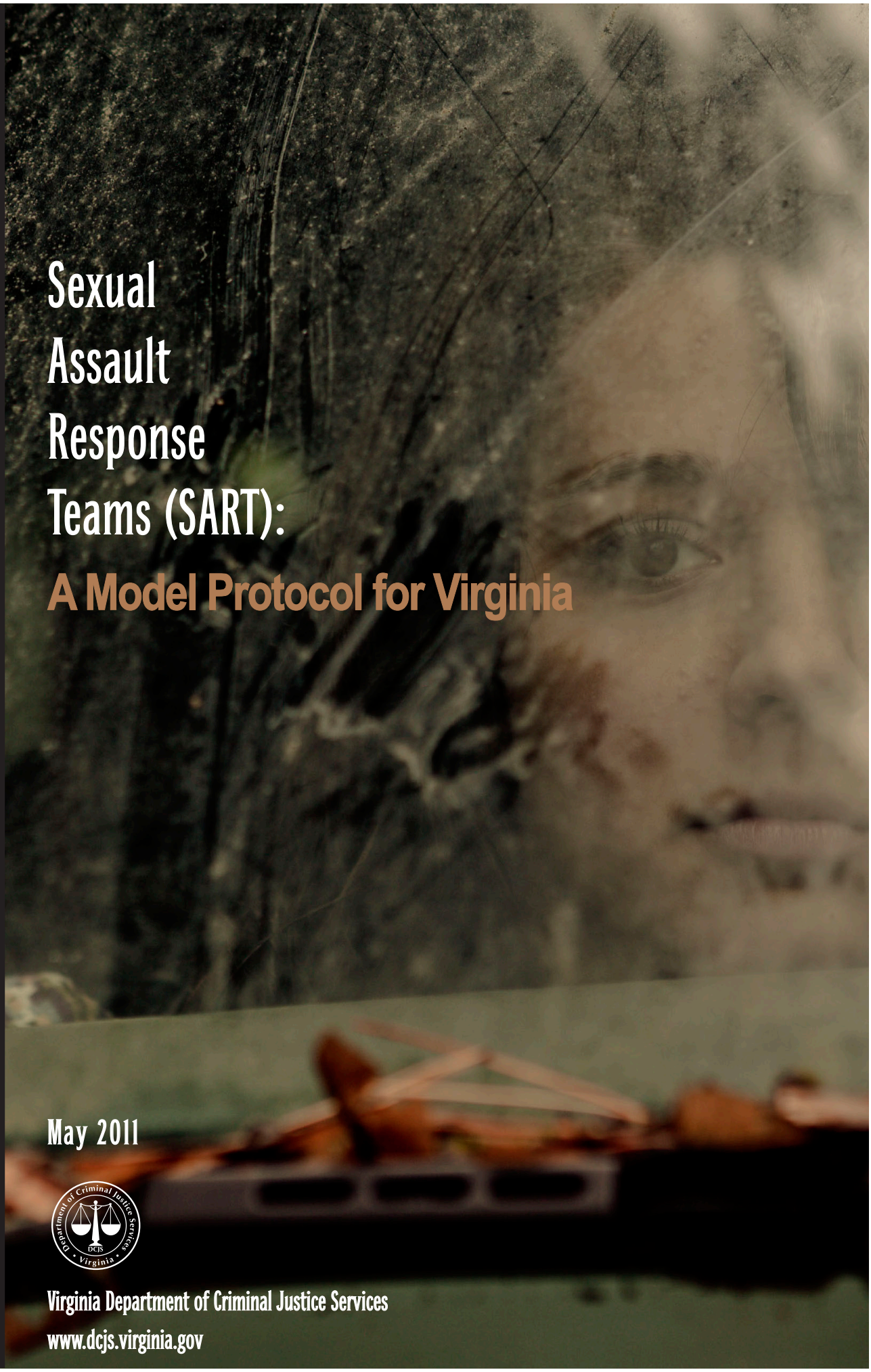

S A R T

Sexual Assault Response Teams (SART):

A Model Protocol for Virginia

May 2011

Virginia Department of Criminal Justice Services
www.dcjs.virginia.gov

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Introduction

In 2004, the Virginia General Assembly passed legislation stating that "the Department of Criminal Justice Services shall promote the use of local and regional sexual assault response team policy and protocol, established pursuant to subdivision 46 of §9.1-102 of the ***Code of Virginia***, as an integral part of an effective coordinated community response to sexual assault" (Virginia Acts of Assembly, Chapter 980). The Code directs that DCJS shall "establish training standards and publish a model policy and protocols for local and regional sexual assault response teams" (§9.1-102).

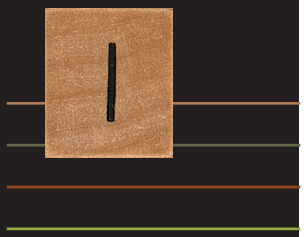
Legislation passed in 2008 and 2009 also contributed to the need for statewide guidelines on a coordinated response to sexual violence. In 2008, in response to federal mandates attached to the Violence Against Women Act which provides millions of dollars to the state for violence against women programming, the Virginia General Assembly passed a bill that made significant changes to laws describing the provision of, and payment for, forensic examinations in sexual assault cases. In essence, the new law requires that victims must have access to forensic exams and evidence collection, even if victims choose not to participate in the criminal justice system, or otherwise cooperate with law enforcement authorities. Additionally, the state must pay for all out-of-pocket costs associated with the gathering of evidence.

It was, however, legislation in 2009 that codified the creation of SARTs in Virginia. Starting July 1, 2009, Commonwealth's Attorneys have the responsibility to coordinate a multi-disciplinary response to sexual violence in their communities which is consistent with the guidelines established by DCJS.

In accordance with these legislative mandates, DCJS has developed the following guidelines based on review of existing state and national protocols and best practices and consultations with local Virginia sexual assault response team members.

This model protocol focuses on adult sexual assault. Many localities in Virginia have established child sexual assault response teams and developed the necessary protocols for those multi-disciplinary teams. DCJS also provides technical assistance to localities in responding to child sexual assault crimes. Appendix G includes contact information for communities if they are responding to child/teen sexual assault or if they are developing a sexual assault response team that responds to child/teen sexual assaults.

Virginia has very few localities that have active adult sexual assault response teams and an even smaller number of these teams have written protocols. This protocol can be used in all cases of adult sexual assault, regardless of the gender of, or relationship between the victim and perpetrator. Since both females and males are sexually assaulted, the manual has been written with gender-neutral terminology as much as possible. Gender-neutral terminology is used to acknowledge that sexual violence is both experienced and perpetrated by people of all genders and sexual orientations. However, in sections pertaining to victims of sexual assault where a pronoun is necessary, the female pronoun is used because the majority of sexual



assault survivors are female. In sections pertaining to alleged perpetrators of sexual assault, the male pronoun is used because the majority of assailants are male.[1]

A person reporting a sexual assault may encounter three systems: criminal justice, medical, and advocacy. For the criminal justice system, the person is referred to as a crime victim. For the medical system, the person is referred to as a patient. For sexual assault crisis centers, the person is referred to as a victim or survivor (sometimes referred to as a client). All four terms will be used throughout the protocol.

The following protocol includes five chapters that provide essential information concerning sexual assault response teams. The appendices include additional information on specific issues and populations as well as sample forms for teams to use and adapt as needed.

[1] **National Center for Women and Policing** (1997). Successfully Investigating Acquaintance Sexual Assault: A National Training Manual for Law Enforcement. Published by the Feminist Majority Foundation's **National Center for Women and Policing**, Arlington, VA. Available from ***www.womenandpolicing.org.***

Chapter 1

A Coordinated Community Response

Sexual assault is a chronically underreported crime, and those assaults that are reported and investigated are often difficult to prosecute. Research indicates that when a sexual assault response team has come together to respond to a victim of sexual assault in a coordinated fashion, cases are reported more quickly, have more evidence available, and have more victim participation. SART intervention is also a factor in the identification and arrest of a suspect, the strongest predictor that charges will be filed, and helps to increase the likelihood of conviction[2].

Many communities have recognized the importance of collaboration with allied professionals to address sexual violence and its affect in their communities and have established community groups to address the needs. These groups have been called task forces, working groups, advisory boards, coalitions, coordinated community response (CCR) teams, and sexual assault response teams (SART). While each community is responsible for creating their own team, regardless of its name, it is important to define the unique purpose of a SART and how it differs from the other groups. To provide this clarification, the concepts of CCRs and SARTs are discussed in this chapter. Specifically addressed are the differences between a CCR and a SART, and how they work together to address sexual violence.

What is a Coordinated Community Response Team? [3]

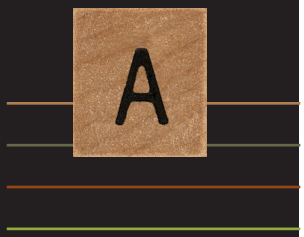
A coordinated community response team brings together key players in community systems to *develop strategies and procedures in the systems' response* to sexual assault and/or domestic violence. These strategies will aim to establish ways for the community to intervene to end abuse. Sexual assault and domestic violence victims can be of any age, gender, race, ability, or sexual orientation and there may be an array of places in the community where victims may go to seek help or report their assault.

Intervention through a coordinated community response is a way of using legitimate sources of power in a community, such as the court system, to tell a perpetrator of abuse that the community cares about sexual and domestic violence and will do everything in its power to protect the victim. Perpetrators of sexual and domestic violence can be very coercive and manipulative. Without a coordinated response, offenders will avoid responsibility for their behaviors and likely move on to another victim.

Some victims will choose to report their situation to criminal justice authorities—others will not. A coordinated community response needs to encompass all the options that victims have, and to provide for their support and healing in varied community settings.

[2] M. Elaine Nugent-Borakove ; Patricia Fanflik ; David Troutman ; Nicole Johnson ; Ann Burgess ; Annie Lewis O'Connor. (2006). Testing the Efficacy of SANE/SART Programs: Do They Make A Difference in Sexual Assault Arrest and Prosecution Outcomes? Published by the American Prosecutors Research Institute. Available at http://www.ncjrs.gov/pdffiles1/nij/grats/214252.pdf.

[3] Wisconsin Coalition Against Sexual Assault, Inc. (2009). Sexual Assault CCR Toolkit. Available at: http://www.wcasa.org/programs/systems.htm.



The difference between a CCR team and a SART

It is important to clarify how the purpose and function of a SART differs from a broader Sexual Assault CCR team or a dual team addressing both domestic violence and sexual assault. A SART is not merely a CCR that addresses sexual assault. A Sexual Assault Response Team (SART) is a very specific intervention model that is focused on the immediate response to victims of sexual assault. It uses a team approach to implementing a comprehensive, sensitive, coordinated system of intervention and care for sexual assault victims. The team typically involves professionals from three community systems: law enforcement, community-based advocacy, and medical/legal. SART members are focused not only on addressing policy and practice issues related to their respective systems' response to sexual assault, but may conduct case reviews as a part of an on-going assessment and planning process.

The purpose of a broader sexual assault CCR is to provide a multidisciplinary approach and response to issues around sexual assault. These CCR teams can facilitate communication, networking, and collaboration among a broad base of service providers and community members to assist service providers/system members in bringing to light gaps in protocols or other services needed to support victims. The team is also a place where members of the community, offender treatment providers, schools, and clergy members work together with system/service providers to discuss sexual assault and its effect on the community, and then equally and collectively participate in developing services, planning events, and creating prevention strategies needed to boost community awareness and decrease sexual violence. While the CCR team often will include some of the same service/system members as the SART, it is considerably larger and includes other professionals, community members, and stakeholders. The structure and format of these larger CCRs is quite different from a SART and should not include individual case review and/or discussion of confidential information.

Members of a CCR Team may include (but are not limited to):

- Commonwealth's Attorneys
- SANE/FNE nurses/medical personnel
- Sexual assault/domestic violence advocates
- Victim/witness advocates
- Law enforcement officers
- Probation officers
- Community corrections
- Social services staff
- Clergy
- Business owners
- School staff
- Homeless shelter staff
- Ethnic minority advocates
- Immigration/trafficked advocates
- Representatives from the disabilities and aging network
- Survivors

The goals of a CCR team should be to maximize community awareness and safety, protection and response for victims without the use of case reviews; ensure a victim-centered response to violence and access to community resources; hold sex offenders accountable; and work for decreased violence in the community through systems advocacy and change.

The goals of a SART, by contrast, relate to the immediate, on-site response to a victim of sexual violence, and dictate the roles of only those first responder professionals. While realizing the importance of a coordinated community response team and its effects on, and interplay with SART programs, this model protocol will focus mainly on SART development and implementation. Brief additional information about supporting and collaborating partners of the SART (who may also be a part of the community's CCR) is found in *Chapter 3: Roles and Responsibilities of SART Members.*

Chapter 2

What is a Sexual Assault Response Team (SART)?

A Sexual Assault Response Team (SART) is a multi-disciplinary, interagency, sexual assault intervention model. It uses a team approach to implement a comprehensive, sensitive, coordinated system of intervention and care for sexual assault victims. The partners in a SART are both public and private agencies.

Purpose

SART serves two essential purposes:

1. It organizes the process of intervention.
2. It organizes the community response to sexual assault.

Mission

The mission of a SART is to provide a sensitive and competent multi-disciplinary response, to support efforts to restore well-being to the victim, and to bring the responsible person(s) to justice.

Goals

The goals of a SART are to:

- ensure competent, coordinated, and effective intervention;
- provide a sensitive and caring response to survivors of sexual assault by all disciplines;
- ensure cultural competency;
- ensure complete, consistent, and accurate case investigations;
- provide high quality and consistent forensic sexual assault physical examinations;
- ensure the provision of medical and forensic follow-up care;
- provide crisis intervention and follow-up counseling referrals; and
- effectively support the mission of the criminal justice system.

A SART recognizes that the victim of sexual assault and the criminal justice system have two distinct sets of needs. Sometimes there are inherent conflicts between these two sets of needs. Through professional collaboration by sexual assault crisis centers, health care providers, and law enforcement agencies, both sets of needs can be accommodated and divisiveness avoided. However different the needs may be, all involved professionals agree that victim safety is first and foremost.

The needs of the sexual assault victim may include:

- safety;
- coordinated response;
- sensitive intervention;
- cultural competency;
- medical assessment and treatment of any injuries;
- early emotional support and advocacy;

- information about investigative, forensic sexual assault physical examination and evidence collection, and criminal justice procedures;
- accessible, prompt, high quality forensic sexual assault physical examination;
- prompt and efficient response to minimize time at the hospital;
- prophylaxis against sexually transmitted infections;
- assessment of possible pregnancy risk and prophylaxis with oral emergency contraception, if requested;
- follow-up forensic and/or medical care;
- emotional support and/or mental health care;
- emotional support and/or mental health care for family members;
- justice; and
- trauma recovery.

The needs and goals of the criminal justice system are:

- protection of the victim and the community;
- participation by the victim in the investigative and judicial process;
- accessible, prompt, high quality forensic sexual assault physical examinations;
- forensic and physical follow-up evaluation, if indicated;
- optimal recognition, collection, handling , and storage of potential evidence;
- accurate documentation of physical findings and evidence-based interpretations;
- accessible, prompt, high quality forensic sexual assault physical examinations to promote efficient investigation;
- identification and apprehension of a suspect;
- competent case investigation;
- reliable analysis of evidence;
- credible expert testimony;
- effective prosecution; and
- competent representation for the defendant by defense counsel.

Chapter 3

Roles and Responsibilities of SART Members

Key Players

The primary partners in a successful SART are:

- forensic/sexual assault nurse examiner(s)**;
- area law enforcement officer(s); and
- the local sexual assault crisis center advocate(s).

**If SANE/FNE is not available in your locality, the SART should include the health care provider responsible for performing forensic exams.

Although prosecutors are not considered primary players because they do not respond immediately and on-site to the sexual assault victim, prosecutors play an integral role in developing and sustaining a coordinated community response to sexual assault. Prosecutors also provide leadership in the prosecution of criminal cases, in the development of local protocols, and in supporting the efforts of the other partners. These roles and responsibilities are defined in this chapter.

Generally, sexual assault crisis center advocates not victim/witness program advocates are considered a part of SART, because sexual assault crisis centers:

- respond 24/7, year round;
- usually serve sexual assault victims exclusively;
- provide services both for sexual assault victims who report and sexual assault victims who do not report the crime to law enforcement authorities;
- provide greater client confidentiality for sexual assault victims, contesting attempts to gain access to victims' records.

Victim/witness programs provide advocacy services to all types of crime victims and witness of crimes, not just sexual assault victims. Because they are located within the criminal justice system and their positions are housed in governmental agencies, victim/witness programs generally do not work with sexual assault victims who are not participating in the criminal justice system. The information they gather from the victim belongs to the office for which they work and therefore is not confidential. However, like prosecutors, victim/witness program advocates play a critical role in supporting the SART response and participate as a key player in the long-term, coordinated community response to sexual assault. Coordinating services provided by sexual assault crisis centers and victim/witness programs are discussed in this chapter as such collaboration is critical to accomplishing the mission of the SART and the coordinated community response.

Forensic / Sexual Assault Nurse Examiner

Role

The role of the forensic/sexual assault nurse examiner is to conduct a complete physical assessment of the patient that includes a medical/forensic history, and if indicated a collection of potential evidence utilizing the physical evidence recovery kit (PERK). A PERK is used for patients, as

well as for suspects. Examiners provide objective forensic consultation to law enforcement officers, child protective services, adult protective services and the judicial system as requested.

The forensic/sexual assault nurse examiner must be able to build rapport with the patient to effectively obtain a patient history, some of which may be very personal and painful for the patient to relate. This information is essential for the health care provider to obtain because the history is for the purpose of diagnosis and treatment of the patient and will guide the SANE/FNE in the examination process. While it is important for the SANE/FNE to be a patient advocate, it is important that the forensic/sexual assault nurse examiner not take on the role of victim advocate. To do so would effectively destroy the important role of providing an objective forensic evaluation and interpretation of findings. Defense attorneys will discredit the testimony of forensic/sexual assault nurse examiner "advocates" and cast doubt on the physical examination findings. Dueling medical experts are always a possibility, but crossing the boundary into advocacy will increase that probability. Advocacy is the role of the sexual assault crisis center advocate. With the permission of the patient, it is appropriate and encouraged for the sexual assault advocate to be in the examination room to provide emotional support for the patient. It is essential that the advocate not be requested to participate in any way (e.g., packaging evidence, holding the ruler for the photographer, etc.) during the performance of the forensic examination. To do so jeopardizes the advocate's confidentiality with the patient and blurs the role of the advocate. It also has the potential to bring into question or discredit evidence handling and packaging procedures, because advocates are not trained forensic/sexual assault nurse examiners.

Responsibilities

Forensic/sexual assault nurse examiner responsibilities are to:

- Provide medical assessment and treatment of any injuries;
- Inform patient of their options regarding reporting, forensic examination, and contact with law enforcement;
- If part of local protocol, contact sexual assault crisis center advocate to respond to the hospital;
- Obtain patient consent for the forensic sexual assault physical examination, evidence collection (if appropriate), photographs and release of the forensic/medical record;
- Provide medical assessment and treatment of any injuries;
- Obtain patient's history of events through a joint or coordinated interview with the law enforcement officer and sexual assault crisis center advocate;
- Conduct a Wood's Lamp examination (ultraviolet light);
- Use forensic photography to document any injuries or findings;
- Collect foreign materials, stains, and dried and moist secretions. Label, package, and seal;
- Conduct ano-genital examination (based on the event history);
- Collect oral, vaginal, penile, and anal samples as indicated by the event history and time since the event;
- Document examination findings in forensic nurse or medico-legal report;

- Collect drug and alcohol toxicology samples, if indicated by patient's history and/or symptoms or requested by law enforcement and if patient presents within 48 hours of the incident. Evidence should be collected as follows: both blood and urine samples should be collected if the patient presents within 12 hours and urine only should be collected if the patient presents in a time frame greater than 12 hours since the incident.[4] The Drug Facilitated Sexual Assault Questionnaire provided with the PERK should be completed and placed in a plastic bag inside a sealed container with the specimens outside the PERK. [Per Appendix A, Sections A1 and A6, the SANE/FNE should collect evidence of drugs if a drug-facilitated sexual assault is suspected, even if the presence of alcohol alone can prove incapacitation, as drug evidence demonstrates intent and further combats the consent defense.];
- Evaluate and treat prophylactically for sexually transmitted infection (STI), as appropriate and as agreed upon between the patient and the medical provider [To obtain more information concerning treatment and when it is appropriate (e.g., prophylactic HIV treatment), contact the Virginia Chapter of the International Association of Forensic Nurses];
- For female patients, evaluate the possibility of pregnancy, discuss options, and provide emergency contraception when needed, with patient's consent;
- Follow local protocol for pick up and delivery of the Physical Evidence Recovery Kit and other evidence (e.g., clothing, shoes, etc.), preserving the chain of custody [consult with the local crime laboratory and law enforcement agencies on this procedure];
- Develop colposcopic and 35 mm and/or digital photographs and, with patient's consent, provide photographs (not negatives) or CD with photographs to the investigator assigned to the case;
- Refer patient for counseling if sexual assault crisis center advocate is not available at the time of the examination; and
- Provide written, discharge instructions, and arrange for medical and forensic follow-up appointments.

Law Enforcement Officer

Role

The law enforcement officer's role is to protect and serve the public, identify and apprehend perpetrators, investigate crimes, recognize, collect and preserve evidence, and prepare investigative reports. Criminal complaints are reviewed by the local magistrate's office and/or Commonwealth's Attorney's Office to determine whether criminal charges should be filed and the method of placing charges, either through warrants or direct indictments.

Law enforcement officers evaluate sexual assault cases in the context of the criminal and procedural statutes contained in the ***Code of Virginia***. Virginia and federal case law are also considered when investigating and preparing a case. Their objective is to obtain a factual history, identify the perpetrator, collect and preserve evidence, and prepare a case for possible prosecution.

[4] The Virginia Department of Forensic Science revised their evidence collection procedures regarding substance related sexual assault effective March 2006.

Responsibilities
Investigative responsibilities are to:

- determine if a crime has occurred according to the ***Code of Virginia***;
- identify, apprehend and interrogate suspect(s);
- interview the victim and witnesses;
- recognize, collect and preserve evidence;
- authorize collection and payment of PERK examinations on *suspects*;
- maintain chain of custody of evidence;
- arrest where probable cause exists;
- assist the Commonwealth's Attorney in the prosecution of cases; and
- provide articulate testimony and evidence in court.

Law enforcement officers investigate crimes that occur in their jurisdictions. Investigators/detectives investigate the case and either consult with a magistrate to obtain warrants or testify in Grand Jury proceedings for a direct indictment. Law enforcement officers prepare and submit case reports, written investigative summaries, to the Commonwealth's Attorney. The case report is a good tool to inform the prosecutor's decisions regarding prosecution (See Appendix H, Section H1). The case report will allow the Commonwealth's Attorney to plan trial strategy through evidence, interviews, witnesses, records, etc.

Changes to Virginia law in 2008 require that victims must have access to forensic exams and evidence collection, even if victims choose not to participate in the criminal justice system, or otherwise cooperate with law enforcement authorities. Additionally, the state must pay for all out-of-pocket costs associated with the gathering of evidence. These changes in law and policy are intended to reduce trauma to sexual assault victims, while streamlining and improving the collection of forensic evidence in cases of sexual assault. Implementing these Code changes requires local law enforcement officials, sexual assault crisis center advocates, healthcare providers, victim advocates, and allied professionals to develop local implementation strategies and policies that protect victims while promoting the public safety interests of the community. As a result, Virginia passed legislation in 2009 that requires local Commonwealth's Attorneys to establish a multi-disciplinary response to criminal sexual assault by convening at least one meeting annually.

The Department of Criminal Justice Services (DCJS) has developed a model law enforcement directive[5] which local law enforcement departments are encouraged to adapt and adopt. The model directive can serve as a vehicle to promote collaboration among law enforcement agencies and allied professionals within communities resulting in the development of complementary, comprehensive, multi-disciplinary victim-centered policies.

Authorization by Commonwealth's Attorneys, law enforcement officers, or their designees is no longer required in order for a victim to obtain a PERK examination and evidence collection, or for that examination/collection to be paid for by the Commonwealth. **Not allowing victims of sexual assault access to PERK**

[5] Department of Criminal Justices Services (2009). Virginia Code on Sexual Assault: Policies for Law Enforcement. Available at: http://www.dcjs.virginia.gov/cplesampleDirectives/manual/rtf/2-31.rtf.

examinations and evidence collection violates the law. Providing accurate and objective information that assists victims in making informed decisions about reporting is important and complies with the spirit of the law.

When, and if, a victim indicates to law enforcement that she or he is not interested in reporting or cooperating with law enforcement, the law enforcement officer should advise all sexual assault victims of their option to have a PERK examination and evidence collection conducted within 72 hours following the alleged assault and refer them to an appropriate facility. If a victim is unresponsive (i.e., unconscious) but a sexual assault is suspected, a magistrate can authorize the exam, if the victim cannot provide consent within a reasonable period of time. An FNE or SANE should conduct the victim PERK examination and evidence collection. Under no circumstances should a law enforcement officer be present in the examination room, even if the victim requests the officer's presence (See Appendix A, Section A2).

Law enforcement officers are responsible for following up with those sexual assault victims interested in participating in the criminal justice system, not only for investigative purposes, but also to provide the victim with updates regarding how the case is proceeding. Communication with victims regarding the progress of the case is critical (e.g., to inform the victim that the suspect has been questioned by law enforcement, that the Commonwealth's Attorney's Office has decided to go forward with the case, etc.). Sexual assault victims have a legal right to be provided this information, and the support provided to the victim through such communication will improve victim cooperation with the criminal justice system.

Sexual Assault Crisis Center Advocate

Role

The role of sexual assault crisis center (SACC) advocates is to provide continuity of care from the first contact until the victim decides that support is no longer needed. SACC advocates' sole purpose is to provide support to the victim and is not contingent on an active criminal case.

A SACC advocate provides victims with a continuity of care from case initiation to case closure and beyond, providing client wrap-around services, coordination, and case management. Vertical advocacy includes: accompaniment services at the hospital and during the investigative and prosecution procedures; follow-up counseling until the psychological issues are resolved; and assistance with logistical problem solving (e.g., childcare, employer relations, schools and teachers, family members, etc.). Advocates support the survivor after the investigative and forensic sexual assault physical examination procedures are completed, whether or not:

- a suspect is apprehended,
- charges are filed,
- the case goes to trial,
- there is a conviction, or
- the defendant is sentenced to state prison, local or regional jail, or is released.

SACC advocates also provide counseling and supportive assistance to survivors who never report the crime. After a sexual assault, the physical, emotional, and psychological effects experienced by the survivor may persist for months or years. For this reason, on-going crisis intervention, supportive services, and follow-up counseling are essential to every sexual assault survivor. These services are invaluable community resources and are essential to addressing the aftermath of sexual assault and to facilitating the recovery and well being of the survivor. They also contribute to the success of the criminal justice process, because the advocacy provided by the SACC advocate ensures continuous emotional support to the survivor and usually results in a more cooperative victim.

The coordination, integration, and management of the post-sexual assault experience is an invaluable resource to a sexual assault survivor. Support for sexual assault victims through the criminal justice system is vitally important. Survivors who are routinely informed about the process and system in which they are involved are more likely to stay involved and participate. If at all possible, the sexual assault crisis center advocate should assign one advocate to the victim throughout the entire process. Continuity of system advocacy is particularly helpful to the survivor because this means there is one person familiar with the entirety of what she has experienced.

Responsibilities

An advocate's responsibility is to listen and to empathize with the survivor's feelings, to reduce the isolation of the experience, to inform, to explain, to clarify, to support, to ensure the survivor's needs are met to the fullest extent possible, to aid with practical issues and concerns, and to assist the survivor in dealing with others such as family, employers, law enforcement officers, forensic/sexual assault nurse examiners, and legal personnel. The advocate's mission is to attend to the survivor, and provide unconditional support and acceptance. The advocate is ***not*** involved in investigating facts or collecting and packaging evidence, or determining the guilt or innocence of the alleged perpetrator.

Advocacy Role and Responsibilities during the Forensic Sexual Assault Physical Examination

The sexual assault crisis center advocate is responsible for providing emotional support to the survivor during the history gathering and during the examination, providing clarifying information, and advocating for prompt, compassionate forensic sexual assault physical examinations. This includes advocating for qualified health care providers trained in forensic sexual assault physical examination procedures to perform the examination. The advocate must not in any way participate in the forensic examination process. Doing so may prevent the advocate from attending to the survivor, create role confusion for the survivor, and jeopardize the advocate's responsibility to remain uninvolved in the criminal investigation. It is important for sexual assault crisis center advocates to be able to discern their role in providing emotional support and the need of the forensic/sexual assault nurse examiner to develop rapport with the patient.

It is helpful if advocates can arrange for a change of clothing through family or friends, as well as a safe place for the victim to go after leaving the medical center. Some SACC advocates provide new clothing for survivors after the examination and bring them to the hospital. Advocates also provide

supportive counseling to enable the family to cope with the event and explain procedures to them. Additional advocates may be needed to provide services to family and friends.

Advocacy Role and Responsibilities during the Law Enforcement Investigation

The role of a SACC advocate is to provide emotional support for the survivor during the law enforcement investigation and to facilitate communication between the law enforcement officer and the survivor. The victim's description of the assault is an important element of the law enforcement investigation. However, this may be an emotionally difficult experience for the victim and having the support of a sexual assault crisis center advocate can be critical in getting through the interview. Having a sexual assault advocate present during the investigative process allows the investigator to focus energy on gathering the necessary information while the advocate attends to the emotional needs of the victim.

The SACC advocate also acts as a bridge for the law enforcement officer by explaining procedures that the victim and family may feel uncomfortable asking about. The advocate may also accompany the survivor to interviews or photo "line-ups." The advocate should not answer any questions for the victim or take notes for the law enforcement officer during interviews. The advocate serves as a sounding board for victims and their families if the law enforcement investigation does not meet their expectations. Advocates explain procedures and encourage survivors to describe their feelings about how the case is progressing.

Advocacy Role and Responsibilities during Prosecutorial Case Development and Judicial Proceedings

The role of the advocate is to provide information, support, and accompaniment during interviews with the prosecutor and during court hearings. The advocate should not answer any questions for the victim or take notes during interviews. Advocates can explain procedures or facilitate communication with prosecutors. Advocates also provide support to victims during the court proceedings. A SACC advocate will accompany the victim to the courtroom, stay with the victim in the waiting area, provide support to the victim and her family and friends, and explain the court process as it is happening. Victim/witness advocates also provide these services; therefore it is important for each locality to determine how coordination of services will be provided.

The SART: Forensic/Sexual Assault Nurse Examiners, Law Enforcement Officers, and Sexual Assault Crisis Center Advocates

Roles and Responsibilities: Interagency Collaboration in Victim Interviews

Interviews of sexual assault victims can be conducted in one of two ways: joint or coordinated. A joint interview process involves the law enforcement officer conducting his/her interview along with the forensic/sexual assault nurse examiner conducting his/her history gathering and the sexual assault crisis center advocate providing emotional support to the victim. Although this approach takes more coordination between professionals, it eliminates the need for the victim to repeat her account of the assault and reduces the emotional trauma experienced by the victim. A joint interview, however, can

blur the roles of the law enforcement officer and the forensic/sexual assault nurse examiner. The court may ultimately see the role of the forensic/sexual assault nurse examiner as investigative, causing issues with the medical exception to hearsay rules.

Another effective model that SARTs may use is a coordinated interview process. A coordinated interview process involves the law enforcement officer interviewing the victim first and then relaying the information gathered to the forensic nurse examiner. This eliminates the need for the victim to repeat some information, but not all. A coordinated interview is also less likely to cause problems with the medical exception to hearsay rules.

With either approach, the law enforcement officer and the forensic/sexual assault nurse examiner must communicate clearly and use sound judgment. Medical evaluation and treatment of victim injuries and the prompt collection of perishable, biological trace evidence must take priority over the detailed law enforcement interview. The sexual assault crisis center advocate provides emotional support during the joint and coordinated interviews.

In addition to the viewpoints of the partner agencies, the experience for the survivor should always be considered. Obtaining survivor consent for a joint interview is essential. Some jurisdictions prefer a joint interview process, whenever possible, and others prefer a coordinated interview process.

Supporting and Collaborating Partners/Coordinated Community Response Team

PROSECUTORS

Role: Supporting the SART Response

Commonwealth's Attorneys prosecute crimes that occur within their jurisdictions. Although they are not considered primary players in a SART response because they do not respond immediately to the sexual assault victim, prosecutors play an integral role in developing and sustaining a coordinated community response to sexual assault. Prosecutors provide leadership in the development of local protocols, and support for the efforts of the other partners. Using the case report provided by the investigating officer, the Commonwealth's Attorney plans and implements trial strategies through the use of physical, medical and scientific evidence, witness interviews, photo line-ups, medical records, et cetera.

Responsibilities

Beginning in 2009, Commonwealth's Attorneys are statutorily responsible for coordinating the establishment of a multidisciplinary response to criminal sexual assault. They must convene at least one meeting annually to discuss the implementation of protocols and policies for SARTs and establish guidelines for the community's response, including the collection, preservation, and secure storage of evidence from PERK examinations (See Appendix B2).

Commonwealth's Attorneys are critical in supporting the criminal justice goals of a SART response through their role as the prosecuting attorneys in sexual assault cases. They are responsible for the thorough review of all available evidence in a case in order to determine whether there is evidence sufficient to go forward with trial. It is the duty of the Commonwealth's Attorney to represent the citizens of the Commonwealth and to seek justice.

VICTIM/WITNESS PROGRAM ADVOCATES

Role: Supporting the SART Response

Sexual assault crisis centers and victim/witness programs have an important role in serving sexual assault victims. Victim/witness advocates offer invaluable advocacy services to victims navigating the criminal justice system. Victims benefit from local sexual assault crisis center advocates ***and*** victim/witness advocates providing and coordinating their services to create a more comprehensive response. Some client services provided by victim/witness programs and sexual assault crisis centers overlap and some are unique, but all are complementary. In some jurisdictions, there are close positive working relationships, which recognize that each advocacy organization has distinct strengths and capabilities. Achieving collaboration means honestly examining the strengths and opportunities that each organization brings and jointly adopting coordinated strategies.

Responsibilities

Victim/witness programs are generally located in Commonwealth's Attorneys' Offices or local law enforcement agencies. Victim/witness program advocates provide sexual assault victims who are participating in the criminal justice system with courtroom assistance, such as explaining the court process and accompanying victims to court hearings. Virginia Code §19.2-11.01 requires a locality's crime victim and witness assistance program to provide the victims' rights information and assistance outlined in that section of the Code. Victim/witness program advocates provide notifications to victims regarding legal proceedings and the status/location of defendants. Victim/witness program advocates can also provide support to victims during law enforcement investigation and prosecutorial case development, such as providing support to victims during interviews. They assist sexual assault victims with completing the necessary paperwork to apply for victims' compensation (see Appendix A, Section A8), explain crime victims' rights, and can assist in the development of a Victim Impact Statement. Because of their location within the system, victim/witness program advocates may have better access to case information and law enforcement players, than do sexual assault crisis center advocates. Victim/witness advocates can be a key referral source for local sexual assault crisis centers and effective advocates within the system. Most victim/witness program advocates obtain police reports and dockets on a daily basis and can provide timely information to both the victim and the local sexual assault crisis advocate. Furthermore, because they are considered part of the criminal justice system, victim/witness program advocates may be in a better position to intercede on behalf of a victim who is experiencing difficulties with employers or landlords. As previously stated, some victim/witness program services and sexual assault crisis center services are distinct and some overlap; it is therefore vitally important that these advocates understand each other's roles and responsibilities, respect the strengths of each other's positions and coordinate their provision of services to victims.

Chapter 4

Creating a SART Response in Your Community

Localities are encouraged to use this model protocol to develop and implement their own local adult sexual assault response team protocol. DCJS recognizes that some jurisdictions may not be able to replicate this model protocol in their localities due to lack of resources such as a forensic or sexual assault nurse examiner program. The various roles and responsibilities described in this protocol serve as general examples and the roles and responsibilities of each partner agency can vary widely based on funding, available expertise, experience and locally accepted practice. This protocol presents a template, which localities are encouraged to adapt as best they can with the resources at hand. Localities may also use this protocol to request additional funding (e.g., for a SANE/FNE program) and to implement policy and procedural changes in their response to sexual violence.

First Steps In Developing a SART

Effective July 1, 2009, Commonwealth's Attorneys are required to establish a multidisciplinary response to criminal sexual assault. While the legislation does not explicitly require the development of a local Sexual Assault Response Team, these annual meetings may be an effective pathway to formalizing a SART (serving as a start-up group, Task Force, or Steering Committee) or obtaining the Commonwealth's Attorney's participation in an existing group.

The next step is to convene a meeting of local stakeholders to discuss the group's mission and philosophy. At a minimum, these initial meetings should include the key players in a SART (local law enforcement, sexual assault crisis advocate, forensic nurse, and the Commonwealth Attorney). This task force may need several meetings to become familiar with the role of each agency before setting goals. The formality, decision-making processes and structure of task forces will vary. Regardless of the structure and level of formality, several key decisions must be made.

What is the SART's philosophy or mission? What are the SART's goals? It is important that the SART agree on a common commitment and vision. Common philosophies of SART Task Forces and programs include:

- the right of a victim of sexual assault to have access to competent, compassionate care (health care, crisis services, mental health, etc);
- the right of sexual assault victims to have immediate, compassionate, culturally competent and comprehensive evidence collection;
- the right of sexual assault victims to report the assault without encountering difficulty and to receive extra support;
- the right of sexual assault victims to have forensic evidence collected free of charge; and
- the need for community investment in improving the response to sexual assault victims and ending sexual assault.

The task force should also develop goals and objectives for the development and implementation of the SART program. For example, one goal for the SART program

could be to provide compassionate response to victims of sexual assault. The objective would then be to provide training for SART members on how to respond to victims of sexual assault. Another goal could be to provide access to quality evidence collection by a specially trained healthcare provider. The objective would then be to arrange for a 24-hour on-call schedule of forensic/sexual assault nurse examiners to perform the sexual assault examinations. It is helpful to generate timelines for the goals and objectives, and to also decide who will be responsible for working on them.

Organizing Your SART[6]

Much research and work has been done to assist communities in organizing SART Programs. One widely used method is the Eight Step Model Process developed by Boles and Patterson, in their book, Improving Community Response to Crime Victims: An Eight-Step Model for Developing Protocol. This section incorporates their 8-step process:

Step 1: Inventory of Existing Services
Step 2: Victim Experience Survey
Step 3: Community Needs Assessment
Step 4: Writing the Protocol
Step 5: Formal Agency Adoption of Protocol
Step 6: Training
Step 7: Monitoring
Step 8: Evaluation

This section will explain each step in detail to assist in the course of your planning. Additional assistance through sample forms and documents relating to each step can be found in the National Crime Victims Center's Looking Back, Moving Forward: A Program for Communities Responding to Sexual Assault.[7]

Step One: Inventory of Existing Services

The first step in organizing a SART is the inventory of existing services. The purpose of taking inventory of the existing services is to examine areas in the community currently addressing victims of sexual assault and to become aware of all services and resources available to these victims. The inventory should be as comprehensive as possible, and it should include services from law enforcement agencies, Commonwealth's Attorneys' offices, medical facilities, mental health programs, victim service organizations, and other social service organizations that are available to assist victims of sexual assault. The result of the inventory of existing services is a comprehensive directory of agencies and organizations providing services to victims of sexual assault within the community.

[6] Taken from the Kentucky Association of Sexual Assault Programs "Developing a Sexual Assault Response Team: A Resource Guide for Kentucky Communities", which utilizes Boyes and Patterson's Improving Community Response To Crime Victims: An Eight Step Model for Developing Protocol (1996). Sage Publications, Inc.

[7] National Center for Victims of Crime. Looking Back, Moving Forward: A Program for Communities Responding to Sexual Assault. 1993. Available at http://kyasap.brinkster.net/Portals/0/pdfs/SANE-LOOKINGFORWARD.pdf.

To conduct the inventory the task force needs to develop a questionnaire to identify five issues:

- Service availability
- Accessibility
- Quantity
- Quality, and
- Legitimacy

Step Two: Victim Experience Survey

The second step in the process is the Victim Experience Survey (VES). This confidential survey is conducted to determine the victims' assessments of how well the system is responding to their needs. The VES should assess the feelings of crime victims regarding how their cases were handled and how they were treated by each agency. To find out information about how each agency responds to sexual assault victims, it is important to assess victims throughout the criminal justice process, including those whose cases:

- Are not reported to authorities
- Are not pursued because the perpetrator is not apprehended
- Are not filed (or dropped) after the initial investigation
- Are pled out before or during trial
- Are completed through trial, but may or may not obtain a guilty verdict
- Result in a guilty verdict with sentences that may or may not include incarceration

Several agencies can be responsible for conducting this survey. The logical choices include law enforcement or victim service agencies, as these agencies will have the most contact with the victim during the criminal justice process. It is recommended that members work closely with the local sexual assault crisis center in developing and implementing the survey. They can be very helpful in creating a victim-sensitive survey and an appropriate implementation approach. The primary emphasis should be placed on victim experience, not the goal of the system. The survey packet can be mailed to victims through a lottery process to ensure randomization. Once the responses are returned and counted, the information will be used in the third step of the Eight Step Process.

Step Three: Community Needs Assessment

The third step in the process is the community needs assessment. This step is intended to answer two primary questions:

- What services does the community require to meet the needs of sexual assault victims?
- What should the task force do to meet these needs?
- When conducting a community needs assessment, there are several questions that the task force must explore to develop a SART program unique to your own community.

C

- What is the population of your county, city, or community? Is it urban, rural, suburban, or mixed?
- How many sexual assault cases have been reported annually for the past three years in your county, city, or community? Keep in mind that this is only a small percentage of the actual number of sexual assaults occurring because most sexual assaults are not reported.
- How many cases were prosecuted? Convictions?
- How many of the cases were adults, adolescents, and children?
- How many victims were seen by the local sexual assault crisis center in the past three years?

In addition to these general community assessment questions, there are specific questions targeted towards agencies that will be working with sexual assault victims in some way.

Following are some of these agencies and samples of questions pertinent to their involvement in the process.

Law Enforcement

1. How many law enforcement agencies exist in your county, city or community?
2. Do any of them have a special unit that investigates sex crimes?
3. To what facilities do law enforcement officers usually take sexual assault victims?
4. How effective does law enforcement consider the current medical response to sexual assault victims?
5. What is law enforcement's role in maintaining proper chain-of-custody?
6. What training do police officers have in dealing with sexual assault cases?
7. Given what they know about SART programs, what does law enforcement see as the benefits and difficulties in developing and implementing a SART program in this community?

Forensic Science Laboratory

1. Where is forensic evidence analyzed in your area?
2. Do all the law enforcement agencies use the same forensic lab?
3. What improvements would you like to see in sexual assault evidence collection kits?
4. How many sexual assault evidence collection kits are processed in your region?
5. Given what they know about SART programs, what do the forensic scientists see as the benefits and difficulties in developing and implementing a SART program in this community?

Hospitals and Exam Facilities

1. How many hospitals and/or examination facilities exist in your county, city or community?
2. Do all of the hospitals examine and treat sexual assault victims?
3. How many sexual assault examinations does each hospital/exam facility perform on adults each year?
4. Who usually conducts the exams in each hospital?

5. Is specially trained staff available to conduct sexual assault exams?
6. What challenges do facilities face when working with sexual assault victims?
7. What type of policies and procedures have been developed to treat sexual assault victims?
8. What type of referrals do facilities provide to victims?
9. Does the hospital contact the Sexual Assault Crisis Center to coordinate response by an advocate to provide on-site support and crisis services?
10. Given what they know about SART programs, what do the hospitals see as the benefits and difficulties in developing and implementing a SART program in this community?

Sexual Assault Crisis Center

1. What local sexual assault crisis center serves your area?
2. Does the sexual assault crisis center offer 24-hour on-call services?
3. How many survivors does the sexual assault crisis center provide services to each year?
4. What kind of services do they provide?
5. What training is required or provided to sexual assault crisis center staff?
6. What does the sexual assault crisis center think about the effectiveness of the current medical response to sexual assault victims?
7. Given what they know about SART programs, what does the sexual assault crisis center see as the benefits and difficulties in developing and implementing a SART program in this community?

Prosecutors

1. How many sex crimes does the prosecutor's office review each year?
2. How many do they indict each year?
3. What percentage of dispositions are guilty?
4. Does the locality have specialized prosecutors for sexual violence cases? If so, what specialized training is received?
5. What is their experience with the forensic evidence collected in the hospitals?
6. Is the evidence they need provided to them?
7. Do they encounter any difficulties when medical staff testify?
8. Is there a victim witness program in the prosecutor's office?
9. Given what they know about SART programs, what does the prosecutor's office see as the benefits and difficulties in developing and implementing a SART program in this community?

Victim Witness Programs

1. Is there a victim/witness program in your area?
2. What agency houses/sponsors the victim/witness program in your area?
3. What services does the program provide?
4. In what way, if any, do they interact with the local sexual assault crisis center?
5. How many sexual assault victims does the program serve each year?
6. Does the program provide services to victims in cases where an arrest has not been made?

7. Considering what may be known about SARTs, what does the victim/witness program see as the benefits and difficulties in developing and implementing a SART program in their community?

Other

1. What other task forces, committees or coalitions already exist that address related issues, such as sex offender treatment, violence prevention, child abuse, or domestic violence?
2. What funding sources might be available?
3. How are the current services funded?

Once you have performed this community assessment, the SART task force must compile a report of their findings, which will then be used in the next, vital step of the process: writing the protocol.

Step Four: Writing the Protocol

The fourth step in the process, and the most time-consuming, is writing the protocol. The purpose of writing a multiagency protocol is to define the roles and responsibilities of each agency as it responds to the needs of the victims. It is essential to remember that each community differs from others, and development of a protocol for one community is not necessarily a sufficient protocol for another community. There is no "cookie cutter" approach that works for everyone. At this point the SART task force members should be familiar enough with each other and their own community needs to develop an appropriate protocol based on those needs.

Many protocols are developed using an agency responsibility checklist, which specifies what each specific agency should be doing when working with victims of sexual violence. Once the checklist is assembled, it can be easily transformed into a written protocol and distributed to all agencies and personnel involved. Some communities have even developed "pocket protocols" which are small, index-card sized, laminated booklets that SART members can easily carry with them to reference as needed. These booklets usually contain the responsibility checklist in easy-to-read condensed form.

A sample memorandum of understanding (MOU) has been included for your reference. This MOU can serve as your written protocol until your protocol is completed. (See Appendix H3).

Step Five: Formal Agency Adoption of the Protocol

After the protocol is written, each agency affected should review it carefully and secure an official acceptance of the protocol by the agency director on behalf of the organization. This is also an excellent time to consider expanding the membership of the task force so that every agency identified in the protocol has the opportunity to participate in the decision-making process.

Step Six: Protocol-Based Training

The task force should organize and develop a protocol-based training program designed to accomplish two objectives:

- To ensure that all personnel from each applicable agency are aware of how the protocol affects each of their positions; and
- To ensure that personnel affected by the protocol have the necessary expertise to carry out their responsibilities.

The training curriculum should be interdisciplinary, which reflects the character of the protocol. Individuals from various agencies who will be working together to respond to reports of sexual assault should begin their relationships by training together. This means that all "first responders" from law enforcement, sexual assault crisis centers, and medical facilities should be trained together to address their specific roles, but to also understand the roles of other professionals.

Step Seven: Monitoring Protocol Implementation

The task force has the responsibility of overseeing the implementation of its protocol. Monitoring enables the task force to know how well the implementation process is progressing, whether there are problems, and the nature of any problems being experienced. This information is useful for keeping the project operating as intended.

Monitoring may be done through collection of data from program sites or through actual observation by a monitoring team, or a combination of both. The SART task force should appoint a monitoring team that would be responsible for developing a data collection form, as well as performing on-site monitoring. The committee is responsible for reporting their findings to the task force and the agencies they monitor. This process is intended to assist with the implementation of the protocol.

As they perform their tasks, the monitoring team should look for strengths as well as weaknesses. The strengths should receive at least as much attention as the weaknesses in the report. When a problem is identified, the team should attempt to identify a probable cause and suggest solutions. Monitoring is intended to be supportive of the agency's efforts and not intended to put the agency in a bad light.

Step Eight: Protocol Evaluation

Protocol evaluation is the eighth step in this cyclical process. This step is closely related to the previous step of monitoring, as they both help determine how effective the protocol is at meeting victims' needs.

The SART task force needs to appoint an evaluation committee, which will collaborate with the monitoring committee on data collected and utilized. The purpose of this evaluation is to provide programs with information useful to them for guided decision making. The evaluation design and data analysis should meet their needs. The task force needs to formulate a work plan that includes the following:

- Who will collect the data?
- When will data be collected?
- How data will be collected?
- How data will be verified?
- How data will be analyzed?

Upon completion of the evaluation data collection, the committee will then submit an evaluation report outline to the SART task force. This allows for further decision-making in regards to how well the program is functioning for the community as a whole.

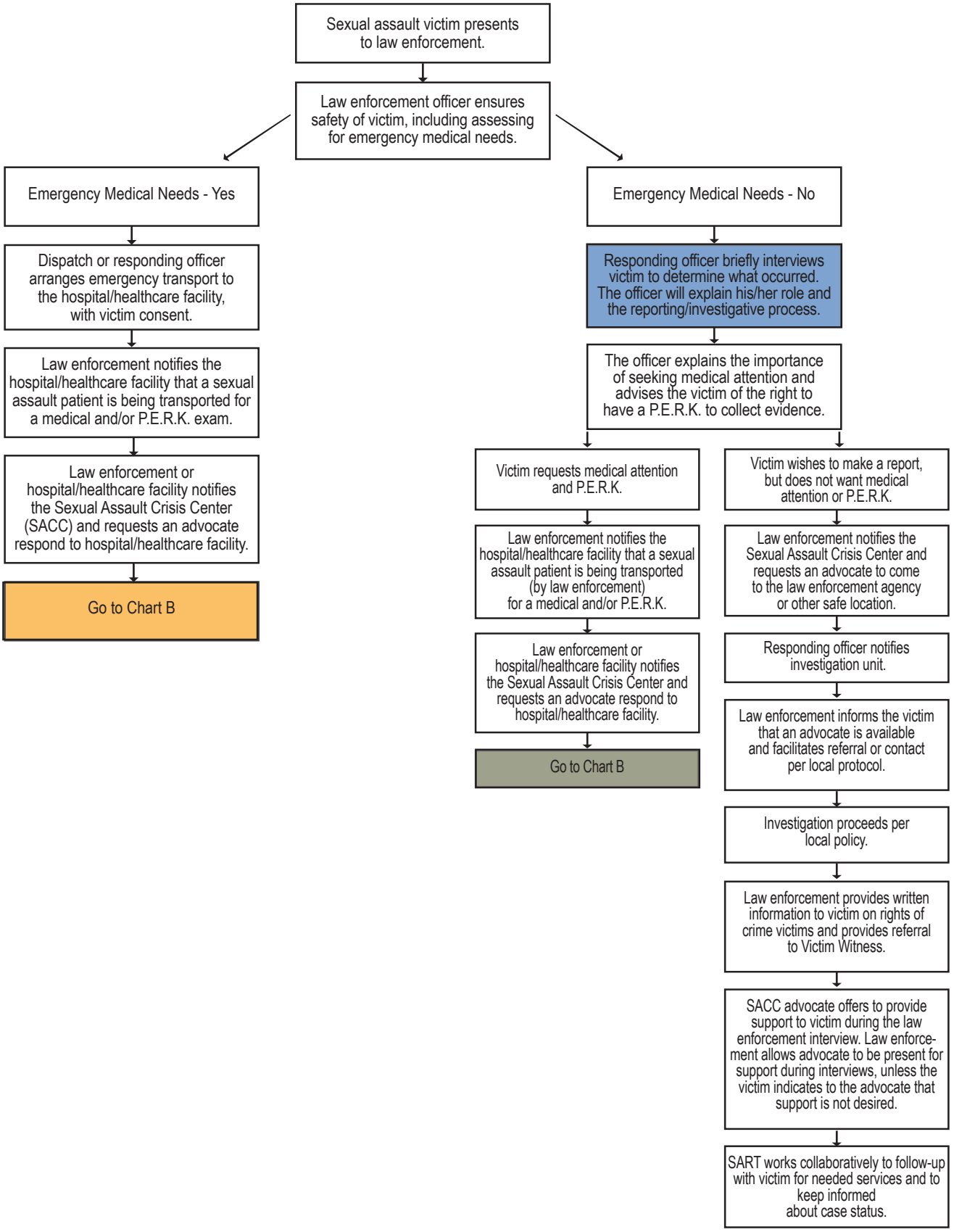
Completing this eighth step by no means infers that the process is finished. This should be a cyclical process that will consistently be changed and monitored to meet the ever-changing needs of victims and the system.

Chapter 5

Model SART Response Charts

A

SART Team Activation or Call-Out Process: The Victim Calls Law Enforcement First



B

SART Team Activation or Call-Out Process: Patient Presents at the Hospital/Healthcare Facility First

The hospital/health care facility triage nurse:
- provides the patient with private area as soon as possible and performs medical screening examination
- contacts the Sexual Assault Crisis Center (SACC) to coordinate response
- contacts the SANE/FNE or designated healthcare provider, and
- explains the **THREE** medical-forensic **OPTIONS** to the patient.

OPTION 1
The victim decides to have evidence collected and wants law enforcement notified. If law enforcement is already involved, skip the next step and proceed two text boxes.

The hospital/healthcare facility notifies:
- Law enforcement agency in the jurisdiction where the event occurred or, if unknown, in the locality where the hospital/ healthcare facility is located.

If response time is ideal and therefore does not significantly delay the P.E.R.K. exam, a patrol officer responds to hospital/healthcare facility to briefly interview victim. Officer determines that crime has occurred according to Code of VA. Patrol officer notifies Investigations Unit about sexual assault.

The investigator and SANE/FNE conduct a coordinated or joint interview. The SACC advocate offers to provide support to the victim during the interview. The advocate is present during the interview, unless the victim indicates to the advocate that support is not desired.

Victim presents within 72 hrs or deemed good cause to conduct P.E.R.K.

YES

SANE/FNE or designated healthcare provider performs the P.E.R.K., maintains chain of custody, and releases evidence to law enforcement.

Law enforcement is not present in the exam room during P.E.R.K. A SACC advocate offers to provide support during the exam and is present in the exam room to provide that support, unless the victim indicates to the advocate that support is not desired.

NO

SANE/FNE or designated healthcare provider:
- Documents injuries
- Conducts testing/provides treatment for Sexually Transmitted Infections (STI's) & HIV
- Obtains baseline pregnancy test if victim is female.

The SANE/FNE or designated healthcare provider gives referrals for crisis intervention and any necessary follow-up medical care.

Law enforcement ensures that the victim has transport home or, if home is not an option, to another safe location.

SART works collaboratively to follow-up with victim for needed services and to keep informed about case status.

OPTION 2
Victim decides to have medical treatment only and does not want law enforcement notified (the victim has a right to refuse unless the case is a mandated report).

SANE/FNE or designated healthcare provider provides health care while SACC advocate provides support, unless the victim indicates to the advocate that support is not desired.

SANE/FNE or designated healthcare provider:
- Documents injuries
- Conducts testing/provides treatment for STI's and HIV
- Obtains baseline pregnancy test if victim is female.

The SANE/FNE provides a method for contacting law enforcement should the survivor decide to file a police report.

SACC advocate arranges for on-going support, including arranging transport home or to another safe location, unless refused.

OPTION 3
Victim decides to have evidence collected without law enforcement notification (the victim has a right to refuse unless the case is a mandated report).

Victim presents within 72 hours (or circumstances deem good cause to do a P.E.R.K. exam).

NO

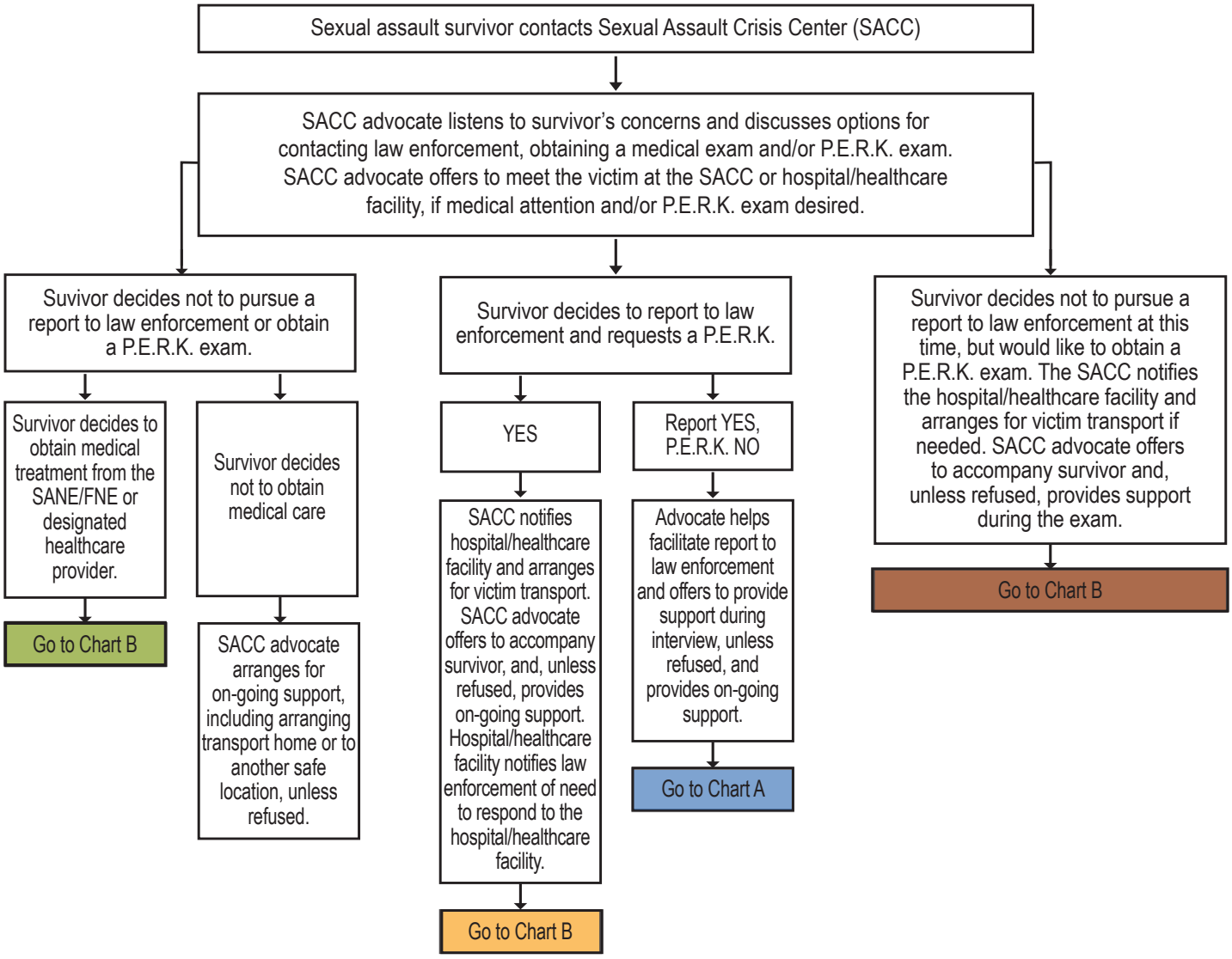
YES

SANE/FNE or designated healthcare provider performs the P.E.R.K. and maintains chain of custody, while SACC advocate provides support unless the victim indicates to the advocate that support is not desired.

Follow hospital protocol for release of evidence to law enforcement, the Division of Consolidated Laboratory Services, or other appropriate agency.

C

SART Team Activation or Call-Out Process:
Survivor Contacts Sexual Assault Crisis Center First



APPENDICES

A

Appendix A: Additional Considerations

A

A1. Physical Evidence Recovery Kit (PERK)

A Physical Evidence Recovery Kit (PERK) is a kit that includes the items and instructions necessary for healthcare providers to collect and preserve physical evidence of sexual assault. These kits are provided to hospitals by the Virginia Department of Forensic Science. PERKs can be conducted on both victims and suspects. For more information about suspect PERKs, please see Appendix A4.

Amendments to the Code of Virginia (see §§19.2-165.1, 19.2-368.3, and 19.2-368.11:1) effective July 1, 2008, made significant changes to laws describing the provision of, and payment for, forensic examinations and evidence collection in sexual assault cases. These changes bring Virginia into compliance with federal law. The laws require that sexual assault victims must have access to forensic exams and evidence collection, even if the victim chooses not to participate in the criminal justice system, or otherwise cooperate with law enforcement authorities. Additionally, the state must pay for all out-of-pocket costs associated with the collection of evidence.

These changes in law and policy are intended to reduce trauma to sexual assault victims, while streamlining and improving the collection of forensic evidence in cases of sexual assault. It is anticipated that the new law may increase the number of victims reporting sexual assaults to law enforcement agencies. Implementing these Code changes will require local law enforcement officials, sexual assault crisis center advocates, healthcare providers, victim advocates, and allied professionals to develop local implementation strategies and policies that protect victims while promoting the public safety interests of the community. This issue will be central to SART development, as communities address the needs of victims both reporting to law enforcement and not reporting to law enforcement at the time of evidence collection.

In response to these changes, DCJS created a Frequently Asked Questions document to address some of the challenges these changes created for implementation. This document can be accessed at http://www.dcjs.virginia.gov/victims/documents/PERKFAQFINAL082208.pdf.

A2. Law Enforcement Presence in the Examination Room

In 2004, DCJS conducted a study of Virginia law enforcement agencies' sexual assault policies. The study was distributed to 324 law enforcement agencies that have investigative responsibilities. One hundred and fifty-one agencies responded, yielding a response rate of 47%. The study found that 5% (7) of law enforcement agencies required that officers be present in the examination room while a PERK examination is conducted on a victim. Forty-three percent (75) of agencies stated that law enforcement officers are present in the room during the examination under certain circumstances. The circumstances cited were when the officer and the victim are the same sex and/or when the victim requests that the officer be present. These circumstances, however, ***do not*** justify a law enforcement officer's presence in the examination room.

Any information provided during the forensic history of events becomes a part of the investigative record, if stated in the presence of the officer. Some information provided during the examination is absolutely necessary for medical care, but it is irrelevant to the investigation. Sensitive information, such as sexual history and health, is essential to the ***medical*** examination. This sensitive information need not, and should not, be discussed with the law enforcement officer in the room. Further, a law enforcement officer's presence inhibits the sharing of necessary medical information and/or makes such information a part of the investigative record, which is an intrusion on the privacy of the victim.

In response to reports of this practice, **the Virginia Association of Chiefs of Police (VACP) and the Virginia Sheriffs' Association (VSA)** distributed a memo, in December 2003 and March 2004 respectively, to Virginia chiefs and sheriffs stating that law enforcement officers' presence in examination rooms with sexual assault victims **"is both inappropriate and unnecessary."** The memo further stated the following:

"There is no known requirement that law enforcement officers have to observe this personal and intrusive examination.... Their presence at this very private and often embarrassing event causes much discomfort for sexual assault victims, who have already been through very traumatic experiences…. The Division of Forensic Sciences confirms that there is no requirement that the law enforcement officer has to witness this examination to preserve the chain of custody of evidence. Additionally, a law enforcement officer would not be qualified as a medical expert to testify to what was observed during the procedure, so the direct observation of the PERK examination does not improve the quality or reliability of the officer's court testimony in a sexual assault case."

The presence of law enforcement officers in the PERK examination room is strongly discouraged. DCJS provides a model general order for Virginia law enforcement agencies on response to sexual assault cases. For further information regarding model policy and best practices, please contact Dana Schrad, the VACP Executive Director, at (804) 285-8227; or John Jones, the VSA Executive Director, at (804) 225-7152, or Gary Dillon, of DCJS, at (804) 786-8421.

A3. Polygraphing

It is **not** appropriate to subject a victim to a polygraph exam and the refusal of a victim to agree to such an exam cannot, by Code, be used as a reason for *not* conducting an investigation. No matter how it is explained, asking a victim to take a "lie detector test" communicates to the victim that she is not believed or supported. Such a message undermines the investigation, as the victim is less likely to trust the process and cooperate with the criminal justice system when she does not feel that the law enforcement officer supports her or believes that she was sexually assaulted. As information gleaned from polygraph examinations is not admissible in a court of law, the risk of alienating the victim is simply not good policy or practice.

While the *Code of Virginia* does not prohibit performing polygraph examinations on victims, performing polygraph examinations on sexual assault victims is strongly discouraged. Per Code, no law-enforcement officer, attorney for the Commonwealth, or other government official shall ask or require a victim of an alleged sex offense to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an offense and the refusal of a victim to submit to such an examination shall not prevent the investigation, charging, or prosecution of the offense. Law enforcement officers are instructed that a victim must be informed that a polygraph examination is voluntary, that the results cannot be introduced as evidence, and that the victim's agreement to take the polygraph examination cannot be the only condition for initiating or continuing an investigation (***Code of Virginia***, §19.2-9.1). This law is consistent with the reauthorized federal Violence Against Women Act (Title I, Section 2013), which states that a State's laws, policies and practices must ensure that no law enforcement officer, prosecutor or other government offices shall ask or require a polygraph as a condition of proceeding with an investigation and refusal of the victim to take a polygraph shall not prevent the investigation, charging or prosecution of the offense. Victims have to be informed in writing that the exam is voluntary. States that do not comply with these provisions will be ineligible for federal grant funding under the Violence Against Women Act.

The polygraph examination may be an appropriate and useful tool that law enforcement officers can use in a sexual assault investigation when interrogating or questioning the ***suspect***. Such examinations, when performed by a qualified professional, can yield useful information, albeit information that cannot be used in court. Unfortunately, law enforcement officers sometimes request that a ***victim*** take a polygraph examination before an investigation has even begun and, prior to, or without taking the steps necessary, to have a suspect undergo the same examination. In addition, law enforcement officers request that sexual assault victims take polygraph examinations more frequently than any other crime victim. The possibility of false allegations in sexual assault is no larger than in any other crime, but the reality is that society has historically viewed sexual assault victims with heightened suspicion (see Appendix A, Section A5). Based on the myth that victims routinely fabricate reports of sexual assault, sexual assault victims' reports are suspect until proven to be valid. Sexual assault victims should be given the same consideration as other crime victims – every report of sexual assault must be assumed to be valid unless proven otherwise.

A4. Suspect PERKs

PERK examinations should be performed on ***all*** identified suspects, within 72 hours following the reported assault. Law enforcement officers should request that all identified suspects consent to a PERK examination and should obtain search warrants for these examinations when such permission is not granted. An FNE or SANE, when available, should conduct the suspect PERK examination, especially under the following circumstances, 1) the event is reported as a stranger assault, 2) in cases where there is increased potential for trace evidence, 3) when there is potential or reported injury to suspect, and 4) if the attending law enforcement officer is inexperienced or untrained in forensic evidence collection. A law enforcement officer may be in the room while the evidence is collected from a suspect. It should be noted that if law enforcement conducts the examination and evidence gathering, there is the potential for defense attorneys to discredit the testimony of the law enforcement officer who performed a PERK examination and cast doubt on the forensic examination findings if that officer is not sufficiently trained or experienced.

Other than timing, the only condition under which a suspect PERK examination should not be authorized is if the suspect refuses to provide consent ***and*** a search warrant is denied.

A5. Unfounded Cases and False Allegations

Definition

Definitions for false allegations of sexual assault, also called false reports, are often imprecise. This creates confusion when discussing the issue, or attempting to estimate its prevalence. For example, many attempts to define what is and is not a false allegation have rested on the motivation of the victim. Several definitions have required that the motive for a false allegation be deliberate deception, yet this is not required for a charge to be baseless. A false allegation of sexual assault could be forwarded due to mental illness or simple mistake (e.g., the individual believes that she was sexually assaulted when she was not). Another critically important issue in this arena is "how false" an allegation needs to be to be considered a "false allegation." Many victims give inconsistent or untrue information as part of their statement, but this should not be confused with a false allegation. For example, victims might give inconsistent or untrue information out of trauma or disorganization, discomfort relaying sexual details, fear of being doubted or blamed, or out of an attempt to make the assault sound more believable, more like the stereotypic "real rape" (i.e., a rape in which the victim is virginal, has engaged in no amount of "risky" behavior such as drinking, and/or the perpetrator is a stranger who overcame her valiant struggles by extreme force).

As defined by leading experts in sexual assault investigations and by Uniform Crime Reporting (UCR), a false allegation is defined as a report of sexual assault where the statutory elements of sexual assault are not met.[8] The false allegation could be made out of deceit, fantasy, or mistake. "False allegation" should not be used to refer to cases in which the assault took place but the victim provided

[8] **National Center for Women and Policing** (1997). Successfully Investigating Acquaintance Sexual Assault: A National Training Manual for Law Enforcement**.** Published by the Feminist Majority Foundation's **National Center for Women and Policing**, Arlington, VA. Available from www.womenandpolicing.org. and Uniform Crime Reporting Program (2004). Uniform Crime Reporting Handbook. Published by the Federal Bureau of Investigations, Clarksburg, WV. Available from www.fbi.gov/ucr/handbook/ucrhandbook04.pdf

inconsistent or untrue information within the context of her statement. Cases in which the victim provides partial or distorted information are certainly difficult to investigate, but they should not be considered false unless there is evidence to prove that the assault simply did not occur. **Every sexual assault report must be assumed to be valid and investigated thoroughly.**

Statistics

Estimates for the rate of false reports vary widely. This is not surprising, given the differences in defining the term and differences in recording practices. This situation suggests that the discrepancies are caused not only by differences in perception and terminology, but also in how the information is gathered and how a report is determined to be "false." One of the primary sources of confusion stems from the terminology of "unfounded" versus "false allegations." Terminology used to refer to false allegations is often confused with that for unfounded or other administrative forms of clearance. Federal UCR reporting requirements in this regard are clear. A case is only to be unfounded if it is determined after investigation to be false or baseless. This does not include cases that are closed because an arrest is not made or the victim refuses to cooperate.

When sex crimes investigators actually try to determine the number of sexual assault reports that are false – based on the evidence from a thorough investigation – estimates begin to converge around 2-4%.[9] This estimate of 2-4% suggests that the American public dramatically overestimates the percentage of sexual assault reports that are false. This tendency to overestimate the percentage of false reports introduces bias into the law enforcement investigation because it may result in less credibility of victims and more credibility of suspects. This is especially true if the victim's behavior is seen as risky or problematic and if the suspect seems like a "nice guy" who "doesn't look like" a stereotypic rapist.

The Determination

A determination that a report is false can only be made when there is sufficient evidence to establish that the sexual assault was not completed or attempted. Such a determination can only be made once the investigation is complete, based on a review of all the findings. This does not mean that the investigation failed to prove that the sexual assault happened – in that case the investigation would simply be inconclusive or unsubstantiated. It also does not mean that the suspect was unable to successfully complete the sexual assault – this would be an attempted sexual assault and/or some other sexual offense. Again the determination that a report is false must be supported by evidence that establishes that the sexual assault (or attempt) did not actually happen, rather than failing to prove that it did happen.

It is inappropriate to use unfounded or other noncriminal codes as a means for ignoring or disregarding sexual assault cases that are considered to be unclear or difficult.

The solution to the problem is two-pronged:

- Every case of sexual assault must be investigated thoroughly, based on the assumption that the report is valid. Sexual assault victims must be given the same consideration as other crime victims – each and every report of sexual assault must be assumed to be valid unless later proven otherwise as the investigation naturally proceeds.

[9] **National Center for Women and Policing** (1997). Successfully Investigating Acquaintance Sexual Assault: A National Training Manual for Law Enforcement**.** Published by the Feminist Majority Foundation's **National Center for Women and Policing**, Arlington, VA. Available from www.womenandpolicing.org

- Departments must implement alternative mechanisms to unfounded dispositions for the purpose of administratively closing cases.

Uniform Crime Reporting (UCR) guidelines dictate that a case should only be unfounded if it is "determined through investigation to be false or baseless." [10] Furthermore, these guidelines indicate that "the refusal of the victim to cooperate with prosecution, or the failure to make an arrest does not unfound a legitimate offense." UCR guidelines recognize "that departmental policy in various law enforcement agencies permits the discontinuance of investigation and the administrative closing of cases in which all investigation has been completed."[11] In addition, the UCR category of "exceptional clearance" can be used for cases in which the offender is identified but cannot be charged or the victim refuses to cooperate. Departments which implement appropriate mechanisms for administrative closure (such as simple inactivation or exceptional clearance) exhibit a decrease in the rate of unfounded cases, in line with that for other index crimes.

Inconsistencies or untruths can destroy the victim's credibility if not handled appropriately by the SART. There are a number of steps that the SART should take in the event of inconsistencies or suspected untruths in the victim's statement. First, it is critically important that professionals understand the dynamics of sexual assault. The rape trauma syndrome is just one example of why these inconsistencies or untruths are understandable and should not be confused with a "false" allegation (see Appendix F). SART members should address inconsistencies or untruths in the victim's statement by exploring the issue gently and nonjudgmentally. If the inconsistency seems to result from the victim's attempt to make the assault sound more like "real rape," SART members should address the victim's underlying fear of being doubted or blamed. Statements made by recanting victims are also viewed as false. A victim may recant either out of fear or when she realizes the impact that the investigation and prosecution will have on her life. It is critical that the SART create a safe, nonjudgmental environment that encourages honesty even for unflattering or illegal behavior.

Having demonstrated that the percentage of false sexual assault allegations is not as high as commonly perceived, **charging victims with making false reports is strongly discouraged**. False allegations do exist, and they are very damaging to an alleged suspect and a SART as well as the victims whose credibility they undermine. However, according to McDowell & Hibler, most of the indicators of false allegations are exactly contrary to those often seen by the police and public as cues for suspicion. This is not a coincidence. If a person is going to fabricate a report of sexual assault, she is likely to base this invented crime on the same stereotype of "real rape." For example, false allegations are more likely than valid reports to include a vaguely

[10] **National Center for Women and Policing** (1997). Successfully Investigating Acquaintance Sexual Assault: A National Training Manual for Law Enforcement. Published by the Feminist Majority Foundation's **National Center for Women and Policing**, Arlington, VA. Available from www.womenandpolicing.org and Uniform Crime Reporting Program (2004). Uniform Crime Reporting Handbook. Published by the Federal Bureau of Investigations, Clarksburg, WV. Available from www.fbi.gov/ucr/handbook/ucrhandbook04.pdf.

[11] **National Center for Women and Policing** (1997). Successfully Investigating Acquaintance Sexual Assault: A National Training Manual for Law Enforcement. Published by the Feminist Majority Foundation's **National Center for Women and Policing**, Arlington, VA. Available from www.womenandpolicing.org and Uniform Crime Reporting Program (2004). Uniform Crime Reporting Handbook. Published by the Federal Bureau of Investigations, Clarksburg, WV. Available from www.fbi.gov/ucr/handbook/ucrhandbook04.pdf.

described stranger who used a great deal of force and to which the victim responded with her utmost, physical resistance.[12]

When law enforcement officers respond to cases with the assumption that they are valid, victims will respond with increased openness and trust that will facilitate the investigation. By utilizing a team approach to sexual assault response, SART members can improve services to victims that will facilitate their recovery and cooperation.

A6. Substance Use/Abuse and Sexual Violence[13]

Sexual violence is any act (verbal and/or physical) which breaks a person's trust and/or safety and is sexual in nature. The term "sexual violence" includes: rape, incest, child sexual assault, marital rape, sexual harassment, exposure, and voyeurism. Substance abuse refers to the overuse/abuse of substances such as: alcohol, drugs, prescription medications, and food.

There are many connections between sexual assault and substance abuse. There are many cases of rape, at the societal and individual levels, where alcohol may be a contributing factor in its occurrence. In many sexual assaults the perpetrator and/or victim may be using/abusing alcohol or drugs prior to the assault. For the perpetrator, being under the influence may remove both physical and psychological inhibitors, which keep all people from acting out violently. A perpetrator may also use the alcohol or drugs as an excuse for criminal behavior. The use of alcohol and drugs also makes it much more difficult for the victim to stay away from dangerous situations and to problem-solve a way out of an assault. Many sexual assault perpetrators have admitted to feeding alcohol or drugs to their victims.

Being under the influence of alcohol and/or drugs is not an excuse for perpetrating sexual violence. It does not give someone a right to hurt other people. Victims who were under the influence of substances at the time of the assault are not responsible for the perpetrators' actions.

Many studies also document the high percentage of people who abuse substances who are victims/survivors of sexual violence. Many of these people report that drugs and alcohol helped them to "numb out" and push away the awful memories of sexual violence. Many of these survivors struggle to stay clean and sober as they deal with sexual abuse issues.

Here are the Facts:

- On average, each year approximately 183,000 (37%) rapes and sexual assaults involve alcohol use by the offender, which is about 1/3 of the total sexual assaults that occur each year. (Greenfeld, L. Alcohol and Crime: An Analysis of National Data on the Prevalence of Alcohol Involvement in Crime. U.S. Department of Justice, 1998.)
- Combined use of drugs and alcohol accounted for 18% of the alcohol-involved sexual assaults. (Greenfeld, L. Alcohol and Crime: An Analysis of National Data on the Prevalence of Alcohol Involvement in Crime. U.S. Department of Justice, 1998.)

[12] C.P. MacDowell and N.S. Hibler (1987). False Allegations (Chapter 11, p.275-299). In R.R. Hazelwood & A.W. Burgess (Eds.), *Practical aspects of rape investigation: A multidisciplinary approach.* Elseview. New York.

[13] Wisconsin Coalition Against Sexual Assault (2003). Sexual Violence and Substance Abuse. Available at www.wcasa.org/docs/subabuse.pdf

- 75% of male college students and 55% of female college students involved in date rape had been drinking or using drugs at the time. (Koss, M.P. 1998. Hidden Rape: Incident, Prevalence, and Descriptive Characteristics of Sexual Aggression and Victimization in a National Sample of College Students. Rape and Sexual Assault, Vol. II. edited by A.W. Burgess. New York: Garland Publishing Company.)
- Date rape drugs such as Rohypnol and GHB (Gamma Hydroxybutyrate) can be given to victims without their knowledge, often by slipping it into a drink, and can prevent the victim from resisting a sexual assault. The drugs create an amnesia-effect so that the victim is uncertain as to what, if anything, occurred. (Sexuality Information and Education Council of the United States, Fact Sheet-Drug Facilitated Sexual Assaults, 28 April, 2000.)
- Analysis of a sample of urine drug tests of sexual assault victims demonstrated that alcohol was present in 63% of the victims, marijuana was present in 30% of the victims and GHB and Rohypnol was present in about three percent (3%) of positive samples. (Slaughter, L. Involvement of Drugs in Sexual Assaults. Journal of Reproductive Medicine. Vol. 45. 2000.)
- College binge drinkers (those who have five or more drinks in one sitting) are 2.3 times more likely than non-bingers to have experienced forced sexual touching and 2.7 times more likely to endure unwanted sexual intercourse. (Presley, CA, Meilman, PD, Cashin, JR, and Leichliter, JS. Alcohol and Drugs on American College Campuses: Issues of Violence and Harassment: A report to College Presidents. The Core Institute, Southern Illinois University at Carbondale, 1997.)
- Fraternity members reported higher levels of using alcohol and verbal coercion to ply females for sex than non-fraternity members. (Boeringer, S.B. Influences of Fraternity Membership, Athletics, and Male Living Arrangements On Sexual Aggression. Violence Against Women. Vol. 2. 1996.)
- In 29% of sexual assaults recorded by a medium-sized, middle Atlantic university, the victim could not have consented to the sexual activity because she was incapacitated by alcohol. (Meilman, P., Haygood-Jackson, D. Data on Sexual Assault from the First Two Years of a Comprehensive Campus Prevention Program. Journal of American College Health. Vol. 44. 1996.)
- According to the UW-Madison University Police Department, the potential for Rohypnol related date rape exists, but the drug most often used for date rape on this campus is alcohol, with 80% of the reported acquaintance rapes related to this substance. (University of Wisconsin-Madison Police Department. Sexual Assault Prevention - What You Can Do to Reduce the Chance of Being Sexually Assaulted, 2000.)
- Substance abuse on the part of the offender occurs less frequently in family rapes (10%) than in rapes by other people (16%). (Crime in the United States. Uniform Crime Reports. Federal Bureau of Investigation, 1998.)
- In a nationally representative sample, youth who experienced sexual assault were twice as likely as their nonvictimized peers to report past-year alcohol or other drug abuse or dependence. (Kilpatrick, D., Acierno, R., Saunders, B., Resnick, H., Best, C., Schnurr, P. Risk Factors for Adolescent Substance Abuse and Dependence: Data from a National Sample. Journal of Consulting and Clinical Psychology 68 (1): 1-12. 2000.)
- Over one half of adolescent victims said that their first use of substances occurred after the year they were first assaulted. (53.8% for alcohol, 47.8% for

marijuana, and 63.5% for hard drugs). (Kilpatrick, D., Acierno, R., Saunders, B., Resnick, H., Best, C., Schnurr, P. National Survey of Adolescents Executive Summary. Charleston, SC: Medical University of South Carolina, National Crime Victims Research and Treatment Center, 1998.)

- Adolescent girls who have been sexually abused are more likely to use a greater variety of substances, initiate substance use at an earlier age, and are more likely to use substances to self-medicate painful emotions than non-abused girls. (Harrison, P.A., Fulkerson, J. and Beebe, T. Multiple Substance Use Among Adolescent Physical and Sexual Abuse Victims. Child Abuse and Neglect. Vol. 21. 1997.)
- When compared to non-victims, rape survivors were 3.4 times more likely to use marijuana, 6 times more likely to use cocaine, and 10 times more likely to use other major drugs. (Orsillo, S. Sexual Assault Among Females. National Center for Post Traumatic Stress Disorder, 2000.)
- 38-45% of women in substance abuse treatment programs are survivors of sexual violence. (Steele, C.T. Sexual Abuse and Chemical Dependency. The Source. Vol. 8, No. 3. 1998.)
- In a recent study of substance-abusing women who were admitted for services sponsored by the New York City Administration for Child Services - the public agency responsible for responding to reports of child abuse or neglect - 24% of the women reporting had been sexually abused in their childhood. (Kang, S., Magura, S., Laudet, A., Whitney, S. Adverse Effect of Child Abuse Victimization Among Substance-Using Women in Treatment, 1999.)

A7. Anonymous/Blind/Jane Doe Reporting[14]

The Violence Against Women and Department of Justice Reauthorization Act of 2005 (VAWA 2005), 42 U.S.C. §3796gg-4(d), provides that states may not "require a victim of sexual assault to participate in the criminal justice system or cooperate with law enforcement in order to be provided with a forensic medical exam, reimbursed for charges incurred on account of such an exam, or both" (the "VAWA 2005 forensic examination requirement"). Under this provision, each state must ensure that victims have access to an exam, and that the state will pay for the exam, even if the victim chooses not to participate in the criminal justice system, or otherwise cooperate with the criminal justice system or law enforcement authorities.

States had to certify that they've complied with these provisions to be eligible to continue to receive federal funds available through the federal Violence Against Women Act (VAWA). Virginia currently receives approximately $2.5 million annually through VAWA – STOP (Services, Training, Officers, Prosecution) funds and awards V-STOP (Virginia-STOP) grants to support programs and initiatives in law enforcement, prosecution, victims services, advocacy and court-based programs throughout the Commonwealth. An additional $2,975,220 in V-STOP funding was distributed to Virginia in 2009 as a result of the American Recovery and Reinvestment Act.

House Bill 956 and Senate Bill 312, passed during the 2008 Session of the General Assembly and signed by Governor Kaine, brought Virginia into statutory compliance with the federal VAWA requirements. These bills clarified that all sexual

[14] Information for this section was compiled using the DCJS *PERK Authorization and Payment FAQ* document available at www.dcjs.virginia.gov/victims/documents/PERKFAQFINAL082208.pdf and Maryland Coalition Against Sexual Assault's *Violence Against Women Act (VAWA) 2005 Reauthorization Forensic Compliance Mandates* fact sheet available at http://www.mcasa.org/uploads/docs/Fact%20sheet%20FINAL.doc

assault forensic examinations and evidence collection conducted are to be paid by the Commonwealth, whether or not victims cooperate with law enforcement authorities and/or participate in the criminal justice system. Additionally, these bills indicated that the Criminal Injuries Compensation Fund (CICF) can pay health care providers directly for the costs of performing the physical evidence recovery kit (PERK) examinations used in cases of sexual assault. (See §§19.2-165.1, 19.2-368.3, and 19.2-368.11:1)

Although the VAWA 2005 reauthorization mandates that states certify that they meet the forensic requirements, it does not articulate to states the method of compliance. Therefore states differ greatly in their approach to compliance. "Anonymous reporting", "Blind reporting" or "Jane Doe reporting" are only examples of ways in which states can meet the forensic compliance mandate.

Blind or Anonymous reporting generally means that law enforcement is involved on some level – in many cases driven by the need to accept the evidence for storage. Therefore, this often translates to a police report generated to continue the chain of custody and establish a tracking mechanism for the evidence to be stored (and tracked) within the local (or state) law enforcement agency. The "type" of police report (sexual assault, rape, miscellaneous, etc.) may vary greatly.

Blind reporting or other systems of anonymous reporting have been used more recently to engage law enforcement in transporting and storing evidence from forensic exams while protecting the identity of victims who are undecided about or declining an immediate report to law enforcement. Blind reporting allows for potential evidence to be preserved and investigators to gain information about crimes of sexual violence that otherwise would go unreported, while allowing victims an opportunity to cope with the acute affects of the trauma and gather information about their legal options without making an immediate decision concerning an investigation and/or prosecution of the assault. Victims have a chance to consider safety issues and to find out about the legal process, such as what chance they have of filing successful charges and what it will be like to work with the investigator,

The term "Jane Doe" (anonymous), however, has a different connotation – especially with law enforcement. When using the terminology "Jane Doe" with law enforcement, it conjures up the image of the same terminology used when responding to "Jane Doe" homicides. Officers may assume that both a police report and an investigation need to be initiated (which is not the case).

Virginia is not required to institute anonymous reporting, however many Virginia localities, as well as other states across the country, are instituting it voluntarily. Under VAWA 2005, states are only required to ensure that victims will not incur costs associated with the gathering of forensic evidence, regardless of whether they choose to report the sexual assaults to law enforcement authorities or cooperate with the criminal justice system. Localities that choose to implement anonymous reporting should develop local policies which outline the handling and preservation of evidence collected in cases where victims do not wish to make a formal police report. Local officials interested in implementing such a process should consider it in consultation with their local prosecutors, victim services agency partners, health care providers, and/or hospital representatives, and forensic lab personnel.

A8. Victims' Compensation and the Criminal Injuries Compensation Fund

Victims of certain crimes in Virginia, those who were injured during a crime, or the surviving spouse, parent, grandparent, sibling, or child of a victim who dies as a result of a crime, may be compensated for certain unreimbursed losses such as loss of earnings and medical, moving, counseling or funeral expenses. Compensation can be received regardless of whether or not an arrest is made, as long as the crime victim has cooperated with authorities in the investigation of the crime.

The prosecutor, victim/witness program staff, and/or some sexual assault crisis centers can advise victims concerning how to apply for victims' compensation and, if necessary, assist them with the application. SART members should be familiar with victims' compensation and the Criminal Injuries Compensation Fund, so that they may provide sexual assault victims with this important resource and referral information. For more information, contact the Criminal Injuries Compensation Fund directly by calling (800) 552-4007. This number is toll-free, statewide.

Physical Evidence Recovery Kit Payments

Effective July 1, 2008, the Supreme Court of Virginia is no longer responsible for payment for sexual assault forensic examinations or collection of the Physical Evidence Recovery Kits (PERKs). The Criminal Injuries Compensation Fund (CICF) will now process payment for these examinations.

Important notes regarding the changes to §19.2-165.1 of the ***Code of Virginia*** and the new payment process are presented below.

- As of July 1, 2008, ***adult*** victims, aged 13 years and older, of an alleged sexual assault are ***no longer*** required to report the offense to law enforcement in order to have a sexual assault forensic examination *or* for payment by CICF. Mandatory child and elder abuse reporting requirements still apply.
- CICF will pay for costs associated with a ***sexual assault*** forensic exam. PERKs, or forensic examinations for any other purpose (such as child physical abuse, gun shot wounds, suspect PERKs, etc.), still have to be approved by the local Commonwealth's Attorney or his/her designee in advance of the examination per rules of the Virginia Supreme Court's Criminal Fund. The Criminal Fund will reimburse non-sexual assault evidence collection in accordance with their rules.
- Hospitals and healthcare providers ***must bill CICF directly*** with an itemized statement and Request for Payment form. This means bills for sexual assault forensic examinations should no longer be sent to the local Victim/Witness Programs to process payment. If a Victim/Witness program receives a bill in error, it should be immediately forwarded to CICF.
- Once the bill has been sent to CICF for consideration, the patient may ***not*** be placed into collections.

All costs associated with the collection of forensic medical evidence will be paid for by the Commonwealth. This includes professional service fees (which includes the collection of the actual PERK), emergency department medical screening fees (associated with the collection of evidence), certain laboratory fees, pregnancy testing, medications such as pregnancy and STI prophylaxis, and ambulance transportation to facilities that have the capacity to complete a PERK examination. CICF will also reimburse a follow-up forensic examination.

Costs not included for reimbursement include the following:

- Cost of treating injuries
- Follow-up medical or second appointments
- Duplicative services
- Medications filled off-site
- Air transport
- Follow-up medications
- Counseling
- Lost wages due to physical or emotional injury

For victims who cooperate with law enforcement authorities, some of these costs (for example medical costs, counseling, lost wages) may be covered if victims apply to the Criminal Injuries Compensation Fund, through the traditional claims process. Applications are available through local victim/witness programs or on-line at http://www.cicf.state.va.us/.

More information relating to PERK payment policies and procedures, as well as requests for payment forms, can be obtained on the CICF website at http://www.cicf.state.va.us/forensic_exams.shtml.

A9. Health Insurance Portability and Accountability Act (HIPAA)[15]

The Health Insurance Portability and Accountability Act (HIPAA) was passed by Congress in 1996 and gives patients greater access to their own medical records and more control over how their personally identifiable health information is used. It allows portability for group coverage from one carrier to another group carrier. HIPPA regulations also address the obligations of healthcare providers and health plans to protect health information. In general, covered entities such as health plans, healthcare clearinghouses, and healthcare providers, which conduct certain financial and administrative transactions electronically, had until April 14, 2003 to comply.

The U.S. Department of Health and Human Services issued Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") to implement the requirement of HIPAA. The Privacy Rule is a set of national standards for the protection of certain health information. A major purpose of the Privacy Rule is to define and limit the circumstances in which an individual's protected heath information may be used or disclosed by covered entities, such as health care providers. A covered entity may not use or disclose protected health information, except either: (1) as the Privacy Rule permits or requires; or (2) as the individual who is the subject of the information (or the individual's personal representative) authorizes in writing (see Appendix H, Section H1).

Professionals have cited concerns about HIPAA's impact on collaborative response to sexual assault victims. Concerns specifically focus on how professionals can exchange information regarding sexual assault cases without violating HIPAA's rules of patient confidentiality. Professionals can coordinate their response to sexual assault patients while still adhering to HIPAA regulations. To collaborate, health care professionals can obtain written consent from the sexual assault patient to communicate with a sexual assault crisis center and/or law enforcement authorities.

[15] Excerpts taken from the Office for Civil Rights (2003). Summary of the HIPAA Privacy Rule. Published by the United States Department of Health and Human Services, Washington, D.C. Available from http://www.hhs.gov/

Even if written permission has not been obtained, the Privacy Rule permits release of certain information under the certain circumstances. There are no restrictions on the use or disclosure of de-identified health information. De-identified health information neither identifies nor provides a reasonable basis to identify an individual (e.g., name, address, birth date, and Social Security Number are not provided). A health care provider is also permitted to use and disclose protected health information, without an individual's authorization, for the following purposes or situations:

- Informal permission may be obtained by asking the individual outright, or by circumstances that clearly give the individual the opportunity to agree, acquiesce, or object. Where the individual is incapacitated, in an emergency situation, or not available, health care providers generally may make such uses and disclosures, if in the exercise of their professional judgment, the use or disclosure is determined to be in the best interests of the individual.
- In cases involving victims of abuse, neglect or domestic violence, health care providers may disclose protected health information to appropriate government authorities.
- Health care providers may disclose protected health information to law enforcement officials for law enforcement purposes under the following circumstances: to identify or locate a suspect, fugitive, material witness, or missing person; in response to a law enforcement official's request for information about a victim or suspected victim of a crime; when necessary to inform law enforcement about the commission and nature of a crime, the location of the crime or crime victims, and the perpetrator of the crime.
- Health care providers may disclose protected health information that they believe is necessary to prevent or lessen a serious and imminent threat to a person or the public, when such disclosure is made to someone they believe can prevent or lessen the threat (including the target of the threat). Providers may also disclose to law enforcement if the information is needed to identify or apprehend an escapee or violent criminal.

Health care providers should establish and implement policies and procedures (which may be standard protocols) for routine, recurring disclosures, or requests for disclosures, that limits the protected health information disclosed to that which is the minimum amount reasonably necessary to achieve the purpose of the disclosure. Individual review of each disclosure is not required.

The above circumstances apply to sexual assault cases. It is recommended that in situations where obtaining written consent is premature (e.g., the victim has just presented at the hospital) or impossible (e.g., the victim is unconscious), the health care provider contact allied professionals to alert them of a case and omit identifying information. For example, when a victim presents at the hospital, the triage nurse can contact a sexual assault crisis center advocate and the local law enforcement agency to respond and simply state that there is a sexual assault victim at the hospital who may need to speak with a sexual assault crisis center advocate and a law enforcement officer. The victim can then personally provide the advocate and the officer with her identifying information at a later time.

Appendix B: Relevant State Statutes

B

B1. PERK/CICF

§19.2-165.1. Payment of medical fees in certain criminal cases; reimbursement.

A. Except as provided in subsection B, all medical fees expended in the gathering of evidence for all criminal cases where medical evidence is necessary to establish a crime has occurred and for cases involving abuse of children under the age of 18 shall be paid by the Commonwealth out of the appropriation for criminal charges, provided that any medical evaluation, examination, or service rendered be performed by a physician or facility specifically designated by the attorney for the Commonwealth in the city or county having jurisdiction of such case for such a purpose. If no such physician or facility is reasonably available in such city or county, then the attorney for the Commonwealth may designate a physician or facility located outside and adjacent to such city or county.

   Where there has been no prior designation of such a physician or facility, such medical fees shall be paid out of the appropriation for criminal charges upon authorization by the attorney for the Commonwealth of the city or county having jurisdiction over the case. Such authorization may be granted prior to or within 48 hours after the medical evaluation, examination, or service rendered.

B. All medical fees expended in the gathering of evidence through physical evidence recovery kit examinations conducted on victims complaining of sexual assault under Article 7 (§18.2-61 et seq.) of Chapter 4 of Title 18.2 shall be paid by the Commonwealth pursuant to subsection F of §19.2-368.11:1. Victims complaining of sexual assault shall not be required to participate in the criminal justice system or cooperate with law-enforcement authorities in order to be provided with such forensic medical exams.

C. Upon conviction of the defendant in any case requiring the payment of medical fees authorized by this section, the court shall order that the defendant reimburse the Commonwealth for payment of such fees.

(1976, c. 292; 1982, c. 507; 1987, c. 330; 1997, c. 322; 1999, c. 853; 2000, c. 292; 2003, cc. 28, 772; 2008, cc. 203, 251.)

§19.2-368.3. Powers and duties of Commission.

The Commission shall have the following powers and duties in the administration of the provisions of this chapter:

1. To adopt, promulgate, amend and rescind suitable rules and regulations to carry out the provisions and purposes of this chapter, to include a distinct policy (i) for the payment of physical evidence recovery kit examinations and (ii) to require each health care provider as defined in §8.01-581.1 that provides services under this chapter to negotiate with the Commission or its designee to establish prospective

agreements relating to rates for payment of claims for such services allowed under §19.2-368.11:1, such rates to discharge the obligation to the provider in full except where the provider is an agency of the Commonwealth and the claimant receives a third party recovery in addition to the payment from the Fund.

2. Notwithstanding the provisions of §2.2-3706, to acquire from the attorneys for the Commonwealth, State Police, local police departments, sheriffs' departments, and the Chief Medical Examiner such investigative results, information and data as will enable the Commission to determine if, in fact, a crime was committed or attempted, and the extent, if any, to which the victim or claimant was responsible for his own injury. These data shall include prior adult arrest records and juvenile court disposition records of the offender. For such purposes and in accordance with §16.1-305, the Commission may also acquire from the juvenile and domestic relations district courts a copy of the order of disposition relating to the crime. The use of any information received by the Commission pursuant to this subdivision shall be limited to carrying out the purposes set forth in this section, and this information shall be confidential and shall not be disseminated further. The agency from which the information is requested may submit original reports, portions thereof, summaries, or such other configurations of information as will comply with the requirements of this section.

3. To hear and determine all claims for awards filed with the Commission pursuant to this chapter, and to reinvestigate or reopen cases as the Commission deems necessary.

4. To require and direct medical examination of victims.

5. To hold hearings, administer oaths or affirmations, examine any person under oath or affirmation and to issue summonses requiring the attendance and giving of testimony of witnesses and require the production of any books, papers, documentary or other evidence. The powers provided in this subsection may be delegated by the Commission to any member or employee thereof.

6. To take or cause to be taken affidavits or depositions within or without the Commonwealth.

7. To render each year to the Governor and to the General Assembly a written report of its activities.

8. To accept from the government of the United States grants of federal moneys for disbursement under the provisions of this chapter.

(1976, c. 605; 1984, c. 619; 1986, c. 422; 1990, c. 551; 1992, c. 547; 1998, c. 484; 1999, cc. 703, 726; 2008, cc. 203, 251; 2010, c. 780.)

§19.2-368.11:1. Amount of award.

A. Compensation for Total Loss of Earnings: An award made pursuant to this chapter for total loss of earnings which results directly from incapacity incurred by a crime victim shall be payable during total incapacity to the victim or to such other eligible person, at a weekly compensation rate equal to 66 2/3 percent of the victim's average weekly wages. The total amount of weekly compensation shall not exceed $600. The victim's average weekly wages shall be determined as provided in §65.2-101.

B. Compensation for Partial Loss of Earnings: An award made pursuant to this chapter for partial loss of earnings which results directly from incapacity incurred by a crime victim shall be payable during incapacity at a weekly rate equal to 66 2/3 percent of the difference between the victim's average weekly wages before the injury and the weekly wages which the victim is able to earn thereafter. The combined total of actual weekly earnings and compensation for partial loss of earnings shall not exceed $600 per week.

C. Compensation for Loss of Earnings of Parent of Minor Victim: The parent or guardian of a minor crime victim may receive compensation for loss of earnings, calculated as specified in subsections A and B, for time spent obtaining medical treatment for the child and for accompanying the child to, attending or participating in investigative, prosecutorial, judicial, adjudicatory and post-conviction proceedings.

D. Compensation for Dependents of a Victim Who Is Killed: If death results to a victim of crime entitled to benefits, dependents of the victim shall be entitled to compensation in accordance with the provisions of §§65.2-512 and 65.2-515 in an amount not to exceed the maximum aggregate payment or the maximum weekly compensation which would have been payable to the deceased victim under this section.

E. Compensation for Unreimbursed Medical Costs, Funeral Expenses, Services, etc.: Awards may also be made on claims or portions of claims based upon the claimant's actual expenses incurred as are determined by the Commission to be appropriate, for (i) unreimbursed medical expenses or indebtedness reasonably incurred for medical expenses; (ii) expenses reasonably incurred in obtaining ordinary and necessary services in lieu of those the victim would have performed, for the benefit of himself and his family, if he had not been a victim of crime; (iii) expenses directly related to funeral or burial, not to exceed $5,000; (iv) expenses attributable to pregnancy resulting from forcible rape; (v) mental health counseling for survivors as defined under subdivisions A 2 and A 4 of §19.2-368.4, not to exceed $2,500 per claim; (vi) reasonable and necessary moving expenses, not to exceed $1,000, incurred by a victim or survivors as defined under subdivisions A 2 and A 4 of §19.2-368.4; and (vii) any other reasonable and necessary expenses and indebtedness incurred as a direct result of the injury or death upon which such claim is based, not otherwise specifically provided for. Notwithstanding any other provision of law, a person who is not eligible for an award under subsection A of §19.2-368.4 who pays expenses directly related to funeral or burial is eligible for reimbursement subject to the limitations of this section.

F. Notwithstanding the provisions of subdivision 3 of §19.2-368.10, §§19.2-368.5, 19.2-368.5:1, 19.2-368.6, 19.2-368.7, 19.2-368.8, subsection G of this section, and §19.2-368.16, the Criminal Injuries Compensation Fund shall pay for physical evidence recovery kit examinations conducted on victims of sexual assault. Any individual that submits to and completes a physical evidence recovery kit examination shall be considered to have met the reporting and cooperation requirements of this chapter. Funds paid for physical evidence recovery kit collection shall not be offset against the Fund's maximum allowable award as provided in subsection H. Payments may be subject to negotiated agreements with the provider. Healthcare providers that complete physical evidence recovery kit examinations may bill the Fund directly subject to the provisions of §19.2-

368.5:2. The Commission shall develop policies for a distinct payment process for physical evidence recovery kit examination expenses as required under subdivision 1 of §19.2-368.3.

In order for the Fund to consider additional crime-related expenses, victims shall file with the Fund following the provisions of this chapter and Criminal Injuries Compensation Fund policy.

G. Any claim made pursuant to this chapter shall be reduced by the amount of any payments received or to be received as a result of the injury from or on behalf of the person who committed the crime or from any other public or private source, including an emergency award by the Commission pursuant to §19.2-368.9.

H. To qualify for an award under this chapter, a claim must have a minimum value of $100, and payments for injury or death to a victim of crime, to the victim's dependents or to others entitled to payment for covered expenses, after being reduced as provided in subsection G, shall not exceed $25,000 in the aggregate.

(1986, c. 457; 1988, c. 748; 1989, c. 335; 1990, c. 552; 1992, c. 687; 1996, c. 86; 1998, c. 484; 2000, c. 847; 2002, c. 665; 2005, c. 683; 2007, c. 381; 2008, cc. 203, 251.)

B2. SART

§15.2-1627.4. Coordination of multidisciplinary response to sexual assault.

The attorney for the Commonwealth in each political subdivision in the Commonwealth shall coordinate the establishment of a multidisciplinary response to criminal sexual assault as set forth in Article 7 (§18.2-61 et seq.) of Chapter 4 of Title 18.2, and hold a meeting, at least annually, to: (i) discuss implementation of protocols and policies for sexual assault response teams consistent with those established by the Department of Criminal Justice Services pursuant to subdivision 45 of §9.1-102; and (ii) establish and review guidelines for the community's response, including the collection, preservation, and secure storage of evidence from Physical Evidence Recovery Kit examinations consistent with §19.2-165.1. The following persons or their designees shall be invited to participate in the annual meeting: the attorney for the Commonwealth; the sheriff; the director of the local sexual assault crisis center providing services in the jurisdiction, if any; the chief of each police department in the jurisdiction, if any; a forensic nurse examiner or other health care provider who performs Physical Evidence Recovery Kit examinations in the jurisdiction, if any; and the director of the victim/witness program in the jurisdiction, if any.

(2009, c. 817.)

B3. Polygraphing

§19.2-9.1. Written notice required for complaining witness who is requested to take polygraph test.

A. For offenses not specified in subsection B, if a complaining witness is requested to submit to a polygraph examination during the course of a criminal investigation, such witness shall be informed in writing prior to the examination that (i) the examination is voluntary, (ii) the results thereof are inadmissible as evidence and (iii) the agreement of the complaining witness to submit thereto shall not be the sole condition for initiating or continuing the criminal investigation.

B. No law-enforcement officer, attorney for the Commonwealth, or other government official shall ask or require a victim of an alleged sex offense to submit to a

polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an offense. If a victim is requested to submit to a polygraph examination during the course of a criminal investigation, such victim shall be informed in writing of the provisions of subsection A and that the refusal of a victim to submit to such an examination shall not prevent the investigation, charging, or prosecution of the offense.

C. A "sex offense," for the purposes of this section, shall mean any offense set forth in Article 7 (§18.2-61 et seq.) of Chapter 4 of Title 18.2.

(1994, c. 336; 2008, cc. 512, 748.)

B4. Confidentiality

§63.2-104.1. Confidentiality of records of persons receiving domestic and sexual violence services.

A. In order to ensure the safety of adult, youth, and child victims of domestic violence, dating violence, sexual assault, or stalking, and their families, programs and individuals providing services to victims of sexual or domestic violence shall protect the confidentiality and privacy of persons receiving services.

B. Except as provided in subsections C and D, programs and individuals providing services to victims of sexual or domestic violence shall not:

1. Disclose any personally identifying information or individual information collected in connection with services requested, utilized, or denied through sexual or domestic violence programs; or

2. Reveal individual client information without the informed, written, reasonably time-limited consent of the person (or in the case of an unemancipated minor, the minor and the parent or guardian or in the case of an incapacitated person as defined in §37.2-1000, the guardian) about whom information is sought, whether for this program or any other Federal, State, tribal, or territorial grant program, except that consent for release may not be given by the abuser of the minor, incapacitated person, or the abuser of the other parent of the minor.

C. If release of information described in subsection B is compelled by statutory or court mandate:

1. The service provider shall make reasonable attempts to provide notice to victims affected by the disclosure of information; and

2. The service provider shall take steps necessary to protect the privacy and safety of the persons affected by the release of the information.

D. Programs and individuals providing services to victims of sexual or domestic violence may share:

1. Nonpersonally identifying data in the aggregate regarding services to their clients and nonpersonally identifying demographic information in order to comply with Federal, State, tribal, or territorial reporting, evaluation, or data collection requirements;

2. Court generated information and law-enforcement generated information contained in secure, governmental registries for protection order enforcement purposes; and

3. Information necessary for law enforcement and prosecution purposes.

For purposes of this section, “programs” shall include public and not-for-profit agencies the primary mission of which is to provide services to victims of sexual or domestic violence.

(2006, c. 135.)

§63.2-1612. Responsibilities of Department; domestic violence prevention and services.

It shall be the responsibility of the Department, to the extent funds are appropriated by the General Assembly or otherwise made available:

1. To support, strengthen, evaluate, and monitor community-based domestic violence programs funded by the Department and to act as the administrator for state grant funds and the disbursal of federal funds pursuant to §§63.2-1614 and 63.2-1615;

2. To collaborate with the Statewide Domestic Violence Coalition in developing and implementing community-based programs to respond to and prevent domestic violence;

3. To prepare, disseminate, and present educational programs and materials on domestic violence to the local departments, community provider agencies, and the general public;

4. To support, strengthen, and act as a resource to local departments on issues of domestic violence, particularly as they relate to both adult and child protective services and self-sufficiency;

5. To establish minimum standards of training and provide educational programs to train workers in the fields of child and adult protective services in local departments and community-based domestic violence programs funded by the Department to identify domestic violence and provide effective referrals for appropriate services;

6. To provide training and educational opportunities on effective collaboration for all staff of local departments and community-based domestic violence programs;

7. To work with the Statewide Domestic Violence Coalition to (a) develop policies and procedures that guide the work of persons providing services to victims of domestic violence and their children; (b) implement methods to preserve the confidentiality of all domestic violence services records pursuant to §§63.2-104 and 63.2-104.1 in order to protect the rights and safety of victims of domestic violence; (c) develop policies and implement methods to assure the confidentiality of records pertaining to the address or location of any shelter or facility assisted under the Family Violence Prevention and Services Act, 42 U.S.C. §10401 et seq.; (d) collect, prepare, and disseminate statistical data on the occurrence of domestic violence and the services provided throughout the Commonwealth; (e) operate the Virginia Family Violence and Sexual Assault 24-hour toll-free hotline and the Statewide Domestic Violence Database (Vadata); and (f) provide a clearinghouse of information and technical assistance on intervention and prevention of domestic violence;

8. To encourage the use of existing information and referral agencies to provide specialized information on domestic violence;

9. To develop and maintain a statewide list of available community and state resources for the victims of domestic violence;

10. To provide technical assistance on establishing shelters, self-help groups and other necessary service delivery programs;

11. To provide leadership and coordination within the Department on domestic violence as it relates to child and adult abuse and neglect, benefits programs, Temporary Assistance to Needy Families, foster care prevention, child support enforcement, child care, and the promotion of healthy family relationships; and

12. To promote collaboration and cooperation with other state agencies, including the Department of Criminal Justice Services, the Department of Health, the Department of Housing and Community Development, the Office of the Attorney General, and the Virginia Employment Commission, for technical assistance, data collection and service delivery to facilitate the appropriate response to victims of domestic violence.

(1980, c. 597, §63.1-317; 2002, c. 747; 2005, cc. 638, 685; 2006, c. 135.)

B5. Written Policies for Law Enforcement

§9.1-1301. Sexual assault policies for law-enforcement agencies in the Commonwealth.

The Virginia Department of State Police and the police and sheriff's departments of every political subdivision in the Commonwealth and every campus police department shall establish written policies and procedures regarding a law-enforcement officer's response to an alleged criminal sexual assault in violation of Article 7 (§18.2-61 et seq.) of Chapter 4 of Title 18.2. Such policies shall, at a minimum, provide guidance as to the department's policy on (i) training; (ii) compliance with §§19.2-9.1 and 19.2-165.1; (iii) transportation of alleged sexual assault victims; and (iv) the provision of information on legal and community resources available to alleged victims of sexual assault.

(2008, cc. 600, 771.)

B6. Mandatory Reporting Laws

This Appendix includes the following statutes from the ***Code of Virginia***:

§63.2-1509. Physicians, nurses, teachers, etc., to report certain injuries to children; penalty for failure to report

§63.2-100. Definitions ("Abused or neglected child")

§54.1-2967. Physicians and others rendering medical aid to report certain wounds

§63.2-1606. Protection of aged or incapacitated adults; mandated and voluntary reporting

Healthcare facilities and jurisdictions may have their own policies regarding mandated reporting, but these are the relevant state codes. These laws are current at the time of publication of this document but may change in the future.

B

§63.2-1509. Physicians, nurses, teachers, etc., to report certain injuries to children; penalty for failure to report.

A. The following persons who, in their professional or official capacity, have reason to suspect that a child is an abused or neglected child, shall report the matter immediately to the local department of the county or city wherein the child resides or wherein the abuse or neglect is believed to have occurred or to the Department's toll-free child abuse and neglect hotline:

1. Any person licensed to practice medicine or any of the healing arts;
2. Any hospital resident or intern, and any person employed in the nursing profession;
3. Any person employed as a social worker;
4. Any probation officer;
5. Any teacher or other person employed in a public or private school, kindergarten or nursery school;
6. Any person providing full-time or part-time child care for pay on a regularly planned basis;
7. Any mental health professional;
8. Any law-enforcement officer or animal control officer;
9. Any mediator eligible to receive court referrals pursuant to §8.01-576.8;
10. Any professional staff person, not previously enumerated, employed by a private or state-operated hospital, institution or facility to which children have been committed or where children have been placed for care and treatment;
11. Any person associated with or employed by any private organization responsible for the care, custody or control of children;
12. Any person who is designated a court-appointed special advocate pursuant to Article 5 (§9.1-151 et seq.) of Chapter 1 of Title 9.1;
13. Any person, over the age of 18 years, who has received training approved by the Department of Social Services for the purposes of recognizing and reporting child abuse and neglect;
14. Any person employed by a local department as defined in §63.2-100 who determines eligibility for public assistance; and
15. Any emergency medical services personnel certified by the Board of Health pursuant to §32.1-111.5, unless such personnel immediately reports the matter directly to the attending physician at the hospital to which the child is transported, who shall make such report forthwith.

This subsection shall not apply to any regular minister, priest, rabbi, imam, or duly accredited practitioner of any religious organization or denomination usually referred to as a church as it relates to (i) information required by the doctrine of the religious organization or denomination to be kept in a confidential manner or (ii) information that would be subject to §8.01-400 or 19.2-271.3 if offered as evidence in court.

If neither the locality in which the child resides nor where the abuse or neglect is believed to have occurred is known, then such report shall be made to the local department of the county or city where the abuse or neglect was discovered or to the Department's toll-free child abuse and neglect hotline.

If an employee of the local department is suspected of abusing or neglecting a child, the report shall be made to the court of the county or city where the abuse or neglect was discovered. Upon receipt of such a report by the court, the judge shall assign the report to a local department that is not the employer of the suspected employee for investigation or family assessment. The judge may consult with the Department in selecting a local department to respond to the report or the complaint.

If the information is received by a teacher, staff member, resident, intern or nurse in the course of professional services in a hospital, school or similar institution, such person may, in place of said report, immediately notify the person in charge of the institution or department, or his designee, who shall make such report forthwith.

The initial report may be an oral report but such report shall be reduced to writing by the child abuse coordinator of the local department on a form prescribed by the Board. Any person required to make the report pursuant to this subsection shall disclose all information that is the basis for his suspicion of abuse or neglect of the child and, upon request, shall make available to the child-protective services coordinator and the local department, which is the agency of jurisdiction, any information, records, or reports that document the basis for the report. All persons required by this subsection to report suspected abuse or neglect who maintain a record of a child who is the subject of such a report shall cooperate with the investigating agency and shall make related information, records and reports available to the investigating agency unless such disclosure violates the federal Family Educational Rights and Privacy Act (20 U.S.C. §1232g). Provision of such information, records, and reports by a health care provider shall not be prohibited by §8.01-399. Criminal investigative reports received from law-enforcement agencies shall not be further disseminated by the investigating agency nor shall they be subject to public disclosure.

B. For purposes of subsection A, "reason to suspect that a child is abused or neglected" shall include (i) a finding made by an attending physician within seven days of a child's birth that the results of a blood or urine test conducted within 48 hours of the birth of the child indicate the presence of a controlled substance not prescribed for the mother by a physician; (ii) a finding by an attending physician made within 48 hours of a child's birth that the child was born dependent on a controlled substance which was not prescribed by a physician for the mother and has demonstrated withdrawal symptoms; (iii) a diagnosis by an attending physician made within seven days of a child's birth that the child has an illness, disease or condition which, to a reasonable degree of medical certainty, is attributable to in utero exposure to a controlled substance which was not prescribed by a physician for the mother or the child; or (iv) a diagnosis by an attending physician made within seven days of a child's birth that the child has fetal alcohol syndrome attributable to in utero exposure to alcohol. When "reason to suspect" is based upon this subsection, such fact shall be included in the report along with the facts relied upon by the person making the report.

C. Any person who makes a report or provides records or information pursuant to subsection A or who testifies in any judicial proceeding arising from such report, records, or information shall be immune from any civil or criminal liability or administrative penalty or sanction on account of such report, records, information, or testimony, unless such person acted in bad faith or with malicious purpose.

D. Any person required to file a report pursuant to this section who fails to do so within 72 hours of his first suspicion of child abuse or neglect shall be fined not more than $500 for the first failure and for any subsequent failures not less than $100 nor more than $1,000.

(1975, c. 341, §63.1-248.3; 1976, c. 348; 1978, c. 747; 1993, c. 443; 1994, c. 840; 1995, c. 810; 1998, cc. 704, 716; 1999, c. 606; 2000, c. 500; 2001, c. 853; 2002, cc. 747, 860; 2006, cc. 530, 801; 2008, cc. 43, 268.)

§63.2-100. Definitions.

As used in this title, unless the context requires a different meaning:

“Abused or neglected child” means any child less than 18 years of age:

1. Whose parents or other person responsible for his care creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon such child a physical or mental injury by other than accidental means, or creates a substantial risk of death, disfigurement, or impairment of bodily or mental functions, including but not limited to, a child who is with his parent or other person responsible for his care either (i) during the manufacture or attempted manufacture of a Schedule I or II controlled substance, or (ii) during the unlawful sale of such substance by that child’s parents or other person responsible for his care, where such manufacture, or attempted manufacture or unlawful sale would constitute a felony violation of §18.2-248;

2. Whose parents or other person responsible for his care neglects or refuses to provide care necessary for his health. However, no child who in good faith is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination shall for that reason alone be considered to be an abused or neglected child. Further, a decision by parents who have legal authority for the child or, in the absence of parents with legal authority for the child, any person with legal authority for the child, who refuses a particular medical treatment for a child with a life-threatening condition shall not be deemed a refusal to provide necessary care if (i) such decision is made jointly by the parents or other person with legal authority and the child; (ii) the child has reached 14 years of age and is sufficiently mature to have an informed opinion on the subject of his medical treatment; (iii) the parents or other person with legal authority and the child have considered alternative treatment options; and (iv) the parents or other person with legal authority and the child believe in good faith that such decision is in the child’s best interest. Nothing in this subdivision shall be construed to limit the provisions of §16.1-278.4;

3. Whose parents or other person responsible for his care abandons such child;

4. Whose parents or other person responsible for his care commits or allows to be committed any act of sexual exploitation or any sexual act upon a child in violation of the law;

5. Who is without parental care or guardianship caused by the unreasonable absence or the mental or physical incapacity of the child's parent, guardian, legal custodian or other person standing in loco parentis; or

6. Whose parents or other person responsible for his care creates a substantial risk of physical or mental injury by knowingly leaving the child alone in the same dwelling, including an apartment as defined in §55-79.2, with a person to whom the child is not related by blood or marriage and who the parent or other person responsible for his care knows has been convicted of an offense against a minor for which registration is required as a violent sexual offender pursuant to §9.1-902.

If a civil proceeding under this title is based solely on the parent having left the child at a hospital or rescue squad, it shall be an affirmative defense that such parent safely delivered the child to a hospital that provides 24-hour emergency services or to an attended rescue squad that employs emergency medical technicians, within 14 days of the child's birth. For purposes of terminating parental rights pursuant to §16.1-283 and placement for adoption, the court may find such a child is a neglected child upon the ground of abandonment.

"Adoptive home" means any family home selected and approved by a parent, local board or a licensed child-placing agency for the placement of a child with the intent of adoption.

"Adoptive placement" means arranging for the care of a child who is in the custody of a child-placing agency in an approved home for the purpose of adoption.

"Adult abuse" means the willful infliction of physical pain, injury or mental anguish or unreasonable confinement of an adult.

"Adult day care center" means any facility that is either operated for profit or that desires licensure and that provides supplementary care and protection during only a part of the day to four or more aged, infirm or disabled adults who reside elsewhere, except (i) a facility or portion of a facility licensed by the State Board of Health or the Department of Behavioral Health and Developmental Services, and (ii) the home or residence of an individual who cares for only persons related to him by blood or marriage. Included in this definition are any two or more places, establishments or institutions owned, operated or controlled by a single entity and providing such supplementary care and protection to a combined total of four or more aged, infirm or disabled adults.

"Adult exploitation" means the illegal use of an incapacitated adult or his resources for another's profit or advantage.

"Adult foster care" means room and board, supervision, and special services to an adult who has a physical or mental condition. Adult foster care may be provided by a single provider for up to three adults.

"Adult neglect" means that an adult is living under such circumstances that he is not able to provide for himself or is not being provided services necessary to maintain his physical and mental health and that the failure to receive such necessary services impairs or threatens to impair his well-being. However, no adult shall be considered

neglected solely on the basis that such adult is receiving religious nonmedical treatment or religious nonmedical nursing care in lieu of medical care, provided that such treatment or care is performed in good faith and in accordance with the religious practices of the adult and there is a written or oral expression of consent by that adult.

“Adult protective services” means services provided by the local department that are necessary to protect an adult from abuse, neglect or exploitation.

“Assisted living care” means a level of service provided by an assisted living facility for adults who may have physical or mental impairments and require at least a moderate level of assistance with activities of daily living.

“Assisted living facility” means any congregate residential setting that provides or coordinates personal and health care services, 24-hour supervision, and assistance (scheduled and unscheduled) for the maintenance or care of four or more adults who are aged, infirm or disabled and who are cared for in a primarily residential setting, except (i) a facility or portion of a facility licensed by the State Board of Health or the Department of Behavioral Health and Developmental Services, but including any portion of such facility not so licensed; (ii) the home or residence of an individual who cares for or maintains only persons related to him by blood or marriage; (iii) a facility or portion of a facility serving infirm or disabled persons between the ages of 18 and 21, or 22 if enrolled in an educational program for the handicapped pursuant to §22.1-214, when such facility is licensed by the Department as a children’s residential facility under Chapter 17 (§63.2-1700 et seq.) of this title, but including any portion of the facility not so licensed; and (iv) any housing project for persons 62 years of age or older or the disabled that provides no more than basic coordination of care services and is funded by the U.S. Department of Housing and Urban Development, by the U.S. Department of Agriculture, or by the Virginia Housing Development Authority. Included in this definition are any two or more places, establishments or institutions owned or operated by a single entity and providing maintenance or care to a combined total of four or more aged, infirm or disabled adults. Maintenance or care means the protection, general supervision and oversight of the physical and mental well-being of an aged, infirm or disabled individual.

“Auxiliary grants” means cash payments made to certain aged, blind or disabled individuals who receive benefits under Title XVI of the Social Security Act, as amended, or would be eligible to receive these benefits except for excess income.

“Birth family” or “birth sibling” means the child’s biological family or biological sibling.

“Birth parent” means the child’s biological parent and, for purposes of adoptive placement, means parent(s) by previous adoption.

“Board” means the State Board of Social Services.

“Child” means any natural person under 18 years of age.

“Child day center” means a child day program offered to (i) two or more children under the age of 13 in a facility that is not the residence of the provider or of any of the children in care or (ii) 13 or more children at any location.

“Child day program” means a regularly operating service arrangement for children where, during the absence of a parent or guardian, a person or organization has agreed to assume responsibility for the supervision, protection, and well-being of a child under the age of 13 for less than a 24-hour period.

"Child-placing agency" means any person who places children in foster homes, adoptive homes or independent living arrangements pursuant to §63.2-1819 or a local board that places children in foster homes or adoptive homes pursuant to §§63.2-900, 63.2-903, and 63.2-1221. Officers, employees, or agents of the Commonwealth, or any locality acting within the scope of their authority as such, who serve as or maintain a child-placing agency, shall not be required to be licensed.

"Child-protective services" means the identification, receipt and immediate response to complaints and reports of alleged child abuse or neglect for children under 18 years of age. It also includes assessment, and arranging for and providing necessary protective and rehabilitative services for a child and his family when the child has been found to have been abused or neglected or is at risk of being abused or neglected.

"Child support services" means any civil, criminal or administrative action taken by the Division of Child Support Enforcement to locate parents; establish paternity; and establish, modify, enforce, or collect child support, or child and spousal support.

"Child-welfare agency" means a child day center, child-placing agency, children's residential facility, family day home, family day system, or independent foster home.

"Children's residential facility" means any facility, child-caring institution, or group home that is maintained for the purpose of receiving children separated from their parents or guardians for full-time care, maintenance, protection and guidance, or for the purpose of providing independent living services to persons between 18 and 21 years of age who are in the process of transitioning out of foster care. Children's residential facility shall not include:

1. A licensed or accredited educational institution whose pupils, in the ordinary course of events, return annually to the homes of their parents or guardians for not less than two months of summer vacation;

2. An establishment required to be licensed as a summer camp by §35.1-18; and

3. A licensed or accredited hospital legally maintained as such.

"Commissioner" means the Commissioner of the Department, his designee or authorized representative.

"Department" means the State Department of Social Services.

"Department of Health and Human Services" means the Department of Health and Human Services of the United States government or any department or agency thereof that may hereafter be designated as the agency to administer the Social Security Act, as amended.

"Disposable income" means that part of the income due and payable of any individual remaining after the deduction of any amount required by law to be withheld.

"Energy assistance" means benefits to assist low-income households with their home heating and cooling needs, including, but not limited to, purchase of materials or substances used for home heating, repair or replacement of heating equipment, emergency intervention in no-heat situations, purchase or repair of cooling equipment, and payment of electric bills to operate cooling equipment, in accordance with §63.2-805, or provided under the Virginia Energy Assistance Program established pursuant to the Low-Income Home Energy Assistance Act of 1981 (Title XXVI of Public Law 97-35), as amended.

"Family day home" means a child day program offered in the residence of the provider or the home of any of the children in care for one through 12 children under the age of 13, exclusive of the provider's own children and any children who reside in the home, when at least one child receives care for compensation. The provider of a licensed or registered family day home shall disclose to the parents or guardians of children in their care the percentage of time per week that persons other than the provider will care for the children. Family day homes serving six through 12 children, exclusive of the provider's own children and any children who reside in the home, shall be licensed. However, no family day home shall care for more than four children under the age of two, including the provider's own children and any children who reside in the home, unless the family day home is licensed or voluntarily registered. However, a family day home where the children in care are all grandchildren of the provider shall not be required to be licensed.

"Family day system" means any person who approves family day homes as members of its system; who refers children to available family day homes in that system; and who, through contractual arrangement, may provide central administrative functions including, but not limited to, training of operators of member homes; technical assistance and consultation to operators of member homes; inspection, supervision, monitoring, and evaluation of member homes; and referral of children to available health and social services.

"Foster care placement" means placement of a child through (i) an agreement between the parents or guardians and the local board or the public agency designated by the community policy and management team where legal custody remains with the parents or guardians or (ii) an entrustment or commitment of the child to the local board or licensed child-placing agency.

"Foster home" means the place of residence of any natural person in which any child, other than a child by birth or adoption of such person, resides as a member of the household.

"General relief" means money payments and other forms of relief made to those persons mentioned in §63.2-802 in accordance with the regulations of the Board and reimbursable in accordance with §63.2-401.

"Independent foster home" means a private family home in which any child, other than a child by birth or adoption of such person, resides as a member of the household and has been placed therein independently of a child-placing agency except (i) a home in which are received only children related by birth or adoption of the person who maintains such home and children of personal friends of such person and (ii) a home in which is received a child or children committed under the provisions of subdivision A 4 of §16.1-278.2, subdivision 6 of §16.1-278.4, or subdivision A 13 of §16.1-278.8.

"Independent living" means a planned program of services designed to assist a child aged 16 and over and persons who are former foster care children between the ages of 18 and 21 in transitioning from foster care to self sufficiency.

"Independent living arrangement" means placement of a child at least 16 years of age who is in the custody of a local board or licensed child-placing agency and has been placed by the local board or licensed child-placing agency in a living arrangement in which he does not have daily substitute parental supervision.

"Independent living services" means services and activities provided to a child in foster care 14 years of age or older who was committed or entrusted to a local board of social services, child welfare agency, or private child-placing agency. "Independent living services" may also mean services and activities provided to a person who was in foster care on his 18th birthday and has not yet reached the age of 21 years. Such services shall include counseling, education, housing, employment, and money management skills development, access to essential documents, and other appropriate services to help children or persons prepare for self-sufficiency.

"Independent physician" means a physician who is chosen by the resident of the assisted living facility and who has no financial interest in the assisted living facility, directly or indirectly, as an owner, officer, or employee or as an independent contractor with the residence.

"Intercountry placement" means the arrangement for the care of a child in an adoptive home or foster care placement into or out of the Commonwealth by a licensed child-placing agency, court, or other entity authorized to make such placements in accordance with the laws of the foreign country under which it operates.

"Interstate placement" means the arrangement for the care of a child in an adoptive home, foster care placement or in the home of the child's parent or with a relative or nonagency guardian, into or out of the Commonwealth, by a child-placing agency or court when the full legal right of the child's parent or nonagency guardian to plan for the child has been voluntarily terminated or limited or severed by the action of any court.

"Kinship care" means the full-time care, nurturing, and protection of children by relatives.

"Local board" means the local board of social services representing one or more counties or cities.

"Local department" means the local department of social services of any county or city in this Commonwealth.

"Local director" means the director or his designated representative of the local department of the city or county.

"Merit system plan" means those regulations adopted by the Board in the development and operation of a system of personnel administration meeting requirements of the federal Office of Personnel Management.

"Parental placement" means locating or effecting the placement of a child or the placing of a child in a family home by the child's parent or legal guardian for the purpose of foster care or adoption.

"Public assistance" means Temporary Assistance for Needy Families (TANF); auxiliary grants to the aged, blind and disabled; medical assistance; energy assistance; food stamps; employment services; child care; and general relief.

"Qualified assessor" means an entity contracting with the Department of Medical Assistance Services to perform nursing facility pre-admission screening or to complete the uniform assessment instrument for a home and community-based waiver program, including an independent physician contracting with the Department of Medical Assistance Services to complete the uniform assessment instrument for residents of assisted living facilities, or any hospital that has contracted with the

Department of Medical Assistance Services to perform nursing facility pre-admission screenings.

“Registered family day home” means any family day home that has met the standards for voluntary registration for such homes pursuant to regulations adopted by the Board and that has obtained a certificate of registration from the Commissioner.

“Residential living care” means a level of service provided by an assisted living facility for adults who may have physical or mental impairments and require only minimal assistance with the activities of daily living. The definition of “residential living care” includes the services provided by independent living facilities that voluntarily become licensed.

“Social services” means foster care, adoption, adoption assistance, adult services, adult protective services, child-protective services, domestic violence services, or any other services program implemented in accordance with regulations adopted by the Board.

“Special order” means an order imposing an administrative sanction issued to any party licensed pursuant to this title by the Commissioner that has a stated duration of not more than 12 months. A special order shall be considered a case decision as defined in §2.2-4001.

“Temporary Assistance for Needy Families” or “TANF” means the program administered by the Department through which a relative can receive monthly cash assistance for the support of his eligible children.

“Temporary Assistance for Needy Families-Unemployed Parent” or “TANF-UP” means the Temporary Assistance for Needy Families program for families in which both natural or adoptive parents of a child reside in the home and neither parent is exempt from the Virginia Initiative for Employment Not Welfare (VIEW) participation under §63.2-609.

“Title IV-E Foster Care” means a federal program authorized under §§472 and 473 of the Social Security Act, as amended, and administered by the Department through which foster care is provided on behalf of qualifying children.

(Code 1950, §§63-101, 63-222, 63-232, 63-347, 63-351; 1954, cc. 259, 290, 489; 1956, cc. 300, 641; 1960, cc. 331, 390; 1962, cc. 297, 603; 1966, c. 423; 1968, cc. 578, 585, §§63.1-87, 63.1-172, 63.1-195, 63.1-220; 1970, c. 721; 1972, cc. 73, 540, 718; 1973, c. 227; 1974, cc. 44, 45, 413, 415, §63.1-250; 1975, cc. 287, 299, 311, 341, 437, 507, 524, 528, 596, §§63.1-238.1, 63.1-248.2; 1976, cc. 357, 649; 1977, cc. 105, 241, 532, 547, 559, 567, 634, 645, §§63.1-55.2, 63.1-55.8; 1978, cc. 536, 730, 749, 750; 1979, c. 483; 1980, cc. 40, 284; 1981, cc. 75, 123, 359; 1983, c. 66; 1984, cc. 74, 76, 498, 535, 781; 1985, cc. 17, 285, 384, 488, 518; 1986, cc. 80, 281, 308, 437, 594; 1987, cc. 627, 650, 681; 1988, c. 906; 1989, cc. 307, 647; 1990, c. 760; 1991, cc. 534, 595, 651, 694; 1992 c. 356, §63.1-194.1; 1993, cc. 730, 742, 957, 993, §63.1-196.001; 1994, cc. 107, 837, 865, 940; 1995, cc. 401, 520, 649, 772, 826; 1997, cc. 796, 895; 1998, cc. 115, 126, 397, 552, 727, 850; 1999, c. 454; 2000, cc. 61, 290, 500, 830, 845, 1058, §63.1-219.7; 2002, c. 747; 2003, c. 467; 2004, cc. 70, 196, 245, 753, 814; 2006, c. 868; 2007, cc. 479, 597; 2008, cc. 475, 483; 2009, cc. 705, 813, 840.)

§54.1-2967. Physicians and others rendering medical aid to report certain wounds.

Any physician or other person who renders any medical aid or treatment to any person for any wound which such physician or other person knows or has reason to believe is a wound inflicted by a weapon specified in §18.2-308* and which wound such physician or other person believes or has reason to believe was not self-inflicted shall as soon as practicable report such fact, including the wounded person's name and address, if known, to the sheriff or chief of police of the county or city in which treatment is rendered. If such medical aid or treatment is rendered in a hospital or similar institution, such physician or other person rendering such medical aid or treatment shall immediately notify the person in charge of such hospital or similar institution, who shall make such report forthwith.

Any physician or other person failing to comply with this section shall be guilty of a Class 3 misdemeanor. Any person participating in the making of a report pursuant to this section or participating in a judicial proceeding resulting therefrom shall be immune from any civil liability in connection therewith, unless it is proved that such person acted in bad faith or with malicious intent.

***The relevant section of §18.2-308 lists the following types of weapons:**

(i) any pistol, revolver, or other weapon designed or intended to propel a missile of any kind by action of an explosion of any combustible material; (ii) any dirk, bowie knife, switchblade knife, ballistic knife, machete, razor, slingshot, spring stick, metal knucks, or blackjack; (iii) any flailing instrument consisting of two or more rigid parts connected in such a manner as to allow them to swing freely, which may be known as a nun chahka, nun chuck, nunchaku, shuriken, or fighting chain; (iv) any disc, of whatever configuration, having at least two points or pointed blades which is designed to be thrown or propelled and which may be known as a throwing star or oriental dart; or (v) any weapon of like kind as those enumerated in this subsection.

(1970, c. 531, §54-276.10; 1972, c. 194; 1975, c. 508; 1976, c. 331; 1979, c. 715; 1988, c. 765.)

§63.2-1606. Protection of aged or incapacitated adults; mandated and voluntary reporting.

A. Matters giving reason to suspect the abuse, neglect or exploitation of adults shall be reported immediately upon the reporting person's determination that there is such reason to suspect. Medical facilities inspectors of the Department of Health are exempt from reporting suspected abuse immediately while conducting federal inspection surveys in accordance with §1864 of Title XVIII and Title XIX of the Social Security Act, as amended, of certified nursing facilities as defined in §32.1-123. Reports shall be made to the local department or the adult protective services hotline in accordance with requirements of this section by the following persons acting in their professional capacity:

1. Any person licensed, certified, or registered by health regulatory boards listed in §54.1-2503, with the exception of persons licensed by the Board of Veterinary Medicine;

2. Any mental health services provider as defined in §54.1-2400.1;

3. Any emergency medical services personnel certified by the Board of Health pursuant to §32.1-111.5, unless such personnel immediately reports the suspected abuse, neglect or exploitation directly to the attending physician

at the hospital to which the adult is transported, who shall make such report forthwith;

4. Any guardian or conservator of an adult;

5. Any person employed by or contracted with a public or private agency or facility and working with adults in an administrative, supportive or direct care capacity;

6. Any person providing full, intermittent or occasional care to an adult for compensation, including but not limited to, companion, chore, homemaker, and personal care workers; and

7. Any law-enforcement officer.

B. The report shall be made in accordance with subsection A to the local department of the county or city wherein the adult resides or wherein the adult abuse, neglect or exploitation is believed to have occurred or to the adult protective services hotline. Nothing in this section shall be construed to eliminate or supersede any other obligation to report as required by law. If a person required to report under this section receives information regarding abuse, neglect or exploitation while providing professional services in a hospital, nursing facility or similar institution, then he may, in lieu of reporting, notify the person in charge of the institution or his designee, who shall report such information, in accordance with the institution's policies and procedures for reporting such matters, immediately upon his determination that there is reason to suspect abuse, neglect or exploitation. Any person required to make the report or notification required by this subsection shall do so either orally or in writing and shall disclose all information that is the basis for the suspicion of adult abuse, neglect or exploitation. Upon request, any person required to make the report shall make available to the adult protective services worker and the local department investigating the reported case of adult abuse, neglect or exploitation any information, records or reports which document the basis for the report. All persons required to report suspected adult abuse, neglect or exploitation shall cooperate with the investigating adult protective services worker of a local department and shall make information, records and reports which are relevant to the investigation available to such worker to the extent permitted by state and federal law. Criminal investigative reports received from law-enforcement agencies shall not be further disseminated by the investigating agency nor shall they be subject to public disclosure; such reports may, however, be disclosed to the Adult Fatality Review Team as provided in §32.1-283.5 and, if reviewed by the Team, shall be subject to all of the Team's confidentiality requirements.

C. Any financial institution staff who suspects that an adult has been exploited financially may report such suspected exploitation to the local department of the county or city wherein the adult resides or wherein the exploitation is believed to have occurred or to the adult protective services hotline. For purposes of this section, financial institution staff means any employee of a bank, savings institution, credit union, securities firm, accounting firm, or insurance company.

D. Any person other than those specified in subsection A who suspects that an adult is an abused, neglected or exploited adult may report the matter to the local department of the county or city wherein the adult resides or wherein the abuse, neglect or exploitation is believed to have occurred or to the adult protective services hotline.

E. Any person who makes a report or provides records or information pursuant to subsection A, C or D, or who testifies in any judicial proceeding arising from such report, records or information, or who takes or causes to be taken with the adult's or the adult's legal representative's informed consent photographs, video recordings, or appropriate medical imaging of the adult who is subject of a report shall be immune from any civil or criminal liability on account of such report, records, information, photographs, video recordings, appropriate medical imaging or testimony, unless such person acted in bad faith or with a malicious purpose.

F. An employer of a mandated reporter shall not prohibit a mandated reporter from reporting directly to the local department or to the adult protective services hotline. Employers whose employees are mandated reporters shall notify employees upon hiring of the requirement to report.

G. Any person 14 years of age or older who makes or causes to be made a report of adult abuse, neglect, or exploitation that he knows to be false shall be guilty of a Class 4 misdemeanor. Any subsequent conviction of this provision shall be a Class 2 misdemeanor.

H. Any person who fails to make a required report or notification pursuant to subsection A shall be subject to a civil penalty of not more than $500 for the first failure and not less than $100 nor more than $1,000 for any subsequent failures. Civil penalties under subdivision A 7 shall be determined by a court of competent jurisdiction, in its discretion. All other civil penalties under this section shall be determined by the Commissioner or his designee. The Board shall establish by regulation a process for imposing and collecting civil penalties, and a process for appeal of the imposition of such penalty pursuant to §2.2-4026 of the Administrative Process Act.

I. Any mandated reporter who has reasonable cause to suspect that an adult died as a result of abuse or neglect shall immediately report such suspicion to the appropriate medical examiner and to the appropriate law-enforcement agency, notwithstanding the existence of a death certificate signed by a licensed physician. The medical examiner and the law-enforcement agency shall receive the report and determine if an investigation is warranted. The medical examiner may order an autopsy. If an autopsy is conducted, the medical examiner shall report the findings to law enforcement, as appropriate, and to the local department or to the adult protective services hotline.

J. No person or entity shall be obligated to report any matter if the person or entity has actual knowledge that the same matter has already been reported to the local department or to the adult protective services hotline.

K. All law-enforcement departments and other state and local departments, agencies, authorities and institutions shall cooperate with each adult protective services worker of a local department in the detection, investigation and prevention of adult abuse, neglect and exploitation.

(1977, c. 547, §63.1-55.3; 1984, c. 628; 1986, cc. 448, 487; 1990, c. 308; 1991, c. 33; 1994, c. 891; 1997, c. 687; 1999, c. 749; 2001, c. 191; 2002, c. 747; 2004, cc. 749, 1011; 2008, c. 539; 2009, c. 538.)

Appendix C: Cultural Competency

To be effective, a SART must be culturally competent. Cultural competence is defined as a set of congruent attitudes, actions, behaviors, and policies that come together among professionals at all levels within an organization. The congruence enables the system, agency, team, and/or individual to work effectively in cross-cultural situations. Becoming culturally competent is a developmental process.[16] Cultural competence should be viewed as a goal toward which agencies and individuals can strive.

The concept of cultural competence is more than having a brochure translated into another language(s), having a Spanish speaking person on staff, or memorizing how different cultures view sexual assault.

Cultural competence also must include areas of sexual and gender diversity so that providers can adequately understand and meet the needs of lesbian, gay, bisexual and transgender (LGBT) survivors of sexual assault. This requires more than having a gay or lesbian employee on staff or revising a brochure to contain gender-neutral terminology.

These are, of course, valuable steps, but do not represent the broad concept. Agencies must become culturally competent at all levels of their system to truly move towards providing culturally competent services[17]. Taking a piecemeal approach to providing culturally competent interventions is not considered acceptable.

Cultural competence must be recognized as an intrinsic part of the overall quality of intervention.

Agencies must become culturally competent at the administrative, policy, and direct services levels.

- Administrators must understand the critical need to provide culturally competent intervention for individuals and families who come to their attention.
- Supervisors must know how to provide culturally appropriate supervision to their staff, including how and when to seek cultural consultation.
- Direct service providers should be culturally competent in their assessment, interventions, and services. This includes understanding the meaning of sexual assault in various cultures. True understanding exists on two levels: the manifest content (what is known or shared) and the latent content (the meaning and significance attached to the event).

Part of cultural competency is to understand the meaning for the individual and the meaning for the individual in the context of family (immediate and extended) and community. With regard to the process of intervention, showing kindness and respect is effective with any culture. Victims may be fearful to report the sexual

[16] "Cultural Competency," R. Guerrero. Chapter 12, California Handbook for the Identification and Management of Child Abuse. In press. Published by the State Department of Maternal and Child Health.

[17] Cross, T., Bazron B., Dennis K., Isaacs M., Towards a Culturally Competent System of Care Volume 1, Washington, D.C.: Georgetown University Child Development Center, CASSP T.A. Center, 1989.

assault due to a history of distrust of law enforcement officers in their own cultures, a fear of being deported if they report to law enforcement officers in this country, a fear of discrimination based on sexual orientation, a fear of retribution from their own community if the perpetrator is a member of that community, etc. Optimally, services should be provided in the preferred language of the individual, or at least with a qualified interpreter. Agencies should seek to hire bilingual, bicultural employees. It is important to note, however, that the sexual assault crisis center advocate should not be used as the interpreter during the investigation. Doing so creates role confusion, jeopardizes client confidentiality, and places the advocate into the role of investigator or forensic/sexual assault nurse examiner. The survivor deserves a person with the single mission of providing support, advocacy, information, and explanation of various procedures. Although resources for interpreters are often lacking for many agencies, translation services must be provided to comply with federal regulations (Title VI). At the very least, AT&T language lines can be used.

Services should also be accessible to LGBT survivors. Sexual assault crisis centers need to evaluate and maximize their ability to provide services to LGBT survivors. Such services as outreach, counseling, court advocacy, and shelter must be tailored to meet the needs of all survivors. Sexual assault crisis centers must reach out to the LGBT community agencies in their areas to work together to achieve this goal.

The list of tasks below provides steps to help move theory into practice. An agency's cultural competency plans must be individualized to the agency. Each agency starts at a different continuum point, has unique internal challenges and different levels of success. Additionally, communities vary, requiring different strategies.

In general, the best approach to achieving cultural competency involves the following steps:

- Establish a clear, committed vision for cultural competency. Cultural competency must be integrated into all aspects of the agency, not isolated as a separate component. Cultural competency should not become the responsibility of one person in the organization who speaks another language. Agencies should encourage internal dialogue and training on multicultural issues.
- Identify cultural consultants within and outside the organization. Utilize internal and external consultants to develop a plan for the agency and establish a multicultural advisory committee. Seek diversity in the committee representation, utilizing individuals who have knowledge and experience with various ethnic or cultural groups.
- Obtain organizational leadership commitment for cultural competence. Develop an overall organizational plan to move the agency toward becoming more culturally competent.
- Conduct a cultural competency assessment of the organization and the community. Assessment of the cultural and linguistic competency of the staff should be included. Work with an advisory committee and, if necessary, hire a consultant to assist in the development of the assessment. Examine what has already been done in the agency. Be aware of current resources in the field.
- Develop specific short and long-term goals and objectives the agency can accomplish. Be realistic. Incorporate cultural competency planning into existing strategic planning efforts.

- Take advantage of planned system change. Strengthen cultural competency by including it in any and all system-change strategic planning.
- Move the agency toward providing culturally competent services. Every agency training should include cultural competency as an intrinsic component. Agencies should provide cultural-specific training that is pertinent to the community they are responsible for serving.
- Work with cultural consultants and community ethnic/cultural organizations in expanding the agency's cultural knowledge. Do not rely on a single consultant; hire a variety of cultural consultants.
- To avoid misunderstandings, make every effort to serve individuals in their preferred, primary language.
- Establish a plan to evaluate efforts and to monitor changes.

Each step listed on the above requires multiple tasks to operationalize. Cultural competency should be viewed as an overall quality of intervention issue, not as a component that stands independent of other efforts.

This section is a summary of documents and represents the leadership of Terry Cross, Rachel Guerrero, M.S.W., Jerry Tello, M.S.W., and many others on this important subject.[18]

[18] "Cultural Competency," R. Guerrero. Chapter 12, California Handbook for the Identification and Management of Child Abuse. In press. Published by the State Department of Maternal and Child Health. Toward A Culturally Competent System of Care: Volume I, II, III. The National Technical Assistance Center for Children's Mental Health, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center. Funded by Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. For copies, call (202) 687-8803 and Cross, T., Bazron B., Dennis K., Isaacs M., Towards a Culturally Competent System of Care Volume 1, Washington, D.C.: Georgetown University Child Development Center, CASSP T.A. Center, 1989.

Appendix D: Considerations for Special Populations

Each survivor of sexual violence should be treated as an individual. Each person will react to the assault in her own way. When attempting to address the individual needs of a survivor, SARTs may need to consider how being a member of a marginalized, underserved and/or oppressed population can affect a survivor's reaction to the assault and participation in the criminal justice process.

Survivors who are College Students

College students who have been sexually assaulted are less likely than non-students to report to the police.[19] This may be the first time students have experienced violence and they are unsure what to do; they do not understand the criminal justice system or their options. Often their assailants are also college students and they may fear retribution, being ostracized by other students or getting a reputation for "being easy." This could be their first sexual experience and they are ashamed, unsure if it was sexual violence, and fearful. Even in cases where the victim reports, colleges often attempt to handle cases internally, are reluctant to acknowledge that a crime has occurred, and will neglect to take disciplinary action due to concerns regarding the school reputation and enrollment rates. On-campus judiciary responses to assaults usually do not include the criminal justice system and therefore the SART may get resistance from the campus. SART members responding to reports of sexual assaults from college students need to include local colleges in their coordinated community response to facilitate an improved response to these survivors. A number of Virginia's four-year colleges have sexual assault victim services on campus, which should be associated with the local sexual assault crisis center. SART members may need to address jurisdiction issues between local community law enforcement and campus law enforcement agencies.

College students have the unique experience of having their assailants on the same campus, even in their classes or in their dorms. Therefore SARTs may need to provide additional protections and/or work with the college to change a student's classes or living situation. Students who do not live on campus, or who attend community colleges, may not need their living situation changed, but may feel less safe walking to the parking deck, walking home or attending campus functions. Even though college students are usually over the age of 18, students may want to involve their parents. Or, the parents may want to be involved despite the student's desire for them not to be involved. SART members need to protect the privacy of the student while respecting the parents' desire to be involved.

[19] Bureau of Justice Statistics (December 2003). Violent Victimization of College Students: A Bureau of Justice Statistics Special Report from the National Crime Victimization Survey, 1995-2000. Available from www.gmu.edu/facstaff/sexual.

D

Survivors who are Older

Survivors who are older, or "elderly," may be even more reluctant than younger survivors of sexual assault to seek services or report the crime. Persons who grew up in a time when people never discussed sex often will not want to discuss the intimate details of a sexual assault, especially with persons of the opposite sex. They may have experienced sexual acts that they did not know existed or they thought were depraved. Persons who are older may have fewer support systems. They may be unaware of how sexual violence is defined now as compared to when they were younger. They are also at greater risk for more significant health concerns from injuries or from the psychological aftermath of assaults. Older survivors who have lived independently in their own homes or apartments before the sexual assault may no longer be able to do so afterwards due to fear for their safety or health problems. They may be living in an assisted living facility and were victimized by a staff person or another resident and harbor very real fears about the impact reporting will have on their living situations. When an assault takes place in a facility or institution, the SART will often be faced with a lack of cooperation from the facility since they do not want to admit such violence could occur in their facility. The Virginia Office for Protection and Advocacy (VOPA) may need to be involved if the assault occurs in a facility. VOPA can provide assistance during various aspects of the sexual assault case, such as pressing charges, prosecution, and civil response (See Appendix H).

Society, and even professionals, may have difficulty believing that someone would sexually assault an older person. The survivor's family may want to be involved in the case. SART members need to respect the wishes of the survivor to determine how informed and involved the family should be. SART members need to be aware of Adult Protective Services (APS) reporting requirements, services and definitions of who is covered under APS. When responding to an assault of a person who meets the definition of a vulnerable adult, it can be useful to include an APS representative on the SART. APS workers can assist SART members in meeting the needs of a survivor who is older (See Appendix H). SART members, however, should not assume that survivors who are older meet their stereotypes of "elderly" persons.

Survivors who are Persons of Color

According to the U.S. Census, Virginia is a diverse state, with a population of 7,078,515 which is 72.3% Caucasian, 19.6% Black, 4.7% Hispanic, 3.7% Asian, 2% reporting two or more races, 0.3% Native American, and 2% other.[20] Communities of color face unique difficulties when dealing with the effects of sexual violence. These challenges are a result of long histories and present realities of individual and institutional oppression and discrimination. Access to resources, fear of law enforcement officers, and victim/survivor believability are just a few examples of the challenges which survivors who are persons of color face. Sexual assault of persons of color is often ignored or given less attention than sexual violence of Caucasian victims. Historically, rape of women of color was not seen as rape, rather a use of property which was a natural consequence of women of color's "lascivious" nature.[21] While Caucasian males raped women of color with impunity, allegations made by Caucasian women that they had been raped by a man of color were vigorously investigated and prosecuted with racist outcomes. Racial profiling remains a reality in our society. Acts of violence are sometimes motivated by racism or religious bias. These hate crimes can include sexual assault. Virginia has specific laws against hate

[20] U.S. Census Bureau. (2001). *Census 2000*. Washington DC: Author. Available at http://factfinder.census.gov/home.

[21] Caulderon, Lisa M. (1998). *Rape, Race and Victim Advocacy*. The Black Commentator, Issue 98.

crimes motivated by race or religious bias. However, often the interplay between race and racism are ignored, and a one-size-fits all approach is applied, not only in the criminal justice system, but in victim service organizations and society as a whole. SARTs must examine the complexities of this interplay in order to effectively respond to survivors of color.

Survivors with Disabilities

According to the U.S. Census, 1,155,083 people in Virginia have disabilities.[22] Survivors with disabilities include, but are not limited to, persons with mental illnesses, cognitive disabilities, brain injuries, physical disabilities, blindness or low vision, deafness, and developmental disabilities. Women with disabilities are raped at a rate at least twice that of the general population of women. Men with disabilities are raped at a higher rate than men without disabilities. There are a variety of contributing factors that include:

- having limited physical and cognitive skills;
- being physically unable to resist or fight back;
- being unaware that the assault is inappropriate or illegal;
- having a history of needing assistance with personal care which can eliminate a sense of personal body space;
- having relationships that encourage dependence and isolation which sets up an unequal and potentially abusive relationship;
- having been raised in an isolated environment with limited access to appropriate sexuality education;
- appearing vulnerable to perpetrators of abusive crimes who seek power and control;
- lack of access to victim services and criminal justice systems;
- living in institutional settings (e.g. group homes, adult care facilities) which offer opportunities for interactions which may be abusive; and
- societal values towards people with disabilities which encourage dehumanizing, depersonalizing, and devaluating them.[23]

For the above reasons, survivors with disabilities may find it more difficult to seek help from service providers and/or the criminal justice system. Persons with cognitive and/or mental health disabilities are often not believed if they report an assault – they are seen as "crazy" or "confused." Similar to survivors who are older, society may be less likely to believe that someone would sexually assault a person with a disability. It is important for SART members to take all reports of sexual violence seriously regardless of the person's abilities. Persons who use personal care assistants and/or are repeatedly receiving medical services may have limited boundaries for personal space – they are used to being touched, moved, bathed, fed, dressed and toileted. Therefore, they are at greater risk for being inappropriately touched in a sexual manner and of having difficulty determining when a touch is inappropriate. If the

[22] U.S. Census Bureau. (2001). Census 2000. Washington DC: Author. Available at http://factfinder.census.gov/home.

[23] Virginia Commonwealth University and Virginia Sexual and Domestic Violence Action Alliance (2004). Violence Against Women with Disabilities: The Response of the Criminal Justice Center. Published by the Virginia Commonwealth University Partnership for People with Disabilities. Available from www.vcu.edu/partnership. and Sobey, D.1994. Violence and Abuse in the Lives of People with Disabilities: The End of Silent Acceptance. Baltimore, MD: Paul H. Brooks Publishing Co., Inc.

personal care assistant or caregiver is the assailant, the survivor may fear she will not have someone to take care of her and therefore not want to report the abuse. SARTs will want to have a list of emergency personal care services to contact if a survivor is in need of such services. If the survivor meets the definition of vulnerable adult for APS, the SART should involve an APS representative in the response (see Appendix H).

Some disabilities can make it more difficult for a person to identify the assailant in the "traditional" manner, especially if the assailant is a stranger. For instance, a survivor who is blind cannot describe the assailant visually, but may be able to use sound, scent, taste or touch to assist the SART in identifying the perpetrator. SART members will need to be creative and to recognize alternative methods of identifying the assailant. Persons with cognitive or mental health disabilities may be confused due to their disabilities or medications and have trouble describing the assault or perpetrator. This does not mean they are lying or that an assault did not happen – it is a by-product of the disability or medication. Working with persons who have expertise in cognitive disabilities or mental health issues can be very helpful to SART members responding to such an assault. Persons who are deaf and communicate non-verbally and persons who have disabilities that affect their speech will need to use interpreters, pictures, written communication – whatever works to facilitate communication with the SART members. SARTs need to have a list of qualified sign language interpreters that they can contact in emergencies. Some persons who are deaf do not use sign language – they may rely on lip-reading, writing, assistive listening devices (e.g. specialized microphone and ear piece, loop system, etc.), or Communication Real-Time Translation (CART – similar equipment as that used by court reporters). SART members should not assume that persons who are deaf use sign language, and instead should determine the most effective way to communicate with the survivor. In almost all cases, lip-reading is not an effective mode of communication – the average lip-reader understands about one-third of what is being communicated. The local community needs to have a clear mechanism and budget for paying for interpreter and CART services or assistive listening devices. For survivors who use sign language as their primary mode of communication, English is almost always a second language; therefore, written documents will also need to be interpreted or provided in simplified English. Under no circumstances should a family member, child or friend of the survivor be used as an interpreter, unless it is simply to establish initial communication needs (once the SART has determined that the "interpreter" is not the assailant).

Persons with physical disabilities can require other special considerations. Depending on the disability and the adaptive equipment used by the survivor, accessible transportation may be needed. SARTs need to have a list of para-transit (i.e., accessible) services that can be contacted on short notice to transport a survivor to the hospital or to an interview. Once at the hospital, the SART members need to make sure the hospital beds are accessible (some hospital beds are not accessible to persons with certain physical disabilities). If there is a criminal justice system response, SART members need to consider the accessibility of the law enforcement agency, the office of the Commonwealth's Attorney, and the courthouse.

Overall, SART members need to be prepared to respond to an assault of a person with a disability. This includes having training for SART members on disabilities and disability services available in the community. SARTs should maintain a list of emergency interpreters, CART providers, accessible transportation companies, and disability services providers such as community services boards' mental health and mental retardation staff; regional offices of the Virginia Department for the Deaf and Hard of Hearing and the Virginia Department for the Blind and Visually Impaired;

Centers for Independent Living, personal care assistants, and Regional Coordinators for deaf services through the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (See Appendix H). Please also note the special considerations listed in the PERK section of this protocol (See Appendix A, Section A1).

Survivors who Engage in Prostitution

Society often denies that persons who engage in prostitution can be sexually assaulted. Prostitutes who have experienced sexual violence will often be reluctant to come forward for fear of prosecution for prostitution and fear of not being believed simply because they engaged in prostitution. Persons who are prostitutes still have the right to say no and to limit sexual acts to those they are comfortable with. Persons who engage in prostitution have the right to not be sexually violated by their pimps or customers. SART members need to treat these survivors with respect, empathy and understanding. Charging a survivor with solicitation will only dissuade other survivors from coming forward when they are assaulted.

Male Survivors

Regardless of their sexual orientation (e.g., gay, heterosexual, bisexual, transgendered), men can be victims of sexual assault. According to a study conducted by the Virginia Department of Health, one in four women and one in eight men in Virginia have been victims of sexual assault.[24] Male survivors are reluctant to disclose sexual assault for several reasons:

- societal beliefs that men should be able to defend themselves, especially against sexual violence;
- fear that their "manhood" has been lost or that their sexual orientation may become suspect or changed as a result of the assault;
- men are taught to be in control of their feelings and so they may fear that disclosure will release overwhelming emotions;
- confusion because they had a physical response (such as an erection or ejaculation) during the assault even though consent was not given;
- fear that no one will understand;
- confusion about one's sexuality if the assailant was a man and the survivor is heterosexual or the assailant was a woman and the survivor is gay;
- fear of being "outed" if the assault was by a male date, partner or acquaintance or occurred in gay bar or similar location;
- misconception that sexual assault crisis centers do not provide services to male survivors; and
- fear that seeking help or receiving assistance will make them feel weak or vulnerable.

Male survivors are more likely to show a "controlled" style of reaction after a sexual assault. This is likely to mask significant psychological trauma. This traumatic experience may produce acute and/or longer-term stress disorder symptoms. SART members need to be sensitive to all of the above listed reasons for men not wanting to report, and provide additional victim services that can support survivors in overcoming these issues. Male survivors need to be taken seriously when they

[24] Center for Injury and Violence Prevention (2003). Prevalence of Sexual Assault in Virginia. Published by the Virginia Department of Health. Available at www.vdh.virginia.gov.

make a report and be treated with respect. Men do not have regular gynecological exams like women do, and therefore they may be even more uncomfortable during a PERK examination and evidence collection, regardless of the gender of the attending medical provider. SART members need to recognize that this may be why a man does not want an exam and work with him to make him feel as comfortable as possible. Sexual assault crisis centers may want to have male volunteers on call in case a male survivor requests a male victim advocate to be present during the PERK examination and interviews.

Lesbian, Gay, and Bisexual Survivors

According to the U.S. Census, 13,802 households in Virginia self-identified as same-sex unmarried partners (7,053 male householders and male partners and 6,749 female householders and female partners).[25] The U.S. Census data has serious limitations, namely, that it requires householders to self-identify or "come-out," it does not count gay or lesbian persons not living with their partners or not currently in relationships, and it does not identify bisexual or transgender people.

Persons who are lesbian, gay or bisexual can be assaulted by a same-sex assailant or an assailant of the opposite sex. Regardless of the assailant, defense attorneys will use the survivor's sexual orientation in court, thereby "outing" the victim. Lesbian, gay and bisexual survivors have the same fears as heterosexual victims of sexual assault (e.g., that of not being believed), but they may also fear that they will be discriminated against and that law enforcement officers, health care professionals, and/or victim advocates will not be able, or know how, to provide services to them. It is important for SART members to be sensitive to the possibility that the survivor may never have had sexual contact with a person of the opposite sex, which may compound the trauma and the survivor's discomfort with describing the details of the assault. Survivors may fear "outing" "one of their own" or retribution for reporting a member of the community. Sometimes persons who are gay, lesbian or bisexual are assaulted because of their sexuality by a person of the opposite sex. Targeting of this minority population can exacerbate fears of future attacks.

To provide the most sensitive response possible, SART members are encouraged to:

- Not assume the assailant is of the opposite gender and use gender neutral language until the perpetrator's gender is clear;
- Be aware of local gay, lesbian and bisexual resources which could include PFLAG (Parents and Friends of Lesbians and Gays), religious groups (e.g., Metropolitan Community Churches), and Equality Virginia. However, these groups may not have expertise in responding to sexual violence. Coupling their services with sexual assault crisis center advocacy services that may have little experience with gay, lesbian and bisexual issues but do have expertise in responding to sexual violence can be more effective and sensitive;
- Recognize the homophobia gay, lesbian and bisexual survivors have experienced (i.e., themselves or second-hand) from the medical, victims services and/or criminal justice systems in the past;
- Respect that survivors may not be "out" to their families, friends or workplace, and therefore are unwilling to be "outed" in such a public venue as the criminal justice system. SART members need to be sensitive to these concerns and offer as much confidentiality as allowed by law.

[25] Bradford, J., Barrett, K. and Honnold, J.A. (2002). *The U.S. Census and Same-Sex Households: A User's Guide*. New York: The National Gay and Lesbian Task Force Policy Institute, the Survey and Evaluation Laboratory, and the Fenway Institute, www.ngltf.org.

- Be aware of heterosexism within themselves and the victims services, medical and criminal justice systems;
- Familiarize themselves with terminology that may be used within the lesbian, gay and bisexual communities;
- Acknowledge that members of the gay, lesbian and bisexual communities have been discriminated against their entire lives and they do not need to be revictimized again through an insensitive response by the criminal justice, medical and/or victims services systems.[26]

Survivors who are Transgender

Transgender is an umbrella term used for individuals whose gender identity, expression, or behavior is different from those typically associated with their assigned sex at birth. This can include persons who have undergone sexual reassignment surgery or hormones to change their gender; persons who "cross-dress," that is, dress in the clothing of the opposite gender; and persons who have not had surgery or hormones but live their lives as the opposite gender from that which they were assigned at birth. Some persons in the transgender community do not identify as male or female, not wanting to limit themselves to gender identities/roles. Traditional cultural discomfort with individuals who are transgender creates additional barriers for transgender survivors of sexual violence who are seeking to receive appropriate, sensitive services. Since the PERK examination will require survivors to "out" themselves as transgender, they may be unwilling to undergo an examination. They may have experienced discrimination and phobic behaviors from health care providers, family, the workplace, etc. and will assume they will have the same experience if they work with the SART.

SART members should keep in mind the following when working with survivors who are transgender:

- Use the gender pronoun that is preferred by the survivor, which may or may not coincide with the assigned biological sex of the individual;
- Avoid making assumptions about a victim's sexual orientation, relationships or parental status based on a particular gender identity or expression; and
- Be aware of uncomfortable feelings that individuals who are transgender may have about their bodies or life histories and the particularly difficult experiences they may have had in the healthcare environment or criminal justice system.[27]

Survivors in Rural Communities

A major obstacle for survivors in rural communities is the difficulty rural communities have simply developing a SART. Lack of resources represents a significant barrier in rural communities' development of SARTs. Rural communities may not be able to develop a SART as indicated in this model protocol. In reviewing the protocol, rural localities may decide against developing a SART, since they are unable to develop one as indicated in this model. However, rural communities are

[26] Adapted from the Virginia Sexual and Domestic Violence Action Alliance (2005). Intimate Partner Violence and Sexual Assault in the LGBTQ Communities Curriculum. Published by Virginia Sexual and Domestic Violence Action Alliance Lesbian, Gay, Bisexual, Transgendered and Questioning Task Force. Available from www.vsdvalliance.org and Lowers, J. Rape: When the Assailant is one of Our Own. Deneuve. September/October, 1995.

[27] FORGE: For Ourselves Reworking Gender Expression. (2004). Implications Report. Published by FORGE. Available from www.forge-forward.org/transviolence.

strongly encouraged to use this model as a guide and adapt the protocol to their own communities with the resources at hand. For example, if a forensic or sexual assault nurse examiner program is not available, one local hospital can be designated to serve the region's sexual assault victims and resources can be targeted to train that particular hospital's emergency medical personnel in conducting PERK examinations. Grants can be sought to fund training for nurses in sexual assault examinations. Priority is generally given to rural localities in providing funding for various sexual assault services. Localities are strongly encouraged to contact DCJS and the Virginia Sexual and Domestic Violence Action Alliance for technical assistance in adapting this protocol to their communities (See Appendix H).

For survivors in rural communities that do have SARTs, there is significant concern for lack of privacy when reporting an assault in a small community. In rural communities often everyone knows everyone else. For example, a survivor may be reporting an assault by someone who is friends with people she knows. She may be interviewed by a deputy she went to school with, examined by a nurse whose mother was her grade school teacher, and supported by a sexual assault victim advocate who lives next door to her cousin. Survivors in close-knit communities can be very reluctant to come forward to report an assault because they fear they will not be believed, will not be able to keep the assault private, will have to share intimate aspects of the assault with professionals they have known all their lives and will experience a backlash from the community for reporting "one of their own." Survivors may lose some of their support systems if their assailants are well known and well-liked in the community or even within their family. It can be very difficult for even the most experienced SART members to remain unbiased when the survivor or alleged perpetrator is someone they know well. SARTs may want to have "back-up" team members who can serve when the survivor or perpetrator has a close association with a SART member. Survivors who are new to the community may be treated as outsiders and not be believed because they are new to the area. Either way, in a small community, survivors are more likely to run into their assailants, and therefore may need extra safety planning and protections to help them feel secure.

In rural communities survivors may have to travel longer distances to receive services or medical treatment. This may mean a loss of evidence – survivors may need to use the rest room before reaching the hospital. SART members can encourage survivors to try to wait to relieve themselves, but while evidence collection is very important, not allowing survivors to use the restroom if it is really necessary can further traumatize them and make them less likely to cooperate later in the process. A longer distance also means a longer period of time that survivors have to wait before they can bathe, brush their teeth or change their clothes. Being able to bathe and try to cleanse or "wash away" the feelings from the assault is often very important to survivors. SART members can be helpful by ensuring immediate service upon reaching the medical facility. The medical facility can also have a private showering area survivors can use and spare clothing they can change into so they do not need to wait to get home before bathing.

Survivors who have to travel to a large and/or unfamiliar city or community to receive victim services, get medical attention and/or participate in the criminal justice process may be fearful of doing so. If it is at all possible, the SART members should be from the rural community or at least be willing to travel to the survivor's community to do interviews and provide services so the survivor is in a familiar environment and more comfortable. However, some survivors may prefer to go to a larger or unfamiliar

community for services so they are not coming into contact with people they know. When flexibility is possible, SART members need to take cues from survivors to determine what their preferences are.

Survivors who are Non-English Speaking

Foreign-born persons represent 8.1% of Virginia's total population; 11.1% of Virginia's residents speak a language other than English at home. While these survivors may have some English skills, the SART response will be much more effective if it can be done in the survivor's native language. This means having a list of qualified interpreters that are available throughout the process. SART members can research their community to determine what languages are most frequently used, and identify resources before they are needed. SARTs need to consider both verbal and written communication with survivors who are not fluent in English. SART members should try to have commonly used written documents translated into other languages. They can research other localities and states for translated resources that can be adapted for their community or Virginia. However, SART members need to keep in mind that some non-English speakers may speak another language but not be able to read it, especially if they use an indigenous language or local dialect.

Using language students, or family or friends of the survivor, are NOT effective ways of facilitating communication. Having a SART member who is fluent in another language can be very helpful when that member is working with a survivor who communicates in that language. However, that member should not serve as an interpreter for the other members or in court, as doing so confuses the role of that SART member. It can also negatively affect the survivor's experience during the process. For instance, if the victim advocate is fluent in Spanish and interprets for other SART members or in court, she cannot serve as a support person for the survivor during those interactions. If the SANE/FNE is fluent in Urdu and is asked to interpret for the law enforcement officer or victim advocate, the SANE/FNE is no longer an impartial collector of evidence.

SART members should also educate themselves on the cultures that relate to the languages most commonly used in their community. The most effective response is one that is bilingual *and* bicultural. Simply having an interpreter is not enough. SARTs need to be aware of any cultural beliefs, traditions, and practices that can affect survivors' abilities to participate in the criminal justice response. This can include a fear of law enforcement officers; what appears to be hyper-modesty by American standards (refusing to disrobe, talk about sex, etc.); a belief that men do not need consent to have sex with women; not being able to look a male SART member in the eyes; being acquiescent to male SART members; not understanding their rights; etc. By being aware of cultural barriers before a case presents itself the SART can be much more effective. The SART can also research local resources that can be useful in making survivors from other countries feel more comfortable. However, survivors may not want persons from their own culture to participate due to the stigma of sexual violence or not wanting persons from their home country to know what happened. Similar to survivors in rural communities, survivors from other countries who speak limited English are very isolated and are usually part of a very small sub-community. They may fear retribution if they report "one of their own." In some cultures survivors are actually punished, shunned, or blamed by their own families for being sexually assaulted or for no longer being a virgin.

D

Survivors who are Immigrants: Documented and Undocumented

Survivors who are undocumented immigrants are rarely willing to report a crime due to fear of deportation. The Violence Against Women Act (VAWA) has provisions that, in some cases, protect domestic violence, sexual assault or stalking survivors and their children from being deported. It can be very helpful if SARTs provide information in immigrant communities about the VAWA provisions to encourage survivors who want to report a sexual assault to do so. For more information about the VAWA provisions, contact the Virginia Poverty Law Center (See Appendix G).

Some sexual assault crisis centers (SACCs) may be unwilling to serve undocumented survivors for fear it will affect their funding. As of July 2009, there are no Virginia or federal laws that preclude a private, non-profit SACC from serving undocumented survivors. The Virginia Sexual and Domestic Violence Action Alliance (VSDVAA) strongly encourages all programs to serve persons who are undocumented.

Working with both documented and undocumented immigrants can offer other challenges to a SART. There may be language and/or cultural barriers (discussed above). There may also be a lack of understanding of the American criminal justice system and the rights of victims and perpetrators that are offered in this system. Undocumented persons may be preyed upon because of their undocumented status – the assailants may threaten to turn them in to ICE if they report the assault. If they work with their assailants, they may be fearful of losing their jobs if they report the assault, and due to their status, have significant difficulty in getting other employment. Documented survivors may fear losing their green cards or worker visas if they report a sexual assault against a figure of authority (e.g., case manager, employer, medical provider, law enforcement officer, attorney, government official, etc.). Documented and undocumented survivors who have children who are American citizens may be threatened with their children being taken away, especially if the children's father or another family member assaults them.

There are a number of reasons survivors who are immigrants do not want to report sexual violence. SART members can work to educate the immigrant communities in their jurisdiction(s) about the safe criminal justice options they have, about the fact that they do not deserve to be sexually assaulted, and about the services they can access without participating in the criminal justice system. These cases are good examples of when a third party or blind report can be very effective in protecting the victim from deportation or retribution while having the crime reported.

If a survivor who is an immigrant does report, the SART members can help that person feel secure and safe throughout the process by taking away the threat of deportation or loss of legal status, children, or gainful employment. As mentioned earlier, having SART members trained on the local community's cultures can help tremendously with bridging the culture gaps. Having access to interpreter services, community resources for immigrant populations, and written materials in languages other than English can help the survivor feel more comfortable. Overall, SART members need to remember that all survivors need to be believed and provided with culturally appropriate responses, regardless of their legal status in this country.

Trafficking

A sub-group under immigrants is those persons who were brought to this country for sex-trade or unpaid labor – trafficking victims. American citizens can also be victims of human trafficking. Each year, an estimated 600,000 to 800,000 men, women, and children are trafficked across international borders (some international and non-governmental organizations place the number far higher), and the trade is growing. Of the 600,000-800,000 people trafficked across international borders each year, 70 percent are female and 50 percent are children. The majority of these victims are forced into the commercial sex trade.[28] Trafficking victims are almost always undocumented. They come to this country under the impression they will have paid, legal work and can work towards becoming documented citizens. They may have been kidnapped and brought here to be forced into slavery or prostitution. Some trafficking victims are forced into the sex-trade or slavery as a way to pay off the persons who brought them to America. Some families are forced to "sell" or "give" their loved ones away to pay off a debt. Some victims work as nannies or domestic help, but much more often they work in sweatshops or as prostitutes and live in deplorable conditions. Many trafficking victims are children. Often times a SART will become aware of sex-trafficking victims when law enforcement officers conducts a raid, rather than a survivor coming forward to report the abuse. These persons are trapped and have few options. They have no family, no legal status, and no rights.

There are currently federal laws that attempt to protect victims of trafficking. The Victims of Trafficking and Violence Protection Act of 2000 (TVPA), and its reauthorization in 2003, provides extensive protections and services for victims of trafficking found in the United States regardless of nationality. This statute defines "severe forms of trafficking in persons" as:

- Sex trafficking in which a commercial sex act is induced by force, fraud or coercion, or in which the person induced to perform such act has not attained 18 years of age; or
- The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery. (106 P.L. 386: 114 Stat. 1470, Sec. 103 (8))

Victims of trafficking are eligible for benefits through several government channels. In addition, non- governmental, community, and faith-based organizations around the country continue to provide a wide range of social services for both U.S.- and foreign-born trafficking victims. American citizens who are victims of domestic trafficking are eligible for social services such as Medicaid, food stamps, and housing subsidies. Foreign-born victims can access similar services as they move through the "certification" process, which gives such victims legal immigrant status under the TVPA.

Foreign victims receive services from grantee organizations who receive funds from the Office for Victims of Crime and Department of Health and Human Services. The services funded by these offices not only provide victims with the essentials for day to day living, but also the training and educational opportunities that will allow them to become self-sufficient in this country. SARTs should be familiar with these laws and how they can assist survivors in their jurisdiction(s).[29]

[28] U.S. Department of State. 2004. Trafficking in Persons Report. Washington, D.C.: U.S. Department of State.

[29] Office for Victims of Crime (2005). *National Victims' Rights Week: Justice Isn't Served Until Victims Are*. Published by the Office of Justice Programs' Office for Victims of Crime. Available from http://www.ojp.usdoj.gov/ovc/ncvrw/.

D

Survivors who are Incarcerated

This section addresses the needs of persons who are sexually assaulted while in prison or jail. Persons in prison and jail deserve the same protections from sexual violence as persons outside the correctional system. In the United States, 39% of female inmates in state prisons reported being sexually abused before they were incarcerated.[30] Sexual violence experienced by these women in prison is a revictimization and adds to the stress of being incarcerated and away from their families and children. Sexual violence in prison can occur between inmates or be perpetrated by prison staff. Reporting can have significant negative consequences on the survivor. A survivor may be labeled as a "snitch" and targeted for further violence if returned to the same prison. Inmates can be coerced into sexual acts by prison staff due to their positions of power over inmates, or by another inmate who has a higher status within the inmate hierarchy. An inmate may be forced to perform sexual acts in order to stay safe from other inmates, or to keep family members on the outside safe. Services for victims within the prison system are severely limited. Survivors are not offered confidentiality in most settings, and so any description of sexual violence during a counseling session will be treated as a report of sexual assault. This leaves survivors who do not want to report very isolated and without support. Inmates are forced to present themselves as strong in order to survive in the prison system, so even if there is someone an inmate feels safe confiding in, a survivor often will not do so for fear of being perceived as weak. It also means if the assault is not reported, the survivor will often try to "play tough" and appear to be more uncooperative than survivors who are not incarcerated. SART members need to recognize this "lack of cooperation" for what it is when interviewing and working with survivors who are assaulted in prison.

SARTs are encouraged to have a policy to address sexual violence that occurs in a prison setting. This means including corrections staff, officers, and counselors on the response team for these cases. It is important that SARTs be familiar with local prison and jail policies for handling reports of sexual violence. SARTs should know whether or not the prisons offer any confidential services or provide access to confidential services (e.g. allowing the SACC to conduct a support group or allowing inmates to call the Virginia Family Violence and Sexual Assault Hotline), and which staff will address reports of sexual violence in the local prisons and jails. Having this background information before a report is made will make the SART much more effective in responding to the assault. Recognizing that a prison is similar to a small community and therefore will provide the same challenges (e.g., people being unwilling to share information, people being reluctant to report violence or get other prison staff or inmates in trouble, etc.) will help the SART be prepared when taking on such a case.

Marital Sexual Assault

Some Virginia Code sections concerning sexual violence between spouses changed in the last ten years. Restrictions which required a spouse to be living apart or to experience bodily injury in order to be raped or otherwise sexually assaulted (e.g., forcible sodomy, object sexual penetration, etc.) were deleted from the *Code of Virginia* in 2002 and 2005, respectively. The laws which are applied to sexual violence cases involving strangers are the same laws which are applied in sexual violence cases involving persons who are married. Sexual violence is sexual violence, regardless of the relationship between the alleged perpetrator and victim. However, there is an option for a perpetrator who is married to the survivor to undergo counseling instead of jail time if the survivor, prosecutor and judge all agree.

Cases of sexual violence between spouses can be very difficult. There is a myth that wives will charge their husbands with rape or other sex crimes in order to gain custody of their children or to get a better deal during divorce proceedings. While this may happen, it is rare. As discussed in Appendix A, Section A5, false reports of sexual violence occur at the same rate as other crimes (i.e., 2-4%). Therefore persons who report sex crimes perpetrated by their spouses need to be taken seriously. These cases should be treated just like other cases. However, there are a few factors for SARTs to consider.

Since sexual violence between spouses most often occurs in the context of domestic violence, the SART may want to involve a domestic violence victim advocate on the response team for these cases. The survivor may need shelter, peer counseling, or a support group to address the domestic violence experienced. The survivor may also have reported domestic violence when reporting the sexual violence and therefore need a legal advocate to assist her during the civil protective order hearings or family abuse case in Juvenile and Domestic Relations Court (rather than Circuit Court where the sex crime case will be heard). Even if the survivor does not report domestic violence, there may be need for temporary emergency shelter if the spouse is released on bail. The SART should work with the local domestic violence program to determine their policies for providing shelter including length of stay, criteria for admission, probability of having space available on short notice, and whether the program will provide shelter for sexual violence victims. The sexual assault crisis center can often work with the domestic violence program to determine the policies and to encourage them to accept victims of sexual violence for shelter. In many localities the sexual assault crisis center and domestic violence program are part of the same agency, thus facilitating communication.

Adults Molested as Children

Virginia does not have a statute of limitations for reporting sex crimes, therefore years after a childhood sexual assault an adult may report the crime and have it investigated. There are a number of reasons adults may want to report assaults they suffered as children or that children/teens do not report assaults when they happened. Adults may not remember they were assaulted as children/teens– they could have repressed what happened to them, and then as adults begin remembering. Adults who are sexually re-victimized as adults may have resulting flashbacks or memories of assaults they experienced as children that they had forgotten. They may have been too afraid to report the assault when they were children but as adults are emotionally ready to do so. They may have guilt as adults that they never reported the assaults and they fear that as a result other children were victimized.

This type of case presents unique challenges for a SART. There will be limited, if any, physical evidence of an assault; interviews of the survivor, witnesses and/or assailant may yield little information due to the amount of time having passed since the assault. It may be difficult to even find witnesses or the assailant after so many years. However, it is important to investigate these cases. Persons who sexually assault children very rarely do so only once, so there may be other survivors, and/or the person could still be assaulting children. SARTs can learn from law enforcement officers' handling of other "cold cases" to determine the most effective way to investigate cases of adults molested as children. Sexual assault victim advocates can work with the survivors to help them overcome their feelings of guilt, shock at remembering assaults, post-traumatic stress, and fear of facing their assailants after so many years. Many SACCs have specialized support groups for adults molested

as children. The SART may also want to consider consulting with a therapist who has expertise in this area to work with the survivor.

Survivors who are Children or Teenagers

This protocol is designed for SARTs responding to adult sexual assault survivors. Communities should also develop SART protocols to address responding to victims who are children or adolescents. For further information on developing a SART for children or adolescents who are victims of sexual assault, contact DCJS.

Appendix E: Victim-Centered Responsibilities Matrix

Critical Elements for Sexual Assault Crime Response								
Instructions: 1. Place a "P" in the column where the ***primary*** responsibility exists 2. Place a check mark (✔) under any other column that may share or possess follow-up responsibility 3. If you have a critical element that is not being adequately addressed or inherently causes problems, or you would like to more fully discuss this element, place an asterisk (*) in the "problem area" column.	Advocate	Medical	Law Enforcement	Prosecutor	Victim Witness	Courts	Corrections	Problem Area
Address victim's concerns of safety								
Arraignment/initial appearance								
Notify victim of time and place of hearing								
Discuss desired conditions of release with victim before bail hearing								
Request any release on bail include protection orders for victim								
Pretrial								
Inform victim of pretrial hearings/motions								
Include victim's participation in all hearings in which defendant has a right to be present								
Consider needs of victim in scheduling proceedings								
Plea Negotiations								
Inform victim of reasons to consider a negotiated plea								
Describe optional courses of action								
Determine what action the victim wants to take								
Consider the needs of the victim in accepting a plea								
Sentencing								
Ensure opportunity for victim impact statement as part of sentence considerations								
Include victim needs as part of sentence (i.e., restitution, protection, emotional security)								
Incarceration								
Notify victim of changes in offender status								
Notify victim of scheduled parole hearings								
Provide opportunity to victim testimony at parole hearings								
Notify victim of release and status of release (i.e., parole, discharge, etc.)								

Adapted from American College of Emergency Physicians (1999). Evaluation and Management of Sexually Assaulted or Sexually Abused Patient, Dallas, TX. Available from http://www3acep.org/WorkArea/downloadasset.aspx?id=8984

E

Appendix E: Victim-Centered Responsibilities Matrix (Continued)

Critical Elements for Sexual Assault Crime Response								
Instructions: 1. Place a "P" in the column where the ***primary*** responsibility exists 2. Place a check mark (✔) under any other column that may share or possess follow-up responsibility 3. If you have a critical element that is not being adequately addressed or inherently causes problems, or you would like to more fully discuss this element, place an asterisk (*) in the "problem area" column.	Advocate	Medical	Law Enforcement	Prosecutor	Victim Witness	Courts	Corrections	Problem Area
Receive Victim Report of Sexual Assault								
9-1-1/police department								
Rape crisis								
Third party reporting: friends, schools, etc.								
Hospital emergency department								
Prosecutor's office								
First Responder								
Ensure safety								
Educate on options: reporting, care, legal								
Determine need/willingness for emergency medical care								
Arrange transportation to/from hospital								
Advise victim of evidence preservation steps								
Determine if assailant is still nearby								
Determine if victim wants crisis counseling								
Determine if victims wants victim assistance								
Work with secondary victims								
Medical Intake								
Record victim's statement/condition accurately								
Determine extent of injuries requiring medical attention								
Inform victim about evidence collection procedures and receive authorization								
Determine if victim wants advocate support during examination								
Forensic Examination								
Collect and preserve evidence in acoordance with established protocol - P.E.R.K.								
Provide clothing at hospital								

Adapted from American College of Emergency Physicians (1999). Evaluation and Management of Sexually Assaulted or Sexually Abused Patient, Dallas, TX. Available from http://www3acep.org/WorkArea/downloadasset.aspx?id=8984

Appendix F: Glossary of Terms

F

Advocate

A person who assists crime victims by providing emotional support, peer counseling, mental health counseling, referrals and/or an explanation of the services available to them.

Sexual Assault Crisis Center (SACC) Advocates

SACC advocates usually work for a private, community-based agency that provides free sexual assault crisis intervention to persons who have experienced sexual violence and to their families and friends. Sexual assault crisis center advocates have an exclusive focus on the needs of the sexual assault victim and provide a variety of victim-directed services in order to promote empowerment and the healing of the individual. These services include crisis intervention, victim accompaniment, systems advocacy, emotional support, support groups, information and referrals, and connecting victims with other appropriate community services.

Victim/Witness Program Advocates

Victim/witness advocates are employed by a public agency (typically a police department, sheriff's office or prosecutor's office). Although their range of responsibilities varies, the primary goal of these professionals is to support the victim in the context of a criminal case and to protect her rights as established by state and federal law throughout the criminal justice process. They can also assist the victim in applying for compensation or accompany her to interviews and court proceedings. Because of their position within the criminal justice system, victim/witness program advocates often have unique access to other criminal justice professionals and information.

Commonwealth's Attorney

A lawyer elected by the people and employed by the state to prosecute criminal and traffic cases. Lawyers who work for a local office of the Commonwealth's Attorney are called Assistant or Deputy Commonwealth's Attorneys. These lawyers are also called prosecutors. Some localities have attorneys who specialize in prosecuting sexual assault crimes. Every locality in Virginia has its own Commonwealth's Attorney's Office. The role of the Commonwealth's Attorney is to prosecute felony and some, or all, misdemeanor violations of law in the courts of the locality. The Commonwealth's Attorney represents the Commonwealth of Virginia and is not the attorney for the victim.

Coordinated Community Response to Sexual Violence

The coordinated community response to sexual violence is an informed, unified, victim-centered multidisciplinary team that addresses the needs of sexual assault victims and increases the community's ability to bring sexual assault perpetrators to justice. The team consists of anyone who may come in contact with a sexual assault victim in the course of his/her job, including law enforcement officers, forensic or sexual assault nurse examiners, sexual assault crisis center advocates, social

workers, college campus representatives, victim/witness advocates, and agencies serving traditionally underserved or misserved populations. Team members include sexual assault response team (SART) members (i.e., those providing immediate community response) and other involved professionals working with victims (i.e., those providing long-term community response).

Cultural Competence

A set of congruent attitudes, actions, behaviors, and policies that come together among professionals at all levels within an organization. The congruence enables the system, agency, team, and/or individual to work effectively in cross-cultural situations. Becoming culturally competent is a developmental process.

Defense Attorney

The Defense Attorney is the lawyer for the defendant. A defense attorney may be employed by the defendant or paid by the Commonwealth (public defender) to represent the alleged perpetrator. The role of the defense attorney is to ensure that the defendant receives a fair trial. The Defense Attorney is not a member of the SART.

Forensic Nurse Examiner/Sexual Assault Nurse Examiner

Forensic Nursing is the application of nursing science to public or legal proceedings; the application of the forensic aspects of health care combined with the bio-psycho-social education of the registered nurse in the scientific investigation and treatment of trauma and/or death of victims and perpetrators of abuse, violence, criminal activity and traumatic accidents.

The forensic nurse provides direct services to individual clients, consultation services to nursing, medical and law related agencies, and expert court testimony in areas dealing with trauma and/or questioned death investigative processes, adequacy of services delivery, and specialized diagnoses of specific conditions as related to nursing.

A sexual assault examination is one type of forensic medical evaluation. The forensic components of the exam includes: gathering a history of events, performing a head-to-toe assessment, documentation of biological and physical findings, collection of evidence, and coordinating a follow-up forensic exam, as needed, to document additional evidence. The medical component includes: a screening for acute medical conditions and mental health needs that are stabilized prior to undergoing a forensic exam, provisions for emergency contraception, testing and treatment of sexually transmitted infections (STIs), and referrals for follow-up medical care. In some localities the Sexual Assault Nurse Examiner (SANE) is the Forensic Nurse Examiner (FNE).

Law Enforcement Officer

A certified police officer, sheriff, deputy sheriff, or state trooper with arrest powers representing a municipality, county, state or other law enforcement agency. Law enforcement officers with specific investigative duties, experience, and training may be found at every level of an agency to include: patrol, trooper, investigator, detective, and special agent. Some localities have law enforcement officers who specialize in investigating sexual assault crimes. The role of the law enforcement officer is to maintain public safety and investigate crimes.

Physical Evidence Recovery Kit (PERK)

A Physical Evidence Recovery Kit (PERK) is a kit that includes the items and instructions necessary for healthcare providers to collect and preserve physical evidence of sexual assault. These kits are provided to hospitals by the Virginia Department of Forensic Science. PERKs can be conducted on both victims and suspects.

Rape Trauma Syndrome

Rape trauma syndrome is an acute stress and/or post-trauma stress reaction experienced by a sexual assault victim. The term is used to categorize a group of signs, symptoms, and reactions of someone who has experienced sexual violence.

Sexual Assault Crisis Centers (SACC)

A sexual assault crisis center (SACC) is a community-based program that provides free sexual assault crisis intervention to persons who have been sexually assaulted and to their family and friends, regardless of race, color, creed, disability, sex, sexual orientation, age, parenthood, political affiliation or financial status. SACCs are generally private non-profit organizations with multiple funding sources. In some localities, SACCs operate as independent agencies and in other localities, sexual assault services are provided in conjunction with domestic violence services, or within a Community Services Board or other entity. Regardless of where the services are housed, all Virginia SACCs provide the following services to victims of sexual violence and the community at large:

- crisis intervention services both for sexual assault victims who report and those who do not report the crime to law enforcement agencies;
- 24-hour accessibility to crisis intervention services via a telephone hotline staffed by trained personnel;
- counseling and/or ongoing support and advocacy based on the needs of the victim (some agencies employ licensed counselors and others work from a peer support model);
- hospital accompaniment services on a 24-hours, 7 days per week basis;
- accompaniment services during law enforcement investigations; interviews with attorneys for the Commonwealth and defense attorneys, judicial proceedings, and other related appointments;
- information about, and referrals to, community resources to address a variety of victim needs;
- training to medical, criminal justice, and other community professionals; and
- community education, programming and activities.

Sexual assault crisis centers value empowerment and promote the dignity and respect of all persons. SACCs' specialized services have been developed based on the belief that persons who have experienced sexual violence have the right to determine their own response to the assault. The immediate availability of crisis intervention and support services facilitates the recovery from sexual violence.

An integral part of all the work done by a SACC is working toward the improvement of the various systems used by the persons who have been sexually violated, which includes the promotion of a multi-disciplinary approach. Through

education of the public and allied professionals, SACCs strive to improve the various systems by providing information that creates a community atmosphere of understanding and support of persons who have been sexually violated.

Sexual Assault Nurse Examiner (SANE)

A nurse who has received specialized education and clinical experience in the collection of forensic evidence specific to sexual assault cases. See also, Forensic Nurse Examiner.

Sexual Assault Response Team (SART)

A Sexual Assault Response Team (SART) is a very specific intervention model, offering an immediate response to reports by victims of sexual assault. It is a team approach to implementing a comprehensive, sensitive, coordinated system of intervention and care for sexual assault victims. The team typically involves professionals from three community systems: law enforcement, community-based advocacy, and medical/legal. These members work together to reduce trauma to the victim and to increase the effectiveness of the response. A SART coordinates its efforts through regular meetings, routine communications and ongoing case management.

Victim Interview/History Gathering

Interviews of sexual assault victims can be conducted in one of two ways: joint or coordinated. The descriptions below presume there has been a screening for immediate medical problems (e.g., injury) before the victim interview.

Joint Interview

A joint interview is conducted with all relevant professionals (law enforcement officer, SANE/FNE, and the sexual assault crisis center advocate) in the room at the same time. This may take place at the hospital, the local police department or another designated place. The purpose of conducting a joint interview is to eliminate the need for the victim to have to repeatedly tell of the sexual assault to several different professionals. During the joint interview, the law enforcement officer typically takes the lead by asking investigative questions. The forensic/sexual assault nurse examiner asks clarifying questions during this first phase of the interview process. After the officer has finished asking questions, the SANE/FNE asks questions about the assault history relevant to the forensic examination. After the sexual assault history is obtained, the officer is excused to enable the SANE/FNE to ask the medical history questions and to perform the examination. Unless the victim requests that an advocate not be present, the sexual assault crisis center advocate provides emotional support to the victim during the joint interview.

Coordinated Interview

In the coordinated approach, interviews by each professional take place one at a time. Sometimes this may happen consecutively within a short time frame and sometimes this may happen over a period of several days. The law enforcement officer interviews the victim first and then the SANE/FNE gathers a history, conducts the examination, and follows the evidence collection procedures. Unless the victim requests that an advocate not be present, the sexual assault crisis center advocate also provides emotional support during the coordinated interviews. This approach requires the victim to repeat and describe the sexual assault which can often be

traumatic. It also requires more time and coordination between professionals to synchronize the information received.

Victim-Patient-Survivor

A person reporting a sexual assault may encounter three systems - criminal justice, medical, and advocacy. For the criminal justice system, the person is referred to as a crime victim. For the medical system, the person is referred to as a patient. For sexual assault crisis centers, the person is referred to as a victim or survivor (sometimes referred to as a client). All three terms are used throughout this document.

Victim/Witness Program

Usually located in either local Commonwealth's Attorneys' offices or law enforcement agencies, victim/witness programs provide advocacy services to all victims and witnesses of all types of crimes, not just sexual assault victims. Because they are located within the criminal justice system and their positions are housed in governmental agencies, victim/witness programs typically do not work with sexual assault victims who are not participating in the criminal justice system. The information they gather from the victim belongs to the office for which they work and therefore is not confidential. Service requirements for victim/witness programs include:

- victim and witness protection;
- financial assistance;
- notifications regarding legal proceedings and the status and location of defendants;
- victim input; and
- courtroom assistance.

Virginia Department of Criminal Justice Services

The mission of the Department of Criminal Justice Services (DCJS) is to provide comprehensive planning and state of the art technical and support services to the criminal justice system to improve and promote public safety in the Commonwealth of Virginia. The Department of Criminal Justice Services is charged with planning and carrying out programs and initiatives to improve the functioning and effectiveness of the criminal justice system as a whole *(§9.1-102 of the Code of Virginia).*

The Department:

- distributes federal and state funding to localities, state agencies and nonprofit organizations in the areas of law enforcement, prosecution, crime and delinquency prevention, juvenile justice, victims services, corrections, and information systems;
- establishes and enforces minimum training standards for law enforcement officers, criminal justice and private security personnel;
- licenses and regulates the private security industry in Virginia;
- provides training, technical assistance and program development services to all segments of the criminal justice system; and
- conducts research and evaluations.

The agency's primary constituents are local and state criminal justice agencies and practitioners, private agencies, private security practitioners and businesses, and the public-at-large. Other constituents include local governments and state agencies, the federal government and victim advocacy organizations.

Vulnerable Adult

The *Code of Virginia* (§63.2-1603) provides that aged or incapacitated adults, when abused or neglected, qualify for protection by Adult Protective Services.

Adult

Any person residing in the Commonwealth who is eighteen years of age and older and is incapacitated and any qualifying person sixty years of age and older; provided, however, "adult" may include incapacitated or qualifying nonresidents who are temporarily in the Commonwealth and who are in need of temporary or emergency protective services.

Incapacitated Persons

Any adult who is impaired by reason of mental illness, mental retardation, physical illness or disability, advanced age or other causes to the extent that the adult lacks sufficient understanding or capacity to make, communicate or carry out responsible decisions concerning his or her well-being.

Appendix G: Statewide Resources

G

- **Commonwealth's Attorneys' Services Council**
  College of William and Mary Law School, Room 220
  613 South Henry Street
  Williamsburg, Virginia 23185
  (757) 253-4146
  (757) 253-7159 Fax
  http://www.cas.state.va.us

- **Criminal Injuries Compensation Fund**
  Mailing Address: P.O.Box 26927, Richmond, VA 23220
  Physical Address: 2201 West Broad Street, Suite 207, Richmond, VA 23220
  (804) 367-1018 Richmond Callers
  (800) 552-4007 Toll-free Statewide
  (804) 378-4390 Fax
  http://www.cicf.state.va.us

- **Department of Criminal Justice Services**
  1100 Bank Street
  Richmond, Virginia 23219
  (804) 784-4000 Main Number
  (804) 371-8981 Fax
  (888) 887-3418 Toll-Free Victim Assistance Info-Line
  http://www.dcjs.virginia.gov

- **Department of Forensic Science**
  700 North 5th Street
  Richmond, Virginia 23219
  (804) 786-4707
  (804) 786-6857 Fax
  http://www.dfs.virginia.gov

- **Department of Behavioral Health and Developmental Services**
  Mailing Address: P.O. Box 1797, Richmond, VA, 23218
  Physical Address: 1220 Bank Street, Richmond, VA, 23219
  (804) 371-8977 Voice TDD
  (804) 786-3921 Phone
  (800) 451-5544 Toll-free
  (804) 371-6638 Fax
  http://www.dbhds.virginia.gov

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- **Office on Violence Against Women**
  800 K Street, N.W., Suite 920
  Washington, DC 20530
  (202) 307-6026 phone
  (202) 305-2589 fax
  (202) 307-2277 TTY
  http://www.usdoj.gov/ovw

- **Supreme Court of Virginia**
  100 N. 9th Street
  Richmond, Virginia 23219
  (804) 786-6455
  (804) 786-7542 Fax
  http://www.courts.state.va.us

- **Virginia Association of Chiefs of Police**
  1606 Santa Rosa Road, Suite 134
  Henrico, VA 23288
  (804) 285-8227
  (804) 285-3363 Fax
  http://www.vachiefs.org

- **Virginia Chapter-International Association of Forensic Nurses**
  PO Box 1044
  Harrisonburg, VA 22803
  Email : bonnie_price@bshsi.com
  www.iafn.org

- **Virginia College of Emergency Physicians**
  Mailing Address: PO Box 911, Norge, Virginia 23127-0911
  Physical Address: 7151 Richmond Road, Williamsburg, VA 23188
  (757) 220-4911
  (757) 258-3042 Fax
  E-mail: info@vacep.org
  http://www.vacep.org

- **Virginia Department of Health**
  Division of Injury and Violence Prevention (DIVP)
  109 Governor Street
  Richmond, Virginia 23219
  (804) 864-7732
  (804) 864-7748 Fax
  http://www.vahealth.org/injury
  Office of the Chief Medical Examiner
  http://www.vdh.virginia.gov/medexam/index.asp

  Central District
  400 East Jackson Street
  Richmond, Virginia 23219-3694
  (804) 786-3174
  (804) 371-8595 Fax

Northern District
10850 Pyramid Place, Suite 121
Manassas, VA 20110
(703) 530-2600
(800) 856-6799 Toll Free
(703) 530-0510 Fax

Tidewater District
830 Southampton Ave., Suite 100
Norfolk, Virginia 23510
(757) 683-8366
(757) 683-2589 Fax

Western District
6600 Northside High School Road
Roanoke, Va. 24019
(540) 561-6615
(540) 561-6619 Fax

- **Virginia Department of Social Services**
  801 E. Main Street
  Richmond, Virginia, 23219-2901
  (804) 726-7000
  (800) 552-3431 Toll-free
  (804) 726-7958 Fax Benefits and Services
  http://www.dss.virginia.gov

  Child Protective Services Hotline
  (800) 552-7096 Toll-free within Virginia
  (804) 786-8536 Calls from Outside Virginia
  (800) 828-1120 Hearing Impaired

  Adult Protective Services Hotline
  (888) 832-3858 Toll-free

- **Virginia Family Violence and Sexual Assault Hotline**
  (800) 838-8238 Voice/TTY

- **Virginia Hospital and Healthcare Association**
  Mailing Address: P.O. Box 31394, Richmond, VA 23294
  Physical Address: 4200 Innslake Drive Glen Allen, Virginia 23060
  (804) 965-1249
  (804) 965-0475 Fax
  www.vhha.com

- **Virginia Office for Protection and Advocacy**
  1910 Byrd Avenue, Suite 5
  Richmond, VA 23230
  (804) 225-2042 Richmond Callers (Voice/TTY)
  (800) 552-3962 Toll-free in Virginia (Voice/TTY)
  (804) 662-7057 Fax
  http://www.vopa.state.va.us

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- **Virginia Poverty Law Center, Inc.**
  700 East Franklin Street, Suite 14T1
  Richmond, VA 23219
  (804) 782-9430
  (800) 868-8752 Toll-free in Virginia (Voice/TTY)
  (804) 649-0974 Fax
  http://www.vplc.org

- **Virginia Sexual and Domestic Violence Action Alliance**
  5008 Monument Avenue, Suite A
  Richmond, Virginia 23230
  (804) 377-0335
  (804) 377-0339 Fax
  http://www.vsdvalliance.org

- **Virginia Sheriffs' Association**
  701 East Franklin Street, Suite 706
  Richmond, Virginia 23219-2503
  (804) 225-7152
  (804) 225-7162 Fax
  http://www.vasheriffs.org

Appendix H: Sample Forms/Documents

H

H1. Confidentiality/Release of Information Form[31]

INOVA Health System: Consent for Adult (Age 14+) Forensic Medical Examination for Sexual and/or Physical Assault

Name of Patient *(Last, First, Middle)*		
Patient Information		
I understand that health care workers are required to report to law enforcement any non self-inflicted wound caused by a gun, knife, or other fighting instrument pursuant to Virginia Code §54.1-2967.		*(Initial)*
I understand that I have a right to decline any part or all of an examination or procedure after it has been explained to me. I understand that if I decline a procedure, it may negatively affect the quality of care and the usefulness of evidence collection. I understand that if I decline any portion of the examination, it may also have a negative impact on a criminal investigation and/or prosecution because evidence not collected may have been useful. I understand that if I decline any portion of the examination, defense attorneys may use that against me. Declining a procedure might also be used by opposing counsel to discredit me in future legal proceedings.		*(Initial)*
IF PATIENT IS 14-17 YEARS OLD: I understand that INOVA Health System personnel will report any suspected child abuse to Child Protective Services pursuant to Virginia Code §63.2-1509 and/or to local law enforcement. I understand that the report to Child Protective Services requires the release of information gained from the examination regardless of whether or not I have consented to that release of information.		*(Initial)*
Choose One	I understand that I may consent to the forensic examination and **I desire** to contact law enforcement and to release evidence obtained. I understand that reporting to law enforcement may trigger an investigation and possible prosecution of the perpetrator.	*(Initial)*
	I understand that I may consent to the forensic examination but **I do not desire** to contact law enforcement or to release evidence. I understand the consequences to certain delays in reporting which may result in loss of evidence and may negatively affect the ability of the criminal justice system to investigate and prosecute a case.	*(Initial)*
	I understand that I may consent to the forensic examination but **I am undecided** about reporting my assault to law enforcement. Policies on collecting and holding evidence, including the amount of time I have to make a report, have been explained to me.	*(Initial)*
PATIENT CONSENT		
I understand that an examination, at public expense, will be conducted by an examiner to collect and preserve potential evidence of the reported physical and/or sexual assault. I understand that the examination may include the collection of reference specimens and blood samples at the time of the examination or at a later date. I understand that I may withdraw consent at any time for any portion of the examination.		*(Initial)*

[31] Obtained, with permission, from INOVA Fairfax Hospital SANE Program.

H1. Confidentiality/Release of Information Form *(Continued)*

I understand that collection of evidence may include photographing injuries, including injuries to the genital area.	*(Initial)*
I hereby consent to a sexual assault nurse examination (SANE).	*(Initial)*
I hereby consent to a physical assalt forensic examination.	*(Initial)*
I understand that data without patient identifiers (e.g., no names used) may be collected from this report for health and forensic purposes and provided to health authorities and other qualified persons with a valid education or scientific interest for demographic, teaching and/or epidemiological stuies.	*(Initial)*
I understand that I have the right to request a translator if English is not my primary language.	*(Initial)*
I hereby consent to the release of information and evidence to law enforcement.	*(Initial)*
I hereby consent to the hospital contacting me at a future date for reasons related to this forensic examination.	*(Initial)*
Patient Signature:	
Date and time:	
Witness:	

Patient Consent Form, IFH/IFHC FACT Department 3300 Gallows Road Falls Church, VA 22042-3300

H2. SART Client Satisfaction Survey

Please rate the service you received and the staff's sensitivity to you. Read each of the following statements and check the appropriate boxes. All responses are anonymous.

INITIAL Contact	Location:		Staff Person:		Date:
	Strongly Agree	Agree	Disagree	Strongly Disagree	Does Not Apply
The police officer(s) treated me with concern and respect when she/he interviewed me					
The hospital staff treated me with concern and respect during my examination					
The hospital staff explained to me what to expect during my examination					
The Sexual Assault Response Team (SART) staff treated me with concern and respect					
The SART staff gave me valuable information about clothing, housing and referrals.					
The SART staff helped me to feel supported instead of along					
The SART staff encouraged me to seek counseling	☐ Yes	☐ No			

H2. SART Client Satisfaction Survey (Continued)

Please rate the service you received and the staff's sensitivity to you. Read each of the following statements and check the appropriate boxes. All responses are anonymous.

TWO WEEK Contact	Location:		Staff Person:		Date:
	Strongly Agree	Agree	Disagree	Strongly Disagree	Does Not Apply
The police detective who handled my case treated me with concern and respect.					
The police detective handline my case listened to me.					
The police detective who handled my case kept me informed about the process.					
The SART staff listens to me and supports me.					
I have seen a doctor for a follow-up visit.	☐ Yes	☐ No			
I still experience some of the following:	☐ Anger ☐ Anxiety ☐ Cry Easily	☐ Depression ☐ Distracted ☐ Fear	☐ Guilt ☐ Insomnia ☐ Nightmares	☐ Physical Pain or Discomfort ☐ Unable to Focus	
I am currently seeing a counselor for individual therapy.	☐ Yes	☐ No			
My family is in therapy.	☐ Yes	☐ No			
I am currently in a support group for victims of sexual assault.	☐ Yes	☐ No			
Someone from the Victim/ Witness Program has contacted me.	☐ Yes	☐ No			

H2. SART Client Satisfaction Survey (Continued)

Please rate the service you received and the staff's sensitivity to you. Read each of the following statements and check the appropriate boxes. All responses are anonymous.

THREE MONTH Contact	Location:		Staff Person:		Date:
	Strongly Agree	Agree	Disagree	Strongly Disagree	Does Not Apply
The Commonwealth's Attorney (CA) and staff have been helpful and supportive.					
The CA and staff have kept me informed of my case and informed me of my legal options.					
The CA and staff gave me information in a sensitive and respectful manner.					
The CA decided not to file charges against the perpetrator because *(please explain):*					
I have seen a doctor for a follow-up visit.	☐ Yes	☐ No			
I still experience some of the following:	☐ Anger ☐ Anxiety ☐ Cry Easily	☐ Depression ☐ Distracted ☐ Fear	☐ Guilt ☐ Insomnia ☐ Nightmares	☐ Physical Pain or Discomfort ☐ Unable to Focus	
I am currently seeing a counselor for individual therapy.	☐ Yes	☐ No			
My family is in therapy.	☐ Yes	☐ No			
I am involved in a support group led by a counselor/ therapist.	☐ Yes	☐ No			
Someone from the Victim/ Witness Program has contacted me.	☐ Yes	☐ No			
My family supports me (e.g., are patient and understanding)	☐ Yes	☐ No			
My case has come to trial	☐ Yes	☐ No			
My case has been dismissed	☐ Yes	☐ No			
The SART staff is still working with me.	☐ Yes	☐ No			
The Victim/Witness Program is working with me.	☐ Yes	☐ No			
I am seeing a counselor for individual therapy.	☐ Yes	☐ No			
My family is in therapy.	☐ Yes	☐ No			

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H2. SART Client Satisfaction Survey (Continued)

Please rate the service you received and the staff's sensitivity to you. Read each of the following statements and check the appropriate boxes. All responses are anonymous.

I am involved in a support group led by a counselor/ therapist	☐ Yes	☐ No
My family supports me (e.g., patient and understanding).	☐ Yes	☐ No
My friends support me (e.g., patient and understanding)	☐ Yes	☐ No
I am currently working with the Victim/Witness Program.	☐ Yes	☐ No

H2. SART Client Satisfaction Survey (Continued)

Please rate the service you received and the staff's sensitivity to you. Read each of the following statements and check the appropriate boxes. All responses are anonymous.

SIX MONTH Contact	Location:		Staff Person:		Date:
	Strongly Agree	Agree	Disagree	Strongly Disagree	Does Not Apply
The Commonwealth's Attorney (CA) and staff have been helpful and supportive.					
The CA and staff have kept me informed of my case and informed me of my legal options.					
My physical trauma symptoms (e.g., pain, discomfort) are lessening.					
My emotional trauma symptoms (e.g., anxiety, fear, anger, depression) are lessening.					
I still experience some of the following:	☐ Anger ☐ Anxiety ☐ Cry Easily	☐ Depression ☐ Distracted ☐ Fear	☐ Guilt ☐ Insomnia ☐ Nightmares	☐ Physical Pain or Discomfort ☐ Unable to Focus	

H

H2. SART Client Satisfaction Survey (Continued)

Please rate the service you received and the staff's sensitivity to you. Read each of the following statements and check the appropriate boxes. All responses are anonymous.

ONE YEAR Contact	Location:	Date:
Looking back over the past year, what service(s) was most helpful to you?		
What service(s) was most helpful to your family?		
What was the least helpful experience you had?		
What would you change?		

H3. Memorandum of Understanding

H

Sexual Assault Response Team Cooperative Working Agreement

The Sexual Assault Response Team is made up of local agencies responsible for responding to victims of sexual assault. This working agreement is recognized as a cooperative, collaborative commitment among the agencies to directly support a multi-disciplinary, coordinated response to adult victims of sexual assault; commitment is acknowledged by the signature of each agency's representative

For the purposes of this collaboration, "adult" is defined as a female who has experienced the onset of menses or a male who is approximately 18 years of age or older. "Acute sexual assault victim" is an adult who has reportedly been sexually assaulted within approximately 72 hours prior to the time that she requested services at an emergency room.

The Office of the Commonwealth's Attorney agrees to:

- Convene a meeting, at least annually, to discuss implementation of protocols and policies for the sexual assault response team;
- Establish guidelines in collaboration with team partners for the community's response, including the collection, preservation, and secure storage of evidence from the Physical Evidence Recovery Kit;
- Ensure an annual review of established guidelines;
- Designate a liaison to participate actively on the Sexual Assault Response Team;
- Refer sexual assault victims, family members and friends to the Sexual Assault Crisis Center for crisis intervention, advocacy, and counseling services, as appropriate;
- Refer sexual assault victims, family members and friends to the Victim/ Witness Program for information about victims' rights, assistance with filing for victims compensation, and support navigating the criminal justice, as appropriate;
- Allow the sexual assault advocate, unless refused by the victim, to be present during interviews;
- Promote policies and practice to increase arrest and prosecution rates for criminal sexual assault, including non-stranger sexual assault;
- Use Forensic Nurse Examiners (FNEs) or Sexual Assault Nurse Examiners (SANEs) as witnesses during sexual assault trials, as appropriate;
- Provide reasonable notification of upcoming trials to the health care provider and/or SANE/FNE who will be called to testify;
- Contact the health care provider and/or SANE/FNE prior to testimony to review the case; and
- Participate, as appropriate, in cross training with allied professionals regarding response to sexual assault.

The Sexual Assault Crisis Center agrees to:

- Designate a liaison to participate actively on the Sexual Assault Response Team;
- Dispatch, upon request of the victim or someone calling on behalf of the victim, a trained sexual assault advocate to the hospital or law enforcement agency location within a reasonable period of time (e.g., 30 minutes or less);
- Provide trained sexual assault advocates to meet with victims, family members and friends at the hospital;
- Provide crisis intervention, advocacy, counseling, criminal justice information and support, and court preparation and orientation for sexual assault victims, as appropriate;
- Coordinate the above victim assistance services for victims, family members and friends with the local Victim/Witness Program, as appropriate;
- Refer sexual assault victims to the hospital, as appropriate;
- Follow established protocols set by the hospital for advocates in the examining room when requested by the victim;
- Support the development and annual review of the community's guidelines; and
- Participate, as appropriate, in cross training with allied professionals regarding response to sexual assault.

The local Law Enforcement Agency agrees to:

- Designate a liaison to participate actively on the Sexual Assault Response Team;
- Refer all acute adult sexual assault victims to the hospital and/or SANE/FNE program for medical treatment and/or a forensic exam.
- Inform sexual assault victims that they are not required to make a report or talk to a law enforcement officer in order to have a forensic exam.
- Transport or arrange for transport of sexual assault victims to the hospital and, once the PERK exam is complete, transport or arrange for transport of victims to a safe location;
- Follow established protocol to notify the hospital and/or SANE/FNE program that a sexual assault victim is being transported;
- Request the assistance of a Sexual Assault Crisis Center advocate, unless refused by the victim;
- Perform a suspect evidence collection kit or provide kit to SANE/FNE program to perform, as appropriate;
- Receive medical/forensic evidence that has been collected from victims and/or perpetrators;
- Follow Department established protocol regarding evidence collection and storage;
- Maintain and revise, as appropriate, written agreements with the hospital and/or SANE/FNE program to delineate services to be provided;
- Coordinate interview processes and/or conduct joint interviews with the hospital and/or SANE/FNE, as local protocol and victim dictates appropriate;

- Allow the sexual assault advocate, unless refused by the victim, to be present during interviews and/or other communications with officers/investigators;
- Promote policies and practice that increase arrest and prosecution rates for criminal sexual assault, including non-stranger sexual assault;
- Support the development and annual review of the community's guidelines; and
- Participate, as appropriate, in cross training with allied professionals regarding response to sexual assault.

SANE/FNE and/or Trained Health Care Provider(s) agrees to:

- Designate a liaison to participate actively on the Sexual Assault Response Team;
- Promote a reasonable response time (e.g., 60 minutes or less) from the time the call is received to the time the trained health care provider and/or SANE/FNE arrives at the hospital;
- Conduct medical/forensic examinations for adult sexual assault patients in accordance with all agreed-upon protocols and procedures;
- Assure that the Sexual Assault Crisis Center has been notified that a victim is being transported or has arrived;
- Encourage/support use of Sexual Assault Crisis Center advocates for sexual assault patients as appropriate and regardless of the patient's decision regarding contact with law enforcement; assure that the patient has given her permission before introducing the patient to a sexual assault crisis center advocate;
- Maintain chain of custody of forensic evidence and transfer to a law enforcement agency or officer;
- Work in collaboration with the local law enforcement agency(s) to ensure adequate supply of Physical Evidence Recovery Kits (PERKs);
- Be available to criminal justice professionals to review the case;
- Maintain contact and communication with criminal justice professionals;
- Support the development and annual review of the community's guidelines; and
- Participate, as appropriate, in cross training with allied professionals regarding response to sexual assault.

Hospital agrees to:

- Designate a health care provider trained in conducting forensic exams, preferably a SANE/FNE, to participate actively on the Sexual Assault Response Team;
- Provide trained health care providers and/or SANE/FNE to conduct medical/forensic examinations for adult sexual assault victims in accordance with all agreed-upon protocols and procedures;
- Encourage and support nursing staff to obtain the education and clinical experience necessary to receive a certificate of completion of the SANE/FNEs for adult examinations;
- Provide time and private space for sexual assault crisis center advocates to establish relationships with the victims, the victims' family/caregivers and friends when appropriate and if the victims and family/caregivers agree;

- Provide private examination rooms and supplies, including PERKs, necessary for the completion of the medical/forensic examinations;
- Allow for SANE/FNE to educate hospital staff on procedures for caring for adult sexual assault patients;
- Ensure that billing procedures for forensic exams are compliant with the policies and procedures developed by the Virginia Criminal Injuries Compensation Fund; and
- Participate, as appropriate, in cross training with allied professionals regarding response to sexual assault.

The Victim/Witness Program agrees to:

- Provide resource and referral to counseling and area resources, such as the Sexual Assault Crisis Center;
- Provide crisis intervention, criminal justice information and support, courtroom assistance, and court preparation and orientation, as appropriate;
- Coordinate the above services for victims, family members and friends with the local Sexual Assault Crisis Center, as appropriate;
- Provide assistance in obtaining family abuse or stalking protective orders;
- Facilitate the provision of separate waiting areas for victims and witnesses of crime;
- Provide assistance in the processing and filing of crime victims' compensation; in obtaining return of the victim's property when used as evidence; in obtaining restitution for economic loss; and in facilitating reimbursement for mileage and lodging for out of town witnesses, as appropriate;
- Upon request of the victim, provide notifications of friends, relatives, and employers of the occurrence of the crime; intervention with employers to prevent loss of pay or other benefits resulting from the crime or participation in the criminal justice system; notices of court dates; and status of release of defendants or prisoners from custody;
- Assist victims in filing a victim impact statement, which affords the survivor the opportunity to tell the court, in writing, the impact of the crime;
- Ensure that victims have reasonable notification of upcoming hearing and/or trial dates;
- Ensure the victim meets with Commonwealth's Attorney, as appropriate, prior to hearings and/or trial;
- Support the development and annual review of the community's guidelines; and
- Participate, as appropriate, in cross training with allied professionals regarding response to sexual assault.

This agreement is effective on (insert month, day, and year) and shall remain in effect until any party terminates their commitment in writing. The agreement will be reviewed bi-annually. Any modifications to the agreement must be mutually agreed upon by all parties, documented in writing, and acknowledged by a signature of each agency's representative.

Required Signatures

H

_____	_____
Executive Director Sexual Assault Crisis Center	Date
_____	_____
Chief of Police/Sheriff Local Police Department/Local Sheriff's Office	Date
_____	_____
Adult SANE/FNE Program Coordinator Hospital	Date
_____	_____
President and CEO Hospital	Date
_____	_____
Commonwealth's Attorney Office of the Commonwealth's Attorney	Date
_____	_____
Director Victim/Witness Program	Date

Acknowledgements

The Virginia Department of Criminal Justice Services (DCJS) thanks the following organizations for their assistance in developing this curriculum: the California Coalition Against Sexual Assault (CALCASA), The National Center for Women and Policing, End Violence Against Women (EVAW) International, the Virginia Sexual and Domestic Violence Action Alliance (VSDVAA), the Virginia Partnership for People with Disabilities at Virginia Commonwealth University, Citizens Against Sexual Assault (CASA) of Harrisonburg/Rockingham County, and the Harrisonburg Police Department.

CALCASA allowed DCJS to use materials from their Sexual Assault Response Team (SART) Manual. CALCASA developed the manual with support provided through Grant Award Number RP98021578 from the California Office of Criminal Justice Planning. The following information in the Virginia protocol was borrowed, in whole or in part, from the CALCASA Sexual Assault Response Team (SART) Manual: Chapters 2,3,4, and 5, and Appendices C, F, and H, Section H2. Additional material gathered from the manual is cited as appropriate.

The National Center for Women and Policing and EVAW International allowed DCJS to use materials from "Successfully Investigating Sexual Assault: A National Training Manual for Law Enforcement". The National Center for Women and Policing developed the national curriculum with support provided by the Office on Violence Against Women, Office of Justice Programs, U.S. Department of Justice (Grant No. 97-WE-VX-K004). EVAW is in the process of updating that curriculum with support provided by the Office on Violence Against Women (Grant No. 2004-X2118-WA-WT) and generously shared this information with DCJS. The following information in the Virginia protocol was borrowed, in whole or in part, from the National Center for Women and Policing and EVAW International curriculum: Appendix A, Sections A5 and A6; and Appendix H, Section H3. Additional material gathered from the curriculum is cited as appropriate.

The Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQQ) Task Force of VSDVAA allowed DCJS to use materials from their "Intimate Partner Violence and Sexual Assault in the LGBTQ Communities Curriculum."

DCJS also used materials from "Violence Against Women with Disabilities: The Response of the Criminal Justice System," a curriculum developed by VSDVAA and the Virginia Partnership for People with Disabilities at Virginia Commonwealth University. The curriculum was developed with support provided through Grant Number 2003-EW-BW-0010 from the U.S. Department of Justice.

Opinions or points of view expressed in the following DCJS protocol do not necessarily represent the official position or policies of CALCASA, the California Office of Criminal Justice Planning, National Center for Women and Policing, EVAW, the U.S. Department of Justice, VSDVAA, or Virginia Commonwealth University.

The Collins Center of Harrisonburg/Rockingham County and Harrisonburg Police Department assisted DCJS in coordinating a discussion group of local Virginia sexual

assault response teams, who provided DCJS with invaluable information concerning SART response in Virginia. The Harrisonburg/Rockingham County SART is one of the established SARTs in Virginia and is a model for SART response. The Collins Center of Harrisonburg/Rockingham County and VSDVAA provided in depth technical assistance to DCJS in developing the following model protocol. Specifically, DCJS would like to acknowledge the time and efforts contributed by Gianna Gariglietti of The Collins Center and Shani Reams of VSDVAA.

DCJS also thanks the following individuals for their assistance in developing the protocol: Jeanine Beiber, VSDVAA; Lisa Biever, Rappahannock Council Against Sexual Assault; Suzanne Rotolo, Fairfax INOVA Hospital SANE Program; Susan Carson, Virginia Commonwealth University Medical Center Forensic Nurse Examiners; Jane Sherman Chambers, Commonwealth's Attorneys' Services Council; Laurie Crawford, Virginia Department of Health; the Honorable Linda Curtis, City of Hampton Commonwealth's Attorney's Office; Gay Cutchin, Virginia Commonwealth University; Jim Fetterman, Harrisonburg Police Department; Bobbie Forkovitch, Rockingham Memorial Hospital SANE Program; Hannah Foster, CASA of Harrisonburg/Rockingham County; Kristine Hall, VSDVAA; Ted Heck, Virginia Department of Health; Sandy Hein, Alexandria Police Department; Connie Kirkland, George Mason University; Jill Langridge, Bridgewater College; Beth Lawler, Harrisonburg Department of Social Services; Brad Jenkins, Department of Forensic Science; Joseph McLaughlin, Jr., Virginia Sheriffs' Association and New Kent County Sheriff's Office; Bill Lightfoot, Richmond Police Department; Ruth Micklem, The Haven; Cherri Murphy, Charlottesville Victim/Witness Program; Rebecca Odor, Virginia Department of Health; Virginia Powell, Virginia Department of Health; Bonnie Price, Forensic Nurse Examiners of St. Mary's Hospital; Lt. Joseph Rader, Virginia State Police; Stacy Ruble, VSDVAA; Dana Shrad, Virginia Association of Chiefs of Police; Melinda Spivey, Richmond YWCA; Kristi Van Audenhove, VSDVAA; Susheela Varky, Virginia Poverty Law Center; Susan Ward, Virginia Hospital and Healthcare Association; and Jennifer Wooley, VSDVAA.