts reported, the location, any physical identifying information provided by the victim or witness(es), and any potential injuries that the victim described inflicting on the suspect. Because the forensic examiner is an agent of the investigating officer, a *Miranda* warning must be provided to any suspect who is questioned while in custody. This includes questioning the suspect about his medical history (since the information will be used to evaluate any possible findings). The examiner should then obtain a medical history from the suspect, if possible. This history should include recent information on any anal or genital injuries, surgeries, diagnostic procedures, or medical procedures that may affect the interpretation of the current findings. Such information can help to avoid confusing preexisting lesions with current injuries or findings.[18] If the suspect invokes his or her right to remain silent, the examiner should bypass the medical history and continue the examination. If the suspect is not in custody, the investigator must clearly document that the suspect was free to decline any part of the examination and to leave at any time.

2. ***Evidence Collection.*** Forensic examination kits used on suspects differ slightly from standard rape kits used for victims. The forensic examination and kit for the suspect should include:

- External examination of the anal area.
- Chest or facial hair reference samples.
- Penile and scrotal swabs, which are especially critical when conducting a suspect forensic exam.

In addition to the collection of such biological and trace evidence, the forensic examiner should also record the suspect's vital signs and document (including through use of body diagrams and photographs) any visible injuries or complaints of pain.[19] Depending on the case history, urine and blood samples may be needed for toxicology or to counter potential defenses that might be raised by the suspect. DNA reference samples of blood and saliva should also be obtained.

During the forensic examination, all physical findings must be carefully documented, including any observable or palpable tissue injuries, physiologic changes, or foreign material (e.g., grass, sand, stains, dried or moist secretions). Unlike in the forensic examination of the victim, there should be no conclusion as to whether the findings are consistent with the history provided by the suspect. Both the examiner and attending officer should be prepared to document any spontaneous statements made by the suspect regardless of whether the suspect is in custody or provided with a *Miranda* warning.

3. ***Location of the Suspect Examination.*** It is critically important to note that the victim and suspect examination must take place in different locations. It is simply not appropriate for suspects to be treated in the same location. Additionally, from a forensic evidence standpoint, it is important that every effort be made to avoid cross-contamination of evidence from the victim and suspect. This is an area that can be vulnerable to attack by the defense.

One possible solution is to have the suspect examined at the police department or other nonmedical facility in cases where the suspect is not injured and does not require medical care. The examiner[20] can respond directly to the police department, and the equipment and space needed to conduct the examination are minimal. Although there may be some added costs initially for police departments that host suspect examinations, they will likely benefit from a more efficient response and an increased likelihood that the examination will provide probative evidence that can be used to prosecute suspects.

I. DNA Technology

The last decade has seen incredible advances in the evolution of DNA technology and its use in law enforcement investigation and prosecution. With the success of DNA technology with respect to sexual assault investigations, many law enforcement agencies have effectively linked cases and identified previously unknown assailants. However, many police agencies and investigators have also experienced frustration because of a severe shortage of crime laboratory resources. In many cases, evidence (such as clothing and evidence collected with sexual assault kits) has been destroyed when the statute of limitation expired.

Although these situations are certainly frustrating for police investigators, it can be devastating for victims. Public outcry has led to the enactment of legislation in many states to expand and sometimes eliminate the statute of limitations for sexual assault crimes. Some jurisdictions have enacted statutes allowing "John Doe warrants" to be issued using only a DNA profile as identifying information. In 2003, the federal government committed to providing 1 billion dollars over five years to clear a massive backlog of genetic samples nationwide. This DNA initiative is expected to help solve thousands of cold cases by processing DNA evidence from 350,000 crime scenes (including from sexual assault evidence kits) and 300,000 convicted offender samples that remain unevaluated.

As DNA technology improves and the investigative applications increase, law enforcement agencies must provide academy recruits and veteran officers with standardized, crime-specific policies, protocols, training, and resources to ensure an appropriate response and timely, thorough forensic evidence collection.[21]

J. A Crime or a False Complaint?

Perhaps the most significant barrier to a successful sexual assault investigation and prosecution, and one that influences victims as well, is the powerful and pervasive myth that most sexual assault allegations are false. Estimates of false rape charges have varied widely, ranging from lows of .25 percent to highs of 80-90 percent. These discrepancies are a result of differences in perception, terminology, methodology of information gathering, and how a report is determined to be false.

The determination that a report of sexual assault is false can

be made only if the evidence establishes that no crime was committed or attempted. **This determination can be made only after a thorough investigation**. This should not be confused with an investigation that fails to prove a sexual assault occurred. In that case the investigation would be labeled unsubstantiated. **The determination that a report is false must be supported by evidence that the assault did not happen.**

1. "Misinterpreted Behaviors." Some cases may be improperly labeled as false because they are not grounded in investigative facts, but rather in the particular reactions of the victim. For example, some factors that are typically responsible for false declarations are the:

- Victim's delayed report
- Failure to locate the victim
- Failure to identify the assailant
- Lack of corroborating evidence
- Lack of cooperation by the victim or witnesses
- Report was filed in the wrong jurisdiction
- Discrepancies in the victim's story
- Wrong address given by the victim
- Victim's drunkenness
- Victim's drug use
- Victim's being thought of as a prostitute
- Victim's sexual history
- Victim's uncertainty of events
- Victim's belligerence
- Victim's failure to follow through with the investigation and prosecution
- Recantation by the victim[22]

These characteristics should not be seen as a basis for labeling a sexual assault report as false (or baseless) and, therefore, never having happened. Research has shown that many of these characteristics represent the realistic dynamics of and are common reactions to sexual assault. Even if aspects of the victim's account of the incident are missing, exaggerated, or false, this does not automatically imply that the sexual assault did not occur.

2. Case Coding. The term "unfounded" is commonly defined as "lacking a sound base, groundless, unwarranted." It is synonymous with another term often used by law enforcement in child abuse cases: "unsubstantiated." Both terms are used to code and administratively clear sexual assault cases that are often mislabeled as "false allegations." Police departments should make every effort to be aware of the implications of improperly clearing cases as unfounded and avoid doing so without a thorough investigation resulting in that determination.

It is important to note that the definition of "unfounded" is not the same in all law enforcement agencies, and certain definitions can lead to confusion and an inaccurate understanding of the scope of the crime. The UCR defines "unfounded" as "false or baseless." Police departments routinely administratively clear a number of reports of sexual assault, perhaps mistakenly, in one combined category of "unfounded OR false." Because of these varying definitions of "unfounded" among reporting agencies and the UCR, law enforcement professionals may have similar misunderstandings and inaccurately place false and unfounded reports in the same category.

The FBI reporting requirements make it clear that a case cannot be closed (administratively cleared) because an arrest is not made or the victim refuses to participate. There is an additional UCR category, "exceptional clearance," which may only be used for cases in which the offender is identified but cannot be charged or the victim refuses to cooperate. It is critical that law enforcement administrators evaluate current police decision-making practices regarding the clearance of sexual assault cases.

3. False Reports. When an investigation does support a false report, it is understandable that an investigating officer may feel frustrated or betrayed. Police supervisors and administrators are encouraged to recognize and reward officers for conducting thorough investigations that are based on the evidence and to support their conclusions and outcomes. If a suspect was identified, and possibly even arrested, for an allegation that was later determined to be false based on the evidence, the results of a complete investigation can exonerate a suspect rather than leave doubt in the minds of others.

K. Polygraphs and Other Interrogation Techniques

Based on the misperception that a significant percentage of sexual assault reports are false, some law enforcement agencies use polygraphs or other interrogation techniques (including voice stress analyzers, SCAN) when interviewing victims. Victims often feel confused and ashamed, and experience a great deal of self-blame because of something they did or did not do in relation to the sexual assault. These feelings may compromise the reliability of the results of such interrogation techniques. The use of these interrogation techniques can also compound these feelings and prolong the trauma of a sexual assault. Some states have even enacted laws prohibiting the police from offering a polygraph examination to sexual assault victims or from using the results to determine whether criminal charges will be filed. A competent, evidence-based investigation will reveal the truth much more effectively than these interrogation tactics. Law enforcement agencies should establish policies to clearly state that officers should not require, offer, or suggest that a victim take a polygraph examination or submit to SCAN or voice stress analysis during the investigation stage.

On the other hand, there are some states and jurisdictions where polygraph examination is used strategically with sexual assault victims during courtroom proceedings. This tactic can be particularly useful in the case of a nonstranger sexual assault resulting in a consent defense, but it should only be used in the courtroom proceedings phase and not during the investigation. To illustrate, many defendants state that they will take a polygraph examination only if the victim will also take one at the same time. In addition, many defense attorneys will not allow the defendant to take a stipulated polygraph if the victim has already passed a polygraph or voice stress test. In this type of situation, it can sometimes be strategically beneficial in court to offer a polygraph examination of the victim. If stipulated to do so in court, the examiner may be allowed to testify as an expert at the trial. This strategy must be used only if the situation is discussed with the victim in advance, in the presence of a victim advocate or another knowledgeable support person.

Endnotes

[1] For the purpose of the policy and this paper, those victimized by sexual assault are referred to as "victims" because this is the term most often recognized and used by professionals in the criminal justice system. Members of the medical community may refer to the same person as a "patient," whereas rape crisis centers may prefer to use the term "survivor" or "client."

[2] The estimate of 150 per 100,000 was calculated based on the rate of 1.5 per 1,000 people provided by the NCVS.

[3] Bureau of Justice Statistics, National Crime Victimization Survey (2003). Criminal Victimization, 2003. Bureau of Justice Statistics: Washington, D.C. Available at http://www.ojp.usdoj.gov/bjs/abstract/cv03.htm.

[4] Federal Bureau of Investigation (2002). Crime in the United States—2002. Federal Bureau of Investigation: Washington, D.C. Available at http://www.fbi.gov/ucr/02cius.htm. Normally the UCR defines rape rates per total population. In this part, US Census data were

used to base a rate on the female population.

[5] For more information on statistics on rape and sexual assault, see Kilpatrick, Dean G. (2004). *Making Sense of Rape in America: Where Do the Numbers Come From and What Do They Mean?* National Crime Victims Research Center: Medical University of South Carolina.

[6] Tracy, C.E., and Fromson, T.L. (2001, May 22). Call for Change in FBI Definition of Rape. Public letter to the Federal Bureau of Investigation. Women's Law Project, Philadelphia (http://www.womenslawproject.org).

[7] Kerstetter, W.A. (1990). "Gateway to Justice: Police and Prosecutor Response to Sexual Assaults against Women." *The Journal of Criminal Law and Criminology*, Vol. 81, No. 2, pp. 267-313. Spears, J.S. and Spohn, C.C. (1997). "The Effects of Evidence Factors and Victim Characteristics on Prosecutors' Charging Decisions in Sexual Assault Cases." *Justice Quarterly*, Vol. 14, No. 3, pp. 501-524.

[8] Lewis, S.H. (2003). Unspoken Crimes: Sexual Assault in Rural America. National Sexual Violence Resource Center, A Project of the Pennsylvania Coalition Against Rape. Available at http://www.nsvrc.org.

[9] For the purposes of the policy and this paper, the suspect in a sexual assault case will typically be referred to as male. While this terminology is problematic in that it excludes female sex offenders, it is used for simplicity in recognition of the fact that the vast majority of sexual assault perpetrators are men.

[10] Horney, J. and Spohn, C. (1996). "The Influence of Blame and Believability Factors on the Processing of Simple Versus Aggravated Rape Cases." *Criminology*, Vol. 34, No. 2, pp. 13–162.

[11] Dripps, D.A. (1992). "Beyond Rape: An Essay on the Difference between the Presence of Force and the Absence of Consent." *Columbia Law Review*, Vol. 92, No. 7, pp. 1780–1809.

[12] Falk, P.J. (2002). "Rape by Drugs: A Statutory Overview and Proposals for Reform." *Arizona Law Review*, Vol. 44, No. 1, pp. 131–212.

[13] Hammock, G.S. (1997). "Perceptions of Rape: The Influence of Closeness of Relationship, Intoxication, and Sex of Participant." *Violence and Victims*, Vol. 12, No. 3, pp. 237–246.

[14] According to the DOJ, "confidential communications are any information, whether written or spoken, which is transmitted between a victim...and a victim counselor in the course of the counseling relationship and in private, or in the presence of a third party who is present to facilitate communication or further the counseling process." Report to Congress, supra note 1, Model Legislation, 102 (A). The terms "victim," "victim counseling center," and "victim counselor" are also defined.

[15] Green, W., Kaufhold, M., and Schulman, E. *Sexual Assault Evidentiary Exam Training for Health Care Providers*. California Medical Training Center, University of California at Davis, Module 7, Page 45, Slide 100.

[16] 42 USC 3796gg-4.

[17] National Drug Intelligence Center and Sexual Assault Services Office (2003, May). *Drug Facilitated Sexual Assault Resource Guide*. Published by George Mason University and available by calling NDIC at (703) 362-6044 or George Mason University at (703) 993-4364.

[18] Green, W., Kaufhold, M., and Schulman, E. *Sexual Assault Evidentiary Exam Training for Health Care Providers*. California Medical Training Center, University of California at Davis, Module 7, Page 63.

[19] The California Office of Criminal Justice Planning has a state-approved forensic medical report for the suspect examination. The report is available online at http://www.ocjp.ca.gov/medforms2/950.pdf.

[20] Because of a severe shortage of nurses throughout the country and in view of the cost, some forensic examiner programs and police departments use licensed vocational nurses (LVNs) and Emergency Medical Services personnel to conduct the suspect examination, which reduces the cost of the suspect forensic examination.

[21] The National Institute of Justice has developed a brochure and training curriculum, in cooperation with the National Commission on the Future of DNA, titled "What Every Law Enforcement Officer Should Know About DNA Evidence. Best Practices for Identification, Preservation and Collection of DNA Evidence at the Crime Scene." (NCJ 182992) http://www.ojp.usdoj.gov/nij/pubs-sum/000614.htm. Both are extremely valuable resources for first responders and prosecutors.

[22] These factors were originally reviewed in Kanin, E.J. (1994). "False Rape Allegations." *Archives of Sexual Behavior*, Vol. 23, No. 1, pp. 81-93.

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Every effort has been made by the IACP National Law Enforcement Policy Center staff and advisory board to ensure that this model policy incorporates the most current information and contemporary professional judgment on this issue. However, law enforcement administrators should be cautioned that no "model" policy can meet all the needs of any given law enforcement agency. Each law enforcement agency operates in a unique environment of federal court rulings, state laws, local ordinances, regulations, judicial and administrative decisions and collective bargaining agreements that must be considered. In addition, the formulation of specific agency policies must take into account local political and community perspectives and customs, prerogatives and demands; often divergent law enforcement strategies and philosophies; and the impact of varied agency resource capabilities among other factors.

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International Association of Forensic Nurses

Position Statement
on
Collaboration With Victim Advocates

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

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

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

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

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

Rationale: As stated in the **A National Protocol for Sexual Assault Medical Forensic Examinations**, developed by the U.S. Department of Justice,"Advocates can offer a tangible and personal connection to a long-term source of support and advocacy."[2] The Protocol goes on to recommend that, in order for health care responders to facilitate a victim-centered approach they

should "understand the importance of victim (support) services within the exam process....(and) involve victim service providers/advocates in the exam process (including the actual exam) to offer support, crisis intervention, and advocacy to victims, their families, and friends."[3]

The **Protocol** recognizes that a coordinated community approach "can help afford victims access to comprehensive immediate care, minimize trauma victims may experience, and encourage them to utilize community resources. It can also facilitate the criminal investigation and prosecution, increasing likelihood of holding offenders accountable and preventing further sexual assaults."[4] Research demonstrates that victims of sexual assault that receive medical care at a facility that provides a Rape Victim Advocate obtain rape examinations and forensic evidence collection at a higher rate than victims who did not have advocacy services.[5] Victims provided with advocacy services also demonstrate fewer secondary victimization behaviors and secondary victimization emotions.[6]

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

References

[1] **World Health Report on Violence and Health: Summary**, World Health Organization, Geneva, 2002.
[2] **National Protocol for Sexual Assault Medical Forensic Examination,** United States Department of Justice 2004. p. 34
[3] Id at p. 27.
[4] Id at p. 1.
[5] Campbell, R. (2006) Rape survivors' experiences with legal and medical systems: Do rape advocates make a difference? **Violence Against Women Volume** 12 No 1 p. 42.
[6] Id at p. 43.
[7] **Guidelines for Medico-Legal Care for Victims of Sexual Violence**. (2003) World Health Organization, Geneva p. 20

APRIL 2013

A National Protocol for Sexual Assault Medical Forensic Examinations

Adults/Adolescents

Second Edition

DNA INITIATIVE

For complete protocol, please see:
http://www.iafn.org/associations/8556/files/SAFE%20PROTOCOL%202013-508.pdf

1. Coordinated Team Approach

Recommendations at a glance for jurisdictions to facilitate a coordinated team approach:

- Understand that the purpose of the exam is to address patients' health care needs and collect evidence when appropriate for potential use within the criminal justice system.
- Identify key responders and their roles.
- Develop quality assurance measures to ensure effective response during the exam process.

Communities should ensure that victims, regardless of their backgrounds or circumstances, have access to medical, legal, and advocacy services. Use of a coordinated, multidisciplinary approach in conducting the medical forensic examination can afford victims access to comprehensive immediate care, help minimize trauma they may be experiencing, and encourage the use of community resources. Such a response can also enhance public safety by facilitating investigation and prosecution, thereby increasing the likelihood that offenders will be held accountable for their behavior and further sexual assaults will be prevented. Raising public awareness about the existence and benefits of a coordinated response to sexual assault may lead more victims to disclose the assault and seek the help they need.[27]

Understand that the purpose of the exam is to address patients' health care needs and collect evidence when appropriate for potential use within the criminal justice system. The medical/forensic examination in its entirety addresses the medical and evidentiary needs of the consenting patient:

- Conducting prompt examinations.
- Providing support, crisis intervention, and advocacy.
- Obtaining a history of the assault.
- Performing a complete assessment.
- Documenting exam findings.
- Evaluating and treating injuries.
- Properly collecting, handling, and preserving potential evidence.
- Providing information, treatment, and referrals for STIs and pregnancy.
- Providing follow-up care for medical and emotional needs as well as further forensic evaluation.
- Providing language assistance services for limited English proficient, Deaf and hard-of-hearing individuals, and those with sensory or communication disabilities.

It is also possible that examiners may provide the following as a routine part of their post-examination process depending upon the criminal justice system response:

- Interpreting and analyzing examination findings.
- Presenting findings and providing factual and/or expert opinion related to the medical forensic examination.

Coordination among involved disciplines is strongly recommended to simultaneously address the needs of both victims and the justice system. Ensuring that victims' needs are met often can increase their level of comfort and involvement with the legal system.

Identify key responders and their roles. Two types of teams are recommended to facilitate a coordinated community response to sexual assault. Some form of a sexual assault response team (SART/SARRT) is useful to coordinate immediate interventions and services, including victim support, medical care, evidence collection and documentation, and the initial criminal investigation. A communitywide coordinating group (often called a "council") can help promote efforts to improve comprehensive response to sexual violence,

[27] This paragraph is drawn partially from American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, p. 7.

including prevention education and outreach,[28] training and technical assistance, improvement of victim services, protocol development, public policy advocacy, dissemination of materials, and evaluation of the effectiveness of these efforts.[29] A communitywide coordinating council may also oversee activities of a SART/SARRT. Military bases, school campuses, and tribes may develop coordinating councils or SARTs or SARRTs of their own to allow for a more specialized response tailored to the needs of their populations. Coordinating councils may also exist to encourage consistent responses across a state, territory, tribal land or region.

SART/SARRT membership. A SART/SARRT is composed of professionals involved in immediate response to disclosures of sexual assault. A core SART/SARRT commonly includes health care providers, law enforcement representatives, and victim advocates. Prosecutors and forensic scientists also are often involved, but more as consultants than first responders. Civil attorneys who represent victims are sometimes involved as well. Broad roles for SART/SARRT members include (listed in alphabetical order):[30]

- **Advocates** may be involved in initial victim contact (via 24-hour hotline or face-to-face meetings), offer victim advocacy, support, crisis intervention, information, translation or interpretation, and referrals before, during, and after the exam process, and facilitate transportation for the victim to and from the exam site. They often provide comprehensive, longer term services designed to aid victims in addressing any needs related to the assault, including but not limited to counseling and legal (civil, criminal, and immigration) and medical systems advocacy.
- **Civil attorneys** protect the interests of sexual assault victims, address concerns that affect immediate everyday life and long-term wellbeing of victims, and represent victims in civil legal matters. Civil legal matters may include: privacy, safety, immigration, education, housing, employment, and financial issues. Because civil attorneys represent the individual victim, and not the prosecutor, they play a very different role from that of the prosecutor.
- **Forensic scientists** analyze forensic evidence and provide results of the analysis to investigators and/or prosecutors. They may respond to crime scenes to assist in the collection and processing of evidence. They also testify at trial regarding the results of their analysis.
- **Health care providers** assess patients for acute medical needs and provide stabilization, treatment, and/or consultation. Ideally, sexual assault forensic examiners perform the medical forensic exam, gather information for the medical forensic history, collect and document forensic evidence, and document pertinent physical findings from patients. They offer information, treatment, and referrals for sexually transmitted infections (STIs), pregnancy, and other nonacute medical concerns. They may also testify in court if needed. They coordinate with advocates to ensure that patients are offered crisis intervention, support, and advocacy during and after the exam process and encourage use of other victim services. They may follow up with patients for medical and forensic purposes. Other health care personnel that may be involved include, but are not limited to, emergency medical technicians, staff at hospital emergency departments, gynecologists, surgeons, private physicians, and/or local, tribal, campus, or military health services personnel.
- **Law enforcement representatives** (e.g., 911 dispatchers, patrol officers, officers who process crime scene evidence, investigators, and federal law enforcement officers) respond to initial complaints, work to enhance victims' safety, arrange for victims' transportation to and from the exam site as needed, interview victims, coordinate collection and delivery of evidence to designated labs or law enforcement property facilities, and investigate cases (e.g., interviewing suspects and witnesses, requesting crime lab analysis, reviewing medical and lab reports, preparing and executing search warrants, writing reports, and presenting the case to a prosecutor).
- **Prosecutors** determine if there is sufficient evidence for prosecution and, if so, prosecute the case. They should be available to consult with first responders as needed. A few jurisdictions more actively

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[28] Although victim advocacy programs and coordinating councils often lead local prevention efforts, SARTs play a role in prevention by helping victims plan for their safety and well-being and connecting them with resources that may reduce the likelihood of their future revictimization (e.g., emergency shelters and longer term housing programs, protective orders, programs offering free cell phones that automatically dial 911 when activated, or businesses that can help change locks and install alarm systems). Initial evidence collection and investigative efforts can play a pivotal role in holding offenders accountable and preventing them from reoffending.

[29] American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, p. 19.

[30] Bulleted section partially adapted from Pennsylvania's *SART Guidelines*, 2002, created by the Pennsylvania Coalition Against Rape.

2. Victim-Centered Care

Recommendations at a glance for health care providers and other responders to facilitate victim-centered care during the exam process:

- Give sexual assault patients priority as emergency cases.
- Provide the necessary means to ensure patient privacy.
- Adapt the exam process as needed to address the unique needs and circumstances of each patient.
- Develop culturally responsive care and be aware of issues commonly faced by victims from specific populations.
- Recognize the importance of victim services within the exam process.
- Accommodate patients' requests to have a relative, friend, or other personal support person (e.g., religious -and spiritual counselor/advisor/healer) present during the exam, unless considered harmful by responders.
- Accommodate patients' requests for responders of a specific gender throughout the exam as much as possible.
- Prior to starting the exam and conducting each procedure, explain to patients in a language the patients understand what is entailed and its purpose.
- Assess and respect patients' priorities.
- Integrate medical and evidentiary procedures where possible.
- Address patients' safety during the exam.
- Provide information that is easy for patients to understand, in the patient's language, and that can be reviewed at their convenience.
- Address physical comfort needs of patients prior to discharge.

It is critical to respond to individuals disclosing sexual assault in a timely, appropriate, sensitive, and respectful way.[37] Every action taken by responders during the exam process should be useful in facilitating patient care and healing and/or the investigation (if the case was reported).

Give sexual assault patients priority as emergency cases. This includes a prompt medical screening exam. Recognize that every minute patients spend waiting to be examined may cause loss of evidence and undue trauma. Individuals disclosing a recent sexual assault should be quickly transported to the exam site, promptly evaluated, treated for serious injuries, and offered a medical forensic exam. (For more discussion on this topic, see *C.2. Triage and Intake.*) Have plans for what to do, if the examiner is not available right away. For example, is there a quiet, private place the patient can wait? Is there a phone available so the patient can talk to an advocate or a friend or family member while waiting? Jurisdictions should consider policies and training for facility staff and administration regarding what to do while sexual assault patients are waiting.

Provide the necessary means to ensure patient privacy. Exercise discretion to avoid the embarrassment for individuals of being identified in a public setting as a sexual assault victim. Some health care facilities use code plans to avoid inappropriate references by staff to sexual assault cases. Also, do not leave sexual assault patients in the main waiting area at the exam site. Instead, give them as much privacy as possible (e.g., a private treatment room and waiting area) and be cognizant of their sense of safety (e.g., do not examine suspects in same location at the same time). Make sure that the first responding health care providers attend to patients' initial medical needs and arrange for an on-call advocate to offer onsite support, crisis intervention, and advocacy. It may be useful to give patients the option of speaking with an advocate via a 24-hour crisis hotline (if one exists) until an advocate arrives. Health care providers should provide patients with access to a phone to contact family members and/or support persons as desired, and should promptly contact law enforcement, if not already involved, if patients want to report the assault.

[37] The chapter was partially built on information from the *North Carolina Protocol for Assisting Sexual Assault Victims*, 2000.

Health care providers should explain, in a language the patients understand, the scope of confidentiality during the exam process and during communication with advocates. (For information on this topic, see *A.4. Confidentiality*.)

Adapt the exam process as needed to address the unique needs and circumstances of each patient. Patients' experiences during the crime and the exam process, as well as their post-assault needs, may be affected by multiple factors, such as:

- Age.
- Gender and/or perceived gender identity/gender expression.
- Physical health history and current status.
- Mental health history and current status.
- Disability.
- Language needs for limited English proficient patients, Deaf and hard-of-hearing individuals, and those with sensory or communication disabilities.
- Ethnic and cultural beliefs and practices.
- Religious and spiritual beliefs and practices.
- Economic status, including homelessness.
- Immigration and refugee status.
- Sexual orientation.
- Military status.
- History of previous victimization.
- Past experience with the criminal justice system.
- Whether the assault involved drugs and/or alcohol.
- Prior relationship with the suspect, if any.
- Whether they were assaulted by an assailant who was in an authority position over them.
- Whether the assault was part of a broader continuum of violence and/or oppression (e.g., intimate partner and family violence, gang violence, hate crimes, war crimes, commercial sexual exploitation, sex and/or labor trafficking).
- Where the assault occurred.
- Whether they sustained physical injuries from the assault and the severity of the injuries.
- Whether they were engaged in illegal activities at the time of the assault (e.g., voluntary use of illegal drugs or underage drinking) or have outstanding criminal charges.
- Whether they were involved in activities prior to the assault that traditionally generate victim blaming or self-blaming (e.g., drinking alcohol prior to the assault or agreeing to go to the assailant's home).
- Whether birth control was used during the assault (e.g., victims may already have been on a form of birth control or the assailant may have used a condom).
- Capacity to cope with trauma and the level of support available from families and friends.
- The importance they place on the needs of their extended families and friends in the aftermath of the assault.
- Whether they have dependents who require care during the exam, were traumatized by the assault, or who may be affected by decisions patients make during the exam process.
- Community/cultural attitudes about sexual assault, its victims, and offenders.
- Frequency of sexual assault and other violence in the community and historical responsiveness of the local justice system, health care systems, and community service agencies.

Clearly, the level of trauma experienced by patients can also influence their initial reactions to an assault and to post-assault needs. While some may suffer physical injuries, contract an STI, or become pregnant as a result of an assault, many others do not. The experience of psychological trauma will be unique to each patient and may be more difficult to recognize than physical trauma. People have their own method of coping with sudden stress. When severely traumatized, they can appear to be calm, indifferent, submissive, jocular, angry, emotionally distraught, or even uncooperative or hostile towards those who are trying to help.[38]

[38] Paragraph adapted from Iowa's *Sexual Assault: A Protocol for Forensic and Medical Examination*, 1998, pp. 1–4.

parts at all. Reflect the victim's language when possible and use alternative means of communication (such as anatomically correct dolls or paper and pen for the victim to write or draw) if necessary

- Vaginas that have been exposed to testosterone or created surgically are more fragile than vaginas of most non-transgender women and may sustain more damage in an assault. There may be additional layers of psychological trauma for patients with a male identity or a constructed vagina when they have been vaginally assaulted.
- Transgender male individuals who still have ovaries and a uterus can become pregnant even when they were using testosterone and/or had not been menstruating.
- Transgender people may engage in self-harm as a coping mechanism. However, cutting and genital mutilations are also frequently part of anti-transgender hate crimes. Be nonjudgmental and careful when documenting such injuries.
- Some transgender victims may want to talk about their perceptions of the role their gender identity might have played in making them vulnerable to an assault. Because of their value in possible prosecutions under hate crime laws, document any anti-transgender statements the victim says were made during the assault. Otherwise, listen to the victim's concerns and what the experience was like for them. Assure them that it was not their fault they were sexually assaulted. If needed, encourage discussion in a counseling/advocacy setting on this issue as well as on what might help them feel safer in the future.
- Ensure that all referrals given to a transgender victim have been trained on or have significant experience with the special needs of transgender survivors of sexual assault.
- Include opportunities for LGBT individuals to influence the development of sensitive responses for victims of sexual assault.

Recognize the importance of victim services within the exam process. In many jurisdictions, sexual assault victim advocacy programs and other victim service programs offer a range of services before, during, and after the exam process (see below for a description of typical services). Ideally, advocates should begin interacting with victims in a language the victims understand prior to the exam, as soon after disclosure of the assault as possible. Victims who come to exam sites in the immediate aftermath of an assault are typically coping with trauma, anticipating the exam, and considering the implications of reporting. Most responders that victims come in contact with are focused on objective tasks. Law enforcement officials gather information and collect crime scene evidence to facilitate the investigation. Health care personnel assess medical needs, offer treatment, and collect evidence from victims. Victims must make many related decisions that may seem overwhelming. Advocates[68] can offer a tangible and personal connection to a long-term source of support and advocacy. Community-based advocates, in particular, have the sole purpose of supporting victims' needs and wishes. Typically, these advocates are able to talk with victims with some degree of confidentiality, depending on jurisdictional statutes, while statements victims make to examiners become part of the medical forensic report.[69] When community-based advocates support victims, examiners can more easily maintain an objective stance.[70] In addition, civil attorneys may be able to help victims assess legal needs and options, including privacy, safety, immigration, housing, education, and employment issues.

Be aware of the extent of services. Services offered by advocates during the exam process may include: [71]

- Accompanying the victims through each component (advocates may accompany victims from the initial contact and the actual exam through to discharge and follow-up appointments).
- Serving as an information resource for victims (e.g., to answer questions; explain the importance of prompt law enforcement involvement if the decision is made to report; explain the value of medical and evidence collection procedures; explain legal aspects of the exam; help them understand their

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[68] To prepare them to competently provide sexual assault victim services, community-based advocates are typically trained according to the policies of the sexual assault advocacy agency where they are employed/volunteer and receive supervision related to their interactions with victims. In addition, many jurisdictions have specific requirements that community-based advocates must meet in order to fit within jurisdictional confidentiality or privilege laws. Advocates should meet these requirements. System-based advocates may be required to have specific credentials based on system and jurisdictional policies and laws.

[69] K. Littel, *SANE Programs: Improving the Community Response to Sexual Assault Victims*, 2001, p. 6.

[70] Ibid. See also IAFN position statement Dated Nov 19, 2008: Collaboration with Advocates http://iafn.org/associations/8556/files/IAFN%20Position%20Statement-Advocate%20Collaboration%20Approved.pdf.

[71] This bulleted section was drawn partially from Iowa's *Sexual Assault: A Protocol for Forensic and Medical Examination*, 1998, p. 7, and the 1989 *Volunteer Manual* of Virginians Aligned Against Sexual Assault (VAASA).

treatment options for STIs, HIV, and pregnancy; serve as a resource and follow-up point of contact for any future inquiries such as payment method for the exams; and provide referrals).

- Assisting in coordination of victim transportation to and from the exam site.
- Providing victims with crisis intervention[72] and support to help cope with the trauma of the assault[73] and begin the healing process.
- Actively listening to victims to assist in sorting through and identifying their feelings.
- Letting victims know their reactions to the assault are normal and dispelling misconceptions regarding sexual assault.
- Advocating for victims' self-articulated needs to be identified and their choices to be respected, as well as advocating for appropriate and coordinated response by all involved professionals;
- Supporting victims in voicing their concerns to relevant responders.
- Responding in a culturally and linguistically sensitive and appropriate manner to victims from different backgrounds and circumstances and advocating for the elimination of barriers to communication.
- Providing replacement clothing when clothing is retained for evidence, as well as toiletries.
- Aiding victims in identifying individuals who could support them as they heal (e.g., family members, friends, counselors, employers, religious or spiritual counselors/advisors, and/or teachers).
- Helping victims' families and friends cope with their reactions to the assault, providing information, and increasing their understanding of the type of support victims may need from them.
- Assisting victims in planning for their safety and well-being.

Postexam, advocates can continue to advocate for victims' rights and wishes; offer victims ongoing support, counseling,[74] information, and referrals for community services; assist with applications for victim compensation programs;[75] and encourage victims to obtain follow-up testing and treatment and take medications as directed. They can also accompany victims to follow-up appointments, including those for related medical care and criminal and civil justice-related interviews and proceedings. They can work closely with the responders involved to ensure that postexam services and interventions are coordinated in a complementary manner and are appropriately based on victims' needs and wishes.

Contact the victim service/advocacy program immediately. Utilize a system in which exam facility personnel, upon initial contact with a sexual assault patient, call the victim service/advocacy program and ask for an advocate to be sent to the exam site (unless an advocate has already been called).[76] Prior to introducing the advocate to a patient, exam facility personnel should explain briefly, in a language the patient understands, the victim services offered and ask whether the victim wishes to speak with the onsite advocate. Note that some jurisdictions require that patients be asked whether they want to talk with an advocate before the advocate is contacted.[77] If possible, victims should be allowed to meet with advocates in a private place prior to the exam. Ideally, a patient should be assisted by the same advocate during the entire exam process.[78]

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[72] Crisis intervention counseling is short term in nature, aimed at returning individuals to their precrisis state through the development of adaptive coping responses. Broadly, it entails establishing a relationship with the individual in crisis, gathering information about what is occurring, clarifying the problem, helping the individual identify options and resources so that they are able to make an informed decision as to what, if any, actions will be taken. (Adapted from the 1991 Women Helping Women *Volunteer Training Manual*, Cincinnati, Ohio.) Note: Crisis intervention is not intended to address longer term counseling and advocacy needs.

[73] See A. Burgess and L. Holmstrom, Rape Trauma Syndrome, *American Journal of Psychiatry*, 131: 981-986, September 1974, for a summary of the psychological, somatic, and behavioral impact of sexual assault on victims.

[74] Many advocacy agencies offer ongoing support and advocacy to victims. Some also provide professional mental health counseling, but many refer victims to community or private agencies.

[75] For more information on crime victim's compensation, please see http://www.ovc.gov/publications/factshts/compandassist/welcome.html.

[76] Use community-based sexual assault victim advocates where possible. If not available, victim service providers based in the exam facility, criminal justice system, social services, or other agencies may be able to provide some advocacy services if educated to provide those services. Patients should be aware that government-based service providers typically cannot offer confidential communication.

[77] In very small communities, patients may know some or all advocates (e.g., a small, close-knit community that speaks an uncommon dialect). Some patients may feel comfortable being supported by an advocate known to them while others may not. Patients concerned about anonymity should be provided with as many options as possible. For example, ask if they would like to speak with an on-call advocate on the phone prior to making their decision about whether they want an advocate present during the exam. Another option may be for the local advocacy program to partner with an advocacy program in a neighboring jurisdiction, so they can provide one another with backup to handle situations such as this one.

[78] Continuity of advocates can be challenging when response by other professionals is delayed, the exam process is lengthy, or travel to the exam site is considerable. Volunteers may or may not be able to continue providing services after the end of their on-call shift.

Understandably, immigrant victims may be reluctant to discuss or report the victimization. It is inappropriate to ask patients about aspects of their health, body, legal status, or identity that are not related to the assault. It is, however, appropriate to ensure that all victims are provided with information regarding U-Visas, in the event that this relief would be appropriate.[79]

Accommodate patients' requests to have a relative, friend, or other personal support person (e.g., religious and spiritual counselor/advisor/healer) present during the exam, unless considered harmful by responders.[80] An exception would be if responders consider the request to be potentially harmful to the patient or the exam process.[81] Patients' requests to not have certain individuals present in the room should also be respected (e.g., adolescents may not want their parents present). Examiners should get explicit consent from patients to go forward with the exam with another person present. When others are present, appropriately drape patients and position additional persons. (It is also important to inform patients of confidentiality considerations regarding the presence of support persons during the medical forensic history. For a discussion of this topic, see *C.4. The Medical Forensic History*.)

Strive to limit the number of persons (beyond the patient, examiner, advocate, personal support person, and any necessary interpreters) in the exam room during the exam. The primary reason is to protect patients' privacy, but also because exam rooms often cannot accommodate more than a few individuals. Law enforcement representatives should not be present during the exam. When additional health care personnel are needed for consultation (e.g., a surgeon), patients' permission should be sought prior to their admittance. In cases in which examiners are supervising an examiner-in-training/licensed health care student, patients' consent should be obtained prior to the student's admittance to examine patients or observe the exam. It is inappropriate to ask patients to allow a group of nonlicensed medical students to view the exam. It is also inappropriate to ask patients about aspects of their health, body, legal status, or identity that are not related to the assault.

Accommodate patients' requests for responders of a specific gender throughout the exam as much as possible. For a variety of reasons, some patients may prefer to work with a male or female law enforcement official, advocate, and/or examiner.

Prior to starting the exam and conducting each procedure, explain to patients in a language the patients understand what is entailed and its purpose. In addition, it is important to explain the exam process and the purpose of the exam more generally (e.g., how the evidence may be used by the criminal justice system). A clear explanation is particularly important for individuals who may not previously have had a pelvic exam or medical care, or who have difficulty understanding what has happened and why they are being asked to undergo a medical forensic exam. Remember that some exam procedures may be uncomfortable and painful to patients, considering the nature of the trauma they have experienced. By taking the time to explain procedures and their options, patients may be able to better relax, feel more in control of what's occurring, and make decisions that meet their needs. After providing the needed information, seek patients' permission to proceed with exam procedures. (For a more detailed discussion on seeking informed consent of patients, see *A.3. Informed Consent*.)

Address and respect patients' priorities. Although medical care and evidence collection may be encouraged during the exam process, responders should provide patients with information about all of their options and assess and respect their priorities.

Integrate medical and evidentiary procedures where possible. Medical care and evidence collection procedures should be integrated to maximize efficiency and minimize trauma to patients. For example, draw blood needed for medical and evidentiary purposes at the same time. Also, coordinate information-gathering by health care and legal personnel to minimize the need for patients to repeat their statements. (For more information on coordination in information gathering, see *C.4. The Medical Forensic History*.) Consider the

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[79] Legal Momentum has extensive resources available regarding U-Visas. See: http://www.legalmomentum.org/our-work/immigrant-women-program/u-visa.html. Additionally, immigrant women are entitled to emergency medical and post-assault healthcare. For a state-by-state breakdown of the benefits afforded see: http://www.legalmomentum.org/assets/pdfs/4_nilc_table_10.pdf.

[80] Paragraph partially drawn from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 15.

[81] For example, in cases involving adolescents or vulnerable adults, caretakers should not be allowed in the exam room if they are suspected of committing the assault or of being otherwise abusive to the patient.

implications of the evolving law on hearsay exceptions when determining the level and nature of coordination. *See Appendix C* for more information on the relevant case law and how it relates to medical forensic examinations.

Address patients' safety during the exam. When patients arrive at the exam site, health care providers should assess related safety concerns. For example, a caretaker, partner, or family member who is suspected of committing the assault may have accompanied the patient to the facility. Some victims, including transgender people, may also fear assault or belittlement by health care professionals' and/or law enforcement officials' responses to their gender identity or expression and/or transgender body. Follow facility policy on response to this and other types of threatening situations. Also, exam sites should have plans in place to protect patients from exposure to potentially infectious materials during the examination. (See *B.1. Sexual Assault Forensic Examiners.*) Prior to discharge, assist victims in planning for their safety and well-being. Planning should take into account needs that may arise in different types of cases. For example, patients who know the assailants may not be concerned only about their ongoing safety but also about the safety of their families and friends. Local law enforcement may be able to assist facilities in addressing patients' safety needs. (See *C.10. Discharge and Follow-up.)*

Provide information that is easy for patients to understand, in the patient's language, and that can be reviewed at their convenience.[82] Information should be tailored to patients' communication skill level/modality and language. This includes providing interpreter services and the translation of documents into languages other than English for limited English proficient (LEP) patients. Developing material in alternative formats may be useful, such as information that is taped, in Braille, in large print, in various languages, or uses pictures and simple language.[83] A victim booklet or packet that includes information about the following topics may be helpful:

- The crime itself (e.g., facts about sexual assault and related criminal statutes).
- Normal reactions to sexual assault (stressing that it is never the victim's fault), and signs and symptoms of traumatic response.
- Victims' rights.
- Victim support and advocacy services.
- Civil, criminal, and immigration legal services.
- Mental health counseling options and referrals.
- Resources for the victim's significant others.
- The examination—what happened and how evidence/findings will be used.
- Medical discharge and follow-up instructions.
- Planning for the victim's safety and well-being.
- Examination payment and reimbursement information.
- Steps and options in the criminal justice process.
- Civil and immigration remedies that may be available to sexual assault victims.
- Procedures for victims to access their medical record or applicable law enforcement reports.

Address physical comfort needs of patients prior to discharge. For example, provide them with the opportunity to wash in privacy (offering shower facilities if at all possible[84]), brush their teeth, change clothes (clean and ideally new replacement clothing should be available); get food and/or a beverage, and make needed phone calls. They may also require assistance in coordinating transportation from the exam site to their home or another location.

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[82] Many local sexual assault advocacy programs and state coalitions of sexual assault programs offer publications that speak to victims' concerns in the aftermath of an assault. However, any involved agency, SART, or coordinating council could develop such literature.
[83] For example, one sexual assault advocacy program offers a booklet "for those who read best with few words" designed for people with developmental disabilities who have been sexually assaulted. For more information on this publication, contact the Los Angeles Commission on Assaults Against Women by phone (213–955–9090) or e-mail info@lacaaw.org.
[84] It would be useful for the exam room to have an attached bathroom with a shower.

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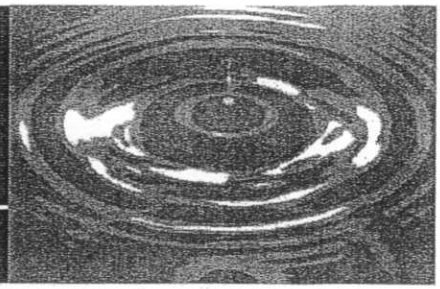

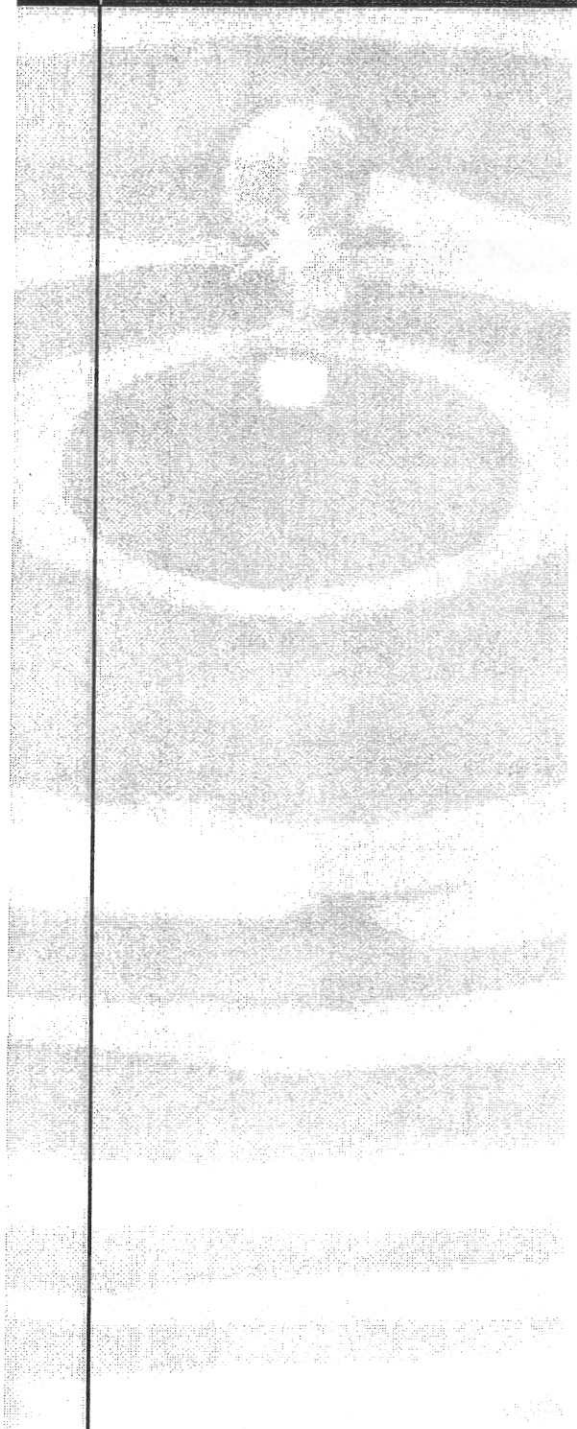

Wisconsin
Adult Sexual Assault Response Team Protocol

May 2011

For complete protocol, please see:
http://www.doj.state.wi.us/sites/default/files/ocvs/vawa/sart-protocol.pdf

Summary of Best Practices

A best practice is defined as a technique or methodology that experience and research has proven to lead to a desired result.[24] Best practices rely on strategies and approaches that have been documented, accessible, repeatable and efficient. By implication, best practice means that through trial and error, a guideline has been developed which is deemed to be most likely successful if followed faithfully.

The Wisconsin Statewide Protocol Development Team has identified the following best practice approaches for each of the four major disciplines who participate in a Sexual Assault Response Team. While the needs and resources of each community vary, the table below presents a snapshot of what each discipline should aspire to in developing a victim- centered response.

Recommended Best Practices	
Advocacy	■ 24 hr. hotline staffed with a live voice ■ Multi-lingual and multicultural availability, including American Sign Language, TTY, etc ■ Accessibility based on victim need ■ 24 hr. in person advocacy ■ Two advocates available, one may be system based ■ Most independent advocate available ■ Victim centered ■ Advocate called at same time as SANE nurse ■ Advocate present in all places victim requests ■ Advocate facilitates transportation needs
Law Enforcement	■ Responding Officer (non-SART trained) shall limit the scope of their investigation to: critical needs, safety, scene preservation, confirmation of crime, venue and suspect apprehension ■ Evidence preservation advisories provided to the victim ■ Give victim choice of exam or interview and in what order ■ Advocate called immediately by Responding Officer ■ Advocate present in all places victim requests ■ Be available to review case /do more investigation in coordination with reviewing attorney
Prosecution	■ Meet with victim and advocate (if victim requests) before charging decision is made ■ Vertical prosecution – same prosecutor for the entire case ■ If not charging – meet with victim face to face with advocate present ■ Work with advocate to prepare victim for court proceedings ■ Meet/talk with victim before any deal is offered/ accepted and to solicit victim's input on disposition alternatives ■ Acknowledge victim's range of options for participation in the prosecution process
SANE	■ Utilize SANE services when available ■ SANE will notify advocacy and respond as a team ■ Give victim options of care, explain each procedure and why it's necessary ■ The victim has the right to choose what procedures they will and will not have

[24] Baltimore County Sexual Assault Response Team. Found online at: http://www.goccp.maryland.gov/bestPractices/best-practices3.php.

Law Enforcement Response

The Role of Law Enforcement

The role of law enforcement is to protect and serve the public, which includes the obligation to investigate alleged crimes. In cases of sexual assault, this means protecting the safety of the victim and the community while collecting evidence in a fair and lawful manner. Law enforcement agencies are often the point of first contact for the victim. They initiate the multidisciplinary response by calling the advocate. The primary responsibility of law enforcement in relation to sexual assault is to determine if there has been a sexual assault that meets the criteria for a crime as defined by Wisconsin statutes that include 940.225.[8]

Determining the criteria for a crime involves putting together a factual history by collecting statements from the victim, any witnesses, and suspect(s) as well as collecting any physical and corroborative evidence.

Victim Centered, Trauma Informed and Offender Focused Response

It is crucial for every discipline to have a victim-centered response when dealing with sexual assault. It is equally important for every discipline to be informed about the effect of trauma on an individual. Trauma can affect an individual's affect, memory, and ability to give detailed information. For law enforcement, this means being educated about the effect of trauma on an individual and treating each alleged victim with consideration, professionalism, and compassion.

A victim-centered response to sexual assault recognizes the assault as a "critical incident" and uses the understanding and knowledge of "critical incident stress" when dealing with a victim of sexual assault.

Law enforcement understands the impact of an officer involved in a "critical incident". A critical incident is defined as "any event that has a stressful impact sufficient enough to overwhelm the usually effective coping skills of an individual."[9]

Common reported reactions following a "critical incident" include:

- Anxiety
- Fear for the safety of yourself or loved ones
- Preoccupation with the stressful event
- Flashbacks in which the individual mentally re-experiences the event
- Physical symptoms; muscle aches, headaches, fatigue
- Disbelief at what has happened, feeling numb
- Problems with concentration or memory (especially aspects of the traumatic event)
- A misperception of time
- Increased startle response
- Feelings of guilt and/or self doubt related to the traumatic event, even if misplaced when evaluated by an impartial person

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[8] Wisconsin Statute 940. Crimes Against Life and Bodily Security. Available online at: http://www.legis.state.wi.us/Statutes/Stat0940.pdf.

[9] Kulbarsh, P. Critical Incident Stress: What is expected and when to get help. Posted online on Officer.com. Available online at: http://www.officer.com/web/online/Police-Life/Critical-Incident-Stress/17$38344.

A victim-centered response to sexual assault recognizes the assault as a "critical incident" and uses the understanding and knowledge of "critical incident stress" when dealing with a victim of sexual assault.

Law enforcement must also be offender focused in its response to sexual assault. Being offender focused means understanding that offenders often choose victims based on the victim's accessibility, vulnerability and perceived lack of credibility. A victim centered law enforcement response acknowledges that victims of sexual assault are *very often* those individuals perceived as lacking in credibility. Offenders hope that law enforcement will participate in victim blaming, not educate themselves about offenders, and not have a solid understanding of the effects of trauma. All of these can combine to allow the offender to continue to re-offend.

Best Practices for Law Enforcement

Initiating the Collaborative Response

Law enforcement is often the first contact for a victim of sexual assault and therefore, should initiate the collaborative response by calling the community based advocate. The community based advocate should be contacted whether or not a victim chooses to have a sexual assault exam.

Role of Law Enforcement During the Forensic Exam

Law enforcement can be present and participate with the SANE during the taking of the assault and forensic history. However, the victim should always be allowed to determine who is present (e.g. community advocate, system advocate, law enforcement) during the forensic exam. Note that for court purposes, the SANE nurse can adequately present all relevant facts regarding the exam.

Conducting an Initial Victim Statement Interview

The initial victim statement is typically taken upon first contact with the victim and law enforcement. The initial victim statement is the opportunity for law enforcement to obtain basic information and establish the location and elements of the crime. The community based advocate should be available to sit in on the initial victim statement if the victim chooses. The initial victim statement is **not** a comprehensive interview – the initial statement is used to assess safety and health needs, ascertain jurisdiction, identify and preserve sources of evidence and determine next steps.

Conducting a Comprehensive Interview/Assault History

The comprehensive interview and assault history should be performed by officers who have specific training in sexual assault interview and investigations. The interview should take place *after* the forensic exam has been completed and the victim has been allowed to shower (if desired) and dress. A community based advocate should be allowed to be present during the interview, if the victim desires. The community based advocate and law enforcement officer should work together to minimize re-victimization during the interview process.

Victim interviews take time to complete. Law enforcement should allow ample time to conduct a thorough victim interview. The comfort and needs of the victim should be taken into consideration throughout the course of the interview process. Law enforcement should consider that trauma, cultural differences, cognitive ability, fear, self-blame and other factors can influence the victim's ability to provide concise details about the assault. Law enforcement and the community based advocate should work together

to ensure the victim's comfort in order to facilitate the disclosure of as many relevant details as possible.

Purpose of Comprehensive Interview/Assault History

The purpose of the comprehensive interview is to develop a fuller picture of the circumstances of the sexual assault. The interview presents an opportunity for the victim to provide additional information she/he may not have remembered, may have been afraid or embarrassed to share, or may have suppressed immediately following the assault. It presents an opportunity for law enforcement to:

- Verify, clarify and expand on the initial interview
- Confirm and establish the elements of the crime
- Develop supporting details related to the assault and the circumstances surrounding the assault

Offenders often target victims whom they perceive as not believable if they report the crime, especially victims who have a previous criminal history, who abuse alcohol and/or drugs and victims with physical, cognitive and or mental disorders. Victims may also fear not being believed. A victim centered approach to interviewing acknowledges these factors and attempts to make the victim comfortable by:

- Establishing a rapport before beginning the interview
- Explaining how the investigative process works and why certain questions are necessary
- Avoiding victim blaming questions – such as "why did you" or "why didn't you"- unless the context and purpose of such a question is explained to the victim
- Encouraging the victim to provide a comprehensive statement of the event from beginning to end – with only minimal interruption but with the understanding that follow up questions will be necessary for clarification of various points throughout the statement
- Acknowledging the impact of trauma on the victim during the interview

Reluctant and/or Recanting Victims

It is not uncommon for sexual assault victims to be reluctant about reporting to law enforcement and participating in the criminal justice system. Victims who are reluctant often feel they have no other choice but to recant in an effort to disengage from the criminal justice system. A victim centered approach by law enforcement recognizes the tremendous cost to a victim who proceeds with the criminal justice system and understands that recantation of one or more aspects of a prior statement doesn't necessarily mean false reporting. Various influences affect a victim's willingness to participate and/or recant. Among those influences are:

- A victim's feeling of embarrassment, fear, and shame
- A victim wanting to put the assault behind them, avoid answering questions, repeating the story or facing the perpetrator in court
- Pressure from offender, friends, family or community
- Pressure from cultural and/or religious communities
- Concern or confusion about the likely outcome of a prosecution
- Concern that the victim will not be believed

Law Enforcement Best Practices Protocol

Best practice protocols for law enforcement should focus on: (a) protecting the safety and well-being of the victims and ensuring they receive proper medical attention; (b) initiating a collaborative response; (c) collecting and preserving evidence, including initial

witness statements; (d) identifying whether a crime has occurred; and (e) conducting an investigation. Each law enforcement responder has a unique role and process that should be followed:

Dispatcher Protocol Checklist:

- ❒ Check safety (weapons, injuries, direction of travel of suspect, etc.)
- ❒ Check special language/access needs.
- ❒ Confirm victim's safety and medical needs; activate Emergency Medical Services as needed.
- ❒ Seek suspect information; description, direction of travel, vehicle, etc
- ❒ Provide SANE related evidentiary advisories – not to bathe, change clothes, comb hair, brush teeth, touch any touch any articles or furniture the assailant may have touched, etc.
- ❒ When a SART trained officer is on duty, the SART trained officer will be dispatched to the scene. When a SART trained officer is not on duty, a uniform officer will be dispatched to the scene.
- ❒ Dispatcher is to remain on the line with the victim, if practical, until officers arrive, especially if the victim is alone and/or the scene is not safe.
- ❒ If it is obvious through the discussion, that the incident is a sensitive crime and venue is confirmed, dispatch may activate the SART (SART trained officer, advocate, SANE) immediately upon the approval of the shift commander.

Responding Officer Protocol:

- ❒ Re-evaluate safety for victim and any other person at potential risk
- ❒ Activate emergency medical services as needed
- ❒ Identify crime
- ❒ Establish jurisdiction
- ❒ Preserve evidence /secure scene.
- ❒ Determine if offender is known and possible locations.
- ❒ If Responding Officer is not SART trained, activate SART response (SART trained officer, advocate, SANE)
- ❒ If the victim is a juvenile contact the Department of Human Services
- ❒ Do not conduct a comprehensive interview of the victim; seek confirmation of the crime, venue and suspect information
- ❒ If SART trained officer has a delayed response, work with community based advocate to facilitate transportation to hospital
- ❒ Remain with the victim until SART trained officer arrives and the information is transferred to the investigating officer
- ❒ Promptly complete initial incident report

Sensitive Crime Team Member Protocol:

- ❒ Re-evaluate safety, activate Emergency Medical Services as needed
- ❒ Verify collaborative response has been initiated (Advocate, SANE)
- ❒ Ascertain what disclosure has already been made and to who (initial officer, friend)
- ❒ Provide victim with "victim rights" information
- ❒ Conduct initial victim statement – short interview to determine evidence collection as requested by the victim - community based advocate should be present during initial and comprehensive statements
- ❒ Follow-up with comprehensive/complete victim interview; generally will follow the SANE exam

- ❒ Coordinate audio/visual taped statements in accordance with local District Attorney's guidelines. Recorded statements are mandatory for juvenile offenders in custody and adult felons
- ❒ Determine need for search warrant
- ❒ Secure search warrant if needed
- ❒ Collect evidence from the scene(s)
- ❒ Conduct witness interview(s) – including potential disclosure witnesses
- ❒ Conduct suspect interview(s)
- ❒ Promptly and completely document case
- ❒ Conduct comprehensive review of case prior to sending case to the District Attorney – including reviewing all reports, evidence, review SANE documentation, statements, etc.
- ❒ Be available to provide case follow-up in consultation with prosecutor

Sexual Assault Nurse Examiner (SANE) Response

The Role of SANE

The role of the SANE in the response to sexual assault is to provide for the immediate medical care of patients/victims, to collect and document forensic evidence, and to provide expert testimony in the cases that go to trial. The goal in the response to sexual assault is to ensure that compassionate and sensitive services and care are provided in a non-judgmental manner.

Best Practice for SANE

The guideline that is included at the end of this chapter was developed by the Wisconsin Chapter of the International Association of Forensic Nurses and is recommended for the care of the adolescent and adult when there is a history or concern of sexual abuse or assault. The guideline is not intended to include all the triage issues, medical evaluations, tests, and follow-up that may be necessary for appropriate care for an individual patient. Not all the steps outlined in this guideline will be appropriate for every patient. The purpose of this guideline is to provide direction for the SANE in the care of the adolescent or adult sexual assault patient.

Prioritizing Victim Well-Being

The physical and psychological well-being of the sexual assault patient should always be given precedence over forensic needs. In some cases, the investigation may have to be delayed if law enforcement identifies that strangulation or a loss of consciousness occurred during the assault or if the victim complains of active bleeding or is pregnant or has abdominal pain. The SANE examination of the victim of sexual assault may assist with the investigation and prosecution of the case but is foremost intended to assist the survivor of sexual assault in her/his recovery. The victim of sexual assault needs prophylaxis to prevent sexually transmitted infection and pregnancy. The victim should always be referred to SANE for assessment and care.

The SANE examination of the victim of sexual assault may assist with the investigation and prosecution of the case but is foremost intended to assist the survivor of sexual assault in her/his recovery.

Ensuring Competency in Forensic Evaluation

Assessment, examination and evidence collection should only be done by those healthcare providers trained as SANE. The examination and evidence collection of the victim which follows a sexual assault is complicated and time consuming. If done by healthcare providers who are poorly trained in the evaluation and/or who have a limited understanding of the many needs and concerns of sexual assault victims, it can be as intrusive, invasive and as traumatizing as the assault.

The collection of evidence and the documentation of injury cannot be done in retrospect. If the evidence collection is done improperly or the chain of custody not properly maintained, the result may be a thwarted investigation and unsatisfactory prosecution. Expertise is also important to establish credibility when testifying in a court of law.

Patient Consent

Best practice guidelines inform us that **the patient must consent** to a SANE examination and evidence collection. *Consent can be given or withdrawn for any portion of the exam at any time.*

Victim Reporting of Sexual Assaults

Best practice guidelines indicate that an adult victim of sexual assault should be offered the following reporting options:

- Report the assault to law enforcement and having evidence collected.
- Choose NOT to report and NOT having evidence collected.
- Choose to have evidence collected even though the victim is undecided or choose to remain anonymous about reporting. In these cases, collaboration between law enforcement and the SANE is essential. A protocol that includes how this process will take place and what information is to be given to the patient must be developed. Confidentiality of the victim is important as well as the maintenance of the chain of custody (evidence).

The advantage of collecting evidence without a report is to facilitate reporting and allow for early evidence collection without putting pressure on the victim to make a decision about reporting before she/he is able to do so. *Whatever decision is made by the victim should be supported by the SANE.* The victim who decides not to report or who is undecided should be assessed and treated in the same manner as the victim who is reporting.

Community Based Advocacy

Advocacy is included in the healthcare response. SANE must be objective in order to provide the best treatment and collect the most accurate information. The emotional needs of victims are best cared for by the rape crisis advocate. The SANE should contact advocacy when a victim presents for evaluation, and the SANE and advocate together should respond as a team. Community based advocates can provide support to a victim from the beginning, throughout the investigative and prosecution process. Many cases will not be prosecuted and the victim will need assistance from advocacy if the case is not taken to court.

Timeliness of Evidence Collection

Evidence can be compromised or lost if not collected within a timely manner. Evidence collection is usually done within 96 hours of an assault but may be done beyond that time. The documentation of injury can be compelling evidence and injury can persist beyond 96 hours. However, injury may not be visible for hours or days. Patients/victims seen within hours of a sexual assault may have injury that cannot be seen and documented during an initial examination and should be instructed to return if injury becomes apparent later.

Release of Medical Information

Medical information, including evidence collected during a medical forensic examination, is protected under the Health Insurance Portability & Accountability Act (HIPPA). It can only be released to law enforcement or accessed for legal proceedings with the adult victim's written consent or when ordered by a court with jurisdiction in the matter. At the time of the adult victim examination, discussion of the need for the completion of a release of medical records form to facilitate the legal investigation and subsequent action should be done.

Prophylaxis Treatment

Prophylaxis for the prevention of sexually transmitted infection and emergency contraception should be offered and provided to all patients following current standards. The Centers for Disease Control and Prevention (CDC) Sexually Transmitted Disease Treatment Guidelines are an excellent resource for appropriate treatment. **Wisconsin Statute 50.375 mandates that a hospital that provides emergency services must provide emergency contraception to victims of sexual assault.**

Mandatory Reporting

There is mandatory reporting of suspected child victims of physical and sexual assault and neglect. There is no mandatory reporting for adult victims (18 years and older) unless the adult victim cannot make their own healthcare decisions i.e., those patients who have a legal guardian who makes decisions for them. The other exception to this law is in the case of injuries caused by a weapon or incidents involving life-threatening assault. These incidents must be reported to law enforcement agencies regardless of reporting the sexual assault.

Financial Responsibility

Best practice guidelines are very clear in their position on treating uninsured and underinsured sexual assault victims: ***ability to pay should never be an obstacle to obtaining a medical forensic examination!*** It is the responsibility of the SANE to provide the victim with accurate information about Crime Victim's Compensation (CVC) and Sexual Assault Forensic Exam (SAFE) funds—including how and where to apply for these funds.

Crime Victim Compensation (CVC) Program

If a victim is reporting the crime to the police, she/he may be eligible for Crime Victim Compensation (CVC) Funds. These funds can be used to pay for the medical costs of sexual assault exams (if the patient does not have insurance or medical assistance), clothing taken for evidence, et cetera. The requirements that applicants need to meet, in order to receive these funds are included in the brochure "A Measure of Justice – Financial Help for Victims of Crime" produced by the CVC Program and available by calling 1-800-446-6564.

Sexual Assault Forensic Exam (SAFE) Funds

The SAFE funds assist victims who have had a sexual assault forensic exam without requiring them to:

- Report to law enforcement
- Participate in the criminal justice process
- Have their own insurance company billed for the exam

It should be noted that the funds available through the SAFE fund are only intended to cover the cost of forensic exams.

Examination of the Suspect of Sexual Assault

The SANE may be asked to conduct a suspect exam as a part of the criminal investigation. Examination and evidence collection from the suspect of sexual assault is as important as the examination and evidence collection from the victim. Important biological or trace evidence and/or physical findings may be found which will link the suspect to the crime or provide useful corroborative information to the investigation of

the crime and to its successful prosecution. Neutrality, objectivity and patient confidentiality is critical for both the victim and suspect exams.

Although the possibility of cross contamination is virtually impossible if proper procedures are followed, it is prudent to meticulously document the measures taken to prevent any cross contamination such as the changing of gloves and clothes, the washing of hands and/or the cleaning of the room between the exams.

SANE Training

The Wisconsin Coalition Against Sexual Assault (WCASA) SANE Faculty provide training to healthcare providers in the evaluation and treatment of the adult and child victims of sexual assault. For additional information about this training, contact WCASA at 608-257-1516. The content of these trainings adheres to the standards of such established by the International Association of Forensic Nurses.

Certification as a SANE-A and as a SANE-P is obtained through the International Association of Forensic Nurses. Certification as a SANE-A demonstrates expertise in the evaluation of the adult victim of sexual assault and certification as a SANE-P is considered competency in the evaluation of the child victim of sexual abuse.

Wisconsin Chapter of the International Association of Forensic Nurses

The professional organization that represents forensic nursing is the International Association of Forensic Nurses (IAFN). SANE is the largest subspecialty of forensic nursing. Information about the Wisconsin chapter of the IAFN and its members can be obtained at the website www.wi-iafn.org.

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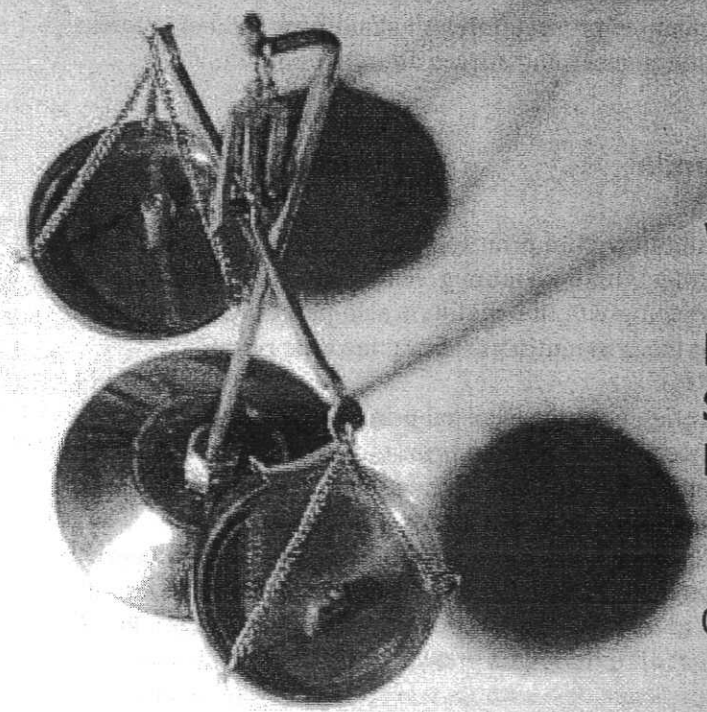

Wisconsin

Prosecutor's Sexual Assault Reference Book

October 2009

For complete resource, please see:
http://www.wcasa.org/file_open.php?id=3

prosecution may also improve efficiency, which would result in utilizing fewer resources and less time for each case. It sends a message that the prosecution will stand firm and may increase the opportunity of obtaining meaningful consequences and successful rehabilitation.[111]

3. Meeting with the Victim is Essential

It is recommended that prosecutors meet with the victim prior to making a determination about whether or not to charge the offender. Meeting with the victim gives prosecutors a feel for the case they cannot get just reading reports. Meeting with the victim is also part of being victim-centered and demonstrates to the victim that the prosecution is taking the case seriously.

If the prosecutor's office has a policy of meeting with the accused prior to charging or declination, the prosecutor should always meet with the victim prior to meeting with the defendant or defense attorney. It is necessary that a law enforcement witness be present during any interviews with the victim if any facts of the case will be discussed. Failure to have a witness present could result in the prosecutor becoming a witness. In addition, law enforcement personnel will memorialize for purposes that include mandated discovery any factual assertions by the victim that may need to be disclosed to the defense in a prosecution. Prosecutors should determine who will attend the meeting so that all individuals present will aid in the investigation and prosecution of the case and secure the presence of a witness who can testify at any hearing, and at trial concerning information disclosed by the victim during meetings.

Include Community Based Advocates

Meetings with victims should include a community based advocate whenever possible. An advocate can provide emotional support to the victim and encourage the victim to share details that are important to reviewing and potentially charging the case. Advocates maintain a privilege not to disclose communication between the advocate and the client. Advocates, therefore, can not be used by the prosecutor as a witness to document the facts discussed by the victim during meetings.

Meetings with victims should include a community based advocate whenever possible.

Interviewing the victim provides an opportunity to review the case from the victim's perspective, explain the process, uncover details that may have been overlooked in the initial investigation, and determine what outcome the victim is seeking. Creating a safe environment for the victim to explain all relevant facts and her/his perspective regarding the sexual assault is essential to obtaining a full picture of the case. To ensure the best outcome, prosecutors should:

- Allow adequate time for the interview.

[111] Backstrom, James C. and Gary L. Walker, "The Role of the Prosecutor in Juvenile Justice: Advocacy in the Courtroom and Leadership in the Community," *William Mitchell Law Review*, 2006.