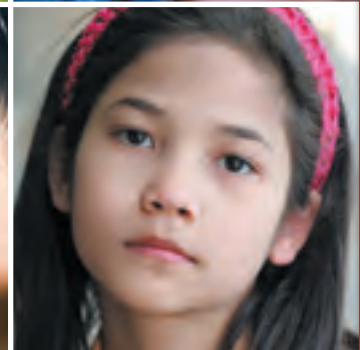
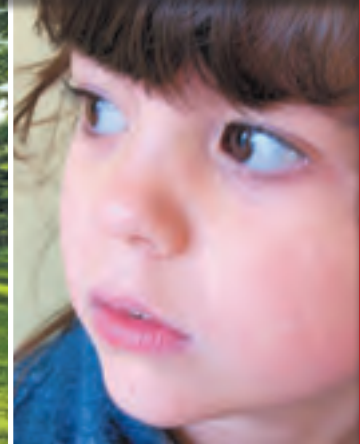


FROM HURT TO HOPE

A Child Sexual Abuse/Assault **ADVOCACY** GUIDE



Washington Coalition of Sexual Assault Programs

This guide is dedicated to all the children who have been hurt,
the people who love them and support them,
and the advocates who accompany them on their journey.

FROM HURT TO HOPE

A Child Sexual Abuse/Assault ADVOCACY GUIDE



Washington Coalition of Sexual Assault Programs

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Special thanks to the Core Group writers and the Reviewers for their dedication, hard work and guidance.

Thank you!

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TABLE OF CONTENTS

		Introduction	1
		CSA Overview	7
		System Coordination	23
		Information and Referral	33
		Crisis Intervention	41
		General Advocacy	51
		Medical Advocacy	71
		Legal Advocacy	91
		References.....	121
		Acronyms/Definitions	123
		Appendices	125

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INTRODUCTION



Welcome to your Child Sexual Abuse/Assault Advocacy Guide!

Working with child sexual abuse/assault (CSA) victims and their nonoffending parents/caregivers/families can present a unique dynamic for Community Sexual Assault Programs (CSAPs) and advocates. What does confidentiality look like for a 10-year-old or a 15-year-old? What decisions can children or teens make for themselves? Who is my client, the child or the parent? Why is the child going through a medical assessment when the last abuse was three months ago? Why does the parent act like this is no big deal? Do we need a separate advocate for the parent? There is so much more to consider when the victim is a child or teen.

Some CSAPs have been working with CSA victims for a while and see several children a day. Other CSAPs may only work with six children and families a year. All agencies should have working relationships with their county child abuse protocol multidisciplinary teams.

While this guide cannot address every level of CSAP work with kids, or every possible scenario, it does provide a solid foundation for advocates working with this population.

A little history

In the 2008 Legislative session, funding was allocated to enhance services for CSA victims and their nonoffending family members/caregivers. As part of that effort, the Washington Coalition of Sexual Assault Programs (WCSAP) was contracted to develop a “best practices” manual/guide for advocates from CSAPs.

The goal of this guide is to provide direct service providers a general best practice approach in carrying out Core Service Standards specifically geared to children.

The goal of this Guide is to provide direct service providers a general best practice approach in carrying out Core Service Standards specifically geared to children. Providing a foundation for services to victims of CSA in a guide will help formalize these services and provide ongoing reference for agencies and advocates. Not all agencies have the resources to meet the best practice guidelines set forth in this Guide. These agencies still carry out the Core Service Standards provided by the Office of Crime Victim Advocacy (OCVA) and should strive to find creative ways to initiate best practices in their community.

Information for the Guide was provided with input from CSAPs all over the state. We received feedback through an electronic survey, multidisciplinary focus groups, the core writing group and the review process. The core writing group incorporated information from the field, individual and organization experiences, and current research. The material produced is relevant and practical in meeting the Core Service Standards and providing good advocacy for children and their caregivers. The draft documents were synthesized, edited and reviewed by professionals in the field who have varying levels of experience in working with children. All of this culminated in the Guide before you.

HOW TO USE THIS GUIDE

Considerations

The Guide's information may not feel relevant to every community. It is meant to provide best practice in working in child sexual abuse situations. Best practice is based on the synthesis of years of experiences and current research. In addition to providing best practices and enhancing services to CSA victims and their families, we want this Guide to be a practical resource for advocates.

There is no way to address every situation or community in this Guide. When utilizing this Guide and the information contained, it is important to realize that while there may be commonalities in child sexual abuse situations, advocates need to consider each victim and nonoffending caregiver situation uniquely and individually.

Some essential considerations to include in assessments of client situations are:

- ◆ Does the child and/or caregiver want an advocate? Victims and caregivers may not want an advocate. Best practice includes realizing when support is not wanted by a client.
- ◆ What does this victim need? Advocates identify what victims need using a strength-based and victim-centered services approach. [See below for additional information.]
- ◆ What is impacting this child's situation? Advocates identify other considerations that may impact a child's situation – developmental age; disability; offender relationship to the caregiver; length of time from the abuse to the disclosure and seeking services; support systems; and accessibility of resources.
- ◆ What cultural issues need to be considered? Advocates identify cultural considerations such as community, religion, spiritual beliefs, national origin, gender, sexual orientation, and other beliefs and norms the client adheres to. Of special note is that tribal and military situations often have very different implications related to cultural and jurisdiction issues.
- ◆ Who is the client? Identifying the client may not always be easily apparent. Preverbal children will best be helped through their nonoffending caregivers. Nine-year-olds and their nonoffending caregiver may both be clients. Teens may be seen separately as the client with no caregiver present.



Victim-centered services

The philosophy that guides the provision of victim services in Washington State is that services are victim-centered; that is, services are grounded in an awareness of and commitment to victims and their needs. It is imperative that services are child-centered and family/caregiver-focused. Sexual assault service providers must strive to:

- ◆ Meet the unique needs and circumstances of children and caregivers in need of support and assistance;
- ◆ Engage, on behalf of victims, with systems involved; and
- ◆ Coordinate services when appropriate.

It is important to note that, due to the nature of child sexual abuse/assault, caregiver-focused services may not be the most appropriate practice in sexual abuse/assault cases involving offenders who are family members.

Due to the nature of child sexual abuse, advocates may find that a significant amount of their time will focus on coordinating services for a child or caregiver, working with systems, and providing support and assistance to secondary victims such as primary caregivers and other nonoffending family members. It is vital that service providers strive to meet the unique needs of each child and nonoffending family member/caregiver.

Sections

The guide is divided into sections:

- ◆ General Child Sexual Abuse/Assault Overview
- ◆ The State of Washington Sexual Abuse/Assault Core Service Standards
- ◆ References
- ◆ Acronyms/Definitions
- ◆ Appendices

The General Child Sexual Abuse/Assault Overview explores the broader context of CSA. It identifies trends, common dynamics and experiences in CSA. This section is intended to address overarching dynamics and issues inherent in CSA. It is not meant to mirror every community's experience but rather addresses what the general landscape of CSA looks like, in understanding the larger issues, and in better implementing the Core Service Standards.

There are many systems that intersect with a child and nonoffending caregiver in sexual assault situations. System Coordination is the first Core Standard reviewed, as it provides a wonderful foundation for doing effective advocacy with children. Information and Referral, Crisis Intervention, General Advocacy, Medical Advocacy, and Legal Advocacy all require a good system coordination base.

Each of the sections identifies a specific Core Standard, outlines best practices, states what an advocate needs to know, provides tips, and includes scenarios demonstrating best practices and key points for quick reference.

While we hope you will read through the whole Guide, you may find yourself referring to separate sections as each situation presents a different question or challenge.

Language

Words often have multiple definitions and their meaning can vary depending on the reader. In order to provide consistent language and simplify the reading, we have identified common terms for particular groups or situations as explained below.

- ◆ “Caregiver” refers to nonoffending parents, guardians, foster parents and any individual assuming a caregiver role for a child.
- ◆ “Victim” for victim/survivor. We understand that each child is in a different place in his or her healing and recovery process.
- ◆ “Client” or “caller” may also be used in different sections when referring to the victim or caregiver.

You may use the language preferred by your agency or that which you feel best reflects your client.

For the purposes of this Guide, CSA refers to all sexual violence/abuse/assault of children under 18.

The Guide also contains References, Acronyms/Definitions, and Appendices sections. There are many statutes that are referred to in the Guide. These are in the Appendix titled “Laws and Statutes.” Updates can be found on the WCSAP or state websites.



Whether you are a new advocate,
somewhat seasoned with a little CSA experience,
or a veteran, this is your guide.
You gave us input.
Use it, put post-its in it, write in it
and request a new one if necessary.

CSA OVERVIEW



What Advocates Need to Know About CSA

What is Child Sexual Abuse/Assault (CSA)?

Child Sexual abuse/assault takes many different forms.

10-year-old girl is sexually abused by her stepfather for two years

7-year-old boy is molested a few times by a teenage babysitter

5-year-old is molested along with other children at the day care center

17-year-old has a sexual relationship with her teacher

14-year-old is at a party and an acquaintance has sex with her against her will

12-year-old girl is abducted by a stranger and raped

15-year-old girl meets a man on the internet and agrees to meet him for sex

CSA is defined as sexual touching and sexual penetration of children. The definition generally includes attempts to touch or penetrate the child as well as completed assaults. There are other forms of illegal or unwanted sexual experiences such as exposure, peeping (looking at a child for sexual gratification purposes), or sexual harassment in the form of talking in a sexually inappropriate or intimidating way. This guide primarily focuses on CSA that involves touching or penetration.

CSA is defined as sexual touching
and sexual penetration of children.

All forms of sexual contact by an adult with a child are illegal regardless of the circumstances, the use of force or threats, or the child's behavior. The law is based on the premise that children are unable to consent to sex with adults. The law also applies to teenagers who use force to have sex or have sex with children who are significantly younger. The same laws apply to teenage and adult offenders although the penalties are different. The laws that are specific to children do not require proving that force was used or that there was lack of consent. The child-specific laws make some distinctions based on age differences between the victim and the offender.

Sexual contact by a child under the age of twelve with a younger child can only be prosecuted under very specific circumstances. When the offending child is between the ages of eight and eleven it is possible to prosecute if certain legal requirements are met, but this is rare. Children under eight years cannot be prosecuted regardless of the behavior.

Scope of the problem

CSA is a common experience in children's lives. Estimates of lifetime prevalence are that between 20-30% of girls and about 15% of boys will have some kind of sexual abuse experience. A study of a representative sample of Washington State women found that 38% of women reported some type of sexual assault experience during their lifetime, 80% of which took place before they were 18 years old (Berliner, Fine, & Moore, 2001; Bolen & Scannapieco, 1999).

There is good news about the prevalence of CSA. Both officially reported and self-reported rates of CSA have declined substantially since the early 1990's (Finkelhor & Jones, 2006). In Washington State, official reports of CSA to Child Protective Services (CPS) have dropped by almost 50% during this time. The only type of CSA that has increased is online victimization. Nationally, arrests for victimizations that began online increased by 50% between 2001 and 2006. These increases are likely because the use of the internet has increased dramatically in recent years (Finkelhor, Wolack, Mitchell, & Jones, 2009; Wolak, Finkelhor, Mitchell, & Ybarra, 2008).

Nature of the problem

As can be seen by the examples at the beginning of this section, CSA involves many different types of sexual abuse or assault experiences. Some cases involve the use of force or threat but most do not. In many cases, the offender takes advantage of the child's youthfulness, inexperience, or trusting nature. Sometimes the abuse is misrepresented as normal behavior, or a game. In other cases, the offender manipulates children by offering rewards, inducements, or a special relationship to get them to go along with the abusive behavior.

One reason this is possible is because most sexual abuse involves a known or related offender. About a third of cases involve a family member (both immediate and extended) and only about 10% are committed by strangers (Berliner, Fine, & Moore, 2001). The most typical offender is someone a child knows but is not related to, such as a babysitter, neighbor, or family friend. The relationship to the offender may also vary depending on the age of the victim.

TIP

Offenders typically groom the child, the caregiver and the community. Grooming is the deliberate action taken by an offender to form a trusting relationship with the intent of having sexual contact with the child in the future.



There are some differences of the nature of sexual assault on young children and teenagers.

- ◆ Teenagers have a broader variety of types of victimization.
- ◆ Many cases involving teenagers-- especially older teens-- involve acquaintance or date rape.
- ◆ Teen abuse often involves single episodes that take place in the context of risky behavior. These situations may include drinking or taking drugs, going somewhere with people whom the victim does not know well unsupervised, or where the youth has run away.
- ◆ There are some situations where the victim does not consider him or herself to be a victim.
- ◆ Cases may involve teachers, coaches, youth leaders, religious personnel, or individuals that the victim has met online.
- ◆ In almost all cases of online victimization, the victims have voluntarily agreed to meet the person for the purposes of a sexual relationship. The victims in these types of cases may believe that they are in love with the offender or that the relationship is mutual.

The typical CSA experience involves one or a few incidents of sexual abuse. This includes situations that occur with family members. Although there are some situations that go on for extended periods of time, this is relatively uncommon overall.

Most sex offenders are male, although up to 20% of cases may involve female offenders (Bolen & Scannapieco, 1999). Female offenders are most likely in cases involving teenage girls and younger children, or in cases of teenage boys who do not consider themselves victims. These are situations where an older woman involves a teenage boy in a relationship that the victim sees as consensual. Female offenders are rarely involved in cases where force or threat is used; when they are, it is most often along with a male offender.

Impact of CSA

Sexual abuse affects children in different ways. Most children are upset by the experience and have some psychological reactions, especially in the beginning. The reactions can range from mild distress and confusion all the way to the development of serious psychological conditions that can persist unless there is formal therapeutic intervention. Sexual abuse is also a risk factor for developing problems later on in life. This does not mean that all victims will have problems as adults, but it does mean that they are at higher risk depending on other circumstances.

The most specific serious psychological response to sexual abuse is Posttraumatic Stress Disorder (PTSD) or significant posttraumatic stress symptoms (PTS). PTSD is a specific psychological reaction to the memory of the abuse. It can include flashbacks or very upsetting memories; avoidance of reminders or numbing, or all these reactions. There may also be increased arousal responses such as hypervigilance, concentration problems, or irritability. In younger children these symptoms of anxiety can be expressed through regressed or aggressive behavior, or physical symptoms. About one third of victims develop PTSD and even more have significant PTS. Children who develop PTSD commonly are depressed as well. As an advocate, you can recognize symptoms of PTSD and help clients address them, but you should never attempt to diagnose or use such terminology with clients without a formal diagnosis.

Sexual behavior problems are another specific reaction that some children have to their experiences. About one-third of sexual abuse victims will show some kind of unusual or inappropriate sexual behavior. Sometimes this involves sexualization and sexual preoccupation; in other cases it involves sexual behavior with other children. However, not all children who have sexual behavior problems have been sexually abused. Sexual behavior problems can develop for many other reasons, including exposure to sexuality or sexually explicit materials, family sexualization and lack of boundaries, or even just high levels of family disruption and chaos. The presence of sexual behavior problems does not mean that a child was sexually abused. While a history of sexual abuse is a risk factor for becoming an offender later on, this is a rare outcome.



TIP

Many children can recover with caregiver support and access to accurate information, crisis support and advocacy services.

There are a variety of factors that determine how affected a particular child is. These factors generally fall into three basic categories:

- 1 The child's previous experiences and history of other abuse or trauma;
- 2 The nature of the sexual abuse experience and the child's reactions during the abuse; and
- 3 What happens after the abuse, especially how caregivers respond to the child.



The most important response is how caregivers react to the abuse and that the response is not negative.

1 Child's previous experiences

Critical pre-abuse factors that increase the risk that a child will develop serious problems include the child's prior psychological concerns, especially a history of anxiety problems. If the child has previously been sexually abused or experienced other trauma such as physical abuse, or witnessed domestic violence, the risk is higher. Many studies have shown that the more trauma and adverse life experiences a child has, the higher the risk of developing problems.

2 Nature of the sexual abuse experience and the child's reactions

Abuse characteristics make a big difference in the impact on the child. More serious abuse experiences, especially those involving force and violence, tend to have more impact. The most important factor is if the child subjectively believed that s/he was in extreme danger, and might be killed or hurt during the assault. The subjective experience is even more important in determining the outcome than objective factors. Abuse that goes on over time is also more harmful. This is likely because the child is living with the fear and worry about being abused instead of being able to put the experience behind him or her.

The relationship of the offender to the victim sometimes makes a difference but not always. To some extent it depends on how important the person is, not what the legal relationship is. Finally, what the child believes about the experience makes a big difference. When children have beliefs such as, it is their fault, that they are ruined, or that no one can be trusted, they are more likely to be seriously affected.

3 Responses after the abuse

The most important response is how caregivers react to the abuse and that the response is not negative. Reactions such as not believing the child and blaming the child for the victimization, or for causing trouble to the family or the offender increase the risk for negative outcomes. Children may internalize these reactions and come to believe that they are bad or deserve to be victimized. Studies show that most caregivers believe their children and are supportive. The biggest complications arise when the offender is a parent or close relative. The family is torn about whom to believe, or wants to avoid the complications of accepting that a person they care about would do such a thing. However, even in family situations, most families do believe and support their children.

It turns out that the Criminal Justice System (CJS) response to child victims does not have a major impact overall. For most children whose cases become involved in the CJS, their involvement is relatively modest. In Washington, most children are only interviewed once for the investigation, and for the majority of children this is the only contact they have with the system (Cross et al., 2008). Most cases that are prosecuted result in a guilty plea and the child does not have to testify. Even when children testify, the studies show that while the children are temporarily more distressed, this abates over time.

TIP

The CJS provides a method of holding people accountable based on legally admissible evidence and standards of proof. It is important not to overemphasize the importance of what happens in the CJS in terms of determining truth. The truth is what happened, not what is decided in a court. It is helpful for victims when advocates communicate this so victims can put the experience into its proper perspective.

Impact of Involvement in the Criminal Justice System

Overall most children will have limited contact with the CJS, usually one to two interviews. If they have accurate information, support, and advocacy, these interviews have minimal impact.

- ◆ Many cases where sexual abuse occurred will not result in criminal charges. This can be upsetting and disappointing to victims and their caregivers. Advocates can minimize this disappointment by providing accurate information about the CJS and its legal requirements for proving cases based on legally admissible evidence. Also, advocates can provide support and reassurance that the truth is what actually happened, not what a court decides.
- ◆ The CJS process can be confusing and frustrating because it must follow legal requirements and procedures and often involves delays. Accurate information, support, and putting the experience into perspective can minimize these consequences.
- ◆ A minority of children will have more extensive involvement and might even have to testify in a trial. While testifying does not usually have long-term negative effects, it does create anxiety and distress. Teaching coping strategies and providing accurate information and support can minimize the intensity of this distress.
- ◆ Sometimes a case will result in an acquittal. This usually has a negative impact because caregivers feel that they are not believed. Providing accurate information about the legal process, preparing them for a possible “not guilty” verdict, and emphasizing that the victim is the only one who really can know the truth can help minimize this impact.
- ◆ Besides psychological behavior issues, CSA may also impact children’s health. For example, they may suffer from chronic constipation, gastric upsets, bulimia or anorexia.

Telling and Help Seeking

Studies of adults who were victimized as children show that most victims eventually tell someone about their experiences, although many do not tell right away. The supportiveness of the response makes a difference. Among children whose victimization is reported, most are reported within days or a few months of the last time the abuse occurred. However, some children wait years before reporting. The studies of adults in the general population show that in recent years, more victims are telling sooner compared to the past when a majority of victims either did not tell anyone or waited years to tell (Berliner, Fine, & Moore, 2001).

Studies of adults who were victimized as children show that most victims eventually tell someone about their experiences, although many do not tell right away.

In terms of reporting to the police, the Washington state study showed that only 15% had reported to the police. However, a higher percentage of younger women had reported, about 25% (Berliner, Fine, & Moore, 2001). Other studies find that the rate of reporting to police is higher now than it used to be. This suggests that in recent years with the changes in the societal climate regarding sexual abuse of children and improvement in the support available to victims, a higher percentage is willing to report to the authorities.

Only a minority of victims seek services following sexual abuse experiences. In part, this is because not all children report their experiences to their caregivers. And unless they report, caregivers cannot seek services. Not all children need formal treatment services. For example, in cases of abuse that only happened once or a couple of times, if the child does not show significant psychological effects and the caregivers are protective and supportive, treatment may not be necessary.

TIP

Sexual assault is almost always a significant and upsetting experience in a child's life, but in most cases children recover and do not have lasting negative psychological effects. Advocates can communicate a message of optimism and hope.

What Helps Victims?

Children and caregivers may look for advocacy and support at any time during the abuse or their recovery process. They may seek out services right after the victimization, maybe after legal proceedings or years down the road when the child is having a difficult time coping.

Once victimization has happened, what is most important is that the child tells someone and receives a protective and supportive response from caregivers. In addition to the family response, all children and their families are likely to benefit by receiving specialized information and referrals, crisis response, general advocacy, medical care, and legal advocacy.

Those seeking help may contact a CSAP for many different reasons, sometimes only requiring **information and referrals** to community resources. A grandparent may be questioning a grandchild's sexual behavior and call for information to better understand if this is natural behavior or something to be concerned about. A father may call for a referral for information on how to talk with his child about touching and keeping secrets. A foster parent may be seeking information on alternate healing resources related to a child's culture. [Refer to Information and Referral section for more details.]

Crisis response advocacy involves providing victims and their caregivers with support and validation for the experience. It should include information about typical reactions, how to be helpful, what to look for, and problem solving regarding next steps. There is every reason to believe that this type of advocacy will enhance victim recovery. It is very important that the information provided be accurate and reassuring if it is to be helpful. For example, letting caregivers know that most children will recover and not be permanently affected by abuse creates a positive and hopeful expectation. [Refer to Crisis Intervention section for more details.]

General advocacy may also be accessed anywhere along the spectrum. Advocates may be called to arrange for health, financial or housing needs to enhance recovery months after the initial disclosure. Two years after the disclosure, a child victim entering puberty may require ongoing personal support, including outreach calls or visits. Case-specific, client-focused referrals may help a caregiver provide needed support to the child if a case does not go to court. Often a CSAP advocate is the only support system available to the child or caregivers months or years after the disclosure. [Refer to the General Advocacy section for more details.]

The **medical response** has the primary function of reassuring the child and caregivers that there are no permanent physical effects of the abuse. While rarely found, an attempt may be made to gather forensic evidence. Only a very small percentage of cases have any kind of medical-legal evidence such as injuries or sexually transmitted diseases. Sometimes caregivers and even professionals think that a medical evaluation will traumatize a child. Specialized medical providers are trained to be sensitive and supportive. The exam should not involve an internal examination unless it is medically necessary to diagnose an injury or when the victim is a teenager and such an exam is appropriate. The reassurance aspect of the exam is a key component of the recovery response to victims. There is no evidence that children find medical exams traumatizing. [Refer to Medical Advocacy section for more details.]

Legal advocacy is a service intended to provide support and information about legal processes that may occur following reporting. Many caregivers have misconceptions or fears about what is involved in participating in the legal process because they are not familiar with criminal justice system procedures. These concerns can create unnecessary anxiety and distress for the victim. Caregivers' worries can be reduced and managed when they are given accurate information. They need to know what to expect, and that they will have a supportive advocate available to answer questions and be present during the process. [Refer to Legal Advocacy section for more details.]

Therapy for Children

Some children will benefit from formal psychological services. It is likely that most caregivers would benefit by contact with a qualified counselor who can learn about the risk factors (e.g., prior history, the nature of the abuse, caregiver responses) and how the child is currently functioning. This will help the caregiver decide whether treatment is necessary. Some children and caregivers may only need one or a few sessions to learn about what to look for and how to be helpful. For those children with significant symptoms, there is an evidence-based treatment called Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). [See Appendix 2 for additional information.]

TIP

Some children and caregivers will benefit by formal treatment. Fortunately there are brief effective therapies that really work and are available in most Washington communities. Trauma-Focused CBT is the best practice for the specific effects of sexual abuse.



Addressing Cultural Considerations

When working with children and caregivers we always need to consider the impact that culture has on the child and caregiver. Culture influences how one defines the effects of sexual violence, how one accesses support systems and resources, the victim's healing and recovery journey, and even whom one tells. All these factors need to be understood if an advocate is to successfully work with victims and caregivers.

It is important to understand that cultural groups interpret their experiences differently, have different experiences with dominant mainstream systems and have different healing strategies. An understanding of these issues can therefore be reflected in the activities and resources advocates provide.

Cultural considerations may include a client's community, national origin, gender, the language spoken in the home, and spiritual and religious beliefs. Tribal and military communities also have different jurisdiction issues.

Advocates must explore and become aware of their own cultural biases and learn to respect:

- ◆ Boundaries, customs and values of other cultures
- ◆ Traditions that may be different than their own
- ◆ Services and resources that may be used by different cultures

TIP

Meeting the unique needs of a client calls for advocates to assess cultural norms, strengths and values of the individuals they work with.

Addressing Development Differences

Children at different ages express the impacts of sexual assault experiences differently. Older children overall tend to be more affected because they have greater cognitive awareness of what sexual assault means and how it might affect other aspects of their lives. Younger children are primarily focused on their immediate safety and security.

Anxiety and posttraumatic stress in young children are often expressed by developmental regression, aggression, and distress at separation from a caregiver. Older children are more likely to withdraw, avoid situations that are distressing, or shut down emotionally. Adolescents who experience severe anxiety may have panic attacks, abuse substances, or engage in self-harming behaviors.

No matter what the developmental stage of a child, caregivers are the most important influence on children. Insuring that caregivers have accurate information, are supportive to their children, and manage their own emotional reactions in a constructive way is by far the most important factor in helping children.

Younger children

The most important help for young children is an increase in reassuring and supportive responses by caregivers who at the same time maintain consistency and predictability. It is helpful if caregivers give their children opportunities to talk about and express feelings about the sexual assault.

TIP

Young children rarely need or benefit from independent relationships with professionals. Advocacy is best delivered through the caregiver who then can create the sense of security and support for the children.

School-age children

These children still depend primarily on caregivers and benefit most when caregivers provide support, reassurance, and opportunities to talk about the sexual assault experience and their feelings. These children are capable of understanding and handling the CJS process and procedures if the language and explanation of concepts is simple and understandable. They do not need extensive amounts of information. Advocacy for school-age children should always actively involve caregivers in all aspects because they are the most important influence in the children's lives.

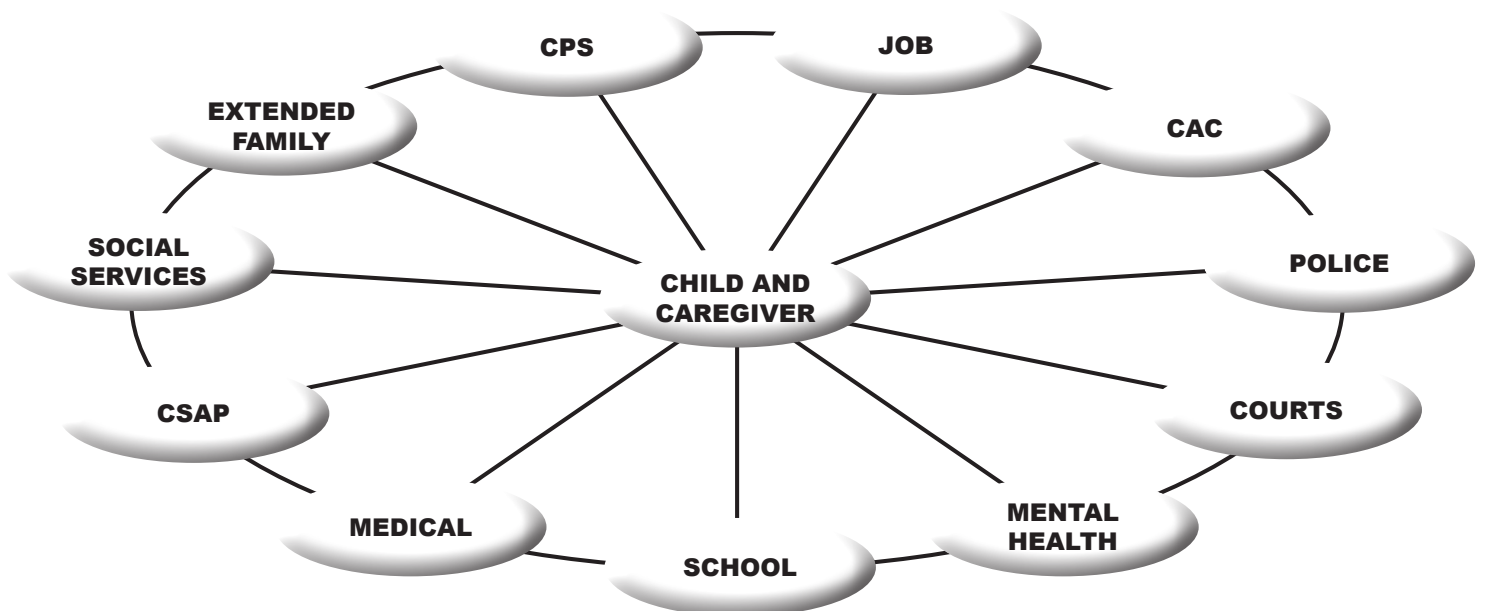
Adolescents

At this developmental stage youth are beginning to add peers and other adults as important influences. They are establishing their own independent identities. Like younger children they benefit from support, reassurance, and opportunities to talk about their experience and feelings. However, the manner in which this happens is more important to adolescents. They respond best to advocacy approaches that treat them respectfully and actively involve them in all aspects of the process. They are capable of a more complex understanding of the CJS process and procedures, will often appreciate more information, and have more thoughtful questions that need to be answered, compared to younger children. However, they are still children who are part of a family and it is important to respect and include caregivers.

Children and the Wider Community

Children and caregivers do not live in isolation. There are many complex systems that impact children and caregivers in everyday life. These can be even more overwhelming when children and caregivers are already managing feelings and crisis surrounding child sexual abuse.

The diagram below illustrates the many systems that may impact the child and caregiver. An advocate should be aware of these and help the child and caregiver understand, utilize and negotiate these systems.



State of Washington Sexual Abuse/Assault Service Standards

SYSTEM COORDINATION

Definition	Coordination of the service system entails the development of working relationships and agreements (formal and informal) among programs and services with a role in the array of sexual abuse/assault service provision with the goal of improving service delivery
Goal	To operate a permanent, client-centered system which offers, or assures access to, a comprehensive continuum of specialized sexual abuse/assault services, which is mutually accountable despite individual changes over time in regulations, procedures or people who provide service.
Duration	An on-going process
Eligible Activities	<ul style="list-style-type: none"> • Develop partnerships • Increase collaboration • Assess gaps in service • Foster cooperation • Develop accountability process • Develop new ways of delivering services • Develop new sources of funding
Potential Participants	<ul style="list-style-type: none"> • Law enforcement • Prosecutors • Judiciary • Child Protective Services (CPS) • Schools • Social services (private and public) • Mental health services • Medical facilities/practitioners • Emergency services • Other relevant groups, task forces, networks and individuals
Qualifications	<p>System coordination should be initiated and led by a Community Sexual Assault Program.</p> <p>The staff and volunteers representing the Community Sexual Assault Program should represent the issues of sexual abuse/assault to the community accurately, fairly and regularly. They should understand the public policy-making process, build coalitions and articulate opinion to shape public policies that are beneficial for the organization and victims of sexual abuse/assault.</p> <p>They should commit to building community around sexual abuse/assault issues; promote effective relations among diverse agencies working with victims of sexual abuse/assault; facilitate cooperation between all of the agencies/organizations involved with victims of sexual abuse/assault.</p> <p>They also should encourage cooperation and collaboration with other organizations, seeking ways to improve services and/or reduce costs through cooperative efforts; share expertise with others to achieve partnerships; and organize and operate partnerships effectively.</p>

March 1999

SYSTEM COORDINATION



Best Practices

System coordination is a required Core Service included in the State of Washington Sexual Abuse/Assault Service Standards. It emphasizes the importance of sexual assault service providers representing the perspective and best interest of victims of child sexual abuse. This is achieved by establishing relationships with other professionals and systems within the community. The goal of systems advocacy is to improve the delivery of services to victims of sexual abuse and their nonoffending caregivers.

Systems advocacy is an ongoing process and includes both formal and informal working relationships with other service providers or agencies. Such agencies include Children's Advocacy Centers (CAC), law enforcement, prosecutors, mental health providers, Child Protective Services, and medical practitioners.

While systems advocacy on behalf of sexually abused children and their caregivers can be done in the context of specific cases, it is essential and often most effective to engage in systems advocacy outside of working with individual clients.

While systems advocacy on behalf of sexually abused children and their caregivers can be done in the context of specific cases, it is essential and often most effective to engage in systems advocacy outside of working with individual clients. When advocates approach a professional working with another system in the context of a direct client service, they may encounter territorial issues and sensitivities. These may not exist if they approach the same professional or agency in a more generic context. It is therefore important that advocates generate opportunities for systems advocacy that are independent of their work with specific children.

**TIP**

Often professional partnerships progress through a process, during which they may begin as informal relationships and then progress to formal agreements, such as a task force, a memorandum of understanding, or a business agreement.

Often when working with children and their caregivers, it can be difficult to accomplish any tasks other than direct client services, particularly those that may not result in obvious immediate benefits. However, it is essential to view systems advocacy as a way to better serve the clients with whom you are working. When advocates engage in system coordination, other service providers gain a better understanding of the issues and perspectives of children who have been sexually abused. Advocates also develop more comprehensive understandings of other agencies that child victims may work with. By establishing quality professional relationships based upon respect and mutual understanding, every client benefits from comprehensive and victim-centered services.

A key component of system advocacy is to be proactive.
Agencies and partners will occasionally approach advocates
with opportunities, but more often, advocates need to seek them out.

A key component of system advocacy is to be proactive. Agencies and partners will occasionally approach advocates with opportunities, but more often, advocates need to seek them out. Advocates need to initiate meetings with other service providers, invite themselves to the table to sit on task forces and advisory committees, and develop every opportunity to represent child sexual abuse victims. When working within an agency with limited resources, this can be difficult. However, by dividing the responsibility and prioritizing contacts, agencies can accomplish much with little means.

Limited resources are another reason why system advocacy is best accomplished outside the context of individual cases. If each advocate only focuses on the systems and contacts they are involved with for a particular case, then it will take many more resources to eventually address all potential partnerships.

What Advocates Need to Know

- Advocates need to be knowledgeable about the services and systems in their community, as well as their own agency's services.
- While system coordination provides valuable educational opportunities for advocates to learn about other service providers, ideally advocates should not take on this responsibility alone when they are new to the field.
- In order to effectively participate in system coordination on behalf of sexually abused children, advocates must be knowledgeable regarding victim services and issues in order to represent these children fairly and accurately.
- It is also necessary for advocates to be confident enough in their own knowledge and perspective that they are able to professionally challenge other providers when they are not engaging in victim-centered practices.
- If it is necessary for inexperienced advocates to attend a system coordination activity, their role should be to observe, take notes and report back to the agency rather than to participate actively. Training for system coordination should always pair an experienced advocate with a less-experienced advocate until such time as that advocate can independently take a leadership role with the meeting or event.

TIP

If advocates are involved in system coordination activities, they should be experienced in working with child sexual abuse.

Cultivate Relationships with Systems and Providers Focused on Children

- ◆ When it comes to system coordination related to child sexual abuse, it is particularly important to cultivate relationships with those systems and providers focused on children, specifically, CPS, law enforcement, prosecutors, and children's mental health and medical providers.
- ◆ Also required by Washington statute is the development of county protocols for the investigation of child sexual and physical abuse [see Appendix 4]. Many of the county protocols include the provision of a Multidisciplinary Team (MDT) designed to staff cases, identify gaps in services, and develop service networks to ensure that victims of child abuse receive appropriate services. Advocacy should be involved with the process of developing and reviewing each county's protocols. However, if the protocols were developed without the participation of advocacy services, make sure that a copy is obtained and opportunities for community advocates are identified.



TIP

Washington laws mandate that community-based sexual assault advocates be involved with the county child abuse protocols. Specifically, it says "local advocacy groups," which by definition include CSAPs.

- ◆ Large systems such as CPS and law enforcement are often the most challenging to advocate within, as they include so many people and often rigid policies which regulate their work with clients. However, these systems also have some of the most formalized opportunities for engaging in systems advocacy. For example, all Departments of Child and Family Services (DCFS) offices' CPS and Child Welfare Services (CWS) are required to facilitate a Child Protection Team (CPT). The role of a CPT is to staff cases under guidelines set forth by statute. By sitting on a CPT, an advocate has the opportunity to interact with numerous social workers and other professionals who make up the Team, represent victim perspectives in the DCFS decision-making processes, and encourage appropriate referrals for victims of child abuse. DCFS also has other structured opportunities for systems advocacy, such as Family Team Decision Making Meetings and Foster Care Review Boards. These meetings are required by statute, so every Washington DCFS office facilitates them. Getting involved is often no more complicated than getting in touch with the facilitator and passing necessary background checks.

- ◆ Most opportunities for advocacy within the system are not so formal as to be required by statute, but still exist in every community. Identify task forces, work groups and networks to join. Agencies that often facilitate such opportunities and therefore are good contacts to pursue are county health departments, county human services offices, and Children's Advocacy Centers. If there are no networks or task forces around child abuse services in a community, it would be appropriate for the CSAP to take a leadership role in developing collaborations.

TIP

System Coordination activities and the development of community partnerships should be part of a strategic plan for the agency. Contacts should not be made without consultation with one's supervisor and other advocates in order to avoid duplication of efforts.

- ◆ If a Children's Advocacy Center (CAC) exists in the community, an essential system coordination activity would be to develop a partnership with it. CACs bring together professional services to address the issues of child abuse. Advocacy is a vital component of these services. CACs often facilitate the MDT in the community, and may facilitate other meetings or networks. A CAC may be a group of completely independent service providers or a cooperative arrangement between providers who work for different agencies. Either structure is likely to have a coordinator or executive director who would be an appropriate first contact. CACs may have their own advocates, who would also be very useful initial contacts. Do not consider the CAC to be a duplication of services. These agencies can be very beneficial partners to CSAPs in order to effectively address child sexual abuse.

TIP

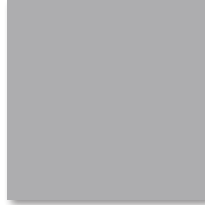
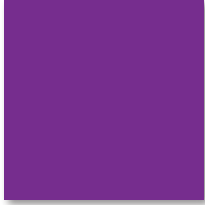
The National Children's Alliance has useful information and training about the CAC model. www.nca-online.org

- ◆ Some opportunities for system coordination may involve the discussion of specific cases of child sexual abuse. If these children are currently receiving or have previously received advocacy services, it is important to remember that case-specific information cannot be shared without an appropriate release of information. As a participant in system coordination, even though not advocating on behalf of a specific child, advocates can still provide general information about available services, common reactions of child abuse victims, and ways that other providers can be responsive to children.

As a participant in system coordination, even though not advocating on behalf of a specific child, advocates can still provide general information about available services, common reactions of child abuse victims, and ways that other providers can be responsive to children.

- ◆ In connecting with a new system coordination activity or meeting it is often beneficial to approach it initially as an educational opportunity. Few agencies or providers will turn down the opportunity to educate someone else on their work or perspective. This approach often allows for connection with even the most complex or resistant system. Continuing to develop the relationship after that initial meeting or training often leads to a system coordination prospect. With formalized networks that are established and operating, advocates often simply need to contact the facilitator or another member and request to participate. As everyone is trying to accomplish more with fewer resources, another participant is usually welcomed.





Scenarios

1. *While participating in an Multidisciplinary Team Meeting (MDT) discussing a case of a 13-year-old boy who was sexually abused by his 22-year-old babysitter, it is clear that members of the team have concerns that prosecution of this case will be difficult because of the perception that the 13-year-old would have been a willing participant in this relationship.*

- ◆ An essential component of systems advocacy is to represent the child's perspective and rights to other service providers. In this situation it would be appropriate, even if the child is not a client of the CSAP, to challenge the professional's perspective that a 13-year-old boy would be a compliant victim.
- ◆ It would be appropriate to point out that under statute his willing participation would be irrelevant. More importantly, it would be relevant to challenge the group that they are supporting stereotypes about male victims not being able to be raped because of their sex drive, and they are supporting gender differences in the application of the law.
- ◆ Having preexisting relationships with the members of the MDT allows for this perspective to be shared and the team to be challenged in a way that doesn't jeopardize the advocate's role or standing with the team.

2. *While participating in a shelter services meeting, the local teen shelter indicates that it is their policy to no longer shelter a juvenile who is engaging in prostitution.*

- ◆ In this situation it would be appropriate to discuss the perspective that juveniles engaged in prostitution are often victims of sexual abuse.
- ◆ Under Washington law, the age of sexual consent is 16, and the average age of entry into prostitution is 13. This means that many juvenile commercial sex workers are not of age to engage in consensual sexual contact and the transmission of money or services does not change the fact that these children are victims.
- ◆ The issues of domestic trafficking can also be brought to the attention of those at the meeting. By promoting these perspectives, the advocate may be able to influence the policy of the teen shelter over time, giving young victims the opportunity to be safe and off the streets.

Key Points

- ✓ System coordination is most effective when engaged in outside of the context of an individual client's services.
- ✓ Advocates engaging in system coordination should be knowledgeable about their agencies' services and policies, as well as victim issues and perspectives in order to effectively represent victims.
- ✓ Both formal and informal opportunities for systems advocacy should be developed.
- ✓ System coordination is an ongoing process. System coordination activities should be a part of the agency strategic planning process.
- ✓ Systems advocacy ultimately benefits every child sexual abuse victim and should be prioritized as an essential activity.

TIP

Difficult or complex situations that arise during system coordination activities should be discussed in consultation with the agency supervisor.

State of Washington Sexual Abuse/Assault Service Standards

INFORMATION AND REFERRAL

Definition	Responding 24 hours a day in person or by phone to direct requests for information or assistance related to sexual abuse/assault.
Goal	To provide sexual abuse/assault related information and resources.
Duration	Usually one time.
Activities	<ul style="list-style-type: none"> • Assist caller/client in evaluating what is needed • Provide information verbally or in writing about available resources/services
Service Recipients	<p>Any caller, but typically,</p> <ul style="list-style-type: none"> • Non-offending parents of child victims • Victims • Significant others who require assistance in order to address their own reactions to the victimization and to effectively support the victim • Those whose work brings them into contact with people who have been victimized: health care, mental health, education, law enforcement, legal, social service personnel • Offenders or their families
Qualifications	<p>All volunteer and paid staff must complete 30 hours of initial sexual abuse/assault training plus 12 hours of ongoing sexual abuse/assault training annually. All trainings must be approved by the Washington Coalition of Sexual Assault Programs (both the curriculum and the trainer). The provider must be familiar with the dynamics of sexual abuse/assault and relevant community resources, as well as have an understanding of how medical, legal and social services respond to victims of sexual abuse/assault.</p> <p>Providers must be supervised by a paid staff person who has completed the 30 hours of initial sexual abuse/assault training and has two years of relevant experience.</p>

March 1999

INFORMATION AND REFERRAL



Program Best Practice

- ◆ Knowing how your program operates regarding children and caregivers and what you can and cannot offer
- ◆ Knowing your county's Child Abuse Protocols
- ◆ Knowing your CAC policies, if you have one in your area
- ◆ Being aware of resources available in nearby communities
- ◆ Having current referral information
- ◆ Being familiar with mandated reporting procedures
- ◆ Having packets of information readily available
- ◆ Knowing the medical and legal systems so advocates can describe to the child or caregiver what may happen

Client Best Practice

- ◆ Finding out the caller's primary concern and dealing with it first
- ◆ Providing culturally relevant services and referrals
- ◆ Never making promises
- ◆ Providing a referral staff name and direct line if possible (it is more personal and may be more helpful than just an agency phone number)
- ◆ Letting the caller know what may happen when they call a referral agency (there may be a therapy waiting list; the CAC may ask you to come in at a specific time; the culturally-specific agency may be closed for lunch, etc.)
- ◆ Never offering legal or medical advice, while letting the client know that an advocate will support them through both legal and medical processes

What Advocates Need to Know

- Clients seeking information and referrals may call the agency or just walk in.
- Most often the caller will be the victim or caregiver. Rarely, a child may call.
- Caregivers may call for general information about how to support a child victim.
- Representatives from other agencies who serve children, such as health care agencies, mental health agencies, schools, etc., may call for information about what the sexual assault program has to offer their clients.
- Do not overwhelm them with information during the first call, especially if the caller is a child or teen. Give them the information that pertains to their primary concerns.
- Advocates don't need to know all of the details of a case or situation to provide information and referrals.

It is important to understand that this may be one of the hardest calls the child or caregiver has ever made. Something has happened to give them a reason to call on this day, in this moment; discovering that reason will clarify the advocate's role during the call. The advocate must be present for the caller. It is not best practice to multitask during a call. The advocate's job is to listen first and foremost, then to respond with the best possible options, referrals and information.

The advocate's job is to listen first and foremost,
then to respond with the best possible options, referrals and information.



Whenever possible, advocates should give the caller their name and contact information. This ensures the caller has some consistency with any follow-up contacts. If it is not possible for the advocate to give contact information, another advocate's name and number should be given.

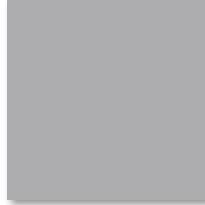
This is most likely the first contact the client will have with a sexual assault agency. It is important to encourage the caller to call again should they have more questions or concerns. Advocates should always assure the client that they are glad s/he made the call.

TIP

Advocates should know the programs and resources in their communities.

TIP

Advocates should not ask "why" questions. The client has no need to justify anything.



Scenarios

1.

A mother (whose primary language is not English), is calling after her child returns from a forensic interview and is trying to find a therapist for her child.

- ◆ Determine if an interpreter is needed.
- ◆ Get basic information on the child.
- ◆ Ask if the family has insurance.
- ◆ Determine if the child needs a therapist who speaks a particular language.
- ◆ Give at least three referrals if at all possible to specially trained CSA therapists in the community.
- ◆ Ask if there are any other referrals or information that would be helpful to the caregiver.
- ◆ Commend Mom for calling to get the therapy referral and explain how important it is for parents to be supportive of their children.

2.

Mom is not sure where to turn. The father of her children has been sent to prison for sexually assaulting her daughter. He was the main provider and now she has no money for food, electricity or rent.

- ◆ Support Mom and validate feelings.
- ◆ Help prioritize her needs.
- ◆ Make appropriate referrals within the program and in the community.
- ◆ Help her sort out how family and friends might be supportive.
- ◆ The advocate should assure Mom s/he is glad she called.

3.

A doctor calls because a minor patient just disclosed a sexual assault and wants to know what services are available.

- ◆ If the assault has not been reported, the advocate should remind the doctor that a mandated report needs to be made, and offer the appropriate phone numbers.
- ◆ Let the doctor know that someone from the program would be glad to be present with the victim during the reporting process and/or medical assessment.
- ◆ The advocate should ask the doctor to pass on his or her contact information and let the victim know the advocate hopes to hear from him or her.
- ◆ Provide the doctor with appropriate referrals (CAC, culturally-specific agencies, college sexual assault support teams, military sexual assault response coordinators, etc.).
- ◆ Thank the doctor for making the call and offer to send the program's brochures to his or her office.

4.

A client calls the crisis line at 4 a.m. but says she just wants information about support groups.

- ◆ The advocate should tell the caller, "I'm glad you made this call."
- ◆ Ask what led her to make the call when she did, and offer options for any primary issues raised.
- ◆ If the caller does not verbalize a concern, offer to mail information about support groups.
- ◆ The advocate should give the caller contact information or information for contacting a specific staff member during regular business hours.

TIP

People do not usually call at 4 a.m. just to get general information. It is always helpful to ask what kind of day they had or what led them to make the call.

Key Points

- ✓ Information and referral must be available 24 hours a day.
- ✓ Find out what the primary concern is and deal with it first.
- ✓ Identify any cultural considerations to ensure appropriate information and referrals.
- ✓ Keep resource and referral lists updated.
- ✓ Be present for the caller and listen.
- ✓ Follow through with any requests for information.

State of Washington Sexual Abuse/Assault Service Standards

CRISIS INTERVENTION

Definition	An immediately available 24-hour personal response provided in a variety of settings to an individual presenting a crisis related to sexual abuse/assault.
Goal	To alleviate acute distress of sexual abuse/assault, to begin stabilization, and assist in determining the next steps.
Duration	Short term. May be episodic.
Activities	<p>Activities to alleviate acute stress including:</p> <ul style="list-style-type: none"> • Information about the effects of victimization • General information about medical and legal issues (Case specific information – see Legal/Medical Advocacy) • Information on services available in the community
Service Recipients	<ul style="list-style-type: none"> • Child sexual abuse/assault victims • Adult or adolescent sexual abuse/assault victims • Non-offending parents whose children are sexual abuse/assault victims • Significant others who require help/assistance in order to address their own reactions to the victimization and to effectively support the victim
Qualifications	<p>All volunteer and paid staff must complete 30 hours of initial sexual abuse/assault training, which must include at least four hours of crisis intervention, plus 12 hours of ongoing sexual abuse/assault training annually. All trainings must be approved by the Washington Coalition of Sexual Assault Programs (both the curriculum and the trainer). The provider must be familiar with the dynamics of sexual abuse/assault and relevant community resources, as well as have an understanding of how medical, legal and social services respond to victims of sexual abuse/assault.</p> <p>Providers must be supervised by a paid staff person who has completed the 30 hours of initial sexual abuse/assault training and has two years of relevant experience.</p>

March 1999

CRISIS INTERVENTION



Program Best Practice

- ◆ Knowing and understanding the effects of child victimization
- ◆ Knowing and understanding county child abuse protocols
- ◆ Having access to current resources
- ◆ Understanding that caregivers will have a wide range of reactions to their child's assault
- ◆ Having familiarity with signs and symptoms of child sexual abuse/assault
- ◆ Understanding reactions adult survivors experience in response to CSA

Client Best Practice

- ◆ Responding to the caller or walk-in within 10 minutes
- ◆ Assessing for safety
- ◆ Determining whether the client is in crisis or in the middle of an emergency (if it is an emergency situation, 911 should be called)
- ◆ Assuring the client that everything is confidential unless it involves a mandated reporting situation
- ◆ Being calm and nonjudgmental
- ◆ Validating the client's feelings
- ◆ Being an empathetic listener
- ◆ Helping identify, validate and stabilize emotions

What Advocates Need to Know

- Clients in crisis may call the agency or just walk in. Clients may be caregivers of child victims, teenagers, and sometimes (though rarely) a child. A crisis can occur at any time during the advocate's contact with a client and can exhibit in many different ways. The anticipation of a child being interviewed by the defense attorney or undergoing a medical assessment may create a crisis for the parent. A caregiver not having childcare for other children during an appointment may consider this crisis.
- A crisis requires the advocate's immediate attention. The first thing an advocate needs to do is establish safety. Is the caller (or child) suicidal, in danger of another assault, or in need of immediate medical attention? The advocate must take the appropriate action.
- It is important for the caregiver or child in crisis to know that the advocate can be trusted with personal information. Reassure that the call is confidential, unless it involves a mandatory reporting situation.
- The role of an advocate is to be calm and nonjudgmental with children and their caregivers. It is not the advocate's place to approve or disapprove of the client's actions. Parents of children who have been sexually assaulted may feel that their parenting skills and ability to care for their children are being questioned and judged. They may, consciously or subconsciously, be dealing with feelings related to their own abuse or assault.

TIP

The key is to be calm and listen. Simply being listened to can reduce the client's crisis state.

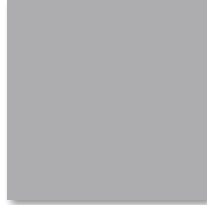
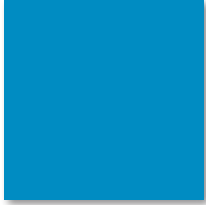
- Advocates also need to understand that caregivers may be feeling they have lost their power. This feeling may be stronger with teens, particularly if the caregiver has responded by taking privileges away from the teen. The role of the advocate in these situations is to be an empathetic listener and validate the client's feelings without judgment. The goal is to help the client calm down, to decrease the feeling of being overwhelmed, and to help the client understand what is going on and what options he or she has. This helps increase the client's sense of control and creates a more "stable" state.



TIP

Stabilization techniques help establish concrete action steps for victims.

- Advocates do not get to determine whether or not something is a crisis. They need to remain calm and not go into a crisis mode themselves.
- Child sexual abuse can create unexpected, powerful emotions. Advocates may have to ask for help and/or support from their supervisor or another advocate. Even the best veteran advocate cannot "do it all" and should feel comfortable asking for help if necessary. Trying to advocate for a caregiver and an older child at the same time would not be best practice. If at all possible, each should have his or her own advocate.



Scenarios

1.

You get a call on the crisis line and the person on the other end is crying and they just keep saying "I'm scared, I'm scared."

- ◆ Assess for safety. Find out what the caller is afraid of.
- ◆ Get contact information (phone numbers and address if possible) from caller.
- ◆ If safety is an issue, call 911.
- ◆ If safety is not an issue, establish whether the caller is a parent, a teen, or a child.
- ◆ The advocate should let the caller know who s/he is and that s/he is there to listen and help.
- ◆ Find out the caller's main concerns and address them.
- ◆ Validate, validate, validate.
- ◆ Determine whether or not the call requires a mandatory report to CPS or law enforcement.
- ◆ Explain what may happen when reporting and that an advocate can be with him or her for support.
- ◆ Tell the caller how courageous s/he is for making the call.
- ◆ Give contact information and appropriate current resources or referrals.
- ◆ Even if this client is referred to another advocate, call and check in with the caller the next day.

2.

A mother calls and says she was told by the police officer when she reported her 6-year-old child's abuse that she needs to schedule a forensic exam with the hospital/clinic/CAC.

- ◆ Let the mother know that this is normal protocol.
- ◆ Find out what the mother's main concerns are and address them.
- ◆ Give general information about what a child's medical assessment may entail.
- ◆ Reassure the mother that the child's medical assessment is usually noninvasive [see medical section].
- ◆ Remind the mother she is not alone. Advocates are available for her and her child's support through the process.

3.

A teenager calls you and says she thinks was raped by a family friend the night before.

- ◆ Assess for safety.
- ◆ Find out whether she has any support currently available. Is she alone?
- ◆ Find out what her main concerns are and address them.
- ◆ Find out whether she has reported the rape or not. If not and if she is under 18, let her know it will need to be reported to law enforcement and that an advocate can be present with her during the report.
- ◆ If necessary, explain mandated reporting.
- ◆ Let her know the advantages of going to the hospital for a medical assessment (to make sure she is okay, possibly to receive medications for sexually transmitted diseases and/or emergency contraception, and possibly to provide evidence collection). Let her know that an advocate can meet her at the hospital or clinic to provide support if she would like.
- ◆ Let her know her therapy options. If she is 13 or older she can see a therapist without her parent's consent.

Key Points

- ✓ Listen and validate.
- ✓ Remain calm.
- ✓ Be nonjudgmental.
- ✓ Help the caller prioritize issues. This can be difficult for people in crisis to do on their own.
- ✓ Tell the client you are glad s/he called.
- ✓ Characteristics like genuineness and patience are critical to establishing a relationship with victims and caregivers.
- ✓ Know your County Child Abuse Protocols.
- ✓ Have a current resource list.

State of Washington Sexual Abuse/Assault Service Standards

GENERAL ADVOCACY	
Definition	Personal support and/or assistance in accessing sexual abuse/assault related services.
Goal	To ensure needed services and adequate support to enhance recovery from sexual abuse/assault
Duration	Generally, 1 to 4 times per month; 3 months to a year
Activities	<p>All activities and services are client-focused and case specific.</p> <ul style="list-style-type: none"> • Ongoing personal support, including outreach calls/visits (including in-patient or residential care settings) • Practical help as needed; information and referrals which are case specific and client focused • Ongoing, repetitive crisis intervention • Arranging for services to enhance recovery (e.g., health, financial, housing) • Consulting with others (such as CPS, APS, Indian Child Welfare) regarding an individual case
Service Recipients	<ul style="list-style-type: none"> • Adult/adolescent sexual abuse/assault victims • Non-offending parents whose children are sexual abuse/assault victims • Significant others who require help/assistance in order to address their own reactions to the victimization and to effectively support the victim
Qualifications	<p>All volunteer and paid staff must complete 30 hours of initial sexual abuse/assault training, plus 12 hours of ongoing sexual abuse/assault training annually. All trainings must be approved by the Washington Coalition of Sexual Assault Programs (both the curriculum and the trainer). The provider must be familiar with the dynamics of sexual abuse/assault and relevant community resources, as well as have an understanding of how medical, legal and social services respond to victims of sexual abuse/assault.</p> <p>Providers must be supervised by a paid staff person who has completed the 30 hours of initial sexual abuse/assault training and has two years of relevant experience.</p>

March 1999

GENERAL ADVOCACY



Program Best Practice

- ◆ Maintaining confidentiality
- ◆ Meeting advocate training requirements
- ◆ Staying informed and involved and protecting existing rights for child victims
- ◆ Knowing community resources and agency policies

Client Best Practice

- ◆ Taking into account the child's age, disability, ethnicity, economics, rural or urban setting, sexual orientation
- ◆ Encouraging victims and their caregivers to advocate for themselves
- ◆ Working with caregivers to support their children
- ◆ Working cooperatively with other agencies, and offering referrals to best meet the needs of children and their caregivers
- ◆ Consulting your supervisor with any questions and challenging situations

Confidentiality

Confidentiality is fundamental to providing services to children who have been sexually assaulted and their nonoffending caregivers. It maintains trust and lays a foundation for healing. Confidentiality is inherent in the relationship between the child and the advocate. It should only be broken in the case of a mandatory reporting issue, suspected harm to self or others, or upon the request by a victim or caregiver for assistance in the coordination of services [refer to legal section for more information]. Programs must offer training on mandatory reporting and all aspects of confidentiality, including appropriate use of release of information forms.

Confidentiality is fundamental to providing services to children who have been sexually assaulted and their nonoffending caregivers. It maintains trust and lays a foundation for healing.

Meeting Advocate Training Requirements

Child sexual assault is a complex issue and no one is prepared to work with victims without appropriate training. The comprehensive training an advocate receives provides a foundation of knowledge, empathy, multicultural awareness, and confidence. Ongoing training enhances the skills an advocate develops during initial training. To meet the advocate training requirement every sexual assault advocate must complete 30 hours of initial sexual assault training plus 12 hours of ongoing sexual assault training annually. Training must be approved by the Washington Coalition of Sexual Assault Programs (both curriculum and trainer).

The advocate must be familiar with the dynamics of sexual assault and relevant community resources, as well as have an understanding of how medical, legal and social services respond to victims of sexual assault. Advocates must be able to work with other agencies in order to provide the most comprehensive and supportive services for child victims and caregivers.

Agencies should make cultural competency trainings available to advocates. Trainings cosponsored by sexual assault programs and agencies representing diverse communities can be very effective.

TIP

Advocacy requires that an individual be able to acknowledge and put aside their own biases and personal opinions in order to genuinely support children and caregivers who may have vastly different belief systems and life circumstances.

Staying Informed and Involved and Protecting Existing Rights for Child Victims

Child sexual assault is a complex issue. It is important that agencies and advocates remain current on best practices and laws pertaining to child sexual assault victims and their caregivers. CSAPs must provide required core sexual assault training for each advocate. Additional trainings should be offered regularly, and advocate records monitored to make sure they are up-to-date and appropriate. It is imperative that advocates attend ongoing training sessions within their agencies. Also, they should seek out other nonoffending caregiver and child sexual assault training opportunities. Current information is provided to advocates through WCSAP, other agency newsletters, websites and “webinars,” continuing education, and community service providers. These include special attention given to diverse communities. Advocates must stay up-to-date regarding community resources, and be active on committees and task forces dealing with issues affecting children and teens.

Child sexual assault is a complex issue.

It is important that agencies and advocates remain current on best practices, and laws pertaining to child sexual assault victims and their caregivers.

When there is a legal case, the advocate must stay informed in order to keep the caregivers and older children updated on dates and times for interviews, possible plea agreements and potential trial dates. Advocates must possess a clear understanding of the legal system and be able to explain each step involved to the child and caregivers. They must offer reassurance, support and information along the way. The Child Victim Bill of Rights [see Legal Advocacy] should be posted, translated, and easily accessible for advocates, older children and caregivers. Every caregiver must be provided with a copy. It is important that advocates understand and protect these existing rights for child victims.

Taking Into Account the Child's Age, Disability, Ethnicity/Culture, Economics, Rural or Urban Setting, Sexual Orientation

The child's age

Advocates need to be aware of what is age-appropriate for each client. For toddlers, separation from caregivers is difficult, especially in novel setting, so advocate meetings with caregivers may need to be short and more frequent. Some preschoolers may be very verbal and need to be listened to and acknowledged. Best practice would be to not discuss the child's case while the child is present. Naptimes may be a consideration and attention spans are extremely short.

Early-school-age children tend to be protective of parents and may want to be included in conversations. Keep remarks to younger children positive and encouraging. Consider what choices the child can make to give them some control.

Elementary-school-age children are better at comprehending complex ideas and relationships and may want to be a part of decisions. Include them in conversations and decisions they can comprehend. Do not have "adult" conversations with children in hearing distance. Do not assume they don't understand what you are talking about. You may have to encourage the caretaker to have certain conversations when the child is not around. Whenever possible, interviews for school-age children should be late in the day so they do not have to miss classes.

Most children will have a difficult time sitting in interviews and answering tough questions. Each interview can take between one and two hours. If possible, prosecutor and defense interviews should not be scheduled for the same day.

TIP

A child should be questioned by only one person during an interview and the length of the interview should be as short as possible, never longer than two hours. Be mindful of the child's developmental and emotional needs.

Adolescents can often communicate like an adult. They can understand and communicate abstract ideas. Whether they are accompanied by a caregiver or by themselves, they have rights and can make many decisions on their own. Peer pressure is a huge part of their life and they may want to schedule visits, interviews or other services at different times so no one will know what they are doing.

Disability

Advocates must be aware of any disabilities a child may have. They should ask caregivers if their children have any special needs or issues, and how to best deal with them. Advocates can help make meetings more comfortable for children with particular issues. Some children are sensitive to fluorescent lights and will do better in a room with a lamp or dim lighting. Giving a child a stuffed animal to hold is sometimes helpful. A child should never be removed from the safety of his or her wheelchair by an advocate. Local committee meetings, support groups and trainings should be held in ADA-accessible locations.

Advocates must be aware of any disabilities a child may have. They should ask caregivers if their children have any special needs or issues, and how to best deal with them.

Ethnicity/Culture

Interpretive services and program information translated into different languages should be easily accessed by advocates. Advocates should attend trainings pertinent to diverse communities. Program representatives should be sitting on community task forces which involve and pertain to these communities. If these communities are not represented, their inclusion should be encouraged and promoted. Advocates should educate themselves about available services and involve themselves in diverse communities in their area.

An advocate needs to consider cultural issues that may impact services and resources provided. For example, an advocate should consider the client's community, language spoke in the home, nationality, religion, individual healing methods, spiritual beliefs, boundaries, parenting values and other beliefs, attitudes and norms associated with their particular culture.

TIP

Program sites and meeting locations should reflect the culture of the client whenever possible.

Economics, rural or urban setting

It is important that advocates be aware of resources available in outlying communities. Gas money may need to be provided to caregivers who have to travel long distances to attend meetings, support groups, and/or therapy sessions. Confidentiality in smaller rural communities may be difficult to maintain and caregivers may want to access services such as therapy outside of their community. Bus passes should be available to clients living closer to services. Basic needs should be addressed to enable all caregivers to participate in the criminal justice system and program services. In addition to bus passes and gas money, food and childcare should be available whenever possible to families in need.

Sexual orientation

It is important to use inclusive language. Brochures relating to sexual orientation should be prominently displayed. Advocate training should include understanding the issues children face when discovering their sexual orientation and, whenever possible, community resources available to meet the needs of children of every sexual orientation.

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Encouraging Victims and Their Caregivers to Advocate for Themselves

It is important to encourage victims and their caregivers to advocate for themselves. Not all clients feel comfortable communicating their concerns. Advocates may need to communicate that it is okay to ask questions and share concerns. Clients can advocate for themselves by discussing their concerns and outcomes they are hoping to see with the advocate and if going to trial, with the Prosecuting Attorney. They can provide input to the presentence investigator, as well as make a victim impact statement at sentencing. A community-based advocate is a wonderful resource for victims and caregivers to express their frustrations, confusion and other emotions surrounding the crime and the social service systems involved as a result of the crime.

TIP

Advocates need to consider cultural and individual differences that may affect one's ability to self-advocate. Use interpreters when needed to ensure all victims and caregivers have the ability to communicate concerns and hopes.

Working With Nonoffending Caregivers to Support Their Children

Best practice means staying involved with the child and his or her caregiver. Caregivers provide access to the child. As secondary victims, they deserve advocacy and support. The more support they receive, the more able they are to support the child. While providing support, it is important to take into consideration the cultural identity of the caregivers. An advocate must recognize the unique needs and rights of children and their caregivers and be willing and able to speak up and speak out to ensure the best possible services for the victim.

TIP

Agency policy and procedures will dictate whether advocates do home or site visits or drive victims and caregivers. Supervisors and advocates must always consider the safety of the advocate as well as the safety of the clients. Have a plan and be sure someone in the agency knows where you are going and when you plan to return.



Working Cooperatively With Other Agencies and Offering Referrals to Best Meet the Needs of Children and Their Families

Good working relationships in the community will result in better services to children and their caregivers. Advocates need to have current and comprehensive lists of resources, whether they are local or located in the nearest available community.

Good working relationships in the community
will result in better services to children and their caregivers.

Sexual assault programs must be responsible for setting the tone in the community. Setting the tone means being involved by representing the program on relevant boards, committees and task forces, including those in diverse communities.

Local representatives including but not limited to those from law enforcement, prosecuting attorneys' offices, mental health providers, and agencies that serve diverse populations should be brought in to do trainings. In turn, in-service sexual assault trainings should be offered. CSAPs should actively seek opportunities to provide educational information to parents, daycares, preschools, teen clubs, faith communities, schools and any other providers of services to children. It is crucial that sexual assault agencies seek out and cultivate a working relationship with diverse community programs.

**TIP**

Advocates should always make referrals as personal as possible. An advocate should have a referral contact's name and direct line, or make the call while the child or caregiver is present.

Good relationships with law enforcement and prosecutors benefit clients. While law enforcement and prosecutors are certainly advocates for children, they do not provide advocacy. They are responsible for investigating and prosecuting child sexual assault cases, and protecting both the child and the community. A sexual assault program advocate's sole responsibility is to the child and caregiver. An agency and advocate demonstrating a good relationship with law enforcement and prosecutors will set the tone for the future relationship the child and caregivers will form with them. Advocates are dependent upon people working within these systems for case information, setting up interviews, and preparing clients for court. An advocate's understanding of county child abuse protocols and individual agency protocols and procedures is imperative to providing the best services possible to children and caregivers.

While working with prosecutors, law enforcement, and other service providers, an advocate must also build rapport with their support staff. The first person an advocate meets when entering the building may be their best source of information. A paralegal can provide information quickly. Building a good relationship with the receptionist may be as crucial as a relationship with the director.

**TIP**

The quality of the relationship formed with other agencies will directly impact the quality of service an advocate can provide to clients.

What Advocates Need to Know

Programs and advocates need to understand their role in providing victim-centered services. Advocates should have a clear understanding of when it is appropriate to coordinate and/or refer a child and/or caregiver to other services and what those services are.

Meeting With Caregivers

The first meeting an advocate has with the caregivers of the child with whom they are working is extremely important. The advocate will be able to offer resources and information, but most importantly, the advocate will begin to build a relationship which will benefit the child.

- Meet with the caregivers and begin building trust and rapport.
- Reassure caregivers that an advocate does not investigate or interview the child.
- Clearly explain the advocate's role.
- Ask what the caregiver's main concern is.
- Talk about the process and "what's next."
- Find out what the child enjoys and ask the caregiver what will make the child most comfortable at a first meeting.
- Give contact information and encourage questions and input because the caregivers know their child best.
- Hand out appropriate program, contact, and other useful information pertaining to child sexual assault and how to support the child.
- Make appropriate referrals for counseling, support groups, and other family needs.

TIP

The advocate can give a child his or her own business card. Younger children will enjoy receiving one. Older children will be able to call the advocate without having to go to their parents for the phone number. This may also help build trust.

Meeting With the Child

With young children, most of the information and contact will be with the caregivers. However, it is important for the advocate to meet with the child and begin to develop some rapport. The child will most likely have to attend interviews with law enforcement, prosecutors and defense attorneys. If the child has a relationship with the advocate, the advocate's presence at the interviews will be very helpful. If the advocate has not met with the child, s/he may be considered one more stranger in the room.

The caregivers may be present. However, this is a meeting for the advocate to get to know the child, so most questions and comments will be directed to the child, regardless of age. The advocate's role here is supportive, not investigative. Questions may be general and directed at getting to know the child. After a brief time with the child and caregivers, and if the child is able to communicate, it is helpful for the advocate to have one-on-one time with the child. This will allow the advocate to ask the child if there are any questions s/he may not have wanted to ask in front of the caregivers.

- Let the child know how brave s/he is and reassure that the child has done the right thing by telling.
- Bring snacks (parent-approved, as the child may have allergies) and small bottles of water.
- Ask the child if s/he knows why s/he is meeting an advocate and what an advocate does. Explain this in age-appropriate language.
- Keep the first meeting short and friendly. The goal is for the child to feel comfortable with the advocate.
- Pay attention to body language.
- Address the child's fears; even just acknowledging them as real is helpful. There may not be a solution, but coping techniques can be discussed.
- Find some decision the child can make.
- Let the child know what choices s/he has, even if it is as simple as taking a stuffed toy to an interview. The advocate should give the child his or her own business card.
- Let the child know "what's next" and when s/he will meet with the advocate again.
- Don't make promises.



For children 12 and under

If caregivers are present explain what you are planning to do and their role.

- Bring something to do with the child, such as a game or coloring pages. (If the child likes a particular cartoon character, animal, etc., there are free coloring pages on the internet for almost any subject.)
- If possible, get down on the child's physical level.
- Most young children will not understand the concept of an "advocate." Let them know you are here to help them and their caregiver.
- LISTEN, even to toddlers, and acknowledge them and their feelings.
- Find out their main concern and address it. Even very young children may express a concern or a fear.
- Explain confidentiality and mandatory reporting to school-age children in language they can understand. Ask if they have any questions.
- Include the child in appropriate conversations.



For children over 12

While the meeting may start with the caregivers and teen, the longest part of the meeting should be with the teen and advocate alone.

- The advocate should let the teen know that s/he will not be asking questions about what happened but is available if the teen wants to talk.
- Get the main concern on the table and address it right away.
- Ask how much information the teen wants. Does s/he want to know about everything? Would the teen like information firsthand or prefer the advocate contact the parents with the information?
- Explain confidentiality and mandatory reporting. Ask if s/he understands and has any questions?
- Once the advocate has explained his or her role, confidentiality and mandatory reporting, let the teen lead the conversation and do most of the talking.
- Texting often works better with teens, but ask if it's okay first and explain possible confidentiality issues.
- The advocate is not a parent; s/he has a responsibility to the child but is not responsible for the child. The teen does not need to justify anything to the advocate.
- Validate feelings without judging them.

TIP

An advocate's role is to be supportive. Advocates are not investigators.

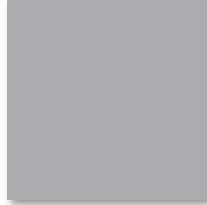
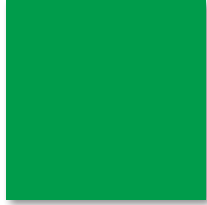
Sibling sexual assault

Sibling sexual assault/abuse is very common. Advocates need to understand the dynamics and particular issues families face when one child sexually assaults another. It is important to acknowledge the difficult place caregivers are in and their relationship with both children. The guilt and self-blame caregivers feel is often more intense when the offender is a sibling. They often feel responsible and that they should have been able to prevent the assault. They may feel that their parenting skills are being judged. They may want to handle things “within the family.” They may fear a breakup of the family unit and often feel that they cannot support one child without being disloyal to the other.

It can be helpful for caregivers to understand that when the system is involved it makes a statement: *The behavior is not tolerable, the victim is believed, and the offending child can get the help needed.*

An advocate needs to:

- Encourage the caregivers to believe and support the child without blame, and without minimizing the offender’s behavior or actions.
- Be clear about the inappropriateness of the offending sibling’s behavior.
- Let the caregivers know that holding the offending sibling accountable is being loving and supportive to both children.
- Explain clearly that an advocate’s role is to support the child and caregivers.
- If possible, provide the caregivers with resource information for the offender.
- Consider separate advocates for the child and caregivers.



Scenarios

1.

Mother calls. Her 10-year-old daughter has reported that the mother's boyfriend has been inappropriately touching her. The mother does not know whether or not to believe her daughter. She does not want to cause trouble for the boyfriend if he really didn't do anything.

- ◆ Validate the mother's feelings and the courage it took for her to make the call.
- ◆ Ask how the child is doing and remind the mother how brave her daughter is to speak up, and that this is not her daughter's fault.
- ◆ Let the mother know that the most important thing her daughter needs is to be believed and supported.
- ◆ Explain mandated reporting and encourage the mother to make the report herself to show that she is protecting her child. Reassure her that CPS does not routinely take children out of the home, especially if they believe the parent is protecting the child. Offer to have the mother come in and make the report from your agency so you can be there to support her.
- ◆ The advocate must follow up and make sure the disclosure has been reported. If the mother does not make the report, the advocate is legally required to report to CPS or law enforcement within 48 hours.
- ◆ Remind the mother that it is not up to her to "investigate" or ask questions to find out what happened to the child. Law enforcement and CPS will do that. She only needs to listen to her daughter.
- ◆ The advocate should reassure the mother that she will support her through the reporting process and whatever follows.
- ◆ Assess the safety of the mom and daughter. Discuss safety plans and their support system.
- ◆ Offer to send a packet of information about child sexual assault.
- ◆ Give appropriate referrals and arrange for follow-up.

2.

A 14-year-old female calls the sexual assault program. Her father has been sexually assaulting her since she was 10 years old. She does not know to whom she can turn or whom to trust. She is scared for her two younger sisters. She is also afraid her mother will not believe her.

- ◆ Find out if she is safe right now.
- ◆ Let her know that an advocate is a mandated reporter and this will have to be reported. Explain mandated reporting.
- ◆ Get her name and phone number.
- ◆ Validate and acknowledge her feelings, how brave she was to call to protect her sisters, how frightening this must be, and that nothing that has happened is her fault.
- ◆ Find out where she is and try to meet with her right away.
- ◆ Consult with the program lead or supervisor immediately.

When you meet with her

- ◆ Ask what her biggest concern is, and address it.
- ◆ Help her in identifying her current support system and people she trusts.
- ◆ Discuss safety planning.
- ◆ Give her as many choices as possible.
- ◆ Call CPS and/or law enforcement (even if you do not meet in person).
- ◆ Assure her you will be there with her.
- ◆ Tell her you can be with her if she decides to talk to her mother.
- ◆ Accompany her to the hospital or CAC if/when appropriate.
- ◆ Stay with the client until she is in a safe place.
- ◆ Arrange for the next contact.
- ◆ Depending on the mother's situation, she may need her own advocate.

3.

An 11-year-old boy has been sexually assaulted by his 17-year-old male cousin. It has been reported. The child is afraid to meet with the prosecutor. He does not want to tell what happened because people will think he is gay. This is a referral from the Prosecutor's Office and they want a meeting with the child.

- ◆ Meet with the child as soon as possible.
- ◆ Validate the child's feelings and remind him that this is not his fault.
- ◆ Address the child's main concern.
- ◆ Explain the role of the advocate and why the prosecutor called.
- ◆ Let the child know that he is not alone, that many young boys are victims of sexual assault, and that has no bearing on their sexual orientation.
- ◆ Explain that the prosecutor has worked with many child victims of sexual assault and understands that a boy being sexually assaulted does not make him gay. Reassure him that everyone is different -- straight, gay, questioning -- and that what is important is what feels right for him.
- ◆ Explain what will happen during the prosecutor's meeting and that you will be there with him the whole time.
- ◆ Provide your contact information and let him know what will happen next.
- ◆ Discuss support systems and ask the 11-year-old boy how the advocate can help/support him.

4.

A mother of a victim on a two-month-old case calls. She is beside herself because the child's dad is threatening to track down the offender and "take care of things." Mother is very concerned.

- ◆ Ask the mother if the child is aware of what is going on with the dad.
- ◆ Either way, depending on the age of the child, check in with her to see how she is doing.
- ◆ Validate the mom's concern and the stress she is undergoing due to the abuse.
- ◆ Set up a meeting with the mother and dad as soon as possible.
- ◆ Talk to the dad about the stress he is undergoing due to the abuse. Provide active listening to develop trust and see if Dad will open up. Discuss the implications of his actions (examples: jail, not being there to support his child, frightening his child, making the child feel even more responsible). The child may shut down or not tell anything else because she is afraid of what might happen to her dad.
- ◆ Give the dad suggestions and referrals to deal with his anger, while validating his feelings.
- ◆ Tell the dad what his child really needs from him (Dad to be home with her, supportive of her, not witnessing his anger outbursts, and to reassure her that none of this is her fault).
- ◆ If the advocate feels the dad is really threatening to hurt the offender, it is a mandatory reporting issue.
- ◆ Check back with the family in a couple of days.

TIP

Anytime there is a question or challenging situation with a client, consult a supervisor.

Key Points

- ✓ Confidentiality and being nonjudgmental are crucial.
- ✓ Always identify and deal with the client's main concern first.
- ✓ Always provide strength-based and victim-centered services.
- ✓ Secondary victims deserve and need services and support so they are better able to support the child victim.
- ✓ Keep in mind the cultural differences of clients and act accordingly.
- ✓ Advocates have a huge responsibility to the people they serve, but they are not responsible for the people they serve. Keep clear boundaries.
- ✓ Strong community relationships will result in better services for clients.
- ✓ Advocates always need to be aware of their own safety.

State of Washington Sexual Abuse/Assault Service Standards

MEDICAL ADVOCACY

Definition	Acting on behalf of and in support of victims of sexual abuse/assault on a 24-hour basis to ensure their interests are represented and their rights upheld.
Goal	To assist the victim to regain personal power and control as s/he makes decisions regarding medical care and to promote an appropriate response from individual service providers.
Duration	May vary significantly depending upon client's medical needs as related to the sexual assault.
Activities	<p>All activities and services are client-focused and case specific. For general information regarding medical advocacy, see Information & Referral.</p> <ul style="list-style-type: none"> • Assistance in making informed decisions about medical care and the preparations needed, including referral for possible forensic exam • Information about medical care/concerns, including assistance with needed follow-up • Support at medical exams and appointments • Information and/or assistance with Crime Victim Compensation applications
Service Recipients	<ul style="list-style-type: none"> • Child sexual abuse/assault victims • Adult/adolescent sexual abuse/assault victims • Non-offending parents whose children are sexual abuse/assault victims • Significant others who require help/assistance in order to address their own reactions to the victimization and to effectively support the victim
Qualifications	<p>All volunteer and paid staff must complete 30 hours of initial sexual abuse/assault training, which must include at least four hours of medical advocacy, plus 12 hours of ongoing sexual abuse/assault training annually. All trainings must be approved by the Washington Coalition of Sexual Assault Programs (both the curriculum and the trainer). The provider must be familiar with the dynamics of sexual abuse/assault and relevant community resources, as well as have an understanding of how medical, legal and social services respond to victims of sexual abuse/assault.</p> <p>Providers must be supervised by a paid staff person who has completed the 30 hours of initial sexual abuse/assault training and has two years of relevant experience.</p>

March 1999

MEDICAL



Best Practice

The thought of a child being sexually assaulted causes significant emotional response on the part of family and professionals alike. Coupled with the likelihood that a medical assessment is probable, this stress rises exponentially. The provision of effective and accurate medical advocacy can serve to decrease this response with a resulting positive medical experience.

Key components of medical advocacy are being available 24/7 and providing information and referral for the medical assessment.

Key components of medical advocacy are being available 24/7 and providing information and referral for the medical assessment. It is important that the advocate (or agency) identify what protocols, agreements, memoranda of understanding, and/or contracts are currently in place. These may already identify types of providers, locations, and other pertinent factors necessary to provide medical services to this population. Advocates should proactively seek out specialized providers, promoting the importance and value of their services.

TIP

Asking hospital, clinic or CAC personnel to come in and talk about their CSA medical services is a good way to establish positive relationships and let them know you are available to support victims.

Both the International Association of Forensic Nurses and the Department of Justice have presented opinion papers on the importance of the role of the trained sexual assault advocate during medical assessments. Additionally, the majority of medical and nursing providers are not aware of specific victims' rights affording a victim this support during medical assessments.

The purpose of this section is to provide information on how best to respond to children in a medical setting or those considering medical care. This section is not intended to provide an advocate with a "how to" on providing medical care, but to provide information that serves to increase collaboration and partnership between disciplines with a resulting increase in appropriate medical care provided to victims.

TIP

The information provided is to assist the advocate in providing support and information to the child and caregiver. The actual provision of medical information to the client, including sexually transmitted diseases, symptoms, treatment modalities, expected outcomes, and descriptions and explanations of medical procedures is within the role and responsibility of the medical provider.

What Advocates Need to Know

Who is your client?

The age range for child victims extends from newborn up to 18 years of age. While providing advocacy directly to a child, the advocate may also be providing advocacy to the caregivers. However, children who are developmentally able to understand and participate in medical decision-making may have different advocacy needs than their caregivers. This may require the assignment of separate advocates for the child and caregivers. In addition to consent laws and other client and caregiver rights, providers may use their professional discretion to provide assessment and treatment. Additionally, consent laws regarding healthcare for a minor may specifically dictate what may or may not be shared with a parent. It is also important to understand that those afforded the right to consent also have the right to decline assessment and treatment.

TIP

Consider the need for two advocates if the client and the caregiver have different advocacy needs.

TIP

While Washington State's general age of majority for health care is 18 [RCW 26.28.010], single, unemancipated minors can receive treatment without consent in the following areas:

Sexually transmitted disease testing and treatment: 14 years of age and older [RCW 70.24.110]

Birth control and abortion services: Any age [RCW 9.02.100 (1) (2)]

Why do an assessment?

TIP

The main reason to conduct an assessment is to address the health status of the child; specifically, to note any identified symptoms or concerns and to provide reassurance to the child and caregiver.

The most common reasons to conduct an assessment is to document the history, health status, and injuries associated with the sexual assault and to identify potential evidence. However, even delayed assessments months or years later are beneficial to the child and may be valuable to the investigation. Many children associate pain or bleeding with permanent and disfiguring scars. Often an assessment provides reassurance and emotional healing for both the child and caregiver. Concerns regarding pregnancy and sexually transmitted diseases may arise even years later.

The most common reasons to conduct an assessment is to document the history, health status, and injuries associated with the sexual assault and to identify potential evidence.

TIP

It's normal to be normal. According to Dr. Joyce Adams, et al. (1994) in a large study of confirmed sexual assault cases, approximately 20% of children had medical findings. Advocates need to be prepared to respond to a wide variation of reactions from caregivers. Lack of medical findings does not mean that a sexual assault did not occur. However, being told that there are no medical findings may be interpreted by the caregiver as "nothing happened." Knowledge of the range of offending behaviors can also significantly aid the advocate in helping the caregiver process this information.

Who are the medical and nursing providers?

A wide variation exists across Washington State as to who might conduct a sexual assault assessment.

- In some cases there may be providers with specialized sexual assault or forensic training; this could include licensed independent providers such as physicians and nurse practitioners, and/or mid-level providers such as physician assistants and registered nurses.
- There may also be sexual assault nurse examiners (SANE) available within a hospital setting or in a stand-alone clinic. A growing number of communities have developed children's advocacy centers which include specialized medical services.
- In some areas the initial assessment may be provided by a generalized or emergency department provider within the community then referred to a specialist.
- In some areas there may be no access to specialized providers with or without referral.

It is important to know or to actively seek information regarding the community's specialized medical and nursing services.

What happens in a sexual assault assessment?

The type of assessment a child is offered is largely dependent on the physical maturation and age of the child and medical concerns. For medical purposes, differing techniques and risk assessment are based on whether a child has or has not entered puberty.

When referring to the medical process it is preferable to refer to it as an *assessment* rather than an examination. The term assessment is more encompassing in its scope and is less threatening than *examination*. It also implies collaboration and partnering between the provider and the child.

When referring to the medical process
it is preferable to refer to it as an assessment
rather than an examination.

Prepubescent children

Due to the genital anatomy of this population, this assessment is similar to a well-child check. It should include a general health assessment. It should also include a comprehensive assessment of the external genitalia and anal area. Various techniques may be utilized including visual magnification with or without image recording, irrigation with warm water, and physical movement of the labial structures. It is very rare to sedate a child to complete this assessment. Sedation or anesthesia may be utilized if a foreign body is suspected or surgical trauma repair is required. Nothing should be inserted or placed through the hymeneal tissue into the vaginal vault of a prepubescent child without sedation or anesthesia.

TIP

Caregivers should be assured that in prepubescent children the examination is similar to a well-child check and no speculum is used. A common expression is "Nothing will go inside your child and nothing should hurt."

Postpubescent children

With the average age of entry into puberty in the United States being 10 years of age, advocates may see seemingly adult assessments offered to young children. The clinical decision to perform an internal vaginal or anal assessment is based on many factors. This generally includes concern regarding internal injury (history of bleeding, pain) and ascending infection (history of discharge/itching, pain, urination problems). Some decisions may be made on the basis of the child's medical and sexual history irrespective of the sexual assault concern. Items most commonly inserted may include cotton-tipped swab, Foley catheter, speculum, anoscope, and the provider's finger.



Role and responsibilities

The role of a provider differs drastically from those of the advocate providing medical advocacy, both in philosophy and practice. The purpose of the medical and nursing assessment is first and foremost to determine the health status of the child. Evidence and case building are of secondary concern. The role of the advocate is to assist the child and parent in making informed decisions and to provide support and information.

Communication and support

TIP

Provide general information about what someone can expect during the medical assessment. Do not provide specific assurances of care or treatment to clients, for example, you will receive emergency contraception; you will not have a speculum examination.

In most health care settings, and particularly emergency departments, clients are seen according to an acuity rating or criteria. This can be frustrating for both the advocate and the child and caregivers as the wait can be quite long at times. The advocate can facilitate provision of care by maintaining communication with either the nursing staff or with the specialized provider and passing on this information to the child and family.

Advocates can also discuss the Crime Victim Compensation application, provide a general discussion of what to expect in an assessment, and gain an understanding of any specific concerns the child or caregiver may have. It is important to not provide the child or caregiver with any specific guarantees regarding care provided or outcomes expected. The most common pitfalls in this area are informing a child or caregiver that they will receive certain medication or specific components of the assessment.

TIP

Never give any medical advice. This includes discussion or recommendations regarding over-the-counter medication or remedies or information from your personal experiences.

TIP

In some cases you may find yourself the recipient of a disclosure from a child. Provide encouraging responses without introducing any information. Your agency's policies and procedures will dictate any further action.

Role during the medical history

The purpose of the medical history is to determine the extent and degree of injury, health risk, past medical history, collateral considerations, and the possibility of evidence. The history is considered the most important component of the assessment. As such it may be afforded the right of Medical Exception to Hearsay in a court of law. In order to enjoy this exception the provider must follow specific expectations of questions, answers and documentation. The provider, in addition to health considerations, is also aware of the legal ramifications of decisions made based on the extent and quality of the history provided. This may include assessing the protectiveness of a caregiver, determining the level of sexual knowledge and sophistication, determining the capacity and competency of the child to provide accurate information, and assessing the consistency of history with the medical findings. It is important to provide minimal interruptions for education or clarification during the medical history.

TIP

Avoid interrupting, clarifying or educating during the history portion of the assessment. Statements like “that is normal for you to feel that way, I will spend more time talking with you about that” are useful to insert quickly into a conversation to decrease a child’s anxiety without significantly altering the history.

Role during the assessment

The main role of the advocate during the assessment is to provide support for the child. The advocate should not participate in the assessment by holding or touching the child, or assisting the provider.

TIP

Do not provide medical assistance in the physical assessment. Do not assist in the assessment by touching or holding a child. Any touching of the child should be for the purpose of comforting or focusing him or her.

Food wars

The prevailing philosophy in an assessment is to always consider worst case scenarios. One potential area of conflict between emergency department personnel and advocates is providing the client with food or drink. Even seemingly benign and mild symptoms or pain may result in intervention and treatment that could be delayed or impacted by a child having food or drink.

TIP

No food or drink should be provided to the child.

Preventing inappropriate discussions in front of a prepubescent child

The advocate may be faced with a variety of opportunities to stop or reduce conversations that may be emotionally injurious to the child and/or detrimental to the criminal or safety investigation. Additionally, the disclosure provided by a child may be changed in a variety of ways. This could happen for example, if the advocate introduces herself or himself as being from a sexual assault center, if the parent makes coercive or emotionally laden statements, or if the provider asks leading questions or introduces new terminology or language to or around the child.

The advocate may be faced with a variety of opportunities to stop or reduce conversations that may be emotionally injurious to the child and/or detrimental to the criminal or safety investigation.

TIP

If a caregiver or provider engages in inappropriate conversation to or around the child, comments such as "Could we talk about that outside for a second, I have additional information for you" are useful to stop the conversation in a professional manner.

Mandated reporting

Providers and advocates are mandated reporters [RCW 26.44.030]. Your agency policies and procedures will determine whether the advocate makes a separate report from that of the provider. As a rule, the provider should not abdicate their obligation to an employee from a different agency or organization. Make certain, however, that both you and the provider have clarified who is making the formal report prior to leaving the facility. In some situations the provider may contact law enforcement or CPS prior to your arrival or without the child's or caregiver's knowledge. [See Appendix 1 on Mandated Reporting.]

Confidentiality Health Information Portability and Accountability Act

Health Information Portability and Accountability Act (HIPAA) is a federal law protecting a patient's health information. Protected health information (PHI) means any information, including demographic information, which is created or received by a medical or health provider. PHI includes the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. It is information that identifies the individual or that which there is a reasonable basis to believe can be used to identify the individual. PHI includes information concerning persons living or deceased and may be written, oral, or electronic.

Protected health information (PHI) can be released with consent from the patient and/or caregiver, or under a statutory compulsion. Your agency likely will require additional consent from the victim to provide information to the medical or nursing provider that you gain during the course of the assessment.

TIP

HIPAA web site link <http://www.hhs.gov/ocr/privacy/hipaa/administrative/index.html>

Crime Victim Compensation (CVC) Benefits

Many victims do not seek medical care due to lack of insurance or other financial concerns. Advocates can significantly decrease any concerns the client may have regarding incurring significant costs. RCW 7.68.170 mandates that any initial medical forensic evaluation be billed to CVC and may not be billed directly or indirectly to the client, regardless of the client's intent to make a report to law enforcement. This initial medical forensic assessment is automatically covered if the hospital submits the appropriate billing and documentation requirements to CVC; no claim application is required to receive this benefit. In order for the patient to receive benefits for components of the assessment that are not considered part of the medical forensic assessment, advocates can help the patient complete an application for benefits and mail it to CVC.

TIP

Under the initial medical forensic assessment, CVC will pay for diagnosis but not treatment of injuries or conditions associated with the assault (with the exception of emergency contraception and antibiotics). For example: CVC will pay for the x-ray of the shoulder injury from the assault but not the sling, cast, or pain medication. This portion will be billed to the client's private insurance. If the client does not have insurance, then these bills can be submitted to CVC as a "payer of last resort" if a claim application and report to law enforcement have been completed.

Prophylactic Medication

Emergency Contraception Pills (ECP)

ECP is not the “morning after treatment” commonly envisioned by clients. ECP is high-dose birth control administered 12 hours apart. FDA approval is for use within 72 hours; however, some medical providers will administer it up to 120 hours following unprotected sexual activity. Washington State law [RCW 70.41.350] requires that all emergency departments, regardless of religious affiliation, make ECP available to victims of sexual assault according to medical and FDA guidelines. This includes unbiased discussion of risks and benefits and provision of both doses of the medication. The advocate should anticipate that in most cases a negative pregnancy test is confirmed prior to administration.

TIP

Some agencies, organizations, and businesses may not fully understand the current RCWs relative to the provision of ECP. Advocates should be able to provide information regarding local Planned Parenthood agencies and/or pharmacies that will comply.

Antibiotics

The Center for Disease Control and Prevention (CDC) has developed guidelines for the administration of prophylactic antibiotics for the prevention of gonorrhea and chlamydia following sexual assault. Many medical factors and considerations go into the decision to offer preventative antibiotics and it is not uncommon for the provider not to offer this treatment.

TIP

Do not tell the client that they will receive medication to prevent gonorrhea or chlamydia. A good way to phrase this is “The nurse may talk to you about medication for sexually transmitted diseases.”

Laboratory Testing

Most medical facilities will initiate routine blood tests and other laboratory testing based on clinical guidelines. This may include urinalysis, tests for sexually transmitted diseases, and/or pregnancy testing.

HIV

The CDC has specific guidelines regarding the administration of preventative medication for HIV. Since the treatments in and of themselves pose a significant health risk, a Clinician Hot Line has been established for providers to consult during the course of this decision-making process. As a general expectation, the CDC will not recommend initiation of prophylaxis after 72 hours. Have the client check with the pharmacy first as the medication can be very expensive.

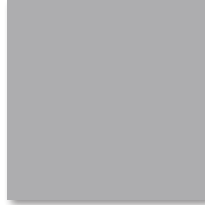
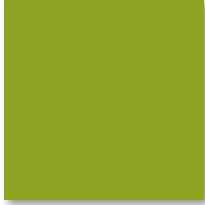
Forensics

The identification, collection, and preservation of forensic evidence range widely and are largely dependent on the history of the sexual assault and subsequent actions taken by the victim. In general, advocates should never accept or handle any items, containers, or bags provided by the client. To do so may place the advocate into the chain of custody and leave him or her vulnerable to subpoena. It is important to understand that even if the client has bathed and changed clothes, forensic evidence may still exist. The advocate's agency's policies and procedures should indicate the response and referral sources regarding forensic questions.

The identification, collection, and preservation of forensic evidence range widely and are largely dependent on the history of the sexual assault and subsequent actions taken by the victim.

TIP

If children have an item that they perceive as evidence ask them to keep it and give it to the provider conducting the assessment. As long as it stays in the possession of the child, then chain of custody is protected.



Scenarios

1.

The advocate is in the emergency department with a four-year-old victim and her 22-year-old mother. When discussing the need for a medical assessment, the mother states upon your arrival "I don't want to do this; I don't want them to stick anything in my daughter."

- ◆ While the advocate cannot categorically advise the mother as to what the provider will or won't do, two actions may be taken:
 - tactfully stop the mother from discussing the case in front of the child and
 - provide general information regarding the examination of prepubescent child.

2.

A 14-year-old child presents to the emergency department accompanied by her mother and her two younger siblings. The mother takes you aside and in addition to the sexual assault concern tells you that she thinks her daughter is having sex with her 15-year-old boyfriend. "I want to know if she is. I have a right to know what my daughter is doing."

- ◆ The conversations and records regarding this situation of a 14-year-old are confidential and can only be released with consent of the child.
- ◆ The advocate will also need to explain the rights of the child to the mother especially if the child declines to release information to the mother.
- ◆ This information is relevant to the decisions that the provider will make. The advocate should request consent to share this information with the medical provider if the client has not already disclosed her sexual history.

3.

The 10-year-old client has requested a snack and drink. Dad says he will go to the cafeteria and get a sandwich and pop for her.

- ◆ Although providing food and other comfort measures is a natural reaction, in the emergency department, nothing can be eaten or drunk without approval from the physician or nurse.
- ◆ Ask the father to talk with the medical provider regarding food and/or drink.

4.

During the course of the assessment the advocate feels that the child is being pressured into consenting to a procedure or examination relative to the sexual assault.

- ◆ In an area away from the client and other staff members, state your concerns to the provider.
- ◆ Determine if there are any other medical concerns that may be driving the provider to this behavior that have not been shared with you. For example: the patient's refusal of a vaginal examination when there is vaginal bleeding will cause the provider to be more insistent.
- ◆ The provider may be reacting to his or her own history related to sexual abuse. Both the advocate and nurse can re-enter the room and have an open discussion clarifying the patient's wishes, rights, fears, and other concerns.
- ◆ Depending on the provider, the treatment plan may be an "all or nothing approach" or "a la carte" (can pick and choose assessment components and treatment).
- ◆ The advocate may also consider contacting his or her supervisor for assistance.
- ◆ If the patient decides to decline part or all of the assessment, the emergency department staff may have him or her sign a *Refusal of Medical Care* and/or *Leaving Against Medical Advice* form.

Key Points

- ✓ Know what medical services are available in your community and actively seek out collaborative agreements with those agencies and individuals.
- ✓ Understand the role that the provider plays is primarily to promote the medical welfare of the child and secondarily to assist in the investigation.
- ✓ While advocates work as a team with the healthcare providers, they and the provider have specific and differing roles and philosophies. While both are equally valuable, the provider may not even be aware of the advocate's contribution to the care of the child.
- ✓ Advocates should seek assistance from their supervisors if they have questions regarding their role or their responses to situations occurring with a provider or a child.
- ✓ If advocates have provider concerns in an emergency department, they should ask to speak to the Charge Nurse.
- ✓ Lack of medical findings does not mean that a sexual assault did not occur. It's normal to be normal. Prepubescent children rarely have medical findings even in a confirmed sexual assault.
- ✓ **Don't:**
 - provide food or drink to a child during a medical assessment
 - promise specific treatments medication, or components of the assessment
 - interrupt the history unless directly pertinent to the care of the patient
 - discuss any components of the sexual assault or investigation within the hearing of the child
 - handle any evidence provided by the child
- ✓ **Do:**
 - communicate actively with the provider or emergency department staff
 - ask questions
 - clarify information or concerns
 - act as liaison and medical process interpreter
 - support the child and caregiver in their rights, choices and beliefs

State of Washington Sexual Abuse/Assault Service Standards

LEGAL ADVOCACY

Definition	Acting on behalf of and in support of victims of sexual abuse/assault on a 24-hour basis to ensure their interests are represented and their rights upheld.
Goal	To assist gaining knowledge of the criminal justice system, gain access to all avenues of participation in the legal system and to promote the responsiveness of individual legal system participants.
Duration	Up to several years
Activities	<p>All activities and services are client-focused and case specific. For general information regarding legal advocacy, see Information & Referral.</p> <ul style="list-style-type: none"> • Assistance in making informed decisions about police reporting and the preparations needed, including the possibility of CVC benefits • Information about the criminal justice systems, civil remedies, and Dependency, Family and Juvenile Courts, including followup • Support at interviews, trial and sentencing • Assistance in preparing for court; informing the victim of her/his rights in legal settings • Active monitoring of case through the legal system • Assistance with protective/no-contact/anti-harassment orders
Service Recipients	<ul style="list-style-type: none"> • Child sexual abuse/assault victims • Adult/adolescent sexual abuse/assault victims • Non-offending parents whose children are sexual abuse/assault victims • Significant others who require help/assistance in order to address their own reactions to the victimization and to effectively support the victim
Qualifications	<p>All volunteer and paid staff must complete 30 hours of initial sexual abuse/assault training, which must include at least four hours of legal advocacy, plus 12 hours of ongoing sexual abuse/assault training annually. All trainings must be approved by the Washington Coalition of Sexual Assault Programs (both the curriculum and the trainer). The provider must be familiar with the dynamics of sexual abuse/assault and relevant community resources, as well as have an understanding of how medical, legal and social services respond to victims of sexual abuse/assault.</p> <p>Providers must be supervised by a paid staff person who has completed the 30 hours of initial sexual abuse/assault training and has two years of relevant experience.</p>

March 1999



LEGAL ADVOCACY

Best Practice

Legal issues arising out of child sexual abuse are often multilayered and complex. The legal system response to child sexual abuse may be conducted by law enforcement, Child Protective Services, caregivers themselves through the civil court system, or a combination thereof. Identifying what pieces of the legal system are involved in a child's life, as well as understanding how those pieces of the system operate and intersect with one another, is critical to effective advocacy on behalf of child victims of sexual violence.

What Advocates Need to Know

Who is your client?

An advocate must be clear who his or her client is. Even though a client may be a child (legally anyone under 18 is considered a minor), this doesn't mean the child has no privacy rights and/or that the child's interests are the same as those of the nonoffending caregiver. Consult your agency's policies and standards of practice before you disclose confidential information to a nonoffending caregiver about a child. At a minimum, each client should have his or her own advocate.

TIP

Washington law allows victims age thirteen and older to consent to counseling services without parental notification [RCW 71.34.530].

Case status

An advocate must be able to determine where a case of child sexual abuse is within the legal system. First determine the type(s) of case; in other words, what system is the family or child dealing with: criminal, family court, juvenile/dependency?

If it is a **criminal case**, what is the status of the case? Has a police report been made? Is CPS involved? Is there a CPS caseworker assigned to the case? What is the status of the investigation? Has the offender been charged?

If it is a **family law case**, is it a divorce action or custody dispute? Have any of the allegations been made to the court in the Family Law Court documents? If yes, then what was the outcome?

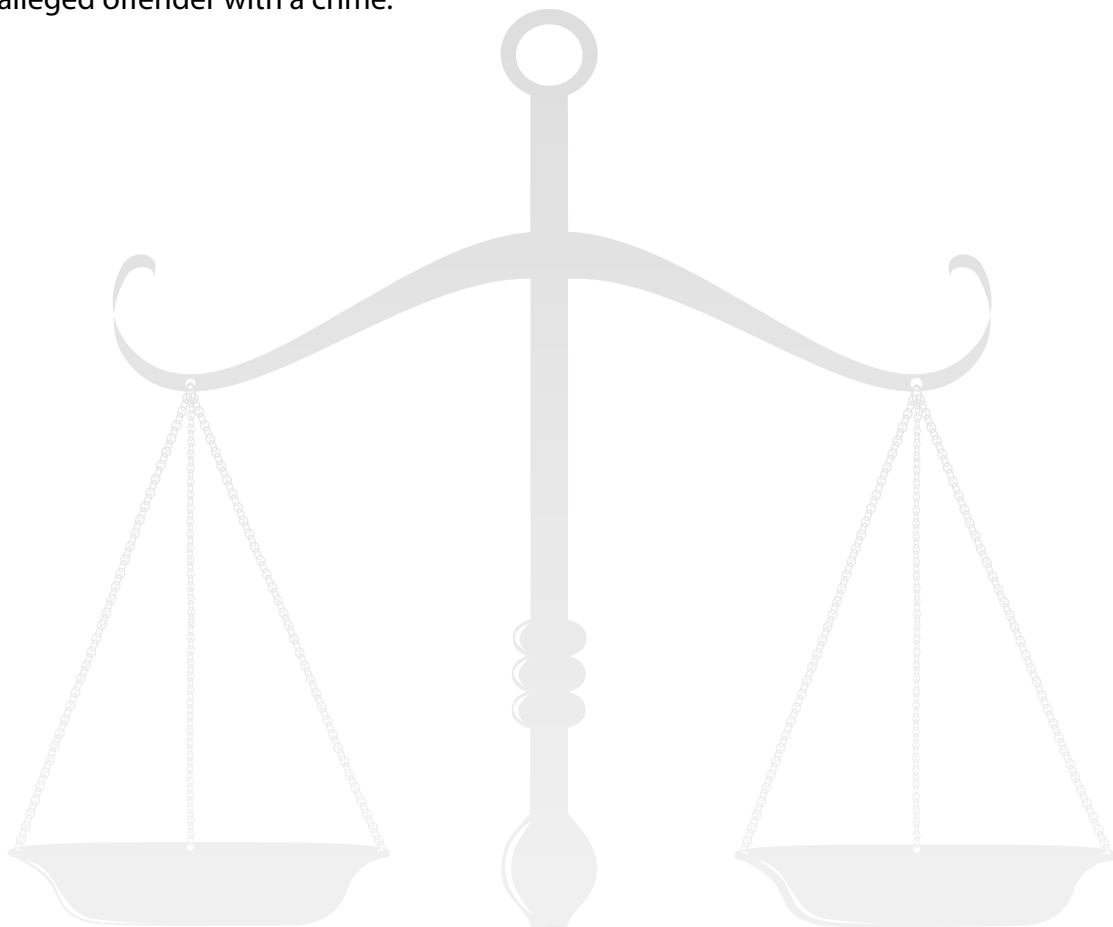
If the **case is with CPS**, what is the status of the case? In some cases Dependency Actions are filed by CPS in Juvenile Court to terminate parental rights. In those actions, CPS is represented by the Attorney General's Office with a goal of trying to help the parent who has control and/or authority over the child to ensure the child is safe in the home. If the parent fails to meet the requirements CPS sets forth, a Dependency Action is begun to permanently terminate the parent's right to the child.

TIP

The law requires CPS and law enforcement to work cooperatively when investigating allegations of child sexual abuse. See your county child abuse protocols for more specific information. [RCW 26.44.035]

Criminal justice process overview

For a case to have any possible criminal response, it must first be reported to law enforcement. Reporting to law enforcement is also required in order for a victim to be eligible for crime victim's compensation. A survivor of sexual assault can report to law enforcement at any time – no matter how long it has been since the assault. If too much time has passed, however, it is more difficult to prosecute. This is because evidence is likely more difficult to collect and potential witnesses are more difficult to find. However, once an initial report is made to law enforcement, if there is sufficient information and a reasonable belief a crime has occurred, there will be an investigation conducted by a detective. The detective then forwards the report to the Prosecuting Attorney's Office, where a decision is made whether or not to formally charge the alleged offender with a crime.



TIP

Significant time can pass while an investigation is being conducted. This can be very stressful for caregivers and children because the offender has not yet been charged with a crime – and ultimately may not be. Often people may struggle with how long the investigation is taking.

First Client Meeting

What will happen?

- ◆ Introduce yourself
- ◆ Explain your role as an advocate – including confidential communications between you and the child and mandated reporting requirements
- ◆ Provide any information about the case that you might have
- ◆ Answer questions
- ◆ Address any concerns
- ◆ Provide support

Who will be there?

- ◆ Advocate, child, and caregivers

Where will it happen?

- ◆ By telephone; in person at your agency; in person at a public place.

Advocate's role:

- ◆ Tell the child and/or caregivers that you will not be interviewing the child about the crime.
- ◆ Give the child and caregivers information about the case.
- ◆ Develop rapport with the child and caregivers.
- ◆ Maintain regular contact.
- ◆ Provide support.
- ◆ Maintain relationships with law enforcement, the courts, main prosecutor's office, CPS, etc.

First Appearance

What will happen?

- ◆ Defendant appears before the judge
- ◆ Defendant is informed of charges
- ◆ Defendant's name is verified, including correct spelling and date of birth
- ◆ Release conditions, bail and whether defendant qualifies for a court-appointed attorney are set forth
- ◆ Arraignment date is set

Who will be there?

- ◆ Defendant
- ◆ Prosecuting Attorney
- ◆ Defense Attorney
- ◆ Supervised Release Staff
- ◆ Judge
- ◆ Child and/or Caregiver (optional)
- ◆ Advocate (if victim attends)

Where will it happen?

- ◆ County Courthouse
- ◆ Cases with juvenile defendants may be heard in another location

Advocate role:

- ◆ Attend the hearing if the child or caregiver is attending and they request your presence.
- ◆ If not attending, check the courthouse the next day to obtain information and pass it on to the child and caregivers.
- ◆ Reminder: child victims do not need to attend this.

Arraignment Hearing

What will happen?

- ◆ Defendant will enter a plea (almost always “not guilty”)
- ◆ Release may again be discussed
- ◆ Trial date will be set by judge

Who will be there?

- ◆ Defendant
- ◆ Prosecuting Attorney
- ◆ Defense Attorney
- ◆ Judge
- ◆ Child and/or Caregiver (optional)
- ◆ Advocate (if child attends)

Where will it happen?

- ◆ County Courthouse
- ◆ Cases with juvenile defendants may be heard in another location

Advocate role:

- ◆ Attend the hearing if the child or caregivers are attending and request your presence.
- ◆ If not attending, check the courthouse the next day to obtain information and pass it on to the child and/or caregivers.
- ◆ Be sure to inform the child and caregivers why the defendant pleads not guilty.
- ◆ It is recommended that a child not attend.

TIP

The defendant will almost always plead not guilty. Generally, judges will usually not accept a guilty plea at arraignment. The defense attorney will not have had enough time to advise their client. A “not guilty” plea leaves options open for plea bargaining.

Prosecutor Meeting

What will happen?

- ◆ Prosecutor will ask questions about the facts of the case, verify dates, identify witnesses, review how the trial will proceed and answer questions
- ◆ The prosecutor will also inform the child and/or caregiver of what will be occurring through the defense interviews and possibly discuss the trial and expectations
- ◆ The prosecutor wants a picture of what kind of witness the child will make

Who will be there?

- ◆ Child and/or Caregiver
- ◆ Prosecuting Attorney
- ◆ Advocate
- ◆ Investigator (possibly)

Where will it happen?

- ◆ Usually the prosecutor's office – but check with prosecutor or staff

TIP

It is best practice not to schedule a prosecutor meeting and defense interview on the same day, especially if you are dealing with a younger child.

Advocate role:

- ◆ Assure the child that the defendant will not be present.
- ◆ Ask the child, “What are you most concerned about going into this interview?”
- ◆ Give information to the child and caregivers about what will be happening in the interview.
- ◆ Let them know who the prosecuting attorney is and that he or she is on our side. They are the “good guys.”
- ◆ Prepare the child but do not tell him/her what to say.
- ◆ Stress to the child the importance of telling the truth.
- ◆ Assure the child that s/he is not in trouble and that the prosecutor is on his or her side.
- ◆ Remember that advocates do not interview the child.
- ◆ At the end of the interview, make sure that the child and caregiver know what will happen next.
- ◆ Tend to the child by:
 - Asking if s/he needs a break, if the child looks like this might be needed.
 - Providing water or tissues, as needed.
 - Asking if the child needs clarification if s/he seems confused.
 - Don’t hesitate to put a hand on the child’s shoulder or to comfort a child.



Defense Interview

What will happen?

- ◆ The Defense Attorney will want to see what kind of witness the victim will make
- ◆ The Defense Attorney will be verifying what is in the original report and asking detailed questions about the report

Who will be there?

- ◆ Child and/or Caregiver
- ◆ Prosecuting Attorney
- ◆ Advocate
- ◆ Defense Attorney
- ◆ Investigator (possibly)
- ◆ Transcriber (possibly)

Where will it happen?

- ◆ Usually the prosecutor's office – check with your supervisor
- ◆ Never at the defense attorney's office

Advocate role:

- ◆ Assure the child that the defendant will not be present for the interview.
- ◆ Find out what is most concerning to the child or caregivers.
- ◆ Stress the importance to the child of telling the truth.
- ◆ As an advocate, monitor the child to make sure that s/he is okay.
- ◆ Let the child know that s/he can always ask for clarifications.
- ◆ Neither the prosecutor nor advocate will say much during the Interview. This is the defense attorney's discovery process.
- ◆ Tend to the child by:
 - Asking if s/he needs a break if it looks like s/he might.
 - Providing water or tissues, as needed.
 - Asking if s/he needs clarification if s/he seems confused.
 - Don't hesitate to comfort the child.

TIP

It is important to listen passively to the child's statements during these interviews. The child's statements may be difficult to hear and outward reactions to the information can be detrimental to the case.

Omnibus Hearing or Preliminary Hearings

What will happen?

- ◆ Exchange of information between attorneys (discovery hearing)
- ◆ Request list of witnesses each attorney is calling
- ◆ Request reports, records or other information each side wants to present
- ◆ Judge determines whether each attorney will be allowed access to opposed information
- ◆ What defense will be used

Who will be there?

- ◆ Judge
- ◆ Prosecuting Attorney
- ◆ Defense Attorney
- ◆ Defendant

Where will it happen?

- ◆ County Courthouse
- ◆ Cases with juvenile defendants may be scheduled somewhere else

Advocate role:

- ◆ Inform child or caregivers if there is any information to pass on from the prosecuting attorney.
- ◆ There is really no reason to attend this hearing unless the child or caregiver wants to.

Change of Plea

What will happen?

- ◆ The defendant will appear before the judge and enter a change of plea that has been agreed upon between the state and the defense
- ◆ The judge will set a new date for sentencing
- ◆ An investigator from the Department of Corrections will start the process of writing the Pre-Sentence Report

Who will be there?

- ◆ Defendant
- ◆ Child and/or Caregiver (Optional)
- ◆ Prosecuting Attorney
- ◆ Defense Attorney
- ◆ Advocate (Optional). If the child or caregivers choose to attend the advocate should offer to attend. If the advocate is unavailable, arrange for another to fill in.

Where will it happen?

- ◆ County Courthouse
- ◆ In the assigned judge's courtroom most likely (always confirm with prosecutor or staff)

Advocate role:

- ◆ Verify that the plea took place.
- ◆ Notify the child and/or caregiver that it did, in fact, happen.
- ◆ Help the child and caregivers prepare for sentencing, i.e., Impact Statement.
- ◆ This is optional for the child or caregiver to attend.

TIP

At times the judge will go ahead with sentencing at the time of Change of Plea. This can be very upsetting to caregivers who wanted to make a statement or witness the sentencing. It is important that you let the prosecutor know that the child and/or caregivers want to be involved in the sentencing. If you are in court for the Change of Plea you may need to speak up if they are going ahead with sentencing. Let them know that the child and/or caregivers are not present and want to be included in the sentencing process.

Competency Hearing (Also called 9A.44)

What will happen?

- ◆ Prosecutor will ask questions of the child (under age 10 or developmentally disabled) to establish that they are competent and know the difference between the truth and a lie.
- ◆ This hearing is like a “mini trial.” It is important that the child and caregivers understand that both attorneys will be asking questions and that the defendant will be present but will not be allowed to speak.
- ◆ All persons who are testifying are not present in the courtroom until they are called to the stand. Usually, waiting rooms are available for the child and caregivers.
- ◆ The judge determines if the child is “competent to testify” and also if the statements of the child (child hearsay) are reliable.

Who will be there?

- ◆ Judge
- ◆ Defendant
- ◆ Defense Attorney
- ◆ Prosecuting Attorney
- ◆ Child
- ◆ Advocate
- ◆ Caregivers
- ◆ Investigator (possibly)
- ◆ Key Witnesses (possibly)

Where will it happen?

- ◆ In the judge's courtroom (always confirm with the prosecutor or staff)
- ◆ Cases with juvenile defendants may be heard in a different room

Advocate Role:

- ◆ Prepare the child and caregivers by arranging a courtroom tour beforehand and discuss what will happen. It is important for the child to feel comfortable in the courtroom.

Prepare the child and caregivers
by arranging a courtroom tour beforehand
and discuss what will happen.

It is important for the child to feel comfortable in the courtroom.

- ◆ Wait with the child in the waiting room and then accompany him or her into the courtroom when called.
- ◆ Debrief with the child and caregivers when the hearing is over.
- ◆ It is important to inform the child and caregivers that the defendant will be present.

3.5 Hearing

- ◆ The 3.5 Hearing may take place at the same time as the Change of Plea.
- ◆ The 3.5 Hearing is to determine admissibility of suspect's statements – to make sure the Miranda proceeding was fulfilled and to ensure statements were not coerced.

Readiness Hearing

What will happen?

- ◆ Prosecutor and defense attorney will either state that they are ready to proceed with trial, or ask for more time and a new trial date will be set. Occasionally, a Change of Plea will take place at readiness.

Who will be there?

- ◆ Judge
- ◆ Defendant
- ◆ Defense Attorney
- ◆ Prosecuting Attorney
- ◆ Advocate (optional)
- ◆ Child and/or Caregivers (optional)

Where will it happen?

- ◆ Sometimes in arraignment courtroom; sometimes in another courtroom. Check in where the courtroom information is posted in your local courthouse.

Advocate Role:

- ◆ This will be a stressful time for the child and caregivers. The advocate's role is to be supportive and reassuring, and to let them know that continuances are more the rule than the exception.

Trial

What will happen?

- ◆ The child only has to be in the courtroom when testifying
- ◆ All subpoenaed witnesses wait outside of the courtroom while others are testifying
- ◆ All subpoenaed witnesses should dress appropriately for a courthouse appearance
- ◆ The jury consists of 12 members if Superior Court; six members if District Court; no jury if Juvenile Court
- ◆ After all witnesses have testified on both sides the judge (if a bench trial) or jury decides if the defendant is guilty or not guilty

Who will be there?

- ◆ Judge
- ◆ Defendant
- ◆ Defense Attorney
- ◆ Prosecuting Attorney
- ◆ Child
- ◆ Advocate
- ◆ Caregivers
- ◆ Jury
- ◆ Witnesses
- ◆ Anyone who wants to be in the courtroom

Where will it happen?

- ◆ In the judge's courtroom (always confirm with the prosecutor or staff)
- ◆ At the Juvenile Detention Center if defendant is a juvenile

Advocate Role:

- ◆ Prepare the child and caregivers by arranging a courtroom tour beforehand and discuss what will happen. It is important for the child to feel comfortable in the courtroom.
- ◆ Talk about fear – what are the child and caregivers most afraid of?
 - Seeing the abuser again
 - Seeing caregivers and other people in the courtroom
 - Not remembering (It is okay to forget things)
- ◆ Reassure that the courtroom is a safe place.
- ◆ Whatever the verdict is, reassure the caregivers that their support of their child is the most important thing that they can do.

TIP

Remind the child and caregivers that a “not guilty” verdict does not mean that the child lied or the abuse did not happen.

Sentencing

What will happen?

- ◆ Prosecutor will talk about recommendations regarding the sentence range. Prosecutor will possibly talk about the PSI (Pre-sentence Investigation).
- ◆ Defense will approach the judge with their recommendation.
- ◆ Impact Statements can be read out loud by the child and/or caregivers or advocate or handed to the judge.
- ◆ Defendant will be asked if they have anything to say.
- ◆ The judge will then possibly ask if the child is present and continue to proceed with sentencing.

Who will be there?

- ◆ Judge
- ◆ Defendant
- ◆ Defense Attorney
- ◆ Prosecuting Attorney
- ◆ Advocate
- ◆ Child (optional)
- ◆ Caregivers (optional)
- ◆ Other Support People

Where will it happen?

- ◆ In the judge's courtroom (always confirm with the prosecutor or staff)

Advocate Role:

- ◆ Support the child and caregivers through the sentencing by attending if your presence is requested. Explain the process and what options are available to the child and caregivers, such as the Victim Impact Statement and recommendations in the PSI.
- ◆ Contact the Prosecutor's Office and verify that the sentencing will be going forward as scheduled.
- ◆ Offer the child and caregivers the opportunity to do an Impact Statement, but also recognize that it is their choice.
- ◆ Always tell the child and caregivers that there is a possibility that the date could be set over numerous times.
- ◆ Follow up with the child and caregivers periodically because this step in the process may be difficult to deal with. Your work as an advocate does not end with the trial. The time after the trial can be extremely difficult and your support may be more necessary than ever.
- ◆ Check in with the child and/or caregivers after sentencing to determine if they require additional services.

TIP

Remind the child and/or caregivers that they can still call the agency at any time if they feel the need to talk with an advocate.

Roles and Responsibilities

In addition to understanding the criminal justice process, advocates need to understand the roles and responsibilities of other professionals serving child victims of sexual abuse, such as Child Protective Services, law enforcement, Guardians ad Litem (GALs), Court Appointed Special Advocates (CASAs), and prosecution-based advocates. By understanding the roles of all these professionals, an advocate is better able to clearly define his or her own role in serving child clients and explaining that role to others.

By understanding the roles of all these professionals, an advocate is better able to clearly define his or her own role in serving child clients and explaining that role to others.

TIP

It is very helpful to know which GALs and CASAs in your community are familiar with CSA. Understand that each professional has different professional obligations – some of which may conflict with your client's interests. Thus, confidentiality plays a key role in fostering client-centered services.

Mandated Reporting

In Washington, advocates are mandated reporters under the law, RCW 26.44.030. This means that advocates play two roles in relation to client-centered victim advocacy. One is to meet legal obligations as a service provider, which requires advocates to report sexual abuse of minors. The other role is to provide confidential services to minors and build trust with child/minor clients. This can be a difficult area to negotiate, particularly with teens. An advocate must report if there is reasonable cause to believe that a child or teenager has suffered sexual abuse. This does not mean the advocate needs to determine age differences between the parties to establish whether a sex crime has occurred. It simply means the advocate must have a reasonable belief that the minor has suffered sexual abuse. [See Appendix 1 on Mandated Reporting.]

Confidentiality

Advocates provide confidential services to all clients. Confidentiality helps create trust and a safe space for the victim after experiencing sexual assault. In Washington, the communications between a sexual assault advocate and client are privileged, RCW 5.60.060(7). Records of rape crisis centers are also confidential under RCW 70.125.065. Thus, advocates working in community-based sexual assault and domestic violence programs are in a confidential, protected relationship with clients. This means that their conversations and records are private and generally cannot be disclosed without the consent of the client.

Advocates provide confidential services to all clients. Confidentiality helps create trust and a safe space for the victim after experiencing sexual assault.

Exceptions

There are exceptions to the privilege law (confidentiality) that protects client victims from having their privacy invaded. They are the following:

- 1 A client-signed release after obtaining informed consent
- 2 Mandatory reporting
- 3 If clients are a threat to themselves or others
- 4 The presence of a third party, except for interpreters, generally waives confidentiality
- 5 A court order

Summary

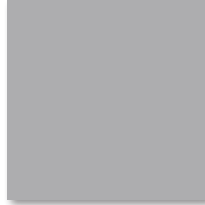
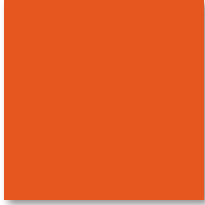
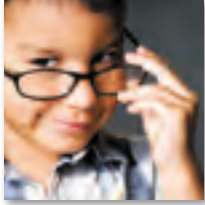
Understanding who the different professionals are that are involved in responding to child sexual abuse and developing relationships with those professionals and their organizations will enhance the advocate's ability to provide effective advocacy for victims. Since children are dependent on others for their safety, health and welfare, it is important for community-based advocates to appreciate the complexity of issues that arise for child victims. Teenage victims of sexual abuse may also struggle with issues of self determination and autonomy.

It is important to remember that the legal processes and systems' responses are often multilayered and complex. For self-preservation, advocates must be clear about the limits of their role as well as the scope of services and assistance available to children and caregivers. Lastly, advocates should look towards the agency's policies and procedures, in consultation with their supervisors, to better understand how to respond appropriately to many different situations.

It is important to remember
that the legal processes and systems' responses
are often multilayered and complex.

TIP

Be aware that different legal processes may apply within tribal and military communities and that advocates should consult their local tribal affiliate, military counterpart or Sexual Violence Law Center attorney for additional information.



Scenarios

1. *The advocate is working with a multidisciplinary team (MDT) in the county which is focused on reducing and preventing child sexual abuse. At the monthly meetings the advocate continually does not share information about specific cases which frustrates many other members of the team.*

- ◆ The advocate should always be clear what his or her role is when acting as a member of a MDT.
- ◆ It is the advocate's responsibility to ensure that other team members are educated about the advocate's role.
- ◆ Advocates can only share client-specific or case-specific information when the client wants the advocate to, and understands the pros and cons of releasing that information. The advocate must obtain the informed written consent of the client before sharing any client-specific information. The client may revoke that consent at any time – orally or in writing. Otherwise the advocate's role is always to be a resource for the team by providing general information about CSA victims.

2. *A parent of a minor child/client comes into the agency requesting copies of the child's files. What should the advocate do?*

- ◆ The advocate should be familiar with the agency's confidentiality policies and know generally what to tell anyone requesting client information.
- ◆ The advocate should also determine if the parent is the same parent who brought the child in for services (if the child is under 13) or if it is the offending parent.
- ◆ The agency's policies should be directive on whether or not to share the records with the parent. At a minimum, if the records are shared, the child client should be informed of the information being shared with the parent.

3.

CPS has requested the agency's entire client file on a child client who is nine years old. What does the advocate do?

- ◆ The advocate should know what the agency's policies are with respect to releasing client information to CPS. RCW 26.44.030(11) states that CPS or law enforcement (the investigating agency) shall have access to all relevant records of the child in the possession of mandated reporters and their employees.
- ◆ Sexual assault programs also have privilege statutes which protect that information as private.
- ◆ The advocate must know what the agency's policy is when CPS requests client records. Either the child or caregiver is notified and the records are released; or the child or caregiver is notified and the records are not released. In the latter instance, the agency sends a letter to CPS telling them that under the privilege statute the documents will not be released without the appropriate waiver from the client.

4.

A mother believes her daughter, age 11, has experienced child sexual abuse by the dad. She has brought her daughter to your agency for services. CPS did not substantiate the allegation and law enforcement is not investigating her claims. The mother has now filed for divorce and is trying to keep the dad from having any contact with daughter. Her attorney requests that the advocate and therapist testify on her behalf at the custody hearing. What do you do?

- ◆ First the agency should contact the mother and communicate that it has received the request from her attorney.
- ◆ If she does want you to testify and share any records the agency has about her daughter, she needs to come into the agency.
- ◆ After having a conversation about the pros and cons of releasing that information, she needs to sign a written waiver.
- ◆ Then the advocate and therapist may testify and release the records to the mother. It is important here that she understand it is not the role of the advocate or therapist to substantiate her allegations of child abuse. By participating in the court case as witnesses, both parties compromise their role in supporting and serving the daughter.

Children

are Victims and Witnesses



of Crime

Sometimes, children become victims or witnesses of crime. From witnessing domestic violence to being the primary targets of abuse and neglect, to experiencing other crimes, our children witness thousands of crimes each year. Washington State has established the following rights to help protect child victims and witnesses in the criminal and/or juvenile court system.

Know Children's Rights

- ☑ To have all legal proceedings and/or police investigations in which the child may be involved explained in language they can easily understand.
- ☑ With respect to the child victims of violent or sex crimes, to have a crime victim advocate or other support person present at any prosecutorial or defense interviews.
- ☑ To be provided a secure waiting area whenever possible during court proceedings and to have an advocate or support person remain with the child prior to and during court proceedings.
- ☑ To not have names, addresses, or photographs disclosed to anyone outside the criminal justice system without the permission of the child or guardian.
- ☑ To allow an advocate to make recommendations to the prosecuting attorney about the ability of the child to cooperate with prosecution and the potential effect of the proceedings on the child.
- ☑ To allow an advocate to provide information to the court concerning the child's ability to understand the nature of the proceedings.
- ☑ To be provided information or referrals to appropriate social service agencies.
- ☑ To allow an advocate to be present in court while the child testifies in order to provide emotional support to the child.
- ☑ To provide information to the court as to the need for the presence of other supportive persons at the court proceedings while the child testifies in order to promote the child's feelings of security and safety.
- ☑ To allow law enforcement agencies the opportunity to enlist the assistance of other professional personnel such as child protection services, victim advocates or prosecutorial staff trained in the interviewing of the child victim.
- ☑ To receive a written statement of the rights of child victims and the contact information for a crime victim/witness program.

Adopted from the Revised Code of Washington 7.69A.030

Key Points

- ✓ Advocates must know their roles and their responsibilities to their clients.
- ✓ Advocates must understand the roles and responsibilities of the different participants in the legal settings and how those roles have different duties and obligations that may conflict with their clients' interests.
- ✓ The advocate must understand the agency's operating policies and procedures when it comes to participating in multidisciplinary teams.
- ✓ The advocate must understand the agency's operating policies and procedures for releasing ANY client information.
- ✓ The advocate should seek to establish working relationships with CPS, law enforcement, child advocacy centers, GALs and any other professionals within the community serving child victims of sexual abuse.



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ACRONYMS/ DEFINITIONS



- ◆ **Assessment** – This term is used to refer to an examination regardless of level of provider and includes the history, physical examination, laboratory and radiology testing, diagnosis, and discharge instructions and referrals.
- ◆ **CAC** – Children’s Advocacy Centers (see Appendix 3)
- ◆ **Caregiver** – Nonoffending parent or caregiver
- ◆ **CJS** – Criminal Justice System
- ◆ **Core Service Standards** – requirements set forth by the Office of Crime Victims Advocacy for certified Community Sexual Assault Programs
- ◆ **County Child Abuse Protocols** – collaborative agency procedures required by Washington law (see Appendix 4)
- ◆ **CPS** – Washington State Child Protective Services
- ◆ **CPT Codes** – Current Procedural Terminology codes are numbers assigned to every task and service a medical practitioner may provide to a patient including medical, surgical and diagnostic services. They are then used by insurers to determine the amount of reimbursement that a practitioner will receive by an insurer. Since everyone uses the same codes to mean the same thing, they ensure uniformity.
- ◆ **CSA** – Child Sexual Abuse. The National Center on Child Abuse and Neglect defines CSA as contacts or interactions between a child and an adult in which the child is being used for the sexual stimulation of the perpetrator or another person. Sexual abuse may also be committed by a person younger than 18 when that person is either significantly older than the victim or when the perpetrator is in a position of power or control over the child.

CSA may include specific acts such as exhibitionism, voyeurism, solicitation, kissing, fondling, oral sex, and intercourse. Particular acts may or may not be considered CSA, depending on culture and family norms (such as nudity). When evaluating cultural influences on CSA, the criterion for determination is harm. Harm is the result of an exploitation of the child’s ignorance, trust and obedience (Wurtele & Miller-Perrin, 1992). While exploitation of a child through sexual abuse can be pursued without conscience, it cannot be pursued without intent.

- ◆ **CSAP** – Community Sexual Assault Program

- ◆ **CVC** – Crime Victims’ Compensation
- ◆ **DCFS** – Department of Child and Family Services
- ◆ **ECP** – Emergency contraceptive pills (two high-dose birth control pills provided 12 hours apart to help prevent pregnancy)
- ◆ **OCVA** – Office of Crime Victims Advocacy
- ◆ **Provider** – This term is used to refer to any medical or nursing clinician providing care to a patient and/or parent/caregiver.
- ◆ **PSI** – Pre-sentence investigation which is conducted by the state to in order to prepare a pre-sentence report for the judge prior to sentencing of the defendant. It is generally very comprehensive and includes things such as employment history, family member relationships, and interviews with victims.
- ◆ **PTS** – Posttraumatic Symptoms
- ◆ **PTSD** – Posttraumatic Stress Disorder is a specific psychological reaction to the memory of the abuse such as flashbacks or very upsetting memories; avoidance of reminders or numbing of all reactions; and increased arousal responses such as hypervigilance, concentration problems or irritability. In younger children these symptoms of anxiety can be expressed through regressed or aggressive behavior or physical symptoms.
- ◆ **SA** – Sexual assault/abuse
- ◆ **Secondary Victim** – A person who is either a family member or someone who is closely associated with the victim, and is impacted by the assault/abuse, but is not the perpetrator of the sexual abuse/assault.
- ◆ **STD** – Sexually Transmitted Disease
- ◆ **Victim-Centered Services** – The provision of culturally appropriate and immediately available services based on the unique needs and circumstances of victims and survivors. Services are specific, client-focused and driven by the individuals impacted by sexual abuse/assault.
- ◆ **WCSAP** – Washington Coalition of Sexual Assault Programs

APPENDICES



Appendix 1 - Understanding Mandated Reporting

An advocate has a legal responsibility to report child abuse and neglect. RCW 26.44.030 (1) defines who is mandated to report and under what circumstances.

- ◆ “When any practitioner, professional school personnel, registered or licensed nurse, social service counselor, psychologist, pharmacist, licensed or certified child care provider or their employees, employees of the department, or juvenile probation officer has reasonable cause to believe that a child or adult dependent or developmentally disabled person has suffered abuse or neglect, he or she shall report such incident, or cause a report to be made, to the proper law enforcement agency or to the department as provided in RCW 26.44.040. The report shall be made at the first opportunity, but in no case longer than 48 hours after there is reasonable cause to believe that the child or adult has suffered abuse or neglect.”

When should an advocate report suspicions of abuse and neglect?

- ◆ When there is reasonable cause to believe that a child has suffered abuse or neglect, call the proper law enforcement agency or the Department of Social and Health Services (DSHS).

TIP

A mandated report must be done at the advocate’s first opportunity, but in no case longer than 48 hours.

What does CPS need to know?

- ◆ Reports should contain as much of the following information as the advocate can provide:
- ◆ The name, address, and age of the child
- ◆ The name and address of the child's parents, stepparents, guardians, or other persons having custody of the child (caregivers)
- ◆ The nature and extent of the reported injury or injuries
- ◆ The nature and extent of the reported neglect
- ◆ The nature and extent of the reported sexual assault
- ◆ Any evidence of previous injuries, including their nature and extent; and
- ◆ Any other information that may be helpful in establishing the cause of the child's death, injury, or injuries and the identity of the reported perpetrator or perpetrators

What will CPS do?

At the first opportunity, but no later than 72 hours:

- ◆ Investigate the report of Child Abuse and Neglect (CA/N) when a parent or caregiver has perpetrated abuse or neglect,
- ◆ Develop a safety plan to address any immediate safety needs of the child, if warranted,
- ◆ Assess factors of risk that may predict the future risk of CA/N to a child,
- ◆ Assess, refer to, and monitor services as needed for the child and caregivers to reduce the future risk of CA/N and assure child safety,
- ◆ Take legal action to protect the child as needed.

Advocates may enter the child welfare process at any point but are most likely to enter when the case is in Child Protective Services (CPS), the investigative program of Children's Administration (CA). There are two divisions in CA: the Division of Licensed Resources (DLR) and the Division of Children and Family Services (DCFS). Both divisions have CPS programs. The purpose of both CPS programs is to determine whether or not allegations of abuse and neglect are more likely than not to have occurred, and to provide appropriate services to ensure the safety, protection, and well-being of the child.

If the DCFS investigation enters a Dependency Action, a dependency court guardian may be appointed for any child under 12. The advocate may want to meet with the dependency guardian; it will depend on the case.

Other services available at Children's Administration

- ◆ Family Reconciliation Services (FRS)
- ◆ Children's Hospitalization Alternative Program (CHAPS)
- ◆ Family Preservation Services (FPS)
- ◆ Alternative Response Services (ARS)
- ◆ Sexually Aggressive Youth (SAY)
- ◆ Child in Need of Services (CHINS)
- ◆ Other services/resources are available

Appendix 2 – Trauma-Focused Cognitive Behavioral Therapy

TF-CBT is a brief (8-12 sessions) treatment for the impact of traumatic events. It has been proven to be effective for sexually abused children. The treatment involves (1) providing children and their families with information to normalize typical reactions; (2) teaching strategies to manage negative emotions such as fear, anxiety, shame, sadness or anger; (3) correcting inaccurate or unhelpful beliefs about the abuse; and (4) helping the child and caregivers talk about the abuse and put it into perspective. Most children will resolve the abuse impact after receiving this treatment; very few children need longer-term therapy.

Sometimes children have very serious problems and need more extensive treatment. In almost all of these cases, there are multiple factors besides the sexual abuse experience. The children usually have very compromised family situations, parents who are not supportive, multiple abuse and trauma experiences, and complex clinical presentations. TF-CBT can be useful even in these situations, but usually a very well-trained and sophisticated therapist needs to be caring for the family.

Appendix 3 – Children’s Advocacy Centers

Children’s Advocacy Centers (CACs) are child-focused, child-friendly facilities where children and their families feel safe enough to get the help they need to stop abuse and begin the process of healing. Representatives from many disciplines meet to discuss and make decisions about investigation, treatment and prosecution of child abuse cases. They also work to prevent further victimization of children. This multidisciplinary team approach brings together, under one umbrella, all the professionals and agencies needed to offer comprehensive services: law enforcement, child protective services, prosecution, mental health, the medical community, and advocacy.

There are nine fully accredited Children’s Advocacy Centers in Washington State. Another two centers are in the process of achieving accreditation and seven additional communities are working to develop a CAC.

Core Components of a Children’s Advocacy Center

The National Children’s Alliance has established the following standards for Children’s Advocacy Centers:

- ◆ Child focused, child-friendly facility for children and their nonoffending family members
- ◆ Multidisciplinary Team Approach including law enforcement, prosecution, medical, therapy, advocacy, and other community resources
- ◆ Medical evaluation onsite or through referral
- ◆ Therapy onsite or through referral
- ◆ Onsite forensic interviews
- ◆ Advocacy, onsite or through referral
- ◆ Case tracking and review
- ◆ Case staffing
- ◆ Culturally competent services
- ◆ Effective organizational capacity

Many CACs work closely with CSAP community-based advocates, and CSAP advocates are valuable members of the multidisciplinary team process.

Advocates from Community Sexual Assault Programs play an important role in the healing process of children and families who have been impacted by sexual abuse. In communities

where there are Children’s Advocacy Centers, CSAPs can be key partners in the multidisciplinary team, providing consultation on issues related to the needs of the child and family, providing support to the child and family during the interview, medical, and court process, and helping the family access community resources. Advocates from CSAPs also provide ongoing support to the child and family after the investigation has closed. There are many cases that do not go to trial, or, if they do, can take months if not years, to complete. The advocate plays a critical role in ensuring that the child and their family receive the help they need. Community Sexual Assault Programs also help raise awareness in the community about sexual abuse and assault.

For more information about Children’s Advocacy Centers, contact the Washington State Association of Children’s Advocacy Centers by email: director@wsacac.org, or by phone: (360) 753-3703.

Appendix 4 - Laws and Statutes: <http://search.leg.wa.gov>

Advocacy

RCW 70.125.060

Personal representative

If the victim of a sexual assault so desires, a personal representative of the victim's choice may accompany the victim to the hospital or other health care facility, and to proceedings concerning the alleged assault, including police and prosecution interviews and court proceedings.

RCW 5.60.060 (7)

Privileged communications

A sexual assault advocate may not, without the consent of the victim, be examined as to any communication made between the victim and the sexual assault advocate.

1. For purposes of this section, "sexual assault advocate" means the employee or volunteer from a rape crisis center, victim assistance unit, program, or association, that provides information, medical or legal advocacy, counseling, or support to victims of sexual assault, who is designated by the victim to accompany the victim to the hospital or other health care facility and to proceedings concerning the alleged assault, including police and prosecution interviews and court proceedings.
2. A sexual assault advocate may disclose a confidential communication without the consent of the victim if failure to disclose is likely to result in a clear, imminent risk of serious physical injury or death of the victim or another person. Any sexual assault advocate participating in good faith in the disclosing of records and communications under this section shall have immunity from any liability, civil, criminal, or otherwise, that might result from the action. In any proceeding, civil or criminal, arising out of a disclosure under this section, the good faith of the sexual assault advocate who disclosed the confidential communication shall be presumed.

RCW 7.90.060

Sexual assault advocates

Sexual assault advocates, as defined in RCW [5.60.060](#), shall be allowed to accompany the victim and confer with the victim, unless otherwise directed by the court. Court administrators shall allow sexual assault advocates to assist victims of nonconsensual sexual conduct or nonconsensual sexual penetration in the preparation of petitions for sexual assault protection orders. Sexual assault advocates are not engaged in the unauthorized practice of law when providing assistance of the types specified in this section. Communications between the petitioner and a sexual assault advocate are protected as provided by RCW [5.60.060](#).

RCW 70.125.065

Records of rape crisis centers not available as part of discovery — Exceptions

Records maintained by rape crisis centers shall not be made available to any defense attorney as part of discovery in a sexual assault case unless:

1. A written pretrial motion is made by the defendant to the court stating that the defendant is requesting discovery of the rape crisis center's records;
2. The written motion is accompanied by an affidavit or affidavits setting forth specifically the reasons why the defendant is requesting discovery of the rape crisis center's records;
3. The court reviews the rape crisis center's records in camera to determine whether the rape crisis center's records are relevant and whether the probative value of the records is outweighed by the victim's privacy interest in the confidentiality of such records, taking into account the further trauma that may be inflicted upon the victim by the disclosure of the records to the defendant; and
4. The court enters an order stating whether the records or any part of the records are discoverable and setting forth the basis for the court's findings.

County Child Abuse Protocols

RCW 26.44.180

Investigation of child sexual abuse — Protocols — Documentation of agencies' roles

1. Each agency involved in investigating child sexual abuse shall document its role in handling cases and how it will coordinate with other local agencies or systems, and shall adopt a local protocol based on the state guidelines. The department and local law enforcement agencies may include other agencies and systems that are involved with child sexual abuse victims in the multidisciplinary coordination.
2. Each county shall develop a written protocol for handling criminal child sexual abuse investigations. The protocol shall address the coordination of child sexual abuse investigations between the Prosecutor's Office, law enforcement, the department, local advocacy groups, and any other local agency involved in the criminal investigation of child sexual abuse, including those investigations involving multiple victims and multiple offenders. The protocol shall be developed by the Prosecuting Attorney with the assistance of the agencies referenced in this subsection.
3. Local protocols under this section shall be adopted and in place by July 1, 2000, and shall be submitted to the legislature prior to that date.

RCW 26.44.185

Investigation of child sexual abuse — Revision and expansion of protocols — Child fatality, child physical abuse, and criminal child neglect cases

1. Each county shall revise and expand its existing child sexual abuse investigation protocol to address investigations of child fatality, child physical abuse, and criminal child neglect cases, and to incorporate the statewide guidelines for first responders to child fatalities developed by the Criminal Justice Training Commission. The protocols shall address the coordination of child fatality, child physical abuse, and criminal child neglect investigations between the county and city prosecutor's offices, law enforcement, children's protective services, local advocacy groups, emergency medical services, and any other local agency involved in the investigation of such cases. The protocol revision and expansion shall be developed by the Prosecuting Attorney in collaboration with the agencies referenced in this section.
2. Revised and expanded protocols under this section shall be adopted and in place by July 1, 2008. Thereafter, the protocols shall be reviewed every two years to determine whether modifications are needed.

Child Victim Rights

RCW 7.69A.030

Rights of child victims and witnesses

In addition to the rights of victims and witnesses provided for in RCW 7.69.030, there shall be every reasonable effort made by law enforcement agencies, prosecutors, and judges to assure that child victims and witnesses are afforded the rights enumerated in this section. Except as provided in RCW 7.69A.050 regarding child victims or child witnesses of violent crimes, sex crimes, or child abuse, the enumeration of rights shall not be construed to create substantive rights and duties, and the application of an enumerated right in an individual case is subject to the discretion of the law enforcement agency, prosecutor, or judge. Child victims and witnesses have the following rights, which apply to any criminal court and/or juvenile court proceeding:

1. To have explained in language easily understood by the child, all legal proceedings and/or police investigations in which the child may be involved.
2. With respect to child victims of sex or violent crimes or child abuse, to have a crime victim advocate from a crime victim/witness program, or any other support person of the victim's choosing, present at any prosecutorial or defense interviews with the child victim. This subsection applies if practical and if the presence of the crime victim advocate or support person does not cause any unnecessary delay in the investigation or prosecution of the case. The role of the crime victim advocate is to provide emotional support to the child victim and to promote the child's feelings of security and safety.
3. To be provided, whenever possible, a secure waiting area during court proceedings and to have an advocate or support person remain with the child prior to and during any court proceedings.

4. To not have the names, addresses, nor photographs of the living child victim or witness disclosed by any law enforcement agency, prosecutor's office, or state agency without the permission of the child victim, child witness, parents, or legal guardians to anyone except another law enforcement agency, prosecutor, defense counsel, or private or governmental agency that provides services to the child victim or witness.
5. To allow an advocate to make recommendations to the prosecuting attorney about the ability of the child to cooperate with prosecution and the potential effect of the proceedings on the child.
6. To allow an advocate to provide information to the court concerning the child's ability to understand the nature of the proceedings.
7. To be provided information or appropriate referrals to social service agencies to assist the child and/or the child's family with the emotional impact of the crime, the subsequent investigation, and judicial proceedings in which the child is involved.
8. To allow an advocate to be present in court while the child testifies in order to provide emotional support to the child.
9. To provide information to the court as to the need for the presence of other supportive persons at the court proceedings while the child testifies in order to promote the child's feelings of security and safety.
10. To allow law enforcement agencies the opportunity to enlist the assistance of other professional personnel such as child protection services, victim advocates or prosecutorial staff trained in the interviewing of the child victim.
11. With respect to child victims of violent or sex crimes or child abuse, to receive either directly or through the child's parent or guardian if appropriate, at the time of reporting the crime to law enforcement officials, a written statement of the rights of child victims as provided in this chapter. The written statement shall include the name, address, and telephone number of a county or local crime victim/witness program, if such a crime victim/witness program exists in the county.

[2004 c 120 § 9; 1997 c 283 § 2; 1993 c 350 § 8; 1985 c 394 § 3.]

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