The Response to Sexual Assault: Removing Barriers to Services and Justice

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The Report of the Michigan Sexual Assault Systems Response Task Force

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Introduction

Sexual assault has a devastating impact on the survivors, their families and friends, and the community. Following a sexual assault, survivors need a compassionate and non-judgmental response from all systems, individuals and communities that will aid in their recovery.

There are areas in Michigan where there is clearly a level of excellence in policies and procedures, model criminal and medical response, and where access to justice and services for survivors of sexual assault is clearly demonstrated. In these areas systems appear to be providing the safety net survivors of sexual assault should be able to expect. However, it is not uniform throughout the state and many survivors are falling through the cracks.

Data and reports from sexual assault survivors and their advocates show many difficulties across the spectrum of systems — from barriers to reporting, lack of uniform police procedures, improper evidence collection procedures, gaps in medical response, absence of support and advocacy services, and limited training for police, medical staff and other systems personnel, to name a few.

Given these reports, many sexual assault survivors are not receiving a comprehensive community response and from their perspective, help, safety and justice are remote.

In response to this, the Michigan Coalition Against Domestic and Sexual Violence, in partnership with the Michigan Crime Victim Services Commission and the Prosecuting Attorneys Association of Michigan, convened a Statewide Sexual Assault Systems Response Task Force.

Those invited to participate represent a broad range of key stakeholders, including the criminal justice system, the medical system, victim advocacy organizations and others concerned with promoting quality services to survivors of sexual assault and ensuring their full access to safety and justice. There were close to 70 individuals and organizations actively participating in the work of the Task Force.

The overall goals of the Task Force were to:

- Enhance the ability of the community, victim advocacy organizations, medical system and criminal justice systems, and other key systems to design and support effective local and state sexual assault system responses for adult and adolescent victims of sexual assault.

- Promote broad-based initiatives aimed at changing attitudes and beliefs that have fostered the acceptance of myths and misconceptions about sexual assault.

- Compile and disseminate findings and recommendations on policy changes, protocol development, and training initiatives to remedy the barriers facing adult and adolescent victims of sexual assault.

The Task Force achieved its goals through the work of four multidisciplinary workgroups: the Prevention Education Workgroup, the Survivor Services Workgroup, the Medical System Workgroup, and the Criminal Justice System Workgroup. Each workgroup was charged with the following:

- Identify barriers to justice and services for survivors of sexual assault.
- Identify short- and long-term remedies to eliminate those barriers.
- Identify strategies for the implementation of the remedies.

These identified remedies are the foundation of the recommendations presented in this report.

The recommendations of the Task Force are broken down into "best practice recommendations" and "recommendations." "Best practice recommendations" address an improvement or change in our policy, protocols or response. "Recommendations" address legislative or fiscal change.

There are many budgetary and staffing considerations inherent in the recommendations to eliminate barriers to justice and services for survivors of sexual assault. This report should not be interpreted to recommend reallocation, diversion, or transfer of resources from existing programs. The Task Force supports the identification and/or development of new funding sources to implement recommendations that require additional money.

Although the Task Force worked consistently and intensively from the conception in April 1999 to the completion in September 2000 on analyzing barriers and researching remedies, it was simply beyond the capabilities of the Task Force to fully address the full spectrum of issues related to a comprehensive systems response to sexual assault. Many systems and institutions, such as the mental health system, prisons, adult foster care, psychiatric hospitals, universities and others, were not addressed as a part of this process but play a vital role in the response to sexual assault survivors and need to be addressed as part of our future work.

It was also beyond the scope of this Task Force to address the sexual assault of children. Although this is a major problem in our society, child sexual assault requires an in-depth and specialized focus that is different from adolescent and adult sexual assault. As more sexual assault programs, the criminal justice system, and medical system begin to work together to develop a unified response to child sexual assault, it becomes more meshed with our work in responding to adolescent and adult sexual assault. Child sexual assault is an issue for future attention.

A note on language: the terms "*victim*" and "*survivor*" are both used in this report to reflect the journey that many people who experience sexual assault make, moving from victim to survivor.

Also, although both women and men are sexually assaulted, throughout this report sexual assault survivors may be referred to as "she" or "her," since the majority of sexual assault survivors are women.

Sexual assault, as referenced in this report, includes rape and other non-consensual sex acts as defined by law.

Sexual Assault Systems Response Task Force Participants

Close to 70 individuals contributed to the creation of these historic recommendations. We would like to extend our thanks to each of them. Through their time, resources, wisdom and dedication they made the creation of these recommendations possible. Individuals are listed along with the organizations they represent and may not reflect the list of endorsing organizations.

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Michigan Protection and Advocacy Services, Inc.

Michigan Sexual Assault Nurse Examiner Council

Michigan State Police

Prosecution Attorneys Association of Michigan

Section 1

Sexual Assault

Prevention Education

Introduction

In order to end sexual assault, we must change the attitudes, beliefs, and actions that perpetuate and justify this violence. Sexual assault is largely supported and condoned by societal attitudes and beliefs. These attitudes and beliefs are conveyed by our laws, by how systems respond to sexual assault, by our culture's portrayal of women, by women's unequal status in society, by the media's coverage of sexual assault, and in interpersonal relationships. Educating our citizens through informational campaigns and presentations and through the media's coverage of sexual assault is a first step in realizing a future free of sexual violence.

The Sexual Assault Prevention Education Workgroup had the large task of addressing the multitude of prevention and education efforts aimed at sexual assault. The Workgroup, comprised of individuals and organizations that either have direct contact with survivors of sexual assault or impact survivors' access to justice and services, focused on universal prevention education programming, training journalists and editors, and doing social change advocacy within the media.

As our knowledge of sexual assault expands, sexual assault prevention education is slowly moving from installing lighting and alarm systems to addressing the realities of acquaintance and intimate partner rape. Despite this movement, very real limitations exist in providing comprehensive prevention education programming from elementary school onward. Many current models and school systems prohibit educators from talking to students about the realities and root causes of sexual assault. Comprehensive, multi-faceted, age-appropriate prevention education programming is a major part of sexual assault social change work and must be available in all schools and other community programs and institutions.

As with prevention education programming, the media is a powerful force in sexual assault social change work. All types of media have the potential to greatly change how we view, discuss and respond to sexual assault. Without accurate information and appropriate training, sexual assault can be one of the most difficult stories a journalist has to cover. Providing specialized training for journalists and raising the standard for how sexual assault stories are covered and reported can help shape a society in which survivors of sexual assault are treated with dignity and respect and sexual assault is recognized as a serious crime.

The Task Force believes that many of the sexual assault prevention education recommendations can be effectively advanced by a careful focusing of current resources and better collaborative efforts of those systems and individuals currently involved in these efforts. New programs that have not been shown through evaluation to have the desired outcomes should only be undertaken on a pilot basis. Substantial new prevention education efforts should include an evaluation component to demonstrate efficacy.

Issues and Recommendations

I. Statewide Sexual Assault Prevention Education

Issue

Sexual assault prevention education is the foundation of our work to end sexual violence. Therefore, a larger coordinated systems effort to collaborate with the existing prevention programs developed and implemented by sexual assault service providers and others doing this work is required.

The goal of sexual assault prevention education is to create a cultural shift in the attitudes that condone, promote, and accept sexual violence. The following recommendations are based on the assumptions that:

- Sexual assault service providers will never be able to end sexual violence by themselves.
- We have little knowledge or research into the effects of prevention education programming.
- Many current prevention programs lack clear, achievable goals and objectives.

Definition of Prevention: Universal Prevention

Although prevention can take place at several different levels, the prevention education workgroup chose to address universal prevention. Universal prevention strategies address the entire population (national, local, community, school, and neighborhood) with messages and programs aimed at preventing sexual assault. The mission of universal prevention is to deter sexual assault by providing all individuals the information and skills necessary to accomplish this. Individual risk is not assessed, but the entire population is seen as capable of benefiting from prevention programs.

Best Practice Recommendations Addressing Sexual Assault Prevention

A. Michigan should develop a statewide plan for sexual assault prevention education. To create this state plan a Sexual Assault Prevention Education Task Force should be formed and should include representatives from the following agencies and organizations: Michigan Coalition Against Domestic and Sexual Violence (MCADSV), Michigan Domestic Violence Prevention and Treatment Board (MDVPTB), educators, substance abuse professionals, prosecutors, law enforcement, sexual assault service providers, healthcare providers, Michigan Department of Community Health, Michigan Department of Corrections, Michigan State Police Prevention Services Section, legislators, university decision makers, and others.

B. The Sexual Assault Prevention Education Task Force will set criteria for the legislation and allocation of resources to create the necessary resources so that every community in Michigan has a prevention education program.

C. Sexual assault should be viewed as a public health problem and a public awareness campaign should be launched to educate the public about the incidence and prevalence of sexual assault, the need for prevention education, and to increase the public's comfort with talking about sexual assault.

D. The Sexual Assault Prevention Education Task Force should review the current use of the Michigan Model in schools for content related to sexual assault prevention, evaluation, grades reached, how much and how often students are being reached through this model, and how many teachers are using it.

E. A forum for prevention education staff should be held at least yearly with the following objectives:
   - to review existing knowledge of successful prevention strategies,
   - to determine best practices in prevention education programming and evaluation,
   - to provide a training for the trainers in reaching specific vulnerable groups, and
   - to conduct an annual review of the state plan for prevention education.

F. With the limited resources for prevention education and the need for program evaluation to create a knowledge base for prevention education efforts, funding sources should encourage the collaboration between researchers, evaluators, and service providers. MCADSV should serve as a clearinghouse between researchers, evaluators, and service providers for the purpose of developing positive relationships among them and to increase the efficiency and benefits of evaluation efforts.

G. The Sexual Assault Prevention Education Task Force should review lessons learned from domestic violence prevention programs and identify areas that are applicable to sexual assault. It is important that sexual assault prevention education learn from other prevention education programs about what has and has not been effective. This information should then be disseminated widely through the aforementioned annual forum, journal articles, the MCADSV Review, and other appropriate venues.

H. There is a need to look beyond the school systems to access populations to target for prevention education. Sexual assault service providers should network and join with other violence prevention groups to increase access to, and partnerships with, a community's high-risk populations that are served by such agencies as Housing and Urban Development (HUD) and Community Mental Health (CMH).

I. Education and substance abuse professionals and the Michigan State Police T.E.A.M. (Teaching, Educating, and Mentoring) School Liaison Program should be looked to as possible partners for sexual assault prevention education programming and for identifying additional resources for prevention programming.

J. To realize a future free of sexual violence, prevention education programming needs to be ongoing from elementary to college, culturally relevant to the audience and linked to services for those who disclose victimization or perpetration before, during, or after the program.

K. Sexual assault prevention education should be geared toward boys and men. Although risk reduction with girls and women is important and should continue, it is not prevention. Because the majority of children, women and men are assaulted by males, prevention needs to be specifically targeted toward males.

L. Sexual assault prevention education programs in schools should include training for teachers, administrators, and coaches before beginning any prevention education programming for students. Because of the prominent and crucial role of school staff and the influence that they have on their students, this specialized programming has the potential to foster an environment within the school that does not condone sexual violence and therefore also supports the philosophy and message of the prevention curriculum.

M. Prevention educators should identify and address contradictory policies and practices that send mixed messages within the organizations targeted for sexual assault prevention education.

II. Working with the Media

Issue

In today's society, the media profoundly influences the thoughts and beliefs of its citizens. It also affects the "political context that shapes social change efforts" (Wallack, Woodruff, Dorfman and Diaz, 1999). Therefore, the media and our use of the media can help or hinder social and attitudinal change with regard to sexual assault. With that said, there are several barriers to working with the media on their coverage of sexual assault. Journalists and editors receive little if any training in school or in the workforce on sexual assault or how to interview victims. While journalists do receive training in investigative reporting skills, this manner of interviewing can revictimize survivors. This lack of education and awareness can lead to stories that promote myths and blame victims. Stories on sexual assault are often presented with no links to the causes of sexual violence, as if each sexual assault occurred as an isolated incident with no relation to the hundreds of sexual assaults that occur daily. These stories are also presented in a

sensationalized manner with the perpetrator often portrayed as the victim and quotes taken out of context. Or, sexual violence is viewed as a non-issue in the community. This coverage creates an environment that is harmful to sexual assault survivors and society in general. On the other hand, systems that work with victims often do not know how to appropriately respond to the media.

The sexual assault prevention education workgroup prioritized the following recommendations to reflect the greatest potential impact of the recommendations and are structured so that the higher priority recommendations build a foundation for the subsequent recommendations to be achieved.

Please note: Several of the following recommendations rely on establishing a strong, state-level network for working with and responding to the media.

"A" Priorities – Vital Best Practice Recommendations for Working with the Media

A. A State-level Sexual Assault Stakeholders Advisory Group (SSASAG), which should include Michigan Department of Community Health, Michigan Coalition Against Domestic and Sexual Violence (MCADSV), Michigan Domestic Violence Prevention and Treatment Board (MDVPTB), Family Independence Agency Rape Prevention Services Program, Michigan Crime Victim Services Commission, Michigan State University, etc., should develop an action plan for the establishment and implementation of a statewide media resource and response network. The action plan should be implemented by a subcommittee of SSASAG.

B. SSASAG should initiate a Media Task Force. SSASAG and the Statewide Sexual Assault Systems Response Task Force Prevention Education Workgroup should recruit members from the following organizations: Michigan State Police Prevention Services Section, Victims in the Media Program at Michigan State University, Michigan Women's Press Association, Associated Press, Michigan Press Association, Michigan Association of Broadcasters, university/college media, local media, and media cable networks.

C. The Media Task Force should develop a Media Guide for journalists that includes facts about sexual assault and a list of sexual assault service providers and individuals who can be contacted for quotes or other background information. The Media Guide should be posted on the web site of the Victims in the Media Program at Michigan State University for dissemination.

D. Sexual assault service programs and other systems should build relationships with journalists and editors. An action plan to provide technical assistance to sexual assault programs should be developed by the Media Task Force.

E. The Media Task Force should encourage college and university journalism programs to research the public's response to both accurately covered sexual assault stories and victim blaming, sensationalistic and inaccurate sexual assault stories (e.g., is sexual assault coverage promoting the myth that perpetrators of sexual assault are strangers).

F. An action plan to provide training for sexual assault program staff on working with the media should be developed by the Media Task Force, in collaboration with Victims and the Media Program at Michigan State University. In addition, the curriculum for this model should be disseminated to all sexual assault programs.

G. The Michigan Resource Center on Domestic and Sexual Violence should develop and distribute an information packet of tips for working with the media.

H. SSASAG and its Media Task Force should explore with MCADSV the possibility of establishing a media coordinator position at MCADSV. This exploration is to include the identification and development of resources for such a position.

"B" Priorities – Important Best Practice Recommendations for Working with the Media

A. The Victims and the Media Program at Michigan State University should partner with MCADSV and local sexual assault programs to provide education to journalism students on the realities of sexual assault and how to interview victims with a view toward future expansion to other schools of journalism.

B. Sexual assault programs should monitor their local media and give good news/bad news awards for accurate coverage and for harmful coverage of sexual assault.

C. The Media Task Force should develop a statewide media response team of sexual assault experts, so that the press can have a contact twenty-four hours a day seven days a week.

D. The Media Task Force should provide technical assistance to agencies (e.g., Forensic Nurse Examiner programs, law enforcement, prosecutors and sexual assault programs) to develop a media strategy, including how to appropriately respond to the media with high profile cases.

E. The Media Task Force, in collaboration with Michigan's media professional organizations, should develop and provide training to help journalists deal with secondary trauma.

"C" Priorities – Valuable Best Practice Recommendations for Working with the Media

A. The Media Task Force, in collaboration with sexual assault programs, should develop a Speaker's Bureau to respond to requests for sexual assault training and presentations.

B. The Media Task Force and others engaging in prevention education should use media that is age, language and culturally appropriate to the group being targeted and should explore all media options for information dissemination.

C. The Media Task Force, in collaboration with sexual assault programs and other systems, should educate the community on "rules" journalists work under so that individuals in the community can respond to the media in an appropriate manner and know their rights with the media.

D. The Media Task Force, in collaboration with sexual assault programs and other systems, should work to motivate community members to respond to inaccurate, sensationalistic, and victim-blaming media coverage.

Future Issues to be Addressed

Sexual assault prevention education is a very complex and multi-faceted issue that encompasses a broad range of strategies, institutions and disciplines. Therefore, it was not possible for this Task Force to comprehensively address all issues related to sexual assault prevention and education. The Task Force has identified several vital issues that need further attention and research.

Sexual assault prevention geared toward boys and male adolescents in elementary, middle and high school has the potential to reduce sexual assault. Because the majority of children, women and men are assaulted by males, prevention efforts need to be targeted toward males. Although risk reduction for women is important, it is not prevention. Because prevention programming designed specifically for males is not offered or allowed in many schools, thoughtful consideration should be given to the idea of legislatively mandating sexual assault prevention education in all elementary, middle and high schools in Michigan. Due to the geographic and cultural diversity in Michigan, a uniform prevention education curriculum should not be created or utilized. Rather, local or regional areas should work with sexual assault programs to fulfill this mandate.

It was beyond the purview of this Task Force to comprehensively address adolescent sexual assault. The workgroup recognizes that adolescents are at high risk for both perpetration and victimization and need special prevention and intervention programming.

There is a dearth of evaluation on sexual assault prevention education, especially at the elementary, middle and high school levels. Without evaluation, the effectiveness of our prevention or education efforts remain unknown. There are several barriers to conducting viable and widespread evaluation. One barrier is a lack of adequate funding for sexual assault prevention education programs to conduct in-depth evaluation or to contract with a professional evaluator. There is also a lack of training for educators to design their own curriculum specific evaluations and analyze their results. Without viable evaluation results sexual assault prevention education programs have a difficult time proving the effectiveness of their programming to outside sources. Michigan's sexual assault prevention education efforts would be greatly improved by increased funding, training and the creation of a collaborative network for educators to share evaluation strategies and outcomes. The magnitude of this issue demands further action.

Section 2

Survivor Services

Introduction

The Survivor Services Workgroup studied the current level of services available to adolescent and adult sexual assault survivors in Michigan and the barriers to accessing those services. The workgroup then embarked on an in-depth discussion of what is needed to ensure that basic services are appropriate and available to all adolsecent and adult survivors of sexual assault. In addition, the workgroup outlined a blueprint of growth for sexual assault programs to move into enhanced services and community collaboration. The overwhelming barrier that the survivor services workgroup identified is the lack of funding for even core services in every county. The following recommendations were born out of that discussion and research.

"Recovery from rape is a lengthy process during which victims may require a range of different services at multiple points in time" (Koss, Goodman, Browne, Fitzgerald, Keita & Russo, 1994). One study found that 48 percent of non-recent sexual assault survivors stated that they had to eventually seek help for rape-related issues (Koss et al., 1994). The support and validation that survivors receive at sexual assault programs are vital components of their recovery process. Sexual assault programs also facilitate survivors' successful navigation through criminal justice, medical and other systems. Sexual assault is unlike other crimes in that it is about "loss of control, loss of ownership, and loss of power over the one thing that is yours and no else's: your body" (Poskin, 1999). Sexual assault is the most degrading, demeaning and humiliating violation perpetrated by one person against another (Poskin, 1999). It is important for a survivor of sexual assault to work with a counselor or advocate who understands the causes of sexual assault and the impact sexual assault has on a survivor's life. For example, many women have learned to use drugs or alcohol to self medicate the pain of sexual assault. If the counselor does not understand the impact of sexual assault, they may see alcohol or drug use as the most serious or the only problem in that survivor's life and may not do victim-centered counseling focusing on the impact of sexual assault (Poskin, 1999). In addition, sexual assault programs play a key role in the education of their community about sexual assault. Education and awareness can create a community commitment and investment to the development of a comprehensive survivor-oriented response to sexual assault and to ending sexual violence. Sexual assault programs provide the unique counseling and advocacy services that survivors need, as well as doing community awareness and systems collaboration work. Traditional counseling and community mental health settings rarely provide these specialized services.

These recommendations are intended to provide an outline of comprehensive services that should be available for all adolescent and adult sexual assault survivors in Michigan. Most of these recommendations for survivor services will require greater resources than those currently available for sexual assault programs.

Issues and Recommendations

I. Need for Services - Core, Additional, Enhanced

Issue

Many counties in Michigan have some level of sexual assault services, although there are many areas of the state that have either no sexual assault services or are underserved, requiring sexual assault survivors to either drive long distances to receive services, to receive services from providers without specialized rape crisis counseling/advocacy knowledge, or to go without services. Relatively few counties have additional or enhanced sexual assault services.

At a minimum, most survivors should have access to a 24-hour crisis line, short-term individual or group counseling, court advocacy, hospital advocacy and police advocacy. There is a need to ensure comprehensive sexual assault services in all counties in Michigan for sexual assault survivors. The following outline of services and collaboration occurs along a continuum with the previous set of services or collaboration providing the building blocks to move to a higher level of service. The higher or more comprehensive the level of services or collaboration, the more resources that are needed. As with most social service agencies, sexual assault programs utilize volunteers in a variety of important roles. However, the following service recommendations are predominately fulfilled by staff.

Core (Basic) Services Best Practice Recommendations

Core (Basic) services are those services that at a minimum should be in operation in every county to ensure a safety net for all survivors of sexual assault. Once these basic services are in place, additional and enhanced services can be added.

A. Base cost to provide core services is projected to be $170,000 per population of 500,000. Communities with higher populations will need a corresponding increased level of money. This cost projection was developed through careful analysis of the costs to provide each of the core services listed below. Core services refer to the following services:

24-hour crisis intervention – provision of crisis intervention either in person or by phone to alleviate acute distress of sexual assault.

24-hour medical advocacy – acting on behalf of and in support of victims of sexual assault on a 24-hour basis to ensure their interests are represented and their rights upheld by assisting victims in regaining personal power and control as they make decisions regarding medical care and by promoting an appropriate response from individual healthcare professionals.

24-hour legal advocacy – acting on behalf of and in support of victims of sexual assault on a 24-hour basis to ensure their interests are represented and their rights upheld by assisting victims in gaining knowledge of the criminal justice system, by gaining access to all avenues of participation in the legal system and by promoting the responsiveness of individual criminal justice professionals.

Information and referral – responding 24 hours a day in person or by phone to direct requests for information or assistance related to sexual assault.

Short-term individual counseling – provision of individual short-term counseling (up to one year or what the sexual assault program determines within its policy) or on an episodic basis in order to facilitate the survivor's identification and understanding of the effects of the sexual assault, to ameliorate the effects of the assault and to promote healing and integration of the sexual assault.

Group counseling – regular facilitated meeting of survivors with a supportive and educational focus, lasting 2 months to 1 year or what the program determines within its policy.

Services for significant others – provision of crisis intervention, information and referral, short-term and/or group counseling for family and friends of sexual assault survivors to minimize their distress and to increase their awareness of the dynamics and effects of sexual assault.

System coordination – the development of working relationships and agreements (formal and informal) among programs and services with a role in the array of sexual assault service provision with the goal of improving service delivery.

Community awareness – informing the community and increasing awareness of and knowledge about sexual assault and the sexual assault program's services through brochures, public education presentations, and presentations in the school system.

(Partially adapted from Washington State Sexual Assault Services Advisory Committee, 1995)

B. Training standards for sexual assault counselors and advocates should be developed through a statewide workgroup of service providers and survivors.

Core (Basic) Services Recommendations

A. The executive branch and the legislature should work together to designate funding to support core services for sexual assault survivors in our communities (including tribal communities).

B. In the fiscal year 2000-2001 appropriations process, a Michigan Coalition Against Domestic and Sexual Violence proposal to obligate Temporary Assistance to Needy Families (TANF) money to sexual assault prevention programs to reduce out-of-wedlock "teenage" pregnancies resulted in a 1.5 million dollar allotment. This represents an important recognition of the need for sexual assault services. Efforts should be made to identify stable and permanent funding sources for core sexual assault services.

Additional Services Best Practice Recommendations

Additional services are an expansion in depth and breadth of the core services. Core services must be in place before they can be expanded to this level.

A. **Sexual assault prevention education in the school system –** these programs would have a more advanced content and longer duration (e.g., 2 days to ongoing) than the core services requirements and would address the root causes of sexual assault and promote attitudes, behaviors, and social conditions that will reduce and ultimately eliminate factors that cause or contribute to sexual violence.

B. **Community events –** develop and implement community-wide events such as Take Back the Night Marches to raise awareness of sexual assault.

C. **Sexual Assault Response Team –** sexual assault programs should participate in the establishment of a Sexual Assault Response Team (SART) program.
A SART is a formalized team with specific protocols and defined roles. The SART should include law enforcement, medical personnel (including, but not limited to a Forensic Nurse Examiner) and a victim advocate. Wherever the survivor enters the system — a police station, an emergency department or by calling a sexual assault program's crisis line — the SART can be activated. A SART has the potential to provide a greater continuum of care for sexual assault survivors, increased quality of care for survivors, and a reduction of the secondary trauma survivors often experience as they move through the medical and judicial/law enforcement systems. SART programs can also increase the investment in providing a better response to survivors of sexual assault by all team members and keep the response survivor-focused. If survivors of sexual assault experience a more compassionate and collaborative response, they may be more likely to want to make a police report and participate in prosecution.

D. **Participation in coordinated community councils and other related task forces.**
Sexual assault programs should develop the organizational capacity to participate in coordinated community councils and other task forces. Organizational capacity refers to the monetary and staffing resources sufficient to participate in community task forces and committees. Organizations need adequate staff to be able to cover both services and outside meetings. Sexual assault programs also need to know what relevant task forces and other community organizing activities are happening in their community in order to participate. Some examples include school violence prevention task forces, substance abuse councils and faith-based organizations/councils. These types of task forces or councils do not exclusively work on sexual assault issues, but sexual assault is an issue that impacts their work.

E. **Capacity to work with the media.**
Sexual assault programs need sufficient resources (monetary and staffing) to respond to the media's requests for quotes, to write letters to the editor regarding coverage of sexual assault, to develop relationships with the local media (e.g., newspaper, television and radio reporters and editors), and to promote articles that address sexual violence. Cases under investigation should not be commented on.

F. **Long-term counseling** – ability to provide long-term counseling for sexual assault survivors (e.g., one year or more or what the sexual assault program determines within its policy).

G. **Special issue/population counseling –** ability to provide counseling for sexual assault survivors with special needs (e.g., teens, survivors with disabilities) or issue specific counseling (e.g., child sexual abuse survivors). This may be short- or long-term counseling.

Enhanced Services Best Practice Recommendations

These enhanced services complete the continuum of care with sexual assault programs offering a comprehensive and broad range of programming to holistically meet the needs of all sexual assault survivors. Ideally, all sexual assault programs in Michigan will, with the advent of additional resources, be providing services at this level.

A. **Forensic Nurse Examiner Programs** – participate in the establishment of a Forensic Nurse Examiner (FNE) program (see medical system recommendations in FNE program development in Section 3).

B. **Provision of comprehensive advocacy** – wrap-around advocacy in which advocacy is provided for all the survivors' needs and is guided by the survivor.

Comprehensive advocacy refers to advocacy that meets the holistic needs of the sexual assault survivor rather than advocacy that is solely assault related. Examples include advocacy for housing, transportation, health insurance, employment, food, shelter, substance abuse treatment, FIA benefits, driver education, English as a second language classes, immigration rights, special needs, etc. Advocacy that is driven by the survivor means that the survivor identifies her needs, prioritizes her needs, and the advocacy is based on what she wants rather than what the advocate believes is best for the survivor. Comprehensive advocacy is a stand-alone service, meaning that the survivor does not have to be receiving other services from the program to receive advocacy.

C. **Involvement in systems change work.**
At this level, the systems change work is constant, ongoing and incorporated into the sexual assault program's daily work. The sexual assault program engages in training and cross training with other systems and is involved in policy education and advocacy on a local and state level. The recommendations contained in the following section outline this further.

II. Need for Cooperation, Coordination, Collaboration

Issue
Any community that coordinates their efforts to address sexual assault will be more successful than a community whose systems and individuals work in isolation to address sexual assault. There can be different levels of working together that are appropriate for the specific need, issue, or task, or for the capacity of the relevant organizations.

For example, a rape crisis center may set up a **cooperative** relationship with a local deaf service organization for interpreter services so that the rape crisis center can provide services to deaf sexual assault survivors. The deaf services organization may not have the capacity or interest in being a part of a coordinated community response to sexual assault but will work with the rape crisis center to meet interpretation needs.

The provision of medical advocacy may require a greater development of working relationships than just cooperation. A local hospital may agree to contact the sexual assault program when a sexual assault survivor enters the emergency department to have an advocate respond to the hospital. The hospital and the rape crisis center may **coordinate** to revise or create protocol to support this agreement. There may not be a task force or other collaborating body in place or the hospital may not want, at this time, to be a part of a group that does exist but will coordinate services with the sexual assault program and law enforcement. In smaller communities, coordination may work to fill gaps in services and to create a more barrier-free and united response to sexual assault.

Collaboration is an end goal, especially in large communities. Ideally, collaboration creates a safety net with no holes for survivors to fall through. Collaboration is an in-depth working relationship where each discipline has a defined role and responsibility and there is mutual understanding of others' roles and responsibilities — often this is in writing. This collaboration can create a community-wide protocol for responding to sexual assault. There is no one way of creating a collaborative response to sexual assault, and individual community differences must be taken into account. While collaboration is an end goal, there are several issues that must be acknowledged when working toward this. A formal collaborative model works when there are enough people in the community who care about the issue to come together to address it. The Duluth Coordinated Community Response (CCR) model, for example, evolved after years of community education that built a commitment to ending domestic violence (Thornley, 1999). Most communities have lacked the time and resources to engage in this intensive building process (Thornley, 1999). The community commitment and education must be built before a collaborative response is going to be successful. A survey conducted by the Wisconsin Coalition Against Sexual Assault over a six-month period from 1997 to 1998 found that out of 57 Coordinated Community Response projects funded in the State of Wisconsin, only 5 were distinct Sexual Assault CCR projects (Thornley, 1999). There are counties in Michigan with zero reported sexual assaults and many more that have less than a dozen reported sexual assaults in a year. If one looks at the report rate to make a case for a collaborative response to sexual assault it may be difficult to convince a community that such a response is needed. Education and relationship building need to be occurring.

Best Practice Recommendations for Cooperation, Coordination, Collaboration

A. Sexual assault programs and the systems and individuals in their community should work together to define the roles, duties, and responsibilities of the criminal justice system, the medical system, victim advocates, and other professionals in responding to sexual assault. This is the foundation of all cooperation, coordination and collaboration.

B. Sexual assault programs and the systems and individuals in their community should work together to educate the community about the nature and prevalence of sexual assault.

C. Sexual assault programs and the systems and individuals in their community should work together to engage in cross training as "trainees" as well as "trainers." Sexual assault programs should train on dynamics of sexual assault, survivor responses, and service provision. Trainers from law enforcement should be certified by MCOLES (Michigan Commission on Law Enforcement Standards).

D. Sexual assault programs and the systems and individuals in their community should work together to network to gain awareness and knowledge of services provided in the community.

E. Sexual assault programs and the systems and individuals in their community should work together to refer survivors to other direct service programs when appropriate.

F. Sexual assault programs and the systems and individuals in their community should work together to build mutual trust and respect in their community.

G. Sexual assault programs and the systems and individuals in their community should work together to create a framework for collaboration. This includes deciding how decisions will be made, deciding who the participants will be, where meetings will be held, who gets a vote, who sets the agenda, and other issues related to developing a truly collaborative body.

H. Sexual assault programs and the systems and individuals in their community should work together to establish community protocols for responding to sexual assault survivors.

I. Per the recommendation in the 1999 Urban Institute Evaluation of the STOP (Services, Training, Officers and Prosecutors) Formula Grants, state STOP agencies should increase their attention to sexual assault by including representatives from state sexual assault coalitions and sexual assault programs on the planning committee and by utilizing the technical assistance offered through the STOP-TA (Technical Assistance) Project to identify and support innovative approaches to services for sexual assault survivors. If the level of STOP funding increases this would be an ideal way of supporting sexual assault collaborations.

J. Sexual assault programs should promote within the agency a cooperative and professional working relationship with, and understanding and respect for, the role and responsibilities of the healthcare professional's, the prosecuting attorney's and law enforcement's handling of sexual assault cases.

K. Sexual assault programs should serve on councils and/or task forces in their community.

L. Sexual assault programs across Michigan need to collaborate with one another on projects, information sharing and development of best practices. This will improve services to all survivors.

M. Sexual assault tribal and non-tribal programs should establish a collaborative agreement, in writing, that defines roles, responsibilities, and services of each program in order to increase native survivors access to the services that the survivor deems most appropriate.

III. Need to Reach "Underserved" Survivors

Issue

"Traditionally Underserved Populations" refers to those survivors to whom sexual assault programs are not regularly providing services. Examples often include lesbian, gay, bisexual and trans survivors; survivors with physical and/or mental disabilities; teen survivors; women of color survivors; male survivors; elderly survivors; survivors in institutions; and survivors whose native language is not English. There are many barriers that these and other survivors encounter when seeking justice and services, and many may not even know that the sexual assault program exists. Although sexual assault programs do not currently have the resources to provide services to all survivors of sexual assault, it is imperative that we build with a goal of providing services to all survivors, either through the sexual assault program or by training other social service agencies. The best solution may not always be that the sexual assault program provides the services, but may be to facilitate that community (e.g., the lesbian, gay, bisexual, transgender community) in providing services to survivors of sexual assault.

The following recommendations require sexual assault programs to be flexible and creative to expand and enhance services for all survivors of sexual assault. Many of the recommendations will also require additional monetary or staffing resources to accomplish, and will take time. Each community should strategize according to its need, population and resources.

Best Practice Recommendations for Outreach to "Underserved" Survivors

The following recommendations are a step-by-step guide for sexual assault programs to follow as they reach out to previously underserved survivors.

A. Sexual assault programs should periodically review the demographic make-up of their community. Data sources include the Census Bureau and web sites operated by cities and counties.

B. Sexual assault programs should have staff, policies, and materials that reflect the diversity of their community.

C. Sexual assault programs should collaborate and build relationships with community leaders and service organizations of traditionally underserved populations in their community.

D. Sexual assault programs should conduct a community needs assessment that includes the involvement of diverse groups in the community.

E. Sexual assault programs should analyze why some survivors of sexual assault are underserved

and determine how to appropriately respond. For example, talk with community organizations or leaders that you have a relationship with about how your organization is viewed by that population and how best to address the issue of sexual assault in that community.

F. Sexual assault programs should develop an Annual Plan for the organization that addresses the needs of the community including an outreach plan for underserved populations. The Annual Plan should be developed with the input of community leaders and service organizations of traditionally underserved populations in the community.

G. Sexual assault programs will not have the capacity to do outreach to all underserved survivors in their community but will have to strategically choose which populations to tar get their outreach efforts.

H. Because the best solution may be to help a community to provide services to its members, the sexual assault program's outreach plan may be to work with a specific population in developing sexual assault services.

I. Sexual assault programs should train staff on special considerations when working with the population that the program decided to do outreach to before starting the outreach.

J. Sexual assault programs should have direct service staff visible in the community as part of their outreach plan.

K. Sexual assault programs should implement culturally appropriate and language appropriate outreach activities.

L. Sexual assault programs should use the media (Internet, magazines, newspaper, radio, television, etc.) to raise awareness about sexual assault services.

IV. Need for Services to be Accessible

Issue

Sexual assault programs need to be accessible to survivors of sexual assault. This should be a standard of service. Accessible refers to physically accessible, but goes beyond that as well. Compliance with the Americans with Disabilities Act is one example of being physically accessible. Accessibility also refers to the hours programs provide services – are counselors available after 5:00 p.m. to do individual or group counseling? Programs can increase accessibility by being located on a bus line, by being in a safe location and by providing childcare so survivors can attend individual and/or group counseling. Creating a comfortable

space with artwork, program materials, staff, etc. that reflects the diversity of the community also creates accessibility. Listed below are several aspects of creating or having accessible services for sexual assault survivors. Each community's remedies for increasing accessibility will be slightly different depending upon geography, community resources and survivor needs. Many of these recommendations will require additional monetary and staffing resources.

Best Practice Recommendations for Increasing Accessibility

A. Sexual assault programs should reduce or eliminate structural and physical barriers that prohibit survivors with disabilities in accessing services.

B. Sexual assault programs should provide services at no cost to survivors.

C. Sexual assault programs should provide childcare for survivors so they can attend individual/group counseling or court proceedings.

D. Sexual assault programs should provide transportation for survivors to attend counseling and support groups.

E. Sexual assault programs should be willing to go to the survivor to provide counseling — at their house or a public location near their home — if the survivor is unable to go to the program location.

F. Sexual assault programs should consider location of their program. Is the program private, is it in a safe location, and is the program located on a bus line? Location can increase or decrease accessibility to survivors.

G. Sexual assault programs should have satellite offices, especially if the program covers more than one county or covers a large county with no public transportation.

H. Sexual assault programs should have flexible program hours including nights and weekends.

I. Sexual assault programs should add TDD/TTY (telecommunications device for the deaf) technology on their crisis line.

J. Sexual assault programs should provide interpreter services for nonverbal survivors.

K. Sexual assault programs should add language line services (some phone companies have a

language line service that employs translators). Careful consideration should be given to this option as cultural differences within a language can lead to miscommunication and misunderstandings.

L. Sexual assault programs should be culturally accessible. Sexual assault program's staff, magazines, artwork, program materials, etc. should be reflective of program philosophy and service recipients.

Future Issues to be Addressed

Although the survivor services workgroup addressed the general provision of services in a comprehensive manner, it was simply beyond the capabilities of this Task Force to address all of the details as they relate to special populations of survivors. As Michigan works to implement the recommendations in this report, there are several important issues left to study.

Campus sexual assault programs bring many unique issues to the discussion of survivor services. Issues of outreach to the general community when there is no other service provider or an overlap of services when there are other providers needs special recommendations. Also, providing services within a campus environment requires some special outreach and accessibility tactics. These are special considerations for future study.

Sexual assault programs benefit from collaborating and communicating with one another. The creation of a statewide think tank for sexual assault programs to discuss and explore philosophy, knowledge and practice should be considered to develop model practices for Michigan.

Individuals confined in institutions such as penal institutions, youth homes, nursing homes and psychiatric hospitals are extremely vulnerable to sexual assault. The nature of these settings often discourages reporting and the receipt of services. The special issues attendant to sexual assault within institutional settings requires further attention and focus.

Section 3

The Medical System

Introduction

The purpose of this workgroup was to provide healthcare professionals with guidelines for responding to the medical needs of survivors of sexual assault and to address current issues in forensic evidence collection. This multi-disciplinary workgroup was comprised of individuals and organizations that either have direct contact with survivors of sexual assault or impact survivors' access to justice, treatment and services.

Although most sexual assault survivors do not sustain serious physical injury as a result of the assault (Kilpatrick et al., 1992), many survivors still access the medical system for sexually transmitted disease (STD) treatment, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) testing, emergency contraception, forensic evidence collection and medical care. Sexual assault also has health effects that extend beyond the immediate medical and forensic needs. Kimerling and Calhoun (1994) found that rape victims seeking care at a rape crisis center had more self-reported physician visits than non-victims up to one-year after the sexual assault. There have been many long-lasting symptoms and illnesses that have been associated with sexual victimization including gastrointestinal disorders and a variety of chronic pain disorders including pelvic, back and facial pain and headaches (Crowell and Burgess, 1996). Given the fact that healthcare facilities are a common point of entry for sexual assault survivors, the medical system is in a unique situation to identify survivors of sexual assault and to refer them to counseling and advocacy services.

Research has shown that the response by healthcare professionals can either increase or diminish survivors' psychological consequences of sexual assault (Cohen, Donohue and Kovener, 1996). As initial responders in many sexual assault cases, the medical system plays an important role in survivors' recovery. This workgroup's goal was to make recommendations that will assist in creating a more sensitive and effective response to sexual assault.

Issues and Recommendations

I. Coordination of Supporting Disciplines

Issue

Rape is a complex, multifaceted problem that no one person or group can resolve alone. Therefore, dealing with sexual victimization requires the collaborative and cooperative efforts of a network of services (Burgess, Fawcett, Hazelwood & Grant, 1995). Without coordination, survivors often receive fragmented non-continuous care. Survivors of sexual assault may not be informed of vital services, such as advocacy and counseling or no-cost follow-up medical care, due to lack of time, organization and/or knowledge on the part of healthcare professionals.

Best Practice Recommendations for Coordination of Supporting Disciplines

Also refer to the recommendations for the mandatory reporting of sexual assaults by medical personnel.

A. Where a sexual assault program advocate is available, the emergency department and sexual assault program should work together to enhance the provision of immediate care and support for survivors. Law enforcement is also a resource for survivors of sexual assault.

B. Hospital staff, physicians, health department nurses, alcohol and drug treatment counselors, dentists, health educators, prenatal healthcare providers, HIV/AIDS counselors, psychologists, social workers, family planning specialists and mental health providers need to be aware of the services available for sexual assault survivors in their community and make appropriate referrals.

C. The medical system should participate in or initiate the community development of a victim-centered coordinated community plan to respond to sexual assault in order to better serve the immediate and long-term needs of sexual assault survivors.

> *Well-planned multidisciplinary community response plans have been demonstrated to be cost effective while diminishing further harm to the [sexual assault] patient and providing comprehensive care (American College of Emergency Physicians, 1999).*

D. The medical system should be included in Sexual Assault Response Teams (SART). A SART is a formalized team with specific protocols and defined roles. The SART should include law enforcement, medical personnel (including, but not limited to a Forensic Nurse Examiner [FNE]) and a victim advocate. Regardless of where the survivor enters the system — a police station, an emergency department or by calling a sexual assault program's crisis line — the SART can be activated. A SART has the potential to provide a greater continuum of care for sexual assault survivors, increased quality of care for survivors and a reduction of the secondary trauma that survivors often experience as they move through the medical and judicial/law enforcement systems. SART programs can also increase the investment in providing a better response to survivors of sexual assault by all team members and keep the response survivor-focused. If survivors of sexual assault experience a more compassionate and collaborative response, they may be likely to make a police report and participate in prosecution.

E. The emergency department directors should promote within the department a cooperative and professional working relationship with, and understanding and respect for, the role and responsibilities of the local sexual assault service programs, the prosecuting attorneys and law enforcement.

II. Mandatory Reporting of Sexual Assaults by Medical Personnel

MCL 750.411 MCL § 750.411; MSA § 28.643 It shall be the duty of every person, firm or corporation conducting any hospital or pharmacy in this state, or the person managing or in charge of such hospital or pharmacy, or in charge of any ward or part of such hospital, to which any person or persons suffering from any wound or other injury inflicted by means of a knife, gun, pistol or other deadly weapon, or by other means of violence shall come or be brought, to report the same immediately, both by telephone and in writing, to the chief of police or other head of the police force of the village or city in which such hospital or pharmacy is located, or to the sheriff of the county, if such hospital or pharmacy is located outside the incorporated limits of a village or city. Such report shall state the name and residence of such person, if known, his whereabouts and the character and extent of such injuries. It shall also be the duty of every physician, or surgeon, who has under his charge or care any person suffering from any wound or injury, inflicted in the manner above mentioned, to make a like report to the appropriate officers herein above named. Any person, firm or corporation violating any provision of this section shall be guilty of a misdemeanor.

Issue

Many healthcare and criminal justice professionals have found this statute to be rather vague and question its applicability as it relates to sexual assault. Reportedly, there is some confusion as to whether emergency department personnel should contact law enforcement under this statute in the case of a sexual assault. The following recommendations are made to address this uncertainty.

Recommendations for the Mandatory Reporting of Sexual Assaults by Medical Personnel

A. The Michigan Domestic Violence Prevention and Treatment Board should initiate a task force to discuss and provide guidance on the implications of mandatory reporting due to the complexity of issues involved. The discussion should include discussion of careful consideration of the patient's right to privacy.

B. At a minimum, this task force should include organizations and individuals representing law enforcement, prosecutors, sexual assault programs, and healthcare professionals.

III. Training

Issue

There is minimal training in medical and nursing schools on meeting the medical and emotional needs of sexual assault survivors as well as on conducting forensic evidence collection. According to a Colorado survey, fifty-six percent of physicians and sixty-three percent of nurses indicated that they received no forensic training (Cohen et al., 1996). Healthcare providers reported that the first time they became familiar with the forensic evidence collection kit was when they were forced to complete one. Lack of training often results in inconsistency of care, incorrect or incomplete forensic examinations and inappropriate documentation. All medical professionals who currently conduct sexual assault evidence collection need specialized training. All trauma responders should possess the same level of competence in responding to sexual assault that they have to respond to other types of trauma (i.e. heart attack, drug/alcohol withdrawal, gun shot, etc.). The goal is to improve the healthcare response to sexual assault survivors through ensuring that all healthcare professionals have a basic understanding of the dynamics of sexual assault and how to appropriately respond to survivors.

Best Practice Recommendations for Training for Healthcare Professionals

A. All healthcare facilities that provide treatment to sexual assault survivors should follow the recommendations outlined in *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient,* a guide by the American College of Emergency Physicians (ACEP) and the Michigan State Police's *Standard Recommended Procedures for the Emergency Treatment of Sexual Assault Victims*.

B. Healthcare professionals that provide medical care and collect forensic evidence should demonstrate competence in the following areas: multidisciplinary team concept; dynamics of sexual assault; sexual assault forensic examination; proper handling of evidence (maintaining chain-of-evidence); anatomy and physiology as it relates to sexual assault; psychological aspects of sexual assault; the role of the forensic examiner in the criminal justice system; medical management of sexually transmitted infections, HIV, and pregnancy; and services available to survivors. These recommendations have been outlined in *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient,* a guide by the American College of Emergency Physicians.

C. Training on forensic evidence collection should utilize the Michigan State Police's *Standard Recommended Procedures for the Emergency Treatment of Sexual Assault Victims.* The Prosecuting Attorneys Association of Michigan (PAAM) and the Michigan State Police (MSP) Crime Lab should be included to address the methodology and procedures of evidence collection.

D. Healthcare facilities should provide training on the above mentioned topics. Trainers can include the local sexual assault program, prosecutors office, law enforcement agency, forensic nurses, health department and other local and national experts in the care of sexual assault survivors.

E. Training should be provided to healthcare professionals on effective, culturally competent, communication with victims including the use of interpreter services and assistive technology.

F. Training for healthcare professionals should also address how to appropriately document in cases of sexual assault. Documentation should be fact-based, use quotes whenever possible and make no judgmental statements. This training should include prosecuting attorneys.

G. The MSP Crime Lab should communicate with evidence collection sites (i.e., hospital emergency department and SANE programs) regarding the quality of sexual assault forensic evidence collection kit completion in order to improve the consistency of evidence submitted for analysis.

H. Healthcare facilities should comply with the Joint Commission on Accreditation for Healthcare Organizations (JCAHO) guidelines requiring emergency and ambulatory care facilities to have protocols on rape, sexual molestation, and domestic violence. To meet these guidelines, healthcare providers must develop services that identify and document cases of sexual assault and refer victims to agencies that can provide further support and advocacy. According to the JCAHO guidelines, appropriate management of the patient requires a standardized clinical evaluation as well as effective interface with law enforcement for the handling of forensic evidence and coordination of the continuum of care with a community plan. It also requires the healthcare providers to address the medical and emotional needs of the patient while addressing the forensic requirements of the criminal justice system. Medical issues include acute injuries and evaluation of potential sexually transmitted diseases and pregnancy. Emotional needs include acute and non-acute crisis intervention and referral for appropriate follow-up counseling, support and advocacy. Forensic tasks include thorough documentation of pertinent historical and physical findings, proper specimen collection and handling of evidence, and presentation of findings and conclusions in court.

I. Healthcare professionals should also receive training on evidence collection techniques with suspects. It is useful in police investigations to collect forensic evidence from the suspect as well as the survivor. The Michigan sexual assault evidence collection kit can be used for collecting evidence from suspects as well as survivors.

J. The Michigan State Police should post the Michigan State Police's *Standard Recommended Procedures for the Emergency Treatment of Sexual Assault Victims* on their web site.

K. In addition to the specialized training for those who provide medical care and collect forensic evidence, all healthcare professionals including: alcohol and drug addiction treatment professionals; dentists; emergency department staff; emergency medical services staff; health educators; medical, nursing and EMS (emergency medical services) students; nurses; obstetricians and gynecologists; osteopaths; primary care physicians; physicians assistants; prenatal healthcare providers; family planning providers; health department nurses; school nurses; and personnel in nursing homes should receive training by their agency on the basic dynamics of sexual assault and how to appropriately respond to sexual assault survivors.

IV. Forensic Nurse Examiner (FNE) Program Development

Issue

Current treatment of sexual assault survivors in traditional emergency department settings oftentimes revictimizes survivors seeking care. Because the vast majority of sexual assault survivors do not sustain serious physical injuries the survivor can wait sometimes up to twelve hours while not being allowed to urinate, drink, shower or change her clothes in order to preserve physical evidence (Thomas and Zachritz, 1993). In seeking ways to treat and collect evidence from sexual assault survivors with more sensitivity and effectiveness, and to ensure empowerment rather than revictimization, some communities have established Forensic Nurse Examiner (FNE) Programs or Sexual Assault Response/Resource Teams (SART) (Lang, 1999). Although most FNE programs started by conducting forensic and medical exams with sexual assault survivors, these programs have increasingly been used to conduct forensic exams (document, collect evidence and treat injury and trauma) with domestic violence survivors. Because of the common application in sexual assault cases, many Nurse Examiner Programs refer to themselves as Sexual Assault Nurse Examiner (SANE) programs.

A FNE program includes the use of a clinician (usually a registered nurse or a nurse practitioner) who conducts the forensic examination of the sexual assault victim (Lang, 1999). Forensic nursing is the application of nursing science to public or legal proceedings that involve the investigation or treatment of trauma or death of victims and perpetrators of criminal violence (Patricia Speck, "Forensic Principles and Primary Care," 29th Annual Review Course). The clinician is specially trained in forensic evidence collection, sexual assault trauma response, forensic techniques using specialized equipment, expert witness testimony, assessment of injuries, STD treatment, and pregnancy evaluation and treatment (Cohen et al., 1996; Ledray, 1998). This clinician is often referred to as a Forensic Nurse Examiner (FNE). A FNE typically responds to a call within one hour and can complete evidence collection more efficiently and effectively.

This Task Force recommends developing Forensic Nurse Examiner (FNE) Programs as a way of increasing the quality of care to survivors of sexual assault. However, we also recognize that FNE Programs require considerable investments of time and resources and may take communities years to develop. Therefore, the previously described training recommendations should be followed in the absence of a FNE program. There is rigorous, specialized training that is necessary to implement a successful FNE program. Sexual assault survivors have a right to specialized, compassionate treatment and care (Lang, 1999).

Best Practice Recommendations for Forensic Nurse Examiner Program Development

A. The medical system should promote the development of FNE programs by collaborating with other systems in the formation of the program. Utilization of medical facilities for the location of the FNE program can be an important resource that the medical community can offer. Many FNE programs are located within medical facilities such as emergency departments, women's health centers and community health departments. The American College of Emergency Physicians (ACEP), the Emergency Nurses Association (ENA), the International Association of Forensic Nurses (IAFN) and the Prosecuting Attorneys Association of Michigan (PAAM) all support the development and use of FNE programs. Many other organizations have also realized the benefits of FNE programs for sexual assault victims, communities, the medical system, and the criminal justice system. The Prosecuting Attorneys Association of Michigan adopted a Policy Statement on the treatment of Sexual Assault Victims in December 1998. The statement contains principles designed to guide communities in the development of programs to respond to sexual assault victims and recognizes that establishing and funding FNE programs will improve a community's ability to assist sexual assault survivors. The Michigan Coalition Against Domestic and Sexual Violence (MCADSV) developed the guide, *Sexual Assault Nurse Examiner Resource Guide for Michigan Communities* (1999), to assist in the development of FNE Programs in Michigan.

B. FNE programs should be developed by a multi-disciplinary task force including, but not limited to, sexual assault survivors; sexual assault program staff; hospital administrators; emergency department personnel including medical directors, physicians and nurses; local law enforcement agencies; probation officers; court judges; county and city prosecuting attorneys; prosecutor's office victim advocates; and state police crime lab personnel. In addition, the task force should reflect the diversity of the community and include representatives from various cultural and other special populations in the community.

C. All FNE programs should establish protocols and procedures to ensure the separation of team roles. Additional safeguards should be in place to maintain the actual and the perceived neutrality and objectivity of the program, the credibility of the forensic nurse examiner, and the integrity of the forensic evidence collected. This is especially important for community-based FNE programs.

D. FNE programs should include an on-site response by a sexual assault advocate. Although forensic nurse examiners are trained in understanding sexual assault trauma response and are concerned for the emotional well-being of the patient, an advocate is able to provide support, advocacy and validation so that the forensic nurse examiner can maintain her objectivity in order to preserve the forensic value of the physical exam (Arndt and Goldstein, 1993). These roles should be clearly defined.

E. Before practicing as a forensic nurse examiner, every healthcare professional should complete a forensic nurse examiner training that is in accordance with the International Association of Forensic Nurses Sexual Assault Examiner Education Guidelines.

F. When a FNE program is not located in a hospital, an agreement should be negotiated with the local hospital(s) so that the forensic nurse examiner has access to the hospital facilities to conduct the forensic exam if the victim needs to remain in the hospital for injuries or does not wish to transfer to another location.

G. When a FNE program is not located in a hospital facility procedures must be developed with hospital emergency departments to assure Federal Emergency Medical Treatment Active Labor Act (EMTALA) violations do not occur.

H. FNE programs not located in a hospital facility should meet the requirements and standards established under the Michigan State Police's *Standard Recommended Procedures for the Emergency Treatment of Sexual Assault Victims*. After careful review of the considerations involved, the Task Force believes such programs can provide a high quality of care for survivors of sexual assault.

I. The Michigan Sexual Assault Nurse Examiner Council should explore the benefits and limitations, the viability and the avenue to creation of standardized educational requirements for forensic nurse examiners in Michigan.

J. FNE programs should be developed and operate with the holistic care of the patient being the primary focus. The forensic examination is performed for the purpose of treatment and diagnosis of a medical condition (sexual assault), as such, the forensic nurse examiner can often testify to statements (made by the patient) as "medical exception to hearsay." In FNE programs it is important to base practice on sound nursing principles.

V. Drug and Alcohol Facilitated Sexual Assault

Issue

Alcohol is the number one drug used to facilitate sexual assault. Besides alcohol there are many other drugs being used to perpetrate sexual assault. According to Dr. Adatsi (personal communication, August 8, 2000) at the MSP Crime Lab Toxicology Unit, ecstasy is the second most common drug that the MSP Crime Lab has found that is being used in drug facilitated sexual assaults. There have been increasing reports of various barbiturates and other drugs being used to incapacitate and immobilize women for the purpose of sexual assault. Although women also consume alcohol and drugs voluntarily, in these circumstances alcohol and drugs can be used as a weapon by perpetrators who use a woman's intoxication and diminished ability to assault her. Some drugs or high amounts of alcohol intake will leave survivors with little or no memory of the assault. Survivors may have unexplained signs of trauma or soreness and may suspect they have been assaulted. Medical personnel, law enforcement and sexual assault programs play an important role in identifying cases of drug and alcohol facilitated sexual assault.

Recommendations to Address Drug and Alcohol Facilitated Sexual Assault

A. These substances should not be referred to as "date rape drugs." Instead, the term "alcohol and drugs used to facilitate sexual assault" should be used so as not to imply that the actions of the victim were consensual.

B. The current and proposed legislation in this area should not refer to this class of substances as "date rape drugs" and should be modified to read "drugs used to facilitate sexual assaults."

Best Practice Recommendations to Address Drug and Alcohol Facilitated Sexual Assault

A. Healthcare facilities, law enforcement agencies, and sexual assault programs should provide their staff with training on recognizing the signs and effects of drugs used to facilitate sexual assault.

Issue

There are several issues related to screening and testing in cases of drug or alcohol facilitated sexual assault. If a survivor presents to the emergency department or SANE program and does not know that she has consumed a drug(s) or the attending personnel do not recognize the effects of the drug(s), no toxicology screen will be done. Medical personnel may not be aware that the Michigan State Police Crime Lab can run toxicology screens in cases of sexual assault. Also, at this time, Michigan has no statewide protocol for drug testing in cases of drug facilitated sexual assaults.

Best Practice Recommendations to Address Screening and Testing

A. The MSP should develop a standard forensic evidence collection protocol that can be applied to every case where drug facilitated sexual assault is suspected, focusing on guidelines for specimen collection times, preservation, packaging, documentation and transportation. All law enforcement, medical personnel, and victim advocates should receive copies of the protocol.

B. Hospitals and crime labs should strive to develop methods and procedures to increase the frequency of testing for the presence of drugs used to facilitate sexual assault. Tests should be performed with analysis techniques sensitive enough to detect single dose levels of the drugs used to facilitate sexual assault.

VI. Sexual Assault Forensic Evidence Collection Kits

Issue

Sexual assault survivors have experienced one of the most traumatic events possible, and experience apprehensiveness and fear about making a police report and going through the forensic evidence collection process and exam.

Best Practice Recommendation Regarding Forensic Evidence Collection

A. The Michigan Domestic Violence Prevention and Treatment Board should coordinate with the Michigan Coalition Against Domestic and Sexual Violence and the Michigan Department of Community Health on the development of a public awareness brochure and campaign focusing on recommending what to do and what not to do following an assault and what survivors can expect from the criminal justice, medical, and service systems.

Issue

Lack of forensic evidence greatly reduces the chance for successful prosecution in a sexual assault case. With the advancements in technology that identifies physical evidence and DNA in trace samples, evidence can be collected after longer periods of time than the previous 24-hours post assault (MCL 333.21527 mandates that if an individual discloses to a physician or other member of a hospital that within the preceding 24 hours they were the victim of criminal sexual conduct, the attending healthcare personnel shall inform the individual of the availability of a sexual assault evidence kit and, with the consent of the individual, shall perform the procedures required by the sexual assault evidence kit). Also, as Michigan continues to enter DNA into CODIS (Combined DNA Index System) the potential to match current unsolved sexual assault cases to convicted offenders or to other cases in which a suspect may be known is greatly increased. The recommendations on training address a need for improvement in forensic evidence collection. The following recommendations address expanded time frames for evidence collection and preservation and expanding the DNA databank.

Recommendations on Forensic Evidence Collection

A. This Task Force recommends that MCL 333.21527 be amended to read 96 hours or longer at the discretion of the forensic examiner.

Issue

The Michigan Sexual Assault Evidence Collection Kit needs to be updated. There have been new advances in DNA technology, collection techniques and evidence analysis that impact the design, protocol and process of the kit.

Best Practice Recommendations Regarding the Sexual Assault Evidence Collection Kit

A. In collaboration with the Michigan State Police, the Michigan Sexual Assault Nurse Examiner Council has been reviewing and updating the Michigan State Police's *Standard Recommended Procedures for the Emergency Treatment of Sexual Assault Victims.* The Michigan State Police should implement this group's recommendations regarding the modification of the document.

B. In collaboration with the Michigan State Police, the Michigan's Sexual Assault Nurse Examiner Council has been reviewing the current sexual assault forensic evidence collection kit. The Michigan State Police should implement this group's recommendations regarding the modification of the forensic evidence collection kit.

VII. Evidentiary Exams: Utilization, Costs and Resources

Issue

The early and appropriate performance of a forensic examination is of critical importance for the health of survivors of sexual assault and for the prosecution of offenders. The performance of this examination has cost implications for healthcare facilities and for survivors, and crime and safety implications for the community at large. The Michigan State Police has developed the standard Evidence Collection Kit, and provides it to facilities at no cost. However, costs are incurred for the use of the facility, for the professional fees of medical personnel, for medical lab fees and for other services appropriate to the level of trauma incurred by the survivor. Managed medical care plans and traditional health insurers should always cover the costs for the emergency treatment of sexual assault as provided under their subscriber contracts. And, many uninsured survivors will be eligible for reimbursement of these costs under the crime victim compensation program through the Michigan Crime Victim Services Commission. However, there are some survivors who do not have these resources; and there are attendant personal issues for some who can access these benefits. Depending on the level of care and the fees commonly charged by a facility, charges currently billed to survivors can range from under $200 to over $2,000. The Michigan Crime Victim Services Commission estimates that most compensation claims received for emergency room evidentiary examinations are in the $400 to $800 range.

There is no solid statistical record of how many exams are actually performed each year. The best we can do is project estimates from other known data and projections. Without going into a statistical analysis here, we generally concur that a large percentage of survivors do not receive prompt medical attention. The fact that much of this is of the survivor's own choosing should be troubling for us all.

Issues for Further Consideration

Issue

According to Kilpatrick, Edmonds and Seymour (1992) it is estimated that eighty-five percent of rape survivors will not report the assault to law enforcement and that only seventeen percent of sexual assault survivors will go to an emergency room. As mentioned elsewhere in this report, there are questions as to the applicability of Michigan's mandatory medical reporting statute as applied to sexual assault cases.

- Survivors who do not report the assault to law enforcement will not be eligible for financial assistance from the crime victim compensation program.

- Survivors who do not seek medical care risk going undiagnosed for STD's and other serious medical complication.

- Lack of criminal justice reporting and evidence collection hinders efforts to apprehend and convict sexual offenders in the community.

Issue

The trauma of sexual assault can cause significant and persistent psychological effects. In addition, there is still a stigma associated with being the victim of sexual assault.

- Survivors who need to access their health benefits by direct personal contact with their employer or a human resources representative may experience anxiety, embarrassment or anger at a time when they are least prepared to successfully incorporate it into their daily activities.

- What considerations does this suggest for reporting and treatment by survivors? How does this effect communication between adolescent survivors of rape and their parents?

It is clear that barriers to reporting and treatment of sexual assault must be reduced and removed whenever possible. A survivor's concern about paying an emergency treatment bill, or the fear of having to publicly proclaim their status in order to receive treatment or get the bill paid, should not be an insurmountable barrier. Efforts to address these issues require a clear and empathetic understanding of the experience and of the natural emotional responses of survivors to the trauma they have endured.

Best Practice Recommendation to Address Cost of Evidentiary Exam

A. It is recommended that representatives from the medical, prosecution, law enforcement, and advocacy and prevention communities continue to work together, and with survivors, to assist identification of resources and processes for policy makers to consider in encouraging survivors to seek treatment and support, criminal justice involvement, and in addressing their unreimbursed expenses.

Future Issues to be Addressed

Although the medical systems workgroup addressed many vital issues, it was beyond the capabilities of this Task Force to address or even identify all issues relating to the medical systems response to sexual assault. As Michigan works to implement the recommendations in this report, there are several important issues left to study.

This Task Force has recommended developing Sexual Assault Nurse Examiner (SANE) Programs as a way of providing a consistent and high quality of care to survivors of sexual assault. Ongoing funding for the operation of SANE programs needs to be explored.

The Michigan State Police *Standard Recommended Procedures for the Emergency Treatment of Sexual Assault Victims* recommended protocol for the length of time evidence should be retained when a survivor has not given consent to have the sexual assault evidence collection kit transferred to law enforcement is at least two weeks. Retaining evidence allows survivors the time to make the difficult decisions regarding reporting and release of evidence. The Task Force recognizes that some hospital emergency departments have limited locked storage space. Therefore, further consideration should be given to alternative methods of storage such as having law enforcement store the kits and not processing it until the survivor has signed a release.

Sexual assault of children, adolescents and victims that are mentally incapable, mentally incapacitated or physically helpless present many complexities to the medical system. A cornerstone issue is consent for forensic evidence collection and medical care. Currently in Michigan, minors do not need parental consent for STD treatment (see MSA 14.15[5127]) or

pregnancy prevention (see MSA 14.15 [9132]). There are no statutes, however, that directly state the age of consent for sexual assault forensic evidence collection. This leaves hospitals and SANE programs with no clear guidance in this area. There are many arguments both for and against adolescents receiving medical care and evidence collection following a sexual assault without parental consent. The legal liability, child protection and state statutes addressing adolescent sexual assault need further study and exploration to clarify this issue. There also is a lack of clear protocol for sexual assault forensic evidence collection when a victim is unconscious or otherwise unable to give consent.

As DNA technology and the use of CODIS improves our ability to connect perpetrators to multiple cases of sexual assault, it becomes increasingly important to build up the DNA databank. If a survivor who did not want to file a police report or participate in prosecution was notified that her perpetrator had also assaulted other victims, the survivor may be more likely to want to proceed. Survivors who do not, at that time, want to make a report may also not consent to release the sexual assault forensic evidence collection kit to law enforcement. This means that, in these cases, the perpetrator's DNA will not be analyzed and entered into the CODIS system. Survivor-oriented, in-depth and exceedingly careful consideration should be given to the issue of all sexual assault forensic evidence collection kits being transferred to law enforcement as evidence.

Section 4

The Criminal Justice System

Introduction

Criminal justice professionals refers to law enforcement, prosecutors and courts.

The purpose of this workgroup was to provide criminal justice professionals with guidelines for responding to complaints of sexual assault, for working with victims, for conducting interviews with victims and witnesses, and for interfacing with local health and welfare agencies. This multi-disciplinary workgroup was comprised of individuals and organizations that either have direct contact with survivors of sexual assault or impact survivors' access to justice and services.

Sexual assault victims often are too fearful of blame, retaliation by the perpetrator or their community knowing about the assault to report the offenses to law enforcement (Kilpatrick, Edmunds and Seymour, 1992). Additionally, many survivors report experiencing victim blaming and disbelief by some criminal justice professionals (Majority Staff Report, 1993). This, in combination with the fear of the investigative, medical, and prosecutorial procedures, may add to a victim's reluctance to report or to assist in the investigation. The manner in which criminal justice professionals interact with victims plays a significant role in the victim's willingness to participate in the investigation. Therefore, it is this committee's recommended policy to provide victims of sexual assault with compassion and consideration and with the necessary information and assistance to reduce the barriers to reporting and cooperating with the criminal justice system.

Sexual assault, as referenced in this report, includes rape and other non-consensual sex acts as defined by law.

Issues and Recommendations

I. Develop a Statewide Law Enforcement Protocol for Sexual Assault Cases

Issue

There is currently no statewide protocol for law enforcement's response to sexual assault. A standardized protocol has the potential to improve both the individual response to sexual assault survivors and the criminal justice response to sexual assault.

Recommendations for the Development of a Statewide Law Enforcement Protocol for Sexual Assault Cases

A. A multi-disciplinary task force should be convened to develop a statewide law enforcement protocol for sexual assault cases.

B. The above mentioned task force should also create a training course and seek Michigan Commission on Law Enforcement Standards (MCOLES) certification for such training.

II. Training

Issue

Every professional working within the criminal justice system, administrators as well as direct service and support staff, needs specialized training on issues related to the crime of sexual assault. Training should be developed that is relevant to their job responsibilities. Moreover, high turnover and competing demands on criminal justice professionals make it necessary for such training to be routinely scheduled. Also, sexual assault training is best handled separately and not just as a subpart of domestic violence training.

Best Practice Recommendations for Training of Criminal Justice Professionals

Criminal justice professionals' participation in, and compliance with, sexual assault training depends in large part upon the elected official or agency department head's commitment to stopping and preventing sexual assault in their jurisdiction. The viability of the following recommendations is dependent upon this commitment.

A. The elected official or agency department head should ensure attitudes and behaviors within the department that do not condone violence in any situation.

B. The elected official or agency department head should incorporate compliance with any written sexual assault procedures into the culture of the department. The elected official or agency department head should send a clear message to all department employees that the department takes seriously its responsibility to respond appropriately to sexual assault crimes.

Strategies could include:

- Establishing procedures for regular review of sexual assault cases for compliance with sexual assault training materials and agency sexual assault policies.
- Providing sexual assault briefing and legal updates.
- Encouraging attendance and/or participation in planning cross-professional training on sexual assault issues.
- Working with local sexual assault service provider programs and participating in the local coordinating council/task force against sexual assault if such exists.

C. The elected official or agency department head should recommend command staff and first line supervisors to receive sexual assault training focusing on:

- The dynamics of sexual assault,
- Laws regarding sexual assault,
- Mandated/recommended police response to sexual assault, as set forth in written protocols. For example, *Standard Recommended Procedure for the Emergency*

Treatment of Sexual Assault Victims, Michigan State Police, Forensic Science Division, and

- Effective, culturally competent communication with victims including the use of interpreter services and assistive technology.

D. Ideally, command staff and first line supervisors should receive this training prior to the in-service sexual assault training of other agency employees so that command staff and first line supervisors can participate effectively in the in-service sexual assault training of other agency employees and ensure that in-service sexual assault training reflects standards considered by command staff and first line supervisors in evaluating employees' job performance.

E. The elected official or agency department head should encourage the provision of on-going in-service sexual assault training to all agency employees to review sexual assault laws and response procedures and to update all agency employees concerning developments in sexual assault laws and response procedures.

F. The elected official or agency department head, whenever possible, should appear at the sexual assault training to directly communicate to employees the elected official's or agency department head's commitment to stopping and preventing sexual assault through appropriate response to sexual assault by the agency.

G. The elected official or agency department head should develop a mechanism for mutual feedback and promote effective communication among the agency and the local service provider programs regarding sexual assault issues.

H. The elected official or agency department head should institute a mechanism to review and update the agency's sexual assault policy, in consultation with the prosecutor or law enforcement and the local sexual assault service provider program.

I. The elected official or agency department head should promote within the department a cooperative and professional working relationship with, and understanding and respect for, the role and responsibilities of the local sexual assault service provider programs, healthcare professionals and the prosecuting attorney's or law enforcement's handling of sexual assault cases.

(Adapted from Best Practices Committee of the Domestic Violence Prevention and Treatment Board Violence Against Women Training Institute, 1999)

III. Prosecution

Issue

Sexual assault victims have been subjected to a traumatic and life-threatening experience. They expect that the prosecutor will represent *their* interests in what they perceive to be *their* case. Prosecutors, on the other hand, do not have a responsibility to represent the personal interests of each sexual assault victim. Their Constitutional duty is to represent society in the state's cases. Because sexual assault victims see themselves as the aggrieved parties, they expect to participate in the decisions made concerning the prosecution of their cases. This dissonance between victim expectation and prosecutorial role has been a source of conflict and concern.

The following recommendations do not advocate altering the level of discretion entrusted to the prosecutor. However, they do urge consideration of the victim's needs in the exercise of prosecutorial discretion. Sexual assault victims deserve to be informed about the reasons motivating decisions that may appear to be adverse to their interests.

Best Practice Recommendations for Prosecutors

Many of these recommendations reflect the Crime Victim's Rights Act (MCL 780.751 et seq.).

A. Prosecutors should assume ultimate responsibility for informing victims of the status of a case from the time of the initial charge to the determination of parole.

B. Prosecutors should strive to bring to the attention of the court the views of victims of violent crimes on bail decisions, continuances, plea bargains, dismissals, sentencing, and restitution. They should establish procedures to ensure that victims are given the opportunity to make their views on these matters known.

C. Prosecutors should charge and pursue any defendants who harass, threaten, injure, or otherwise attempt to intimidate or retaliate against victims or witnesses.

D. Prosecutors should continue to bring to the attention of the court the potential negative effects of case continuances. When such delays are necessary, procedures should be established to ensure that cases are continued to dates agreeable to the victim, if possible. The reasons for continuances should be adequately explained to the victim.

E. Prosecutors' offices should strive to establish and maintain a direct liaison with victim/witnesses and victim service agencies.

F. Prosecutors must recognize the profound impact that crimes of sexual violence have on both adolescent and adult victims and their families.

(Adapted from West Virginia Foundation for Rape Information and Services, 1993)

IV. Suggested Court Practices in Criminal Cases Involving Sexual Assault

The practices listed below are taken from three sources: Schafran & Ben-Jehuda, 1994; The Crime Victims Rights Act, MCL 780.751 et seq.; and Michigan Supreme Court, 1989.

Best Practice Recommendations for the Courts

Sexual assault is a crime of violence. In many sexual assault cases, there is no obvious physical injury. Juries are instructed that they may still find the defendant guilty in a criminal sexual conduct case even with no corroborating evidence, if they believe the victim's testimony beyond a reasonable doubt. Although many individuals involved in the criminal justice system understand the needs of victims in criminal sexual conduct cases, standards should be set. As such, the following recommendations on best practices are made.

The Task Force recommends that:

A. Pretrial and trial processes are conducted so that both the victim and the defendant receive a fair and impartial hearing that conforms to constitutional due process standards and is as free as possible from taint by myths and stereotypes about sexual assault.

B. Judges, magistrates, and probation officers understand the impact of sexual assault on victims.

C. Judges and magistrates understand how their beliefs about a defendant's guilt or innocence may be communicated to others through verbal and/or nonverbal communication, and take steps to ensure that such communication does not take place.

D. Judges and magistrates communicate that they regard sexual assault by non-strangers as seriously as sexual assault by strangers.

E. No judge or court employee make comments that trivialize sexual assault cases. Such comments include remarks about a victim's mode of dress, prior acquaintance with the defendant, personal habits, etc.

F. Courts should avoid continuances of trials, except for good cause.

The Task Force recommends that:

G. Judges and magistrates issue pretrial release orders with no contact or other provisions to protect the victim (as authorized by MCL 765.6b). Violations of such orders are subject to swift, appropriate sanctions. Tethering can be used in appropriate cases to promote victim and witness safety.

H. Courts provide a waiting area for the victim separate from the defendant, the defendant's relatives, and defense witnesses if such an area is available and the use of the area is practical. If a separate waiting area is not available or practical, the court provides other safeguards to minimize the victim's contact with the defendant, the defendant's relatives, and defense witnesses during court proceedings (as authorized by MCL 780.757).

I. Courts prohibit inappropriate courtroom behavior by supporters of the victim and defendant (as authorized by MRE 611, Code of Judicial Conduct, Canon 3(A)(2)).

J. Courts should omit the use of the victim's name in written opinions or in public comments, for example at sentencing.

K. Courts apply the rape shield laws correctly and prohibit attempts to abrogate or circumvent them. Adequate judicial training should be available on this issue.

L. On the witness stand, victims are not required to show on their own bodies how they were touched or to demonstrate the position in which they were assaulted. This does not imply that a victim may not indicate by gesturing to clarify where contact was made. However, this should be used sparingly and only as necessary to clarify the record.

M. Victims are not to be left on the witness stand during lengthy sidebars or colloquies in chambers.

N. In setting bail, judges and magistrates treat non-stranger sexual assault cases as seriously as they treat stranger sexual assault cases.

O. Courts permit thorough voir dire in sexual assault cases so that juror biases and attitudes about sexual and relational issues may be explored to achieve the goal of a fair and impartial jury.

P. The confidentiality of the victim's address and telephone number is preserved in accordance with MCL 780.758(2).

The Task Force recommends that:

Q. Sentences for persons convicted of sexual assault reflect the physical and psychological harm to victims of both stranger and non-stranger assault. Even with no evidence of physical injury, the sentence reflects the violent nature of the crime and the psychological harm suffered by the victim.

R. Victim input is obtained in the preparation of presentence investigation reports as required by MCL 780.764.

S. Courts acknowledge the victim and the impact of the assault at sentencing.

T. In sentencing, courts treat non-stranger sexual assault cases as seriously as they treat stranger sexual assault cases.

U. Courts sentence adult, adolescent and young adult offenders with appropriate severity.

V. Courts do not sentence offenders to community service at rape crisis centers or domestic violence shelters.

W. Sexual assault by acquaintances or intimate partners is a violent crime and probation officers are trained to understand the dynamics of acquaintance and intimate partner sexual assault and develop accurate information about these offenders in presentence reports.

X. Courts are knowledgeable about drug and alcohol facilitated sexual assault and treat it as a violent crime.

Y. Courts shall not admit a defendant convicted of criminal sexual conduct to bail while they are awaiting sentence unless they find by clear and convincing evidence that the defendant is not likely to pose a danger to other persons (as authorized by MCL 770.9a(1)).

Z. After sentencing and pending appeal, courts shall not admit a defendant convicted of criminal sexual conduct to bail unless they find by clear and convincing evidence that the defendant is not likely to pose a danger to other persons, and that the appeal or application for leave to appeal raises a substantial question of law or fact (as authorized by MCL 770.9a(2)).

AA. Courts may not allow a person sentenced to jail for criminal sexual conduct to be released for work or school under any circumstances (as authorized by MCL 801.251 sec.1(2)).

Note: The following are court-related best practices that fall under the prosecutor's responsibilities under the Crime Victims Rights Act. These responsibilities should be fulfilled.

BB. Victims receive notification of and an opportunity to appear at court hearings as required by law (MCL 780.756).

CC. Before finalizing any negotiation that may result in a dismissal, plea or sentence bargain, or pretrial diversion, the prosecutor shall offer the victim the opportunity to consult with the prosecutor to obtain the victim's views about the disposition of the prosecution of the crime, including the victim's views about dismissal, plea or sentence negotiations, and pretrial diversion programs (as required by MCL 780.756(3)).

DD. The victim is notified of the right to make a statement for use in preparing a presentence investigation report, to be present at sentencing, and to make an impact statement at sentencing (as required by MCL 780.763).

V. Sex Offender Treatment and Management

Issue

Sex offender treatment is not "treatment" in the traditional sense, nor is it meant to imply that sex offenders are mentally ill or offend due to mental illness. The efficacy of sex offender treatment programs is still under study. Research shows that rates of recidivism vary following the offender's participation in a specialized sex offender treatment program. Additionally, the term "sex offender" is a catch-all term for pedophiles and exhibitionists, and perpetrators of incest and child sexual abuse, as well as sexual assault of adults. What may be effective with one type of offender may not be effective with another. Research indicates that a combination of educational, cognitive-behavioral, and family system interventions seems to be the most effective mode of treatment. Treatment programs should not be a substitute for incarceration.

Sex offender treatment is not a *cure* but contains the potential to reduce rates of recidivism of sex offenders. Careful consideration should be given when referring sex offenders to treatment programs.

Sex Offender Management

Issue

Most incarcerated sex offenders eventually return to the community. Therefore, effective management of sex offenders, which can reduce recidivism and increase public safety, is imperative. The Center for Sex Offender Management, a program of the U.S. Department of

Justice, has outlined a model process for managing sex offenders in the community that includes the use of specially trained probation/parole officers, victim advocates and sex offender treatment providers.

Best Practice Recommendations to the Courts on Sex Offender Treatment and Management

The Task Force recommends that:

A. If a plea agreement involves a term of probation, courts have the option of placing the offender in a sex offender treatment program and sanction failure to participate with immediate incarceration. Probation orders include no-contact provisions for protection of the victim or others as appropriate.

B. Courts be familiar with options for sex offender treatment programs and especially cognizant of the benefits and limitations of such programs. Courts have the option of requiring specialized sex offender treatment in conjunction with sex offender management through probation rather than traditional psychotherapy.

C. Courts treat an assailant's failure to attend and participate in sex offender treatment or non-compliance with any term of probation with appropriate severity.

D. Courts recognize that sex offender treatment is not a substitute for incarceration.

VI. "John Doe DNA" Arrest Warrants for Sexual Assault Assailants

Issue

At the time of this writing, legislation has been introduced that would eliminate the statute of limitations in cases where a genetic code has been identified for an unnamed suspect. From the forensic evidence, a deoxyribonucleic acid (DNA) genetic code for the suspect is determined. Currently, if the suspect remains unidentified, and therefore unchargeable, in a criminal warrant, the statute of limitations could run out and the opportunity for prosecution would be denied to the victim. While the Task Force is aware that such legislation may raise due process and privacy concerns it supports such legislation.

Recommendations for "John Doe DNA" Arrest Warrants

A. The Task Force recommends that the Michigan Legislature pass legislation eliminating the statute of limitations for criminal sexual conduct cases in which a genetic code has been identified.

B. Prosecutors should be able to issue an arrest warrant in the name of "John Doe, with a genetic code of XXX." This warrant would then toll the statute of limitations. With sex offenders

the recidivism rate is high so it is reasonable to expect that a suspect could be identified in connection with a later assault. Also, the development and implementation of the Federal Bureau of Investigations (FBI) databank, known as the Combined DNA Index System (CODIS), should lead to the successful identification of many more sex offenders through their genetic codes.

Best Practice Recommendations for "John Doe DNA" Arrest Warrants

A. The MSP Crime Lab should enter all perpetrator DNA from sexual assault evidence collection kits into CODIS and run a search for matches in all sexual assault cases regardless of the existence of a police report or investigation.

VII. Sexual Assault of Adolescents

Issue

This workgroup believes that there needs to be a particular and special focus on adolescent victims of sexual assault and adolescent perpetrators of sexual assault. At this time, adolescent victims are not served well by either the adult or child welfare systems.

What Makes Adolescents' Disclosures So Difficult to Work With?

In spite of laws that provide statutory support for arresting and prosecuting adults who have sexual relationships with teenagers, criminal justice officials face challenges in enforcing the laws. There are three main problems with addressing allegations of statutory rape: the victim may not see herself as a victim and may not cooperate with police and prosecutors, jurors do not find teenage victims credible, and there is no scientific basis for knowing which of the adult perpetrators are responsible parties who truly love and care for the adolescent and/or offspring, and which ones are "predators" (which may impact charging and sentencing decisions).

Best Practice Recommendations to Address Sexual Assault of Adolescents

A. A multidisciplinary task force should assess, through case files and records from criminal justice agencies and interviews with criminal justice professionals and sexual assault programs, the rate, point of entry, and response to disclosures of sexual assault by adolescents.

B. There are several investigative strategies that should be employed by law enforcement agencies to improve the response to adolescent sexual assault, including: creating and using a special investigation unit or specialized officers, using a consolidated law enforcement approach, and conducting an early comprehensive interview with the teen survivor and with the older perpetrator.

C. There are several prosecution strategies that should be employed by prosecuting attorneys to improve the response to adolescent sexual assault, including: creating and using a special prosecution unit or specialized deputies, early prosecutorial involvement in the case, vertical prosecution, interviewing of the victim with a victim advocate present, use of expedited prosecution, and developing a strategy for responding to the defense argument that this is accepted in their culture of origin and thus "normal."
D. Along with the preceding listed prosecution strategies, there are a number of ways that prosecutors can improve the criminal justice system response to adolescent sexual assault survivors. Prosecutors should listen to the victim's concerns, needs and wishes regarding the disposition of the case, keep in touch with the victim and inform her about case developments, and follow-up with the victim after the case is over.

(Adapted from Elstein and Smith, Draft 4/1/98)

VIII. Sexual Assault of People with Disabilities

Issue

Respondents to a national survey of 200 disabled women reported abuse and domestic violence as the number one priority issue to confront. They identified two key information needs, the development and dissemination of materials for people with disabilities and service providers about violence and the dissemination of information to victim assistance programs and criminal justice agencies about their legal requirements to serve people with disabilities (Berkeley Planning Associates, 1997).

Disabled girls and women face alarming rates of violence within their families, by acquaintances, in institutions, and throughout society. This violence includes verbal abuse, economic and emotional abuse, physical and sexual violence, forced isolation, intimidation, and the withholding of equipment, medication, transportation, or personal service assistance (Masuda, 1996).

Disabled women are more likely than non-disabled women of the same age to be victimized, to experience more prolonged and severe forms of violence, and to suffer more serious and chronic effects from that violence (Sobsey, 1994). Regardless of age, race, ethnicity, sexual orientation, or class, women with disabilities are assaulted, raped, and abused at a rate more than two times greater than non-disabled women (Sobsey, 1994; Cusitar, 1994: DisAbled Women's Network, 1998).

The Developmental Disabilities Assistance and Bill of Rights Act, Part C, Protection and Advocacy of Individual Rights (42 USC 6000 et seq, Part C, Sec 142(B) and the Crime Victims with Disabilities Awareness Act (PL 105-301) only address certain disabilities, do not address

gender-specific causes and solutions to violence, and were written without the active involvement of members of the disabled community (Fiduccia and Wolfe, 1999).

Many laws are grounded largely in the belief that disability in and of itself makes a person dependent and vulnerable. However, the broader causes of disabled women's disempowerment and abuse includes their segregation into high risk environments such as group homes and institutions, their poverty, and their lack of access to information and services (Fiduccia and Wolfe, 1999).

A related issue, concerning the societal beliefs and attitudes about the capacity of people with disabilities to engage in consensual sexual relations, is beyond the scope of this report. However, systems that respond to sexual assault survivors should be aware of this potential bias and not presume that people with disabilities cannot participate in equality-based relationships.

Best Practice Recommendations to Address Sexual Assault of People with Disabilities

A. Criminal justice professionals should be aware that the abuse of people with disabilities is most often perpetrated by caregivers or family members (Nosek, Howland and Young, 1997), and that the perpetrator may be the very person who accompanies the victim to the interview. To have that person interpret may not allow a full, open disclosure of the facts. For this reason, the use of independent interpreters should be a priority. Furthermore, one interpreter should not be interpreting for both sides.

IX. Michigan's Rape Shield Law and Rules of Evidence

Issue

The rape shield law does not bar general statements allegedly made by a victim to a third party that are otherwise relevant to the defendant's consent defense. In *People v. Ivers* (587 N.W.2d 10 Mich. 1998), the defendant sought to admit testimony that on the date of the alleged rape, the victim had told a friend that she had discussed birth control with her mother in anticipation of going away to college, that she believed that she was ready for sex, and that she asked her friend to "find her a guy." The Supreme Court held that because the proffered testimony did not amount to or reference specific sexual conduct the statements were admissible.

Recommendation for Michigan's Rape Shield Law

A. Michigan's Rape Shield Law and Rules of Evidence should be amended to include the speech of complaining witnesses. This process should incorporate a thorough legal review in order to avoid subsequent constitutional challenge.

X. Legislative Issues

Issue

Criminal Sexual Conduct in the Fourth Degree, MCL 750.520e, involves sexual contact using force or coercion, as well as sexual contact with a victim between the ages of 13 and 16 with the actor being 5 or more years older than the victim, and is a two-year high court misdemeanor. Some of the behaviors that fall within the definition of Criminal Sexual Conduct in the Fourth Degree are as harmful to the victim as Criminal Sexual Conduct in the Third Degree with the only differentiation being lack of penetration. Criminal Sexual Conduct in the Fourth Degree needs the following legislative review.

Legislative Recommendations

A. It is the recommendation of the Task Force that Criminal Sexual Conduct Fourth Degree be reviewed to differentiate conduct within the existing statute to provide for a felony conviction for certain actions which are egregious and have serious physical or emotional impact on the victim. An amendment to the current Criminal Sexual Conduct in the Fourth Degree providing for felony conviction in special circumstances to be defined or an amendment to Criminal Sexual Conduct in the Third Degree to elevate egregious sexual touching to that offense without the element of penetration would provide for a penalty more in line with the nature of egregious actions and impact on the victim.

B. It is the recommendation of the Task Force that any newly established felony conviction for Criminal Sexual Conduct in the Fourth Degree be an offense that must be registered with the sex offender registry. The legislature should establish factors that a prosecutor must establish to the court which would result in the registration of a conviction of a misdemeanor Criminal Sexual Conduct.

Issue

The Criminal Sexual Conduct law MCL 750.520b(1)(f)(I) to (v), at this time defines "force or coercion" as the following:

(f) Force or coercion includes but is not limited to any of the following circumstances:

(i) When the actor overcomes the victim through the actual application of physical force or physical violence.

(ii) When the actor coerces the victim to submit by threatening to use force or violence on the victim, and the victim believes that the actor has the present ability to execute these threats.

(iii) When the actor coerces the victim to submit by threatening to retaliate in the future against the victim, or any other person, and the victim believes that the actor has the ability to execute this threat. As used in this subdivision, "to retaliate" includes threats of physical punishment, kidnapping, or extortion.

(iv) When the actor engages in the medical treatment or examination of the victim in a manner or for the purposes which are medically recognized as unethical or unacceptable.

(v) When the actor, through concealment or by the element of surprise, is able to over come the victim.

Some judges believe that this list is an exclusive definition of force or coercion. Judges, at times, seem focused on these five factors alone to determine if "force or coercion" exists. This limitation can be extremely troubling. For example, a case that the Attorney General pursued against a doctor in Michigan included the doctor making a threat that if the victim/patient did not want to meet him at a hotel, he would "close the file and they could both stay home from now on." The district judge in Michigan determined that this victim/patient could have gone to another physician instead of submitting to sexual acts with the physician so it was not force or coercion.

The victim/patient in that case had received a closed head injury from a car crash and ein chronic pain for approximately 2-1/2 years before seeing the defendant/physician. During the 2-1/2 year period, she attempted to see many different health professionals with no relief to her chronic pain. After six months of treatment with the defendant, the victim began to feel better. It was at this time that the defendant's threat of discontinuing treatment was stated to the victim. The Attorney General appealed the district court judge's ruling, but that ruling was upheld by the circuit court. The Task Force believes that these additions to the "force or coercion" instruction would assist with seeking justice for the victims of sexual assault in Michigan.

Recommendations Addressing the Definition of "force or coercion"

A. It is the recommendation of the Task Force that there be a legislative change of the definition of "coercion" to make it more inclusive of the dynamics of sexual assault.

B. It is the recommendation of the Task Force that the definition of "force or coercion" should include:

When the actor is rendering services as a health professional, as defined by the Public Health Code, MCL 333.1101 et seq, and coerces the victim by threatening to withhold treatment that the actor/health professional is licensed to give the victim.

C. Domestic situations involving sexual assault also need a more specific definition of "coercion." It is the recommendation of the Task Force that the definition state:

When the actor is one of the following; spouse or former spouse of the victim, the victim is the person with whom the actor has a child in common, the victim is a resident or

former resident of the actor's household and the actor threatens the victim to withhold communication with any person or with hold shelter, food, or any other physical immediate physical needs and/or threatens the victim to withhold physical contact with the actor's or the victim's children, and the victim believes that the perpetrator has the apparent ability to execute the threat.

Future Issues to be Addressed

The Criminal Justice System Workgroup addressed a wide variety of issues that pertain to law enforcement, prosecutors, and judges but as with all the workgroups, it was simply not possible to address all the issues that relate to the criminal justice system's response to sexual assault. There are a number of issues that require future attention.

Additional funding for the implementation of the recommendations will need to be allocated on the state level.

The Michigan State Police Crime Labs are reportedly experiencing a backlog in processing sexual assault evidence collection kits due to lack of resources. Allotment of resources should be explored so that all sexual assault evidence collection kits are routinely processed upon receipt at the Crime Lab.

Issues related to parole and probation of sex offenders, such as best practices in monitoring and accountability, play a key role in reducing the incidence and prevalence of sexual assault in our communities. The vital role that parole and probation play in the system's response to sexual assault warrants future attention. Sex offender management is intricately related to a comprehensive systems response to sexual assault. According to the Center for Sexual Offender Management, a Department of Justice program, best practices for sex offender management involve a coordinated response by parole/probation, victim advocates and sex offender treatment. Currently in Michigan, sex offender management is not uniform and varies greatly from county to county. The development of best practices and standards is the next vital step in the creation of a comprehensive solution to sexual assault.

Individuals confined in institutions such as penal institutions, youth homes, nursing homes and psychiatric hospitals are extremely vulnerable to sexual assault. The nature of these settings often discourages reporting and the receipt of services. The special issues attendant to sexual assault within institutional settings requires further attention and focus.

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Appendix A - Map of Sexual Assault Programs in Michigan