

CALIFORNIA
CLINICAL FORENSIC
MEDICAL TRAINING CENTER

PRESENTS

CALIFORNIA SEXUAL ASSAULT RESPONSE TEAM (SART) MANUAL



TRAINING PARTNER with the
CALIFORNIA DISTRICT ATTORNEYS ASSOCIATION

California Clinical Forensic Medical Training Center's

California Sexual Assault Response Team (SART) Manual

Third Edition

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Preface

The purpose of this manual is to inspire the development and enhancement of SARTs throughout California, and to provide organizational guidance for effective teams.

The State Advisory Committee (SAC) on Sexual Assault Victim Services was established by state law in 1980. Its mission is to provide leadership in the development of programs statewide for the provision of sexual assault victim services. The SAC has 11 members. Six members are appointed by the State Commission on the Status of Women, and five are appointed by the California Office of Emergency Services (Cal OES). The SAC first commissioned the development of the *California SART Manual* in 2000. The second edition was published in 2013 and the third edition in 2016 by the California Clinical Forensic Medical Training Center (CCFMTC). The organizational home for the CCFMTC is the California District Attorneys Association (CDAA).

All professional disciplines in the anti-rape movement deserve praise and recognition for the nearly 50 years of continuing work and progress on behalf of sexual assault victims. Pioneers began breaking ground in the 1970s with the establishment of rape crisis centers. From that starting point, advocates and committed professionals from all disciplines enacted rape law reform, standardized sexual assault forensic medical exam procedures, developed SAFE/SANE teams, organized training for specialized investigation and prosecution units, and developed SART in communities throughout California and the nation. SART is acknowledged in the literature as beginning in California and is the optimal community response to address the problem of sexual assault.

California Penal Code Formally Establishes SART Concept in State Law

13898.

- (a) Each county may establish and implement an inter-agency sexual assault response team (SART) program for the purpose of providing a forum for inter-agency cooperation and coordination, to assess and make recommendations for the improvement in the local sexual assault intervention system, and to facilitate improved communication and working relationships to effectively address the problem of sexual assault in California.
- (b) Each SART program shall be established and implemented pursuant to the provisions of this chapter.

13898.1.

- (a) Each SART may consist of representatives of the following public and private agencies or organizations:
 - (1) Law enforcement agencies.
 - (2) County district attorneys' offices.
 - (3) Rape crisis centers.
 - (4) Local sexual assault forensic examination teams.
 - (5) Crime laboratories.
- (b) Dependent upon local needs and goals, each SART may include representatives of the following public and private agencies or organizations:
 - (1) Child protective services.
 - (2) Local victim and witness assistance centers.
 - (3) County public health departments.
 - (4) County mental health services departments.
 - (5) Forensic interview centers.
 - (6) University and college Title IX coordinators.
 - (7) University and college police departments.

13898.2.

- The program established pursuant to this chapter shall have the following objectives:
- (a) Review of local sexual assault intervention undertaken by all disciplines to promote effective intervention and best practices.
 - (b) Assessment of relevant trends, including drug-facilitated sexual assault, the incidence of predatory date rape, and human sex trafficking.
 - (c) Evaluation of the cost-effectiveness and feasibility of a per capita funding model for local sexual assault forensic examination teams to achieve stability for this component of the SART program.
 - (d) Evaluation of the effectiveness of individual agency and inter-agency protocols and systems by conducting case reviews of cases involving sexual assault.
 - (e) Plan and implement effective prevention strategies and collaborate with other agencies and educational institutions to address sexual assault perpetrated by strangers, sexual assault perpetrated by persons known to the victim, including, but not limited to, a friend, family member, or general acquaintance of the victim, predatory date rape, risks associated with binge alcohol drinking, and drug-facilitated sexual assault.

A Brief Word About Terminology

Victim – Patient – Survivor – Client

A person who has been sexually assaulted is identified by different terms depending upon the professional discipline involved. In the criminal justice system, the person is a crime victim. In hospitals, clinics, and for forensic medical examination teams, the person is a patient. For rape crisis centers providing counseling and advocacy, the person is a survivor and sometimes is referred to as a client. All four terms are used throughout the text.

SART – SAFE – SANE

A Sexual Assault Response Team (SART) is a multi-disciplinary inter-agency sexual assault intervention model comprised of public and private agencies. It is not the forensic medical exam team, although these terms are sometimes used interchangeably in publications, local brochures, and operational documents.

A Sexual Assault Forensic Examiner (SAFE) or a Sexual Assault Nurse Examiner (SANE) is a specially trained healthcare provider who performs the sexual assault forensic medical examination. The SAFE acronym encompasses several categories of examiners (e.g., physician, nurse practitioner, physician assistant, and nurse). The SANE acronym means a registered nurse examiner. In some communities, the forensic medical exam team serves as a point of coordination for the SART. The role of the SAFE/SANE team is to provide an independent forensic medical examination, complete documentation, and interpret findings based on objective analysis and scientific evidence-based literature.

Forensic Scientist or Criminalist

A forensic scientist or criminalist applies scientific methods and techniques to examine and analyze evidence, assists in crime scene investigations, and testifies in court regarding findings and analysis. Forensic scientists are employed in public or private forensic laboratories. These two terms for describing this profession are often used interchangeably.

Sexual Assault Forensic Medical Exam

Various terminologies have been used over the years to describe the physical examination, the collection and preservation of evidence, and the documentation and interpretation of findings. The early original terminology was “medical-legal” exam followed by the “evidentiary exam.” The field is now evolving to use the term sexual assault forensic medical exam (SAFE). In some jurisdictions, the term “SART exam” or “SART nurse” is used. This is not a best practice because it implies ownership by the SART team, comprised of public and private agencies, instead of examination findings based upon independent work performed by the SAFE/SANE team. For quick reference, the phrase SAFE or SANE exam is appropriate.

Use of Pronouns

Since both females and males are sexually assaulted, the manual has been written with gender neutral terminology to the extent possible. In sections pertaining to victims of sexual assault, the female pronoun is used because the majority of sexual assault survivors are female. In sections pertaining to alleged perpetrators of sexual assault, the male pronoun is used because the majority of assailants are male.

Introduction

The Meaning of Sexual Assault

Sexual assault is experienced as a physical and psychological traumatic intrusion to the body and spirit of a person. Sometimes survivors are exposed to a near-death experience, both in reality and in perception. Sexual assault survivors experience a complete loss of control over their lives. His or her body and spirit are under the complete subjugation of another person, and mental dissociation may occur to cope with the assault. This experience causes profound psychological trauma. Victims can become survivors. Sexual assault does not have to become a life-defining event. The SART model is a coordinated multi-disciplinary response system of intervention and care to assist sexual assault victims in regaining control over their lives and restoring their dignity.

Community Expectations Regarding Sexual Assault Intervention

Residents of every community expect swift, competent, coordinated intervention in response to sexual assault. Competency is expected at all levels on the intervention continuum. First responders (e.g., paramedics and patrol officers), detectives, medical personnel, rape crisis center advocates, criminalists, and prosecutors are expected to carry out their responsibilities with expertise, efficiency, and compassion consistent with their roles. Effective rape crisis center counselors, advocates, and therapists knowledgeable about acute and long-term effects of sexual assault are vitally important to survivors and family members whether or not survivors report the crime to law enforcement, during the criminal investigation and prosecution process whether or not prosecution moves forward, and long after criminal justice system proceedings are completed.

Needs of the Survivor, Family, and Friends

Survivors of sexual assault benefit from immediate crisis intervention; long-term counseling or therapy for months and sometimes years; emotional support and accompaniment during the forensic medical examination; guidance through the criminal justice system; educational information about possible reactions by family and friends to the event; anticipatory guidance about potential long-term emotional, behavioral, and neuropsychological effects of trauma; and reassurance that sexual assault does not have to be a life-defining event.

Survivors, family, and friends may have many other needs unique to them and their circumstances.

Sexual Assault Statistics

Current statistical information about the frequency of sexual assault can be obtained from the following resources:

- Center for Disease Control (CDC) National Center for Injury Prevention and Control, Division of Violence Prevention—www.cdc.gov/violenceprevention
- National Sexual Violence Resource Center Library—www.resources@nsvrc.org
- RAINN (Rape, Abuse and Incest National Network)—www.rainn.org
- FBI Uniform Crime Reporting—www.ucrdatatool.gov
- CALCASA (California Coalition Against Sexual Assault)—www.calcasa.org
- local rape crisis center and law enforcement agencies

Importance of Successful Multi-Disciplinary Collaborations

No one agency can successfully handle all aspects of a sexual assault given the complexity of the crime's nature. Collaboration strengthens the response of individual agencies and unites them into a coordinated team approach. Each agency is important and has its strengths and limitations. Effective multi-disciplinary teams generate a stronger response and produce more effective outcomes for the victim and the criminal justice system.

There are five stakeholders to successful SART collaborations and intervention:

- the victim or survivor;
- the family;
- the neighborhood;
- the community; and
- the People of California.

SART: A Community Inter-agency Team Intervention Model

SART is a multi-disciplinary, inter-agency, sexual assault intervention model. It is a team approach to implementing a comprehensive, sensitive, coordinated system of intervention and care for sexual assault victims. SART organizes the process of intervention and the community response to sexual assault. The partners of the SART model are public and private agencies.

SART Recognizes Two Distinct Sets of Needs

The SART model recognizes that the victim of sexual assault and the criminal justice system have distinctive sets of needs. Sometimes there are inherent conflicts between these two sets of needs and goals. These conflicts, however, do not have to polarize individuals and agencies. Through professional collaboration among rape crisis centers, hospitals and health care providers, SAFE/SANE teams, and the criminal justice system, both sets of needs can be accommodated.

The needs of the sexual assault victim are:

- coordinated and effective response;
- rapid medical assessment, evaluation, and treatment;
- sensitive intervention;
- cultural competency;
- early crisis intervention, emotional support, and advocacy;
- information about investigative, forensic medical exam, and criminal justice procedures;
- accessible, prompt, high-quality forensic medical examination;
- prophylaxis against sexually transmitted disease;
- assessment of possible pregnancy risk and emergency contraception, if requested;
- follow-up medical care;
- follow-up counseling;
- counseling for family members;
- justice; and
- closure.

The needs and goals of the criminal justice system are:

- protection of the victim and the community;
- participation by the victim in the investigative and judicial process;
- accessible, prompt, high-quality forensic medical examinations;
- forensic medical follow-up evaluation, if indicated;
- optimum recognition, collection, and handling of potential evidence;
- accurate documentation of medical findings and evidence-based interpretations;
- prompt exams to reduce patrol officer waiting time at the exam facility;

- identification and apprehension of a suspect;
- competent case investigation;
- reliable analysis of evidence;
- credible expert testimony;
- effective prosecution; and
- competent representation for the defendant by defense counsel.

What does SART do?

- It organizes the intervention process.
- It organizes the community response to sexual assault.

Chapter 1: First Steps in Developing a SART

Summary of the First Steps

1. Understand the Mission and Goals of SART
2. Plan Strategies for SART Development and Implementation
3. Establish a Broad Base of Community Support
4. Establish a Task Force or Steering Committee to Plan the SART
5. Identify Partner Agencies and Potential Forensic Medical Examination Sites
6. Plan for Continuity of Care for Sexual Assault Victims
7. Generate a Collective Vision, Joint Commitment, and Team Building
8. Implement Team Building Between Agencies
9. Obtain Baseline Statistics
10. Estimate the Costs for Operating the SART Program and Assess Funding Sources
11. Obtain Staff and Organizational Unit Commitments by Partner Agencies
12. Generate an Operation Agreement (OA) or Memorandum of Understanding (MOU)
Signed by Partner Agencies
13. Establish an Inter-agency Operating Policies and Procedures Manual
14. Establish Regular Review of Procedures

Step 1: Understand the Mission and Goals of SART

The mission of SART is to counter the experience of sexual assault with a sensitive and competent multi-disciplinary response, to support efforts to restore well-being to the victim, and to bring the responsible person or persons to justice.

The goals of SART are to:

- ensure competent, coordinated, and effective intervention;
- ensure medical assessment, evaluation, and care;
- provide a sensitive and caring response to survivors of sexual assault by all disciplines;
- ensure cultural competency;
- ensure complete, consistent, and accurate case investigations;
- provide high-quality and consistent forensic medical examinations;

- ensure the provision of medical and forensic follow-up care;
- provide crisis intervention and counseling; and
- effectively support the mission of the criminal justice system.

The primary partners in a successful SART are:

- rape crisis centers;
- law enforcement agencies;
- the district attorney's office;
- the crime laboratory;
- the Sexual Assault Forensic Examination Team; and
- area hospitals or facilities where exams are performed.

Other agencies playing important collaborative roles are:

- victim/witness assistance centers;
- county public health departments;
- licensed mental health professionals, counseling agencies, rape treatment centers;
- children's protective services;
- adult protective services; and
- shelters for battered women.

Step 2: Plan Strategies for SART Development and Implementation

Development of a SART program is sparked in different ways, and each method can achieve success. A typical SART history includes one or all of these components, and may start at any one of these levels:

- Start-up or Formative Group;
- Founding Task Force; and/or
- Steering Committee.

These titles are broad conceptual terms to illustrate a developmental process. The group or task force usually has a distinctive name.

Start-Up or Formative Group

Start-up or formative group leadership can arise from a variety of directions. They may or may not be the same individuals who subsequently serve on the founding task force. Examples of start-up or formative group members include: a member of the county board of supervisors motivated by a constituent; a sexual assault survivor promoting system change; representatives from women's groups (e.g., Junior League, Soroptomist, a university women's center); or a rape crisis center director, police chief or sheriff, a district attorney, or healthcare providers committed to improving the system.

Founding Task Force

The start-up or formative group typically starts by recruiting a task force to handle early conceptual planning, to recruit other partner agencies, and to achieve inter-agency commitments. The task force considers the broad logistics involved in developing a program. They usually turn to upper and middle-management within their organizations for logistical details. This leads to the inception of the steering committee.

Steering Committee

Once the initial developmental work is completed, the steering committee takes over logistical planning and implements the program at the front-line supervisory level. Members of the founding task force sometimes remain on the steering committee for a period of time for continuity. It is important to recognize that SART development is sometimes sparked at the operational or first-line supervisor level. The following sections and chapters assume a founding task force or a steering committee.

Developmental Leadership

Ideally, SART development is a collaborative process with all agencies as equal planning partners at the community table. Sometimes the ideal of equal partnership is not possible because of reluctance on the part of one or more major partners. If this is the case, consider the following options for SART leadership roles:

- Assess the leadership in the city or the county to determine the best way of developing a collaborative approach to developing a SART.

- Request the district attorney's office to take a leadership role. The district attorney has a vested interest in effective sexual assault investigations and prosecutions, and this office should want to ensure that SART developmental processes are taking the right direction. Additionally, the district attorney's office has strong influence on law enforcement agencies in the county, which may be helpful in the SART development process.
- Contact a member of the board of supervisors. They are elected and have public accountability. The board of supervisors has control over the budgets of the district attorney and the sheriff.
- Approach the sheriff (the highest level elected law enforcement official accountable to the electorate), the police chiefs, mayors, city council members, other leaders or influential organizations in the community.
- Consider planning SART as a pilot approach with interested partner agencies to improve sexual assault victim services, to demonstrate the benefits of SART, and to work out issues that create objections or resistance by potential partner agencies. This is a non-controversial approach that is not critical of any potential partner agency.
- Interest in the SART concept can be generated by asking the city editor of the newspaper about doing a series of articles on how sexual assault victims experience the system in your county and show a comparison to a nearby county with a successful SART.

Step 3: Establish a Broad Base of Community Support

Success is achieved through active commitment and support by a broad base of public officials and chief administrators of public and private agencies. SART is most successful if there is a commitment by top officials:

- elected officials such as board of supervisors or city council;
- the district attorney;
- the sheriff;
- the police chief(s);
- the rape crisis center director;
- the SAFE or SANE team coordinator;

- the hospital director or area hospital directors; and
- Children’s Protective Services (CPS).

Obtain Support from Chief Administrators of Public and Private Agencies

Strong support by top agency executives is essential to institutionalize the model in a community. Without this commitment, a SART may develop in limited scope and authority, and may become a fragile entity with no political support. Executive level support must be matched by support from upper- and middle-management, first-line supervisors, and front-line staff. The source of leadership for establishing a SART can be initiated at any level in any of the organizations listed. A systematic approach, however, must be implemented to gain the support of all disciplines at every level of each organizational structure.

Decide How to Involve Elected Officials

It is wise to involve elected officials (e.g., city council or board of supervisors) to establish solid support for the SART and to generate the feeling that “this is bigger than us” or any individual agency, especially if problems arise and discussions disintegrate. Some communities involve them at the very beginning when meetings are held to discuss the concept. Other communities wait until the team is formed and then provide a briefing and tour for elected officials. The best approach is to involve them at both stages. If the elected official cannot personally participate, it is wise to involve the chief assistant. Having a chief assistant is often as valuable as the official because chief executives of public agencies have a vested interest in having a positive relationship with the chief assistant to an elected supervisor or city council member.

Step 4: Establish a Task Force or Steering Committee to Plan the SART

The purpose of the task force is to plan, develop, and implement the SART. Membership on the committee should consist of representatives with delegated authority to represent his or her agency on most issues relating to sexual assault intervention policy and procedures. Membership on this task force should not be delegated to a front-line employee as a “stand-in” for upper- or middle-management. Committee members should not be allowed to rotate

attendance with another agency representative. This breaks continuity of decision making and disrupts historical “group memory” of issues and resolutions. The task force should have a chair, vice chair, and a secretary. Ideally, the secretary should have a clerk to take and then distribute the minutes.

Core members typically include:

- captain, lieutenant, or sergeant from local law enforcement agencies;
- supervising deputy district attorney;
- rape crisis center director or advocate coordinator;
- manager or supervisor of the SAFE or SANE team;
- supervising criminalist; and
- nurse manager of the hospital emergency department or exam facility.

These representatives must have the delegated authority to:

- represent the agency;
- make decisions on policy, procedures, operating principles, and coordinating strategies;
- allocate financial and human resources or possess a high level of influence in the organization to secure resources; and
- develop a model that will be endorsed when sent to executive staff for approval and signature.

Communities and groups vary in how SART program planning works best. Sometimes it is better to start with a core group to draft initial ideas before expanding to a larger group. In some communities, large groups work well by dividing into subgroups with specific tasks.

Meetings

Task force or steering committee meetings are usually held monthly. In the beginning stages of SART development, these meetings are often held weekly, and some assignments are handled by subcommittees.

Naming the Task Force or Steering Committee

The names of the founding task force and/or steering committee vary. Some are called Sexual Assault Committee (SAC), SART Steering Committee, or SART Task Force. The fundamental role of the group is to provide oversight and coordination to the SART process, and to identify and implement ongoing system improvement.

Define the Process and Structure of Task Force Work

- Define the process as a partnership.
- Establish implementation goals and time lines.
- Agree on short-term and long-term tasks and task assignments.
- Set up a matrix worksheet listing tasks, task assignments, person responsible, and completion status.
- Establish policies, procedures, and operating principles.
- Determine financial costs and financing plans.
- Develop and distribute agenda and meeting minutes in advance.
- Establish an operational procedures manual and/or computer file for documentation of policy decisions (do not allow policy decisions to be buried in the meeting minutes).
- Educate all task force members on the roles, responsibilities, strengths, and limitations of each participating agency.

Step 5: Identify Partner Agencies and Potential Forensic Medical Examination Sites

Look around the table and see who is missing. Consider the size of the area to be served both geographically and by population. Determine how many forensic medical teams and/or hospitals are needed to participate. Assess how many law enforcement agencies and rape crisis centers serve the county. Large rural and urban counties often have more than one. See Chapter 4, Development by County.

Step 6: Plan for Continuity of Care for Sexual Assault Victims

Rape Crisis Center

Rape crisis center advocates provide continuity of care from the first contact with the survivor to case closure. Wrap-around counseling, supportive accompaniment services, information about investigative and forensic medical exam procedures, and community referrals are provided. Advocates are there for the survivor after the investigative and forensic exam procedures are completed, whether or not a suspect is apprehended, whether or not charges are filed and the case goes to trial, whether or not there is a conviction, and whether or not the defendant is sentenced to state prison, county jail, or is released. Rape crisis center advocates also provide counseling and supportive assistance to the thousands of survivors who never report the crime to law enforcement.

California rape crisis centers receive state funding and must meet statutory and state program guidelines for services and operations. The role of the rape crisis center advocate was first established by state law in 1980 and has been expanded since that time. All of these services are important community resources. See Chapter 7, Rape Crisis Center Counseling and Advocacy Component.

Rape Treatment Programs and Therapists in Private Practice

Two California programs, San Francisco Trauma Recovery Center and UCLA/Santa Monica Rape Treatment Program, have highly specialized programs in which psychological services are provided by a team of licensed psychologists, social workers, interns, and psychiatrists designed specifically for sexual assault victims. Specialized treatment programs are evolving in California with expertise in treating post-traumatic stress disorder (PTSD). Most communities have licensed professionals in private practice specializing in the treatment of post-traumatic stress disorder for victims of sexual assault and other traumatic events.

Victim /Witness Assistance Centers

Victim/witness assistance centers provide a range of services. (See Chapter 11, Victim/Witness Assistance Center Component.) Importantly, they assist victims to complete the application for the California Crime Victim Compensation Program that funds counseling services for crime victims and other needed services.

Step 7: Generate a Collective Vision, Joint Commitment, and Team Building

Collective vision and joint commitment are the keys to developing and maintaining a SART or any new program. The vision excites the imagination of the professionals involved and maintains them through difficult challenges and problem solving. It lifts thinking to a higher level about what is possible on behalf of those who have suffered. Vision focuses individuals on the “greater good” during policy and decision making when fragmentation begins to set in, and restores the whole. During these discussions, it is important to recognize that departments can have different objectives, but a shared vision. Sometimes the collective vision does not really begin until the benefits to the victim and to the criminal justice system are realized. Until this happens, for some, SART is only a concept.

Some ways of generating a collective vision are to visit a fully operational SART and hear from each discipline how SART works for them, to invite another community SART to present information on the model, or to obtain the Peace Officers Standards and Training (POST) training video on SARTs or the National SART Toolkit DVD.

Step 8: Implement Team Building Between Agencies

Team building is a process by which people get to know one another, become comfortable with one another, and build trust. Consider ways to engage in team building activities to introduce team members to one another. Team building can be implemented at the early, as well as later, stages of the developmental continuum. Some team building methods include:

- Educating all team members about the nature and scope of each organization, their mission, and the challenges and barriers faced by each agency.
- Using humor to enable people to relax and to be more open with one another.
- Engaging in activities in which people share something about themselves (e.g., where did everyone grow up, who were the three most influential people in their lives and why, the achievement (personal or professional) of which they are most proud and why, and a situation or problem that was most challenging and why).
- Hiring a meeting facilitator or arranging for a facilitator to donate time to help with this process.

- Planning off-site retreats because they allow people casual and recreational time to become acquainted.

Step 9: Obtain Baseline Statistics

This information is useful for determining or verifying staff levels needed by each partner agency and to show comparative data for each year of SART operation. Obtain annual baseline statistics for each agency such as the number of:

- sexual assault crime reports and investigations by each law enforcement agency;
- sexual assault forensic medical examinations performed at each facility;
- sexual assault examination kits received by crime laboratory;
- calls to the rape crisis center reported and *not* reported to law enforcement agencies;
- mandated child abuse reports (Pen. Code § 11166) that involve child sexual abuse;
- sexual assault cases filed, plea bargained; and
- sexual assault trials.

Step 10: Estimate the Costs for Operating the SART Program and Assess Funding Sources

Basic budgetary impacts to consider in starting a SART include:

- the costs of equipping and operating the sexual assault forensic medical exam team;
- any increased costs for law enforcement investigation and prosecution of cases;
- the costs for operating the rape crisis center; and
- any increased costs for the crime laboratory.

Step 11: Obtain Staff and Organizational Unit Commitments by Partner Agencies

Organizational Unit Commitments

Large counties may have specialized units. Small counties may have designated individuals. Specialized units are recognized as the best approach; however, they are not essential to success because SART is a coordinated multi-disciplinary intervention model. Examples of specialized units include:

- sexual assault unit in a law enforcement agency consisting of detectives trained in sexual assault investigation;
- sexual assault unit in the district attorney's office consisting of deputy district attorneys trained in sexual assault prosecution;
- sexual assault forensic medical exam team trained in performing forensic medical sexual assault examinations; and
- rape crisis center advocates trained to provide support for survivors of sexual assault.

Sometimes specialized units in law enforcement agencies and district attorney's offices are organized as vertical prosecution units in which one person handles the case from beginning to end. See Chapters 8 and 10 on the law enforcement and prosecution components for more information

Sufficient Staff Resources

Request all partner agencies to assess and indicate whether there is sufficient staff to meet current and projected workload needs. An increase in the potential number of sexual assault survivors reporting the crime should be considered. If the number of staff is insufficient, determine how many are needed. If there are current or projected staffing shortages, develop a short- and long-term strategic plan for addressing these issues. Four important pieces of data to consider are:

- the number of sexual assault survivors calling the rape crisis center who do not report to law enforcement, because SART may increase reporting;
- the number of sexual assault crime reports compared to the number of investigations, because SART may increase investigations;
- the number of sexual assault forensic medical exams may increase because of SART and due to the federal VAWA requirement that victims do not have to report the crime or cooperate with law enforcement agencies to obtain an examination for forensic evidence; and
- the number of cases filed by the district attorney's office compared to the number of investigative reports submitted by law enforcement agencies, because there will be a "ripple" effect of increased numbers.

Interpreting Services

SART planning should include the need for interpreters based upon the languages spoken in the community. Many hospitals have interpreter services. Similarly, law enforcement agencies and county departments of social services have resources for this purpose. Planning must also address the need for training interpreters about sexual assault, about not allowing cultural attitudes to interfere with accurate and complete interpretation, and about not allowing cultural attitudes to be communicated to survivors, thereby inciting or exacerbating feelings of shame. It is important to note that rape crisis center advocates cannot be used as interpreters within the criminal justice process

Step 12: Generate an Operational Agreement (OA) or Memorandum of Understanding (MOU) Signed by Partner Agencies

An inter-agency Operational Agreement (OA) or Memorandum of Understanding (MOU) is essential to confirm the vision, establish the commitment, and describe how each agency will conceptually function under the collective agreement. Development of the OA or MOU is an important process because it requires the agencies to formally commit to their roles and responsibilities in writing.

The rape crisis center director, local police chiefs, the sheriff, the district attorney, SAFE/SANE team director, the hospital director, and the Victim/Witness Assistance Center program director should sign the OA or MOU with original signatures on the document. Copies of the document should be distributed to the executives who signed it and to upper- and middle-management of the agencies involved. The document must be stored so that it is easily retrievable years later when agency administration changes or problems develop, and there is a need to reference the document.

See Appendix A for a sample Operational Agreement or Memorandum of Understanding. Note that some public and private agencies do not sign these documents without legal counsel review due to concerns about liability issues.

Step 13: Establish an Inter-agency Operating Policies and Procedures Manual

SART operating policies and procedures serve four key purposes:

- an operational guide established by the founding agencies;
- a reference guide during problem solving and conflict resolution;
- a resource when there are changes in an agency administration and the new administration has different ideas; and
- an important document for orienting and training new members to the steering committee.

Both electronic and print copies should be retained in an operational procedures binder and distributed to the steering committee. The document must be maintained by a key individual with attention to detail. It should be reviewed annually, and updated revisions must be incorporated and distributed to the committee members.

These policies and procedures are different from an MOU because they are specific operational procedures whereas an MOU is a broad conceptual document with a commitment by each agency. Examples include: The forensic medical examination shall begin within one hour of the patient's arrival at the hospital; or, the law enforcement officer shall transport the sexual assault victim to the hospital if family or friends are not available. An example of SART operating policies and procedures is contained in Appendix B.

An important component of this document is a specified approach to problem solving. (See Chapter 3, Decision Making and Conflict Resolution.)

Step 14: Establish Regular Review of Procedures

Review SART policies and operational procedures on an annual basis to keep them updated. Due to agency rotation of staff and turnover, new team members should be required to read the document and other pertinent orientation materials.

Chapter 2: The Next Steps in Developing a SART

Summary of the Next Steps

1. Determine the Sexual Assault Forensic Medical Examination Team Model
2. Decide Whether to Hire a SART Coordinator or Use Existing Personnel
3. Determine Location for the SART Program Headquarters
4. Determine SART Activation or “Call-Out” Procedures
5. Plan Training and Establish Educational Expectations for Each Agency
6. Determine the Needs for SART Data Collection and Ensure Database Management by Discipline
7. Develop a Policy and Plan for Case Review
8. Be Knowledgeable About Confidentiality Issues
9. Develop Standardized SART Forms
10. Develop a Public Relations Plan
11. Establish Regular Monthly Meetings Between SART Partner Agencies

Step 1: Determine the Sexual Assault Forensic Medical Examination Team Model

The issues to consider are listed below and discussed in depth in Chapter 6, SART: Sexual Assault Forensic Medical Exam Component.

- Determine the target patient populations: adults, adolescents, and/or children.
- Determine team composition: registered nurses, nurse practitioners, physician assistants, physicians, or any combination thereof.
- Determine whether to use an on-call team model or hospital shift employees.
- Make a plan for recruiting a SAFE/SANE team coordinator and a physician medical director.
- Determine the need for a one-site team or multi-site teams to cover the region.
- Determine the budgetary needs for the sexual assault forensic medical exam team.
- Determine where the sexual assault forensic exams will be performed.

Step 2: Decide Whether to Hire a SART Coordinator or Use Existing Personnel

The SART coordinator can be from any of the participating agencies. The practical aspect of this decision is that one of the partner agencies will either have to allocate new or re-direct existing budgetary resources to establish this position. Another option is to obtain grant funding; however, grant funding for this purpose may be difficult to obtain and eventually expire.

In the evolution of the SART concept, the SAFE/SANE team coordinator has sometimes occupied this role. If this person is a hospital employee, the job description can include integration and coordination of the hospital team with the community agencies. One advantage of utilizing the forensic medical exam team coordinator is that the medical team cannot function without a coordinator. There may be contracts or fee-for-service revenue to support the position, the SAFE/SANE team or the hospital has coordination needs for the team to operate efficiently with community agencies, and the position is not usually grant dependent.

Step 3: Determine Location for the SART Program Headquarters

Teams with a SART coordinator may have designated space at one of the partner agencies. The office of the SART coordinator is usually the repository for SART records, including the policies and procedures. Monthly meetings may take place at this location or rotate among SART partners' offices.

Step 4: Determine SART Activation or "Call-Out" Procedures

These procedures are most easily summarized in charts. See Process Charts A, B, and C.

Step 5: Plan Training and Establish Educational Expectations for Each Agency

Training needs to take place on four levels: first responder training, specialized unit/individual training, local inter-agency training, and training by statewide professional associations for each discipline.

First Responder Training

First responder training refers to patrol officers, rape crisis center advocates, paramedics, and emergency department triage nurses. In general, a first responder is any professional who has first contact with the victim. Each group of first responders should be trained according to their needs.

Contact the training organizations listed in Appendix E for copies of training outlines, manuals, and requirements.

Specialized Unit/Individual Training

Units and individuals should receive basic training prior to assignment to the unit. This training should be provided by local trainers or by attendance at statewide professional training associations or organizations.

SART Training

SART basic training is needed to educate each discipline about the other agencies' roles and their role participating as a team member. Advanced training can include in-depth training about court decisions that affect the team (i.e., *Crawford v. Washington* (2004) 541 U.S. 36), new developments in forensic science and crime laboratory special projects, updates in the field of sexual assault medical forensic examinations, and so forth.

Statewide Training Organizations For Each Discipline

Statewide training organizations and associations exist to provide training for each discipline involved in sexual assault intervention, including:

- Peace Officers Standards and Training (POST)
- California District Attorneys Association (CDAА)
- California Sexual Assault Investigators Association (CSAIA)
- California Clinical Forensic Medical Training Center (CCFМTC)
- California Coalition Against Sexual Assault (CALCASA)
- California Network of Child Advocacy Centers (CNCAC)

Contact information for these organizations is included in Appendix E.

Local Inter-agency Training

Local inter-agency in-service training should be conducted to continue professional development among agencies and to transmit the training that has been delivered by the statewide training organizations. In this way, new developments in the field, which directly affect a discipline, and indirectly all disciplines, can be transmitted to everyone.

Step 6: Determine the Needs for SART Data Collection and Ensure Data Base Management by Discipline

The SART needs to determine the type of data elements to be collected. In addition, each participating agency should have its own database, and the database plan should be shared among the agencies. At a minimum, the agencies should maintain the data listed below.

Law Enforcement Agencies

The number of crime reports, the number of cases assigned for investigation, investigation dispositions, the number of cases submitted to the district attorney for review and filing of charges, demographic information about victims and alleged perpetrators, and where the crimes took place.

District Attorney's Office

The number of cases referred by law enforcement agencies, the number of case filings, the number of plea bargains and sentences, and the number of trials. Disposition information (including sentencing information) should be available for plea bargains and trials. Ideally, descriptive information recorded by the prosecuting attorneys about what were the top factors that influenced the outcome of the case (e.g., quality law enforcement investigation, quality forensic medical examination, victim presentation) is useful. This latter information is frequently asked but not routinely kept. Information obtained from polling the jury following the conclusion of the case can be very helpful and informative for all team members.

Sexual Assault Forensic Medical Exam Team

The number and types of forensic medical examinations performed, response time, demographic information about the patient (e.g., age, gender, ethnicity), type of sexual

assault, and examination findings. A software program has been developed for sexual assault forensic medical examiners in California to capture the information from the Cal OES 2-923 Forensic Medical Report: Acute Adult/Adolescent Sexual Assault Examination. With this software program, demographic and examination data can be systematically collected and analyzed at the local level. Contact CCFMTC at www.ccfmtc.org for more information.

Crime Laboratory

Data by law enforcement agency case number, crime laboratory identifying number, types of analysis performed, analytical outcomes, numbers of “rape” kits received, and number analyzed.

Rape Crisis Center

Data on the numbers of survivors served, demographic information (age, gender, ethnicity), and the types of services provided.

Victim/Witness Assistance Center

Statistics on the numbers of sexual assault victims served, demographic information (age, gender, ethnicity), the type of crime, and the types of services provided.

Step 7: Develop a Policy and Plan for Case Review

There are three types of case review: Sexual Assault Forensic Medical Exam, SART, and Internal Agency.

Sexual Assault Forensic Medical Exam Case Review

This includes review of standard state exam form documentation, review of forensic images, and evidence collection procedures and management. Regular feedback notes from the local crime laboratory are very useful for improving quality of exams. For medical professionals, case review is described as quality assurance (QA) and continuing quality improvement (CQI). See Chapter 6, Sexual Assault Forensic Medical Exam Component for more information.

SART Bill

Penal Code sections 13898.1 and 13898.2 (enacted by statute 2015), establish and recognize SART in California state law. These sections establish the principle of inter-agency case review.

SART Case Review

Historically, some jurisdictions have been reluctant to embrace the concept of case review in sexual assault cases; however, inter-agency case review has long been used in the field of child abuse with SCAN (Suspected Child Abuse and Neglect) teams (Pen. Code § 11167.5(7)), Domestic Violence Fatality Review Teams (Pen. Code § 11174.32), Child Abuse Death Review Teams (Pen. Code § 11174.32), and Multi-Disciplinary Interview teams (MDITs) (Welf. & Inst. Code § 18951(d)). The operations of these teams are recognized in California state law, confirming their utility and allowing participants from various disciplines to exchange information. In addition, case review is required for child advocacy centers to be accredited by the National Children's Alliance.

Inter-agency case review can take place at the regular SART meetings. Some teams organize their meetings to set aside one hour for business/administrative matters and one hour for case review. Be sure to include crime lab feedback to both the exam team on specific issues and general crime lab feedback to the whole SART on trends, new technologies, and Fast Track/RADS issues, among others.

Regular, routine feedback, both positive and "improvement needed" is a constructive approach. It can take the sting out of the situation when a case is handled badly. With routine case review, participants become accustomed to procedural review and discussing difficult issues. This orients the team to take an objective problem-solving approach rather than blaming and polarizing when a case is mishandled. It avoids the "gotcha game" in which no one benefits.

Internal Agency Case Review

Various agencies have different methods of internal case review. SAFE/SANE teams have monthly chart and photo review of every exam or a selected number of exams. Rape crisis center advocates review cases with their supervisors and other advocates in case review meetings.

Victim Feedback for the SART

Some SARTs have an evaluation form that enables sexual assault survivors to provide feedback. Forms are mailed to the survivor, with permission, after an appropriate time period, and he or she is asked to rate and comment on each aspect of team operations (e.g., patrol officer, detective, medical team, rape crisis center).

Step 8: Be Knowledgeable About Client Confidentiality Issues

Law Enforcement, Crime Laboratories, and District Attorneys

There are no confidentiality issues among law enforcement agencies, crime laboratories, and the district attorney's office.

Hospitals and Forensic Medical Exam Teams, Law Enforcement Agencies, and District Attorney's Offices

The hospital and/or forensic medical team and law enforcement agencies typically have a written contractual arrangement that includes completion of the standard state forensic medical exam report forms, and transmission to the law enforcement agency. This form is part of the package delivered by the law enforcement agency to the district attorney's office for case review and case filing. The defense attorney then obtains the forensic medical reports through the discovery process from the district attorney's office.

Hospitals and Independent SAFE/SANE Teams: Handling of Documents Internally

Hospitals must have explicit procedures for the handling and insertion of forensic medical records and reporting forms into a patient's medical chart. This should be done to prevent routine copying of forensic medical reports for non-criminal justice purposes (e.g., transfer of health care providers, medical referrals, insurance company requests). Independent SAFE/SANE Teams must develop procedures. See Chapter 6, Sexual Assault Forensic Medical Exam Component. Note that electronic medical record rules and procedures are evolving among hospitals and are not consistent at this point about the inclusion of forensic medical records and photos.

Crime Laboratories

The information is protected and can only be released to the investigating agency and the district attorney's office.

Rape Crisis Centers

Survivors with whom rape crisis center advocates interact are cloaked with client-counselor confidential privilege as defined in state law. See Chapter 7, Rape Crisis Center Counseling and Advocacy Component for information about the state law.

Victim/Witness Assistance Centers

There are 59 victim/witness assistance centers in California, most are part of the county district attorney's office, some in the county probation department, and a few are non-profit organizations. Confidential client-counselor communication is a complex issue for victim/witness assistance centers. Confidential client-counselor communication cannot be provided for sexual assault victims served by public agencies if the information disclosed has relevance to the prosecution of the case. This information must be given to the prosecutor and is discoverable by the defense. Only the non-profit organizations can guarantee confidential client-counselor communication through compliance with the Sexual Assault Counselor Confidentiality provisions in state law. Client records can be subpoenaed; however, the matter is subject to a hearing with a judge to determine relevance before any information can be released. For more information, refer to Chapter 11, Victim/Witness Assistance Center Component. A list of centers and contact information can be found on the California Victim Compensation and Government Claims Board website, www.vcgcb.ca.gov.

Step 9: Develop Standardized SART Forms

Examples of SART forms are contained in Appendix C. SART programs could benefit from using the same forms for data collection and evaluation purposes.

Step 10: Develop a Public Relations Plan

A public relations plan is essential to highlight the important work performed by the SART and to ensure continuous community support for the program. The best public relations strategies are feature stories in the local newspaper, radio interviews of team members, and television news on the formation and operation of the team. It is important to ensure recognition for the agency executives and/or elected officials who support the project as well. Be sure to find a way to recognize the less visible supporters such as the finance director at the local hospital who could see that the business plan for the medical exam team was shaky, but approved it anyway in the spirit of public service.

Step 11: Establish Regular Monthly Meetings Between SART Partner Agencies

These meetings are essential to ensure smooth implementation of the SART model, to discuss operations and updates for problem solving, and to conduct inter-agency case review for quality assurance purposes. See Chapter 5, Team Meeting and Case Review.

SART Resources

- National SART Toolkit—Resources for Sexual Assault Response Teams
www.nsvrc.org/publications/SART-toolk
- California SART Report—Taking Sexual Assault Response Teams to the Next Level
www.ccfmtc.org

Chapter 3: Decision Making and Conflict Resolution

The decision-making process should be explicitly discussed and meet the needs of the group. Groups with a high level of agreement, trust, and a long relationship history often operate by discussion and consensus. A new task force is safer using a modified, not rigid, version of *Robert's Rules of Order*. This booklet can be obtained from the public library and most bookstores. Some individuals will shy away from *Robert's Rules of Order* either through misperception or misunderstanding of what is involved. This is a mistake. Without an orderly decision-making process, decisions can be avoided or stampeded, issues go unresolved, and a strong personality or emotions can rule.

Essentially *Robert's Rules of Order* allows a proposal to be placed on the table for discussion with a motion and a second. Sometimes it is helpful to have a preliminary discussion before a motion is formed. "Friendly amendments" to the motion can be accepted by the maker of the motion. Discussion takes place and a vote is taken. In heated discussions, it is helpful to have the various proponents summarize three pros and three cons and take a vote. Some individuals will take a discussion off course. A useful concept is to "park the idea" by saying "that is an interesting idea. Let's park it for the moment, and take it up later so that we can finish this discussion."

Another useful concept for decision making is called "gradients of agreement." Formulated by Alan Stein, Ph.D., a California management consultant, this concept creates a safe and open environment for discussion when there is disagreement. Training on utilizing the concept of gradients of agreement can be obtained from Dr. Stein, who can be reached by contacting the California Clinical Forensic Medical Training Center (CCFMTTC) at www.ccfmtc.org.

The gradients of agreement are:

- Endorsement — *I like it.*
- Endorsement With a Minor Point of Contention — *Basically I like it.*
- Agreement with Reservations — *I can live with it.*
- Abstain — *I have no opinion.*
- Stand Aside — *I don't like this, but I don't want to hold up the group.*

- Formal Disagreement, But Willing to Go With Majority — *I want my disagreement noted in writing, but I'll support the decision.*
- Formal Disagreement, With Request to Be Absolved of Responsibility for Implementation — *I don't want to stop anyone else, but I don't want to be involved in implementing.*
- Block — *I veto the proposal.*

Develop a Plan for Building Consensus or Agreement and Conflict Resolution

SART is a partnership between agencies with distinctive missions, roles, and responsibilities. In a collaborative partnership, issues such as “who is in charge of the team,” committee chair, and meeting location do not create a tension-filled charge. In tenuous territory, these matters can make a difference. Decision making should be collaborative, if possible, with the chair facilitating the process. The SART task force must establish broad principles for addressing problems and resolving conflicts.

The basic operating principles to establish for resolving problems are:

- a decision-making philosophy grounded in the concept of “what is best for the victim” and “what is in the best interest of the community”;
- a commitment to the SART approach;
- understanding that mistakes and conflicts are expected and that they introduce problems to be solved;
- understand that problems and conflict are opportunities for improvement;
- protocols and constructive methods for resolving mistakes and disagreements will be developed in response to problems;
- problems will be addressed, and not be allowed to continue unresolved;
- always take a constructive approach no matter how difficult the problem; and
- recognize that some problems do not lend themselves to immediate resolution, and taking the “long view” may be indicated.

Anticipate that challenges, disagreements, and conflicts will occur, and be proactive rather than reactive, when problems develop. Engage in problem solving promptly. Chronic unresolved problems create toxic environments for individuals and teams.

Turf Issues

Turf issues may surface at any of the planning, organizing, or implementation stages. Problems usually arise from conflicts or competition about mission and goals, and occasionally are related to stylistic personality differences. Sometimes turf issues arise over attitudes about perceived competency of other agencies and the need to “take over” the case or the survivor to make sure it’s “done right.” The challenge is to build operating relationships that are open, honest, and direct that can withstand the confrontation of conflicting points of view.

Mission and Goal Conflicts

If the focus of the conflict is organizational mission and goals, approach the issue with interdisciplinary training. Identify the mission and goals of each agency or discipline; describe the philosophy, parameters, protocols and operating procedures; and discuss the parameters and limitations by which they operate. Training and utilizing an objective problem-solving approach facilitates understanding and achieves balanced perspectives about each agency. This can prevent personalization and polarization of conflicts.

Difficult Personalities

It is also important to recognize that difficult personalities may occupy key positions for years. Thought must be given to finding avenues of working with them. Sometimes a pathway can be found through a mutual interest, concern, or issue. And sometimes a helpful third person from the same discipline can bridge differences. Building upon small pathways can enlarge the scope of the working relationship.

Personalization of Conflicts

Personalization of conflicts causes rifts that can challenge bridge building. There must be a commitment to working together “for better or for worse,” coupled with a realization that the parties will have to come back for another day for another issue. Recognition that no purpose is served in brinkmanship or breaking relationships needed for another day is essential. With this attitude, trust builds over time, and proponents of firm positions or attitudes can shift and grow as new information and experiences generate fresh perspectives.

In conflict resolution, it is important to remember that the facts of the situation are only one level of the conflict. The second level of conflict is the meaning, interpretation, and significance of the facts to the individuals. Sometimes this meaning can become magnified when people are overwhelmed by their jobs or other circumstances. Reaching understanding of the meaning, significance, interpretation, and ramifications of the facts to the individuals involved in the conflict can facilitate problem solving. In this way, each person can begin to appreciate the other's point of view. The third level is to identify various options for problem solving and to select the best option that works for all concerned. Lastly, it is important to remember that not everything is rational or logical. For seekers of rationality and objectivity, this is a hard concept to accept.

Develop a Problem-Solving Approach in Advance

In the case of differences that have the potential or capacity for jeopardizing survivor care, explicit procedures, agreed upon in advance, are needed. One of the most challenging tasks is to resolve the occasional conflict between criminal justice SART goals and victim-centered SART goals. This is where the team must reach consensus about the best overall approach to maximize everyone's outcome.

Generally, attempting to solve the problem at the lowest level within each agency is best. If indicated, however, an unsolved, persistent, or recurrent problem may need to be taken up through the chain of command or chain of authority. The best way for handling this process is to inform the person directly (e.g., "I have brought this problem to your attention several times, and nothing has changed. This issue causes three negative impacts—(1) ..., (2) ..., and (3) Let's meet with your supervisor to discuss this matter and see if she/he has any new ideas for addressing this situation").

If the problem persists, keep taking the problem to each level in the organization involving the parties from each previous level. Avoid immediately "going to the top" unless it is absolutely necessary, because resentment will develop. Try to allow the people at the lowest level in the organization to solve the problem. Solutions with "buy in" are stronger and often more lasting than those "imposed." Sometimes using the progressive chain of command approach is impossible due to circumstances and going to the top is indicated. If this is the

case, recognize that lower-level relationships may not ever be the same. Continue to be positive, constructive, and take “the long view.” Never avoid telling the person that you are taking the matter up to the next level in the organization. First, they will find out anyway. Second, the discussion can get derailed on your process or handling of the matter rather than the content of your message. Always keep in mind—if people don’t like your message, they will always attack your process or the way that you handled it. Having a sound process ensures that others must focus on the content of your message.

Chapter 4: Development by County

California is a diverse state comprised of some counties with very large populations, and other counties that have smaller populations but geographical areas larger than some states on the East Coast. Within this range, there is a super-size county, large counties, mid-size counties, and rural counties. SARTs develop, in many instances, based upon geography and population.

State Law Requires Trained Medical Personnel

Penal Code section 13823.9 directs each county to designate at least one general acute care hospital to perform examinations for sexual assault and child sexual abuse victims. The statute also requires each county with a population of 100,000 or more to arrange to have professional personnel, trained in the examination of sexual assault and child sexual abuse victims, present or on call in the county hospital or contracting hospitals providing emergency medical services. In counties with populations of one million or more, trained professional personnel must be present or on call for at least one general acute care hospital per one million persons in the county.

Super-Size County: Population and Geography

In a county the size of Los Angeles, SART is typically developed by geographical region. Several law enforcement agencies and hospitals or exam facilities may exist within the region. This size county, by state law, must have one sexual assault forensic medical examiner program per million residents based upon geographic region to ensure maximum accessibility. Each of the 12 rape crisis centers in Los Angeles County serves a geographically defined area, and works with several law enforcement agencies and medical examination sites.

Large Counties

These counties have urban centers and urban spread. Examples include Santa Clara, Alameda, and San Diego counties. These counties typically have anywhere from two to four rape crisis centers, large and small city police departments, and one sheriff's department. This size county, by state law, should have one sexual assault forensic medical examiner

program per million residents, based upon geographic regions to ensure maximum accessibility.

Mid-Sized Counties—Defined by Population

These counties typically have one large and several small city police departments, a sheriff's department, and one rape crisis center. Examples include Sacramento, San Joaquin, and Fresno counties. A mid-size county should have at least one sexual assault forensic medical exam team operating at one central hospital or exam facility serving the urban and rural city police agencies, the sheriff's department, and the rape crisis center.

Mid-Sized Counties—Defined by Geography

In geographically large counties such as San Bernardino and Riverside counties, there may be more than one sexual assault forensic medical exam team operating at major population sites within the county due to the long distances that must be traveled. Each forensic medical exam team serves several city police agencies and the sheriff's department. There may be more than one rape crisis center serving distinctive geographical regions in the county, or one with satellite offices.

Rural Counties

These counties typically have two to three small city police departments, a sheriff's department, and one rape crisis center. In some rural counties in California, one rape crisis center may serve one or more adjacent rural counties. Rural counties, depending upon their size, may develop their own forensic medical exam team or transport victims to a nearby urban center. Rural counties within driving distance to an urban center will sometimes take the position that it is better to use an experienced forensic medical team that performs many exams every month than to train a team on standby that only conducts a few forensic medical exams per year. From a quality exam and cost-benefit perspective, this approach works for them. Another model for rural counties is to form a single forensic medical exam team that provides quality exams for four or five rural counties.

Chapter 5: Team Meeting and Case Review

Meeting Leadership or Chairmanship Needs to be Rotated

Since the concept of SART is an equal partnership among agencies, the position of chair or meeting leader should be rotated annually among the agencies. The role of the chair is to establish the agenda with input from the partner agencies and to facilitate the meeting. *No single agency should be allowed to establish sole leadership over the meeting or the action plans to correct operational problems.* Rotation of meeting leadership broadens the concept of ownership of the SART program. Agree upon a rotation plan for the chairman or elect the chairman annually. Meeting members include:

- sergeants or detectives from law enforcement agencies' sexual assault units;
- supervising deputy district attorney or a deputy district attorney from the Sexual Assault Unit;
- rape crisis center director, SART advocate, or advocate coordinator;
- coordinator of the Sexual Assault Forensic Medical Exam Team; and
- supervisor or experienced crime laboratory personnel.

Regular Monthly Meetings

Meetings should be held monthly and include both a business meeting and case review. There are time periods when operations run so smoothly that monthly meetings begin to seem unnecessary. Some groups will then choose to meet quarterly. Other groups shorten the meeting time, skip a month, or change the meeting to make it a brown-bag lunch. Be cautious about interrupting the momentum of the committee. Sometimes problems develop, operational adherence to standards shifts or changes, some relationships break down, and problems go unsolved.

Meeting Agenda

- Establish a routine process for soliciting agenda items in advance of the meeting.
- Prepare and distribute in advance a formal written agenda and meeting minutes for every meeting.
- Build items into the agenda for feedback, concerns, trends, positive developments, and outcomes.

- Establish and distribute an annual meeting calendar for everyone to the extent possible using the same date such as the second Thursday of every month, with any modification agreed upon by the entire committee.

Agenda for the Business Meeting

The agenda for the business meeting typically centers on the following issues:

- policy or procedural development or revisions;
- process issues and clarification;
- procedural issues and clarification;
- role clarification and agency interaction;
- team functioning issues;
- review of statistics;
- review of documents (e.g., operational agreements, brochures);
- operational problems;
- information on new laws;
- new patterns of drug-facilitated rape or new sexual assault modus operandi;
- notices about training programs;
- monthly updates (e.g., reports by deputy district attorney on trial outcomes); and
- broad topical issues.

Agenda for the Case Review Meeting

Partner agencies will bring cases for review and discussion. The steering committee needs to determine whether all cases can be reviewed (usually in small jurisdictions) or to review selected cases (usually in large jurisdictions). If selected cases are reviewed, it is wise to start with brief presentations of cases that went well, followed by cases with operational problems, to ensure that committee members hear the positives as well as the negatives.

SART cases can be discussed at the monthly SART meetings. Some teams organize their meetings to set aside one hour for business/administrative matters and one hour for case review. It is essential when individual case details are discussed, that this discussion be incorporated into a formal quality assurance process. This ensures thorough and candid evaluation of cases, particularly in cases that involve problems. Consult with the local district

attorney's office to discuss whether both current and past cases can be reviewed. Be sure to build in feedback from the crime laboratory.

Handling the Spectrum of Problems and Issues

Minor problems should be handled at the time they occur or the next day, rather than wait for the monthly meeting. Larger problems need advance planning.

Discussions about operational problems are most successful if the partner agencies involved are notified in advance that a particular case is on the agenda. This provides the opportunity for the partner agency involved to research the case. Agencies should agree to notify one another as soon as possible about problems so they can take corrective action, rather than let a month go by with matters unresolved.

Case reviews can build trust if discussed with the presumption that everyone is trying to do their best and that sometimes, in spite of best efforts, things can go wrong. As a practical matter, a particular case review may not be completed at the meeting in which it is presented. Often more inquiry and data are needed, or more questions are generated by the discussion.

Case reviews of operational problems are not usually successful if the partner agency does not have advance notice that the issue will be on the agenda. This makes them feel put on the spot. Only one side of the story is presented. More often than not there are mitigating circumstances, and, when all facts are brought to light, the partner agency did not do as bad a job as originally presented. Sometimes, however, a poor job was performed. Advance notice gives the partner agency time to review the problem and to develop a corrective action plan. Acknowledging a problem and presenting a corrective action plan is better than being placed on the spot. Some people are able to shrug this off while others develop resentments toward other team members that can last for years.

Chapter 6: Sexual Assault Forensic Medical Exam Component

The roles of the sexual assault forensic medical examiners (SAFE or SANE) are to:

- attend to the medical needs of the patient; and
- perform a quality sexual assault forensic medical examination.

The roles of the SAFE/SANE on the SART are to:

- participate as a team member;
- actively participate in solving systems issues, team education, and community relations related to the SART team; and
- ensure up-to-date knowledge and skills regarding sexual assault forensic medical exam performance and interpretation of findings.

Clinical Forensic Medicine

California has led the nation in the development of this field. Sexual assault clinical forensic medicine was formally launched in California by state law in 1984 by Penal Code sections 13823.5–13823.11. These statutes specified the elements of a sexual assault forensic medical examination; required the development of standard state forensic medical report forms and protocol; defined qualified health care professionals; and mandated that trained examiners be on call or on duty to perform these exams. These developments are described in the subsequent sections.

Trained Medical Professionals Either Present or On Call Are Required by State Law

Penal Code section 13823.9 directs each county to designate at least one general acute care hospital to perform examinations for sexual assault and child sexual abuse victims. The statute requires each county with a population of 100,000 or more to arrange to have professional personnel trained in the examination of sexual assault and child sexual abuse victims, present or on call, in the county hospital or contracting hospitals providing emergency medical services. In counties with populations of one million or more, trained professional personnel must be present or on call for at least one general acute care hospital per one million persons in the county. Counties with less than 100,000 population may choose to partner or contract with an exam team in a nearby county. (See Chapter 4, Development by County for more information.)

Qualified Health Care Professionals

Penal Code section 13823.13(c) defines a qualified health care provider:

As used in this section, “qualified health care professional” means a physician and surgeon currently licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, or a nurse currently licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code who works in consultation with a physician and surgeon or who conducts examinations described in Section 13823.9 in a general acute care hospital or in the office of a physician and surgeon, a nurse practitioner currently licensed pursuant to Chapter 6 (commencing with Section 2834) of Division 2 of the Business Professions Code, or a physician assistant licensed pursuant to Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business Code.

Performance of a Medical Evidentiary Examination

Pursuant to Penal Code section 13823.9, to “perform a medical evidentiary examination” means to evaluate, collect, preserve, and document evidence, interpret findings, and document examination results.

Training for Sexual Assault Forensic Medical Examiners

Training is provided by the California Clinical Forensic Medical Training Center (CCFMTC), established in state statute in 1995 (Pen. Code § 13823.93) and funded by the California Office of Emergency Services (Cal OES), through an annual grant to the California District Attorneys Association (CDAA). See www.ccfmtc.org for more information.

Legal Standards for Hospitals Performing Evidentiary Examinations or Referral

Protocol

Health and Safety Code section 1281 and Penal Code section 13823.9 require all public and general acute care hospitals to comply with the standards set forth in Penal Code section 13823.11 for performance of sexual assault and child sexual abuse evidentiary examinations. If a hospital cannot adhere to the statutory requirements, a protocol must be adopted for immediate referral of sexual assault and child sexual abuse victims to a local hospital that is able to conduct the forensic medical examination according to the standards established by law. If a referral protocol is adopted, the hospital must notify local law enforcement agencies, the district attorney, and local victim assistance agencies.

Required Use of the Standard State Forensic Medical Exam Forms and Procedures

To perform quality forensic medical exams and to be reimbursed by local law enforcement agencies, sexual assault forensic medical examiners must follow the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims* and document findings using the standard state forensic medical report forms (Pen. Code § 13823.5(c)). The minimum standards for performing forensic medical exams are outlined Penal Code section 13823.11. The standard state form and protocol contain the recommended methods for meeting the state legal standards.

State law does not allow for submission of dictated progress notes in lieu of the standard state forms, or the development of a local modified version of the standard state forms. The state forms are designed to ensure standardization and consistency, and contain explicit instructions for completion. Forms and the protocol can be obtained at www.ccfmtc.org or www.caloes.ca.gov. Many states and the U.S. military are using the California forms and protocol, and the *National Protocol for Sexual Assault Medical Forensic Examination of Adults/Adolescents* at www.ncjrs.gov is based on it.

CCFMTC is responsible for developing and updating these forms. Visit the CCFMTC website at www.ccfmtc.org for revision updates.

Timeliness: Immediately Upon Arrival or Within One Hour

Patients must be examined without delay to assess medical status and to minimize the loss or deterioration of evidence. The standard of practice in California for acute sexual assault or child sexual abuse examinations is to start the exam immediately upon the patient's arrival at the hospital, or within one hour (*California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*). Circumstances such as medical stability, incapacity to give consent, intoxication, the emotional needs of the patient, and other variables may impact the exam start time. If this is the case, document the reason for delay in the patient record so that quality assurance reviews are accurate regarding response times.

Confidentiality of Forensic Medical Records

A forensic medical report is subject to the confidentiality requirements of the Medical Information Act (Civil Code §§ 56 et seq.), the Physician-Patient Privilege (Evid. Code

§§ 990 et seq.), Penal Code section 13823.5(c), and the Official Information Privilege (Evid. Code § 1040). It can only be released to those involved in the investigation and prosecution of the case: a law enforcement officer, district attorney, city attorney, crime laboratory, investigating social service agency, county licensing agency, or coroner. Records may be released to the defense counsel only through discovery of documents in the possession of a prosecuting agency **or** after the appropriate court process (i.e., judicial review and a court order). Penal Code section 13823.5(c) addresses the management of the forensic medical report forms as follows: “The forms shall be subject to the same principles of confidentiality applicable to other medical records.”

Key Terms for Sexual Assault and Child Sexual Abuse Examinations

- Acute — Less than 120 hours (5 days) have passed since the incident (< 120 hours)*
- Non-acute — More than 120 hours (5 days) have passed since the incident (> 120 hours) *

Required State Forms

Cal OES 2-923—Forensic Medical Report: Acute (< 120 hours) Adult/Adolescent Sexual Assault Examination

- History of acute sexual assault (< 120 hours)*
- Examination of adults (age 18 and over)
- Examination of adolescents (ages 12–17)

Cal OES 2-924—Forensic Medical Report Acute (120 hours) Abbreviated Adult/Adolescent Sexual Assault Examination

- For patients choosing not to engage with a law enforcement agency*
- Examination of adults and adolescents (age 12 and over)

Cal OES 2-925—Forensic Medical Report: Non-acute (> 120 hours) Child/Adolescent Sexual Assault Examination

- History of non-acute sexual abuse (> 120 hours)*
- Examination of children and adolescents under age 18

* *These terms are used to describe time frames, not a rigid standard, or to suggest that after 120 hours a complete exam should not be done. Some counties have established seven (7) days or 168 hours as the time frame for performing acute forensic medical exams. Contact www.ccfmtc.org for more information.*

Cal OES 2-930—Forensic Medical Report: Acute (< 120 hours) Child/Adolescent Sexual Abuse Examination

- History of chronic sexual abuse (incest) and recent incident (< 120 hours)*
- Examination of children and adolescents under age 18

Cal OES 2-950—Forensic Medical Report: Sexual Assault Suspect Examination

- Examination of persons suspected of sexual assault or child sexual abuse*

Sexual Assault Forensic Medical Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE)

SAFE/SANE examiners are trained healthcare professionals with additional training in how to conduct adult/adolescent sexual assault forensic medical exams and/or child sexual abuse forensic medical exams or both. SAFE is the acronym for sexual assault forensic examiner, which includes physicians, nurse practitioners, physician assistants, and nurses serving on the same team. SANE is the acronym for sexual assault nurse examiners, and these teams are comprised of registered nurses. SAFE is the recommended term.

Sexual assault forensic medical examiners are independent objective fact finders. It is essential that examiners not take on the role of victim advocate. Doing so destroys the important role of providing an objective forensic medical evaluation and interpretation of findings. Dueling medical experts is always a possibility, but crossing the boundary into patient advocacy away from forensic science will increase the probability.

Adept defense attorneys will discredit the testimony of medical examiner “advocates” and cast doubt on the medical exam findings. The appearance of bias jeopardizes the SAFE/SANE examiners’ credibility. Expressions of empathy for the patient are not considered victim advocacy.

Advocacy is the role of the rape crisis center advocate. Similarly, it is essential that the advocate not be requested to participate **in any way** (e.g., packaging evidence, holding the ruler for the photographer, and so forth) during the performance of the forensic medical exam. To do so jeopardizes the advocate’s confidentiality privilege. It also has the potential

to raise questions about evidence handling and packaging procedures because advocates are not trained forensic medical examiners. It is, however, appropriate for the advocate to be in the exam room to provide emotional support for the survivor.

The Value of SAFE and SANE Teams

The benefits of specialized teams include:

- coordinated team notification and assembly;
- medical assessment, evaluation, and triage, if indicated;
- prompt forensic medical examinations for acute cases;
- uninterrupted forensic medical examinations;
- specially trained sexual assault forensic medical examiners;
- defined areas of expertise in sexual assault, child sexual abuse, or both;
- pre-authorization for reimbursement based upon negotiated contracts;
- coordinated interviews with law enforcement officers and rape crisis counselors;
- dedicated exam space and equipment;
- sexual assault forensic medical exam Quality Assurance (QA) or Continuous Quality Improvement (CQI) that includes peer review;
- collaboration and cooperation with community resources;
- standards of practice consistent with the scientific forensic medical exam literature;
- and
- team membership that provides support and reduces isolation in this specialized field.

Membership of SAFE or SANE Team

Determining the team membership model should be a collaborative decision between local law enforcement agencies, the district attorney's office, the SAFE/SANE team, and the hospital(s) or exam facility.

Five issues to consider in making the team membership decision:

- available resources (nurses, nurse practitioners, physician assistants, or physicians) interested and committed to the work given the level of training needed;
- level of knowledge, skill, ability, experience, and training needed by examiners;

- financial cost of the examiner program;
- scope of practice issues defined in the Business and Professions Code that distinguish between nurses and mid-level practitioners (nurse practitioners and physician assistants); and
- the views of law enforcement, as the payer for the service, the views of the district attorney's office, and the views of the hospital or facility where the exams are performed.

Scope of Practice Consideration for Team Membership

In considering team composition, scope of practice should be understood. Scope of practice describes for health care providers the parameters of their roles and responsibilities in the delivery of health care. The Nurse Practice Act of the California State Business and Professions Code describes the basic scope of practice for registered nurses and nurse practitioners; see Chapter 6, Nursing, Article 2, sections 2725–2727.5 and sections 2834–2837. The American Nurses Association (ANA) has several publications describing scope of practice issues. The scope of practice parameters for registered nurses, nurse practitioners, and physician assistants are summarized in the California Clinical Forensic Medical Training Center (CCFMTTC) publication *Developing and Maintaining SAFE/SANE Team Programs* available at www.ccfmtc.org.

Team Membership Models

- *Model A: Nurse Practitioner/Physician Assistant Examiner Teams* — Some communities choose to have a team comprised of nurse practitioners and physician assistants (also called mid-level practitioners) because they prefer to have examiners with extensive clinical experience and advanced training perform forensic medical examinations.
- *Model B: Registered Nurse Examiner Teams* — Some communities choose to have teams comprised of registered nurses because they believe that nurses have the knowledge, skills, and abilities to perform sexual assault forensic medical examinations.
- *Model C: Hybrid Model* — Some teams have both mid-level practitioners, registered nurses, and physicians. Although in hospitals, registered nurses are not permitted to serve on a team with mid-level practitioners performing identical procedures

due to different standardized procedures for their respective positions and pay differentials.

SAFE/SANE Team Coordinator and Physician Supervision

Teams should have a coordinator for daily operations and trained physician supervision *with a close (not distant) relationship to the team*. Penal Code section 13823.5(e) specifies that licensed nurses must work in consultation with a physician who conducts examinations as described in Penal Code section 13823.9. CCFMTC has developed a training program for physicians and team coordinators for this purpose.

Physicians from the fields of Emergency Medicine, Obstetrics/Gynecology, Family Practice, and Public Health provide supervision or case consultation for adult/adolescent examinations; and pediatricians supervise or provide case consultations for the pediatric examinations of children under age 12. For adolescents between the ages of 13–17, the case consultation decision can be made either way and depends upon local resources.

Target Populations Served: Adults, Adolescents, Children, or All Three

Urban counties may have very specialized teams. One team for adult/adolescent sexual assault forensic medical examinations and one team for child/adolescent sexual abuse forensic medical examinations. The patient age distinction between an adult/adolescent team and a child/adolescent team varies by jurisdiction. Jurisdictions use these examples of age differentials for the pediatric exam team: under age 18; under age 16; under age 14; or under age 12. Also non-acute exams for non-sexually active adolescents under the age 18 who have been victimized by intra-familial sexual abuse, are usually handled by the pediatric team.

Many counties have one team that performs both sexual assault and child sexual abuse forensic medical examinations. They may use their SAFE/SANE team to perform the acute examinations (< 120 hours) and transport non-acute child sexual abuse examinations (> 120 hours) to experienced teams at nearby tertiary centers that examine large numbers of children every year. They have made this decision because interpretation of findings in non-acute child sexual abuse cases is complex and requires highly trained examiners.

For SAFE/SANE teams performing non-acute child sexual abuse examinations, it is highly recommended that they employ an experienced pediatrician for case review and consultation on every case.

Public Funds and the Payer Relationship

State law prohibits healthcare professionals, hospitals, and emergency medical facilities from charging victims directly or indirectly for the costs of the forensic medical sexual assault examination. These costs are to be treated as “local costs” and charged to the local law enforcement agency in which the crime was committed (Pen. Code § 13823.95).

Since public funds are allocated for sexual assault forensic medical exams, both the district attorney’s office and the local law enforcement agencies need to be in agreement on the model and program used in their communities. The contractual or payer aspect of this relationship is sometimes overlooked in discussions about the professional membership of the forensic medical exam team. In most contractual or fee-for-service relationships, the payer for the service has to agree upon the qualifications of the professional delivering the service.

Common SAFE/SANE Team Organizational Models

Primary Hospital Program Model

- One hospital is designated by the community and agrees to provide sexual assault forensic medical examinations.
- In large counties, more than one hospital site is involved.
- The team members are regular shift employees or employed on an on-call basis.
- The hospital provides examination space and equipment.
- The hospital contracts with law enforcement agencies for reimbursement.

Independent SAFE/SANE Team Model

- A sexual assault forensic medical exam team with a director/coordinator contracts with law enforcement agencies and community hospitals.
- The team works on an on-call basis responding to contract hospitals.
- The hospital provides examination space and equipment.
- The team may be organized on a private business model or as a non-profit 501(c)(3) organization.

Multi-Agency Program Model

- Collaboration between any of these agencies or institutions: county department of health and human services, local hospital, a university, a victim/witness assistance program, or a medical clinic.
- A facility (e.g., renovated house or building) in proximity to a hospital is provided by one of the agency partners or a private funding source.
- The exam team members' salaries are paid by one of the agency partners.
- Equipment is purchased or provided by one of the agency partners.

Multi-Disciplinary Co-Location Program Model

- A multi-disciplinary team composed of a SAFE/SANE team, law enforcement officers, and advocates are co-located in one facility.
- The facility may be non-medical, but arrangements are made to refer trauma cases to a local hospital.
- There is dedicated space and equipment for examinations.

Space and Equipment Considerations related to SART Operations

Safety for patients and the SAFE/SANE team members, privacy and confidentiality for patients away from busy areas, and comfortable and peaceful surroundings are important considerations. The examination room should generate a feeling of safety and warmth. A designated examination room and patient bathroom, waiting room for patients and family members, and a waiting area for law enforcement officials are important for:

- SART interview coordination;
- privacy for patient, family members, and friends;
- law enforcement officer waiting area for report writing;
- evidentiary exam supplies and sexual assault evidence collection kit storage;
- storage of administrative and forensic medical records; and
- protection of the equipment from loss or damage caused by moving it from room to room; the colposcope; camera equipment; and the team computer, monitor, and DVD player.

Forensic examination equipment and supplies include:

- digital imaging equipment with a macro lens or a colposcope with a mounted camera and a macro lens that provides magnification of findings during the exam,

and imaging capability for large and small findings on the surface of the body and inside body cavities;

- computer, printer, and supplies (paper, ink cartridges) for SAFE/SANE team;
- sexual assault exam evidence kit (“rape kit”) provided by the crime laboratory, plus forensic exam supplies used in the exam process;
- medical exam supplies (overlaps with forensic supplies), vaginal speculums, anosopes, gauze pads, blood drawing supplies, and so forth;
- swab drying box; and
- an Alternative Light Source (ALS).

Equipment notes:

- Use of the historic Woods Lamp is no longer recommended since the development of ALS sold commercially with stronger capability.
- The phase contrast microscope is no longer needed for the wet mount exam, effective January 1, 2016.
- Digital imaging equipment with a macro lens are replacing colposcopes by many SAFE/SANE teams.

Consult CCFMTC about equipment recommendations because emerging forensic and equipment technology may change current recommendations.

Operational needs include:

- budget and business plan detailing projected revenue and expenses;
- examination and photography equipment;
- adequate size examination room, waiting areas, and patient bathroom;
- examiners trained in performing forensic medical examinations, forensic photography, and the capacity to serve as an expert witness in court;
- team coordination and supervision;
- case review, quality assurance, and continuous quality-improvement plan;
- data collection plan and methodology; and
- team coordination with law enforcement agencies, rape crisis center, crime laboratory, district attorney’s office, and Children’s Protective Services.

Details about these elements are described in the CCFMTC publication *Developing and Maintaining SAFE and SANE Teams* at www.ccfmtc.org.

Funding Models for SAFE/SANE Teams: A SART Concern

Current state law stipulates that law enforcement agencies are the payers for forensic sexual assault medical examinations, and funding for examinations is included in their budgets. Law enforcement agencies use the results of forensic medical examinations for investigation purposes, the district attorney's office uses the results in the prosecution of cases, and DNA results recovered from forensic exam evidence are eligible for uploading by the crime laboratory into CODIS, the state DNA database, and NDIS, the federal DNA database, used to identify potential suspects.

The SAFE/SANE team is the most fragile element of any city or county's operations due to unstable funding. There are four possible funding models for a SAFE/SANE team:

- per patient reimbursement;
- per capita funding model;
- county/city funded program model; and
- privately funded with grants/major gifts/donations.

Per Patient Reimbursement: Traditional Model with a Downside—This is the traditional method for reimbursing hospitals, medical facilities, and SAFE/SANE teams for performing examinations. The reimbursement revenue is expected to fund the cost of operating the team. For hospital-based SAFE/SANE teams, the local hospital may or may not subsidize team operations if there is a monthly or annual deficit. For independent teams, there is no financial back-up. A major drawback to this model is that the numbers of examinations performed every month can fluctuate, and stable revenue is needed during low patient volume months or years to financially sustain the team and make payroll (and cover other fixed expenses). This model can create financial stress and instability for teams and the investigative agencies that depend upon them as a vital resource.

Sometimes, law enforcement agencies become concerned about being billed for medical treatment of patients in addition to the cost of the forensic medical examination. See CCFMTC publication, *Developing and Maintaining SAFE and SANE Teams*, which describes the elements of the sexual assault forensic medical exam for billing purposes written for

understanding by law enforcement agencies. Hospital patient billing departments also have questions about this issue.

Per Capita Funding Model: Progressive, Stable Cost-Sharing Model—This model was first pioneered in Santa Barbara and Santa Cruz counties. In this model, each city law enforcement agency and the county sheriff’s department contributes a cost share of operating the SAFE/SANE team based on a population formula. Even the smallest city contributes \$1,000. In Santa Barbara County, the per capita funding model also funds the SART coordinator position based in the victim/witness assistance center. The Public Health Department funds the SAFE/SANE team salaries. In the Santa Cruz County model, the local hospital also contributes. This is the most stable method of funding a team; and there is no need for decision making about whether a victim receives an exam or not. The team is available on an on-call basis to provide services.

County/City Funded Program Model: County Public Health Department Model—Three California counties use this approach successfully—San Francisco, San Luis Obispo, and Santa Barbara counties. This is a stable method of funding a team. Funding for the exam team is allocated to the Public Health Department in these counties. In Butte County, the Public Health Department is very involved with three area hospitals to recruit, develop, and train an exam team. Each hospital has trained sexual assault forensic examiners, and the SAFE team is coordinated under leadership of the director of public health and an emergency department nurse manager from one of the hospitals.

Privately Funded with Grants/Major Gifts/Donations—There are two California programs that have been highly successful with this model—the Santa Monica Rape Treatment Program and the Keller Center in San Mateo County. This requires special aptitudes in acquiring major gifts, sponsoring major fund raisers, and a population in that geographic area that has large-gift-giving capabilities.

Community Benefit Requirement for Hospitals—SART planners should inquire about whether the local hospital is a non-profit organization. California law expressly recognizes that non-profit hospitals receive “favorable tax treatment by the government ... in exchange for a social obligation to provide community benefits.” Community benefits can be interpreted as

subsidizing or funding the costs of operating an exam team. Large hospital systems are often incorporated as non-profit organizations. The law requires non-profit hospitals to submit annual community benefit plan reports to the state detailing their contributions. (Health & Saf. §§ 127350(d), 127355.)

Survivor's Rights to a Victim Advocate and a Support Person

Survivors have a legal right to have a victim advocate and a support person of their choosing present during the medical evidentiary exam (Pen. Code § 264.2) and at any interview by law enforcement authorities, deputy district attorneys, or defense attorneys (Pen. Code § 679.04(a)).

- The law enforcement officer, or law enforcement agency, shall immediately notify the rape victim counseling center, whenever a victim of specified sex crimes is transported to a hospital for any medical evidentiary or physical examination.
- The hospital may notify the local rape counseling center, when the victim of specified sex crimes is presented to the hospital for the medical or evidentiary physical examination, upon approval by the victim.
- Prior to the commencement of any initial medical evidentiary or physical examination, a victim shall be notified orally or in writing by a medical provider that the victim has the right to have present a sexual assault counselor and at least one other support person of the victim's choosing.
- The hospital may verify with the law enforcement officer, or law enforcement agency, whether the local rape victim counseling center has been notified, upon approval of the victim.
- A support person may be excluded from a medical evidentiary or physical examination if the medical provider or law enforcement officer determines that the presence of the individual is detrimental for the purpose of the examination.

Patient Referral Pathways

See Process Charts A, B, and C for illustrations of these pathways. See Appendix D for Patient Consent Discussion.

Patient presents to hospital triage nurse/SAFE/SANE team with no report to law enforcement

- Perform medical screening examination.
- Notify law enforcement agency in whose jurisdiction the crime occurred, pursuant to mandatory reporting law (Pen. Code § 11160).
- Notify rape crisis center to provide accompaniment services.
- Notify SAFE/SANE team about potential forensic medical exam.
- Notify family member or friend of patient, upon request of patient, if not already handled.

Patient presents to hospital triage nurse/SAFE/SANE team with a law enforcement officer

- Perform medical screening examination.
- If the rape crisis center has not been notified by law enforcement, notify the rape crisis center advocate to provide accompaniment services.
- Notify SAFE/SANE team about a potential forensic medical exam.
- Notify family member or friend, upon request of patient, if not already handled.

Victim calls law enforcement agency

Patrol officer responds and determines that a forensic exam is indicated. Patrol officer notifies the rape crisis center **and** hospital triage nurse or SAFE/SANE team about the need for a sexual assault forensic medical exam:

- Rape crisis center advocate is notified by the law enforcement officer or by hospital triage nurse or by SAFE/SANE team.
- SAFE/SANE team is activated.

Survivor contacts rape crisis center

- Advocate provides crisis intervention.
- Advocate discusses options with survivor about reporting the crime to a law enforcement agency and having a sexual assault forensic medical exam. If the survivor decides to notify law enforcement, advocate provides emotional support during the process.
- If the survivor chooses to have a forensic medical exam or a medical exam only, the advocate provides accompaniment services or meets the survivor at the hospital or medical facility.

- The role of the rape crisis center advocate is a provision of continuity of care and/or wrap-around counseling and supportive services from the first contact to closure.

Intake Protocol for Conducting a Sexual Assault Forensic Exam: *Important Changes*

For many decades in California, law enforcement agencies have authorized sexual assault forensic medical examinations for investigative purposes and to reimburse hospitals and SAFE/SANE teams at public expense. As of January 1, 2012, this authorization requirement no longer applies with the enactment of the federal Violence Against Women Act (VAWA) and state law (Pen. Code § 13823.95).

Now any self-identified sexual assault victim can request a sexual assault forensic medical examination, and there is no requirement to cooperate with law enforcement agencies in order to receive this examination. The goal of this federal statute is to increase the numbers of sexual assault victims receiving medical/evidentiary examinations and to give victims the time and the opportunity to consider reporting the crime to law enforcement.

A Cal OES *Informational Bulletin* issued January 2012, was developed jointly by the California Office of Emergency Services, California Police Chiefs Association, California State Sheriffs Association, California District Attorneys Association, California Coalition Against Sexual Assault, and the California Clinical Forensic Medical Training Center and posted on their respective websites with updates. The *Informational Bulletin* provides detailed directions about how to handle various issues related to exams in which the victim chooses not to engage or cooperate with the local law enforcement agency.

A new sexual assault forensic medical report form was developed in response to the VAWA mandate, called the Cal OES 2-924: Abbreviated Adult/Adolescent Sexual Assault Forensic Medical Report Form in which only perishable evidence is collected. See www.ccfmtc.org for the *Informational Bulletin* and for the Cal OES 2-924 form and instructions. As a practical matter, many law enforcement agencies have decided to continue requesting SAFE/SANE teams to use the Cal OES 2-923 form to avoid any real or perceived problems that could develop later.

Sexual Assault Forensic Medical Examinations at Developmental Centers and State Hospitals

The Welfare and Institutions Code was amended in 2015 to address the need for sexual assault forensic examinations for persons residing in the state's developmental centers and state hospitals. The statute addresses investigators at developmental centers and state hospitals, local law enforcement agencies, and sexual assault examiners, as well as the exams performed at the SAFE/SANE exam facility or, for reasons of patient safety, at the developmental center or state hospital, if it has proper equipment.

Residents of Developmental Centers—Welfare and Institutions Code Section 4427.7:

- (a) Designated investigators of developmental centers shall request a sexual assault forensic medical examination for any resident of a developmental center who is a victim or reasonably suspected to be a victim of sexual assault, as defined in Section 15610.63, performed at an appropriate facility off the grounds of the developmental center in accordance with Sections 13823.5 to 13823.12, inclusive, of the Penal Code, which includes, but is not limited to, the requirement that the law enforcement agency having jurisdiction over the city or county in which the developmental center is located be notified by the person performing the sexual assault forensic medical examination and that consent is obtained as required by subdivisions (a) and (c) of Section 13823.11 of the Penal Code.
- (b) The sexual assault forensic medical examination described in subdivision (a) may be performed at a developmental center by an independent sexual assault forensic examiner designated to perform examinations of victims of sexual assault in the jurisdiction of the developmental center only if it is deemed safer for the victim and the developmental center's examination facilities are equipped with forensic examination and evidence collection capability comparable to that of the designated community examination facility, as determined by the independent sexual assault forensic examiner.

Residents of State Hospitals—Welfare and Institutions Code Section 4313.5:

- (a) Designated investigators of state hospitals shall request a sexual assault forensic medical examination for any resident of a state hospital who is a victim or reasonably suspected to be a victim of sexual assault, as defined in Section 15610.63, performed at an appropriate facility off the grounds of a state hospital in accordance with Sections 13823.5 to 13823.12, inclusive, of the Penal Code, which includes, but is not limited to, the requirement that the law enforcement agency having jurisdiction over the city or county in which the state hospital is located be notified by the person performing the

sexual assault forensic medical examination and that consent is obtained as required by subdivisions (a) and (c) of Section 13823.11 of the Penal Code. (b) The sexual assault forensic medical examination described in subdivision (a) may be performed at a state hospital by an independent sexual assault forensic examiner designated to perform examinations of victims of sexual assault in the jurisdiction of the state hospital only if it is deemed safer for the victim and the state hospital's examination facilities are equipped with forensic examination and evidence collection capability comparable to that of the designated community examination facility, as determined by the independent sexual assault forensic examiner.

Develop Policies Regarding Performance of Suspect Exams

Hospitals and SAFE/SANE teams are not required to conduct suspect exams. It is, however, in the best interest of the community if these exams are performed locally. Prior agreements and protocols should be established between local law enforcement agencies, SAFE/SANE teams, hospitals, or contracted professionals to conduct these examinations and to ensure coordination.

If suspect exams are provided by the SAFE/SANE team:

- Develop procedures to ensure that victims do not come in contact with the suspect if the exams are conducted at the same time at the same facility.
- Develop back-up procedures to ensure that the same examiner does not perform both the victim and the suspect exam. (This is a best practice, but may not be realistic in some jurisdictions.)
- Consult the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims* for guidance on conducting suspect exams. There is now a required suspect exam form Cal OES 2-950: Forensic Medical Report: Sexual Assault Suspect Examination and instructions for performance of these exams. This form can be obtained at www.ccfmtc.org and www.caloes.ca.gov.
- CCFMTC has developed a training DVD and online course through the University of California, Davis Extension program for performing these exams.

Develop Evidence Storage and Pick-Up Procedures

Law enforcement officer waiting time can be reduced and officers can return to duty more quickly, if evidence can be stored for later pick up by law enforcement or an evidence technician. Historically, the law enforcement officer has waited for swabs to dry (mandatory

one hour required for swab drying box) and personally transported the evidence. With storage procedures, the forensic medical examiner packages and locks the evidence in a dry storage area or a designated refrigerator for later pick up.

In some jurisdictions, an evidence technician from the crime laboratory picks up the Sexual Assault Evidence Kit on a daily or weekly basis. Chain of custody evidence storage and transport procedures must be worked out collaboratively with the local police departments, the sheriff's department, the district attorney's office, and the crime laboratory. Consult the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims* for detailed instructions pertaining to collection and preservation of evidence and chain of custody of evidence. (See Chapter 9, Crime Laboratory Component.)

Develop Policies for SAFE/SANE Team as Expert Witness Versus Percipient Witness

Sexual assault forensic medical examiners are expected to participate in the judicial process as part of their professional responsibility. They may be reimbursed for expert witness testimony at locally negotiated rates. This policy also needs to address whether the SAFE/SANE team examiner receives the reimbursement directly or whether the reimbursement is sent to the program employing the examiner, if the examiner is testifying during hospital or agency time.

There is an important distinction between an expert witness and a percipient witness, and a difference in reimbursement. An expert witness renders opinions on interpretation of findings, photographs, examination, and chain of custody procedural questions, and the scientific evidence-based literature. A percipient witness is a person who testifies regarding their observations as if they were a witness to an event, not an expert rendering an opinion. Examples of questions directed toward percipient witnesses are: Did you follow standard examination procedure? Did you properly document chain of custody? Did you sign the form?

Determination as to whether a person is considered an expert or not is made by the court after the deputy district attorney and defense attorney present and ask questions of the person about his or her experiences and qualifications.

Develop Agreements Regarding Transportation Between Jurisdictions and Hospitals

If the sexual assault crime is committed in one law enforcement jurisdiction, and the victim is dropped off in another jurisdiction and brought to the hospital or examination facility, courtesy telephone notification about performance of the examination is needed. If, for any reason, the victim needs transportation to another hospital, law enforcement should provide the transportation or the transportation should be provided by ambulance, if the patient is not ambulatory.

Policies also need to be developed to address circumstances such as a patient presenting at a local hospital that has no SAFE/SANE team and for patients who are not medically stable enough to be transferred to an exam facility with a SAFE/SANE team.

Consider the Need for Interpreters Based Upon the Needs of the Community

Planning for the forensic medical exam team should include the need for interpreters. Many hospitals have interpreters on staff or on-call for most languages spoken in the community. Contact the hospital's department of social services or the manager of the emergency department to assess what resources are available. Law enforcement and investigative social service agencies (e.g., Children's Protective Services) usually have interpreter services. Independent SAFE/SANE teams need to work out the need for interpreters with local law enforcement agencies.

Patient Rights, Consent, and Incapacity to Give Informed Consent

See Appendix D.

Training Resources

For a listing of current training resources, visit www.ccfmtc.org

- Comprehensive Sexual Assault Forensic Examiner Training
- Forensic Photography Training
- Courtroom Communications Training
- Medical Directors and Medical Coordinators Courses
- Comprehensive Child Sexual Abuse Examiner Training
- Advanced Training on Child Sexual Abuse Medical Evidentiary Exams
- *Compassionate Care: An Overview of the Sexual Assault Forensic Medical Examination for Healthcare Providers* DVD (available in English and Spanish)
- *Compassionate Care: An Overview of the Sexual Assault Forensic Medical Examination for Criminal Justice Professionals and Victim Advocates* DVD (available in English and Spanish)
- *The Sexual Assault Forensic Medical Examination: An Overview of the Suspect Exam* DVD
- *Sexual Assault Forensic Medical Examination: Procedures and Techniques* DVD
- *Examination Techniques for Medical Professionals in Cases of Child and Teen Sexual Abuse* DVD
- Webinars on sexual assault forensic medical exams and related topics for healthcare providers and other professionals, broadcast live and subsequently stored in an electronic library
- *Developing and Maintaining SAFE/SANE Team Programs*
- Suspect Exam online course through the University of California, Davis Extension program
- Sexual Assault Forensic Medical Glossary of Terms and Definitions (expected publication date September 2016)

Chapter 7: Rape Crisis Center Counseling and Advocacy Component

The roles of the rape crisis center on the SART are to:

- provide leadership advocating for the needs and rights of survivors at the systems and individual levels of intervention; and
- actively participate in solving systems issues, team education, strategic planning, and community relations related to the SART team.

Continuity of Care 24/7

Rape crisis center counselors and advocates provide continuity of care from the first contact to case closure, and after case disposition. Wrap-around counseling, supportive accompaniment services, information and clarification about investigative and forensic medical exam procedures, and community resources are provided 24 hours, 7 days a week.

Importantly, rape crisis center counselors and advocates also provide counseling and supportive assistance to survivors who never report the crime. The role of rape crisis counselors and advocates is to help survivors heal and reclaim personal strength regardless of whether they participate in the criminal justice process or whether the case moves forward in that system.

Counselors and advocates support the survivor prior to and after the investigative and forensic medical exam procedures are completed, whether or not a suspect is apprehended; whether or not charges are filed, the case goes to trial, or there is a conviction; and whether or not the defendant is sentenced to state prison, county jail, or is released. Continuous emotional support throughout this process assists with the continued participation of the survivor in the criminal justice system process of hearings and trial.

After a sexual assault, Post-Traumatic Stress Disorder (PTSD) (also known as Rape Trauma Syndrome) may persist for months and even years. (See Chapter 14: Trauma Reduction for a description of PTSD.) For this reason, crisis intervention, supportive services, and follow-up counseling are essential to every sexual assault survivor. Immediate services and duration are key elements to crisis resolution. These services are invaluable community resources

and are essential to address the aftermath of sexual assault and to facilitate the recovery and well-being of the survivor.

Moving Beyond “Silos” of Intervention

Every discipline—law enforcement, forensic medicine, and legal—has its history, procedures, best practices, and training. Broad in scope and depth of detail, the professional development of these fields tends to cause individuals and teams to operate in “silos.”

Imagine the sexual assault victim, however, entering a bewildering array of silo systems, after having been physically and psychologically traumatized. Rape crisis center counselors and advocates realize that survivors need help participating in these systems, and support them to avoid becoming overwhelmed, re-victimized, confused, or disillusioned.

Counselors and advocates assist victims and facilitate their return to their previous levels of functioning based on the following skills and abilities:

- broad knowledge and ability to negotiate the various systems with which the survivor must interact, e.g., law enforcement agencies, forensic medical examination teams, hospital facilities, criminal justice system, educational institutions, and workplace environments;
- ability to provide information about needed resources and referrals;
- ability to negotiate, navigate, coordinate, integrate, and case manage the victim’s experience of various systems; and
- commitment toward moving the person from victim to survivor, to transcending the experience so that it does not become a life-defining event, and to facilitate the psychological shift from victim to survivor.

The coordination, integration, and management of the post-rape experience is extremely important for sexual assault survivors. Otherwise, victims experience the intense, time-limited focus of each silo. For this reason, it is essential that survivors have an objective and informed support person who can help navigate the array of silos, and through psychological stages of trauma recovery. Survivors who are routinely informed about the process are more likely to stay involved and participate. Continuity of system advocacy is particularly helpful

to the survivor because this means there is one person who knows the full scope of what the survivor has experienced.

Victim Advocacy Is Public Policy in California

Rape crisis centers have sought and achieved many public policy changes and rape law reform. One of many positive outcomes is the codification of the role of the sexual assault victim counselor and advocate. (See the summations at the end of this chapter for important laws relating to required notification by law enforcement about a sexual assault to the local rape crisis center, victims' rights to a support person, counselor–client privilege, provision of client support at interviews, and support of victims at trial.)

Key Intervention Entry Points for Advocates

- **24-Hour Crisis Line**—The historic beginnings of rape crisis centers focused on the provision of a 24-hour crisis line and crisis intervention. The purpose of this service is to provide crisis intervention services for survivors of sexual assault, and their family or friends, 24 hours a day, 7 days a week.

From this entry point, a survivor who calls the crisis line speaks with a trained rape crisis counselor advocate and makes decisions about whether he or she will meet the advocate, report the crime to law enforcement, and go to a hospital for examination of injuries and collection of evidence. Many survivors who contact a confidential 24-hour crisis hotline decide that they will not report to law enforcement, and prefer the anonymity of a crisis line. This is why complete community sexual assault statistics should reflect non-duplicate calls to the local rape crisis center.

- **During the Forensic Medical Examination**—The rape crisis center advocate provides emotional support for the survivor during the interview and the examination, provides clarifying information, and advocates for prompt, compassionate sexual assault forensic medical exams. This includes advocating for qualified personnel trained in sexual assault forensic medical examination procedures to perform the exam locally.

The advocate must not in any way participate in the forensic examination process (e.g., taking the history, handling evidence, or holding the ruler for the photographer). Doing

so prevents the advocate from attending to the survivor, creates role confusion for the survivor, and jeopardizes the client-counselor confidentiality privilege because the advocate becomes part of the investigation process.

It is critical for SAFE/SANE team examiners to develop rapport with patients and obtain their trust and confidence. The history-taking portion of the examination is critically important and includes asking sensitive questions about sexual acts. This information is essential because the history guides the forensic medical examination. Advocates can clarify questions asked by the examiner to the victim; however, they cannot clarify answers from the victim to the examiner or construct the answers for the victim.

Rape crisis centers often arrange for clothing and toiletries to be stored at examination sites to provide a change of clothing or bring sweat suits for survivors to the hospital. Advocates also provide supportive counseling, procedural information, and follow-up services to enable the family to cope with the event. In some situations, additional advocates may need to be called in to provide services to family and friends to help them gain an understanding of sexual assault and how to be supportive of the survivor.

- ***During the Law Enforcement Investigation***—The role of the rape crisis center advocate is to provide emotional support for the survivor during the law enforcement investigation and to facilitate communication between the law enforcement officer and the survivor. The rape crisis center advocate can serve as a bridge for law enforcement by explaining procedures and responding to questions that the survivor and family may not feel comfortable asking. The advocate accompanies the survivor to interviews or photo line-ups. The advocate serves as a sounding board for survivors and their families if the law enforcement investigation does not meet their expectations. The advocate explains procedures and facilitates survivors speaking to detectives and describing their feelings about how things are going from their point of view. This prevents frustration and reduces anxiety for survivors.
- ***During Investigative Interviews and Judicial Proceedings***—The role of the advocate is to provide information and other support during interviews with detectives,

district attorney investigators, the prosecutor, and during court hearings. As with law enforcement, they can explain procedures or facilitate survivors speaking to prosecutors about how things are going from their point of view, preventing frustration and reducing anxiety for survivors. Sometimes survivors call the rape crisis hotline in the middle of the night out of anxiety over impending proceedings. This is part of the 24/7 support system for the survivor.

Counseling Support and Advocacy: What Does This Mean?

This means to listen and empathize with the survivor's feelings; reduce the isolation of the experience by informing, explaining, clarifying, and supporting; ensure that the survivor's needs are met to the fullest extent possible; aid with practical issues and concerns; and assist the survivor in dealing with others such as family, law enforcement officers, medical examiners, legal personnel, and any other system that the survivor may be engaging throughout the duration of the case.

The counselor/advocate's mission is to attend to the survivor, provide unconditional support and acceptance, ensure that the survivor's rights are protected, and that the survivor is treated with respect throughout the process. The counselor/advocate is the only person not involved in investigating facts, collecting and packaging evidence, or prosecuting the alleged perpetrator of the crime.

Counselor/advocates **should never** serve as interpreters. This prevents the advocate from attending to the survivor, creates role confusion for the survivor, and eliminates the client-confidentiality privilege. Complete SART planning includes attention to whether trained interpreters are available to law enforcement agencies, the district attorney's office, and to the SAFE/SANE team consistent with community demographics. It is critical that the SART as a whole be responsible for identifying and obtaining interpreter resources to ensure competent services for all survivors.

Three intervention principles are:

- *"Start where the client is"* — This means to address the survivor's concerns, and not arrive with preconceived notions of what she may be thinking or feeling. The

survivor's focus may not be about feelings and reactions to the sexual assault. It may be about, "who can pick up the kids and take them to a friend or relative's house" or "how am I going to deal with my parents." Sometimes survivors feel they must, out of necessity, put aside their personal feelings and focus on these practical life issues.

- *"It should feel like help"* — This means using intuition and experience to understand the spoken and unspoken needs of the victim, expressing empathy, helping the survivor at the level on which she is functioning with a goal to move her feelings and coping skills forward at her own pace. Moving faster than the victim's pace can cause a disruption in the connection between the victim and advocate. It is important to remember that she is most likely feeling overwhelmed. For the victim, the experience may be surreal. She does not want to be there. She wants her regular life back. The advocate helps her understand the process, provides support, and helps make the process manageable and less overwhelming.
- *"People always remember how you made them feel."*

Provision of In-Person Counseling

Counseling is essential to the healing process for survivors. Rape crisis centers provide follow-up counseling and periodic assessments of each client's needs. Research shows that counseling reduces the impact and duration of Post-Traumatic Stress Disorder. It may mean individual counseling, group counseling, or family counseling. The provision of supportive counseling is not always a formal process; it may be a 20-minute meeting before going into the courtroom.

Rape crisis centers may provide support groups or make arrangements for the provision of these groups through other agencies or therapists in the community. Support groups can be a successful approach due to the concept of "universality." Universality describes the experience of being in a supportive group of people who have had the same experience. Sharing the nature of the experience, the significance and meaning to one's life, and how it has psychologically, socially, and logistically impacted life in various ways, brings relief. This intervention approach can enable survivors to see that sexual assault has not only happened to them but to others as well. By describing and discussing the experience and by expressing their feelings about it with other survivors, they may be better able to move forward with

their lives. Adolescents, especially, describe the group support approach as a successful method for meeting their emotional needs for trauma resolution and emotional support. Some adolescents and elementary-age children are not comfortable in one-to-one counseling and feel empowered by group counseling.

Signs Indicating Need for Psychiatric Support for the Client

Some survivors may experience a level of psychological trauma that requires the assistance of licensed professionals (e.g., psychiatrists, psychologists, licensed clinical social workers, or licensed marriage and family therapists). A survivor may have a past or current mental health history, past traumatic victimization experiences, or the sexual assault can precipitate psychiatric symptoms or suicidal ideation.

Sound intervention involves being alert to the possibility of:

- a previous psychiatric or mental health history;
- psychotic symptoms such as hallucinations, delusional thinking, or bizarre ideation;
- suicidal ideation or attempts;
- risk-taking (high-speed driving, placing themselves in vulnerable or high-risk situations) and self-destructive behavior;
- serious, immobilizing depression;
- severe anxiety and panic attacks; and
- isolation by the victim away from family and friends.

Rape crisis centers should have an established relationship with local psychiatrist(s), the county mental health department, or mental health professionals knowledgeable about Post-Traumatic Stress Disorder as it relates to sexual assault. It is better to have an established relationship with a psychiatrist for evaluation and medication support than to have to find one in a crisis. Sound practice is to provide survivors with three referral sources, if possible. (See Chapter 14: Trauma Reduction.)

Service Standards for the Operations of Rape Crisis Centers

Service standards for the operations of rape crisis centers funded by Cal OES can be downloaded from the CALCASA website at www.calcasa.org. The service standards for

Cal OES-funded rape crisis centers are:

- 24/7 telephone crisis line;
- business hours;
- crisis intervention services;
- follow-up services within three working days after the first contact;
- minimum of 45 percent of clients/survivors must receive follow-up services;
- individual counseling services;
- group counseling services either in-house or by referral;
- accompaniment services on a 24-hour basis to hospitals, law enforcement agencies, the district attorney's office, court proceedings, and other agencies, if indicated;
- advocacy services on a 24-hour basis (advocacy is defined as intervening with agencies or individuals on behalf of the sexual assault survivor);
- information and referral;
- community education programs;
- training for agencies that interact with sexual assault survivors; and
- directly assist or refer survivors to the county victim/witness assistance center or private attorneys for assistance in the preparation of victim crime compensation claims.

The term "advocate" refers to both volunteers and employed staff:

- *Volunteers as Advocates* — Volunteers are trained to be counselors and advocates staffing the crisis line and providing accompaniment services. These advocates receive a minimum of 40 hours of training and have on-going training requirements. They are usually supervised by a coordinator who recruits, hires, trains, and supervises the counselors and advocates.
- *Employed Staff as Advocates* — Some programs are able to employ staff as counselors and advocates. They must also meet the minimum 40-hour statutory training requirement.

Training Requirements for Advocates

Rape crisis center supervisors and advocates are required to have a minimum of 40 hours of training consistent with Cal OES training requirements. (Evid. Code § 1035.2.) Many centers

provide 60–70 hours of initial training. Provision of continuous on-going training is also required. To ensure compliance with the law providing client-counselor privilege for rape crisis center advocates, a certificate is issued by the rape crisis center regarding completion of this training.

The training curriculum must include, but is not limited to, the following subject areas: Overview of Sexual Assault; Discrimination and Oppression; Child Sexual Abuse; Teen Sexual Abuse/Assault; Rape Trauma Syndrome; Crisis Intervention and Counseling Techniques; Referral Resources; Community Collaboration and Coordinated Response; Medical, Law Enforcement, Criminal Justice/Legal Procedures; Documentation; Agency Procedures; Victim Rights and Victim Advocacy; Client and System Advocacy. (For curriculum content, see Cal OES Sexual Assault Training Certification.) In addition, human relations training must be provided annually about groups that have experienced prejudice and discrimination on the basis of race, sex, age, class, religious belief, disability, or sexual orientation and the effect of such practices.

To function effectively, advocates must have knowledge in these broad areas:

- forensic medical examination procedures, law enforcement investigation procedures, and criminal justice system legal procedures in order to provide information, explanations, and clarification;
- knowledge about the misconceptions and facts of sexual assault, and how they will affect the survivor, friends, relatives, and significant others. This includes the concept of attribution of responsibility (victim blaming) in which people seek to attribute responsibility to actions on the part of the victim as a way of distancing themselves from the possibility of sexual assault happening to them;
- knowledge about the variety of reactions of survivors and family members to the sexual assault during, immediately following, and subsequent to the experience;
- knowledge about Rape Trauma Syndrome (also called Post-Traumatic Stress Disorder) and principles of crisis intervention;
- intuitive ability to be empathetic and to extend oneself to another at a time of crisis; and
- knowledge of community resources and how to make referrals.

Supervision of Counselors and Advocates, and Case Management

Adequate supervision of advocates is essential to ensure consistent quality of services. Advocates are supervised by center staff. This includes a system that requires contact between staff and advocates within the time frame outlined in the volunteer policies of the individual agency. The purpose of the contact is to report having provided intervention services and to discuss actions taken or methods of proceeding. Advocates engage in regular case consultation with their supervisors.

Sexual Assault Counselor Privilege

Communications between survivors and sexual assault counselors are privileged under California law. This means that sexual assault counselors cannot disclose their conversations and communications with survivors unless the survivor waives the privilege or the counselor is compelled by a finding of the court. This privilege contributes to a feeling of security and trust between survivors and counselors, as well as empowers survivors by giving them choice to disclose or not. Survivors should be well informed of when and with whom sexual assault counselor privilege applies. Rape crisis center sexual assault counselors should discuss confidentiality and privileged communications with survivors early on in the provision of services.

Prohibit the Use of Advocates as Language Interpreters

Advocates **should not** serve as language interpreters for law enforcement, the medical team, or any other entity that is interacting with the survivor throughout the duration of the case and beyond. Interpreting creates a dual role. It prevents advocates from attending to the survivor, creates role confusion for the survivor, and jeopardizes the client-confidentiality privilege. It places advocates into a role as an “extension” of law enforcement and the SAFE/SANE team. In addition, this practice has the potential of creating liability issues for the hospital and the law enforcement agency investigating the case. Advocates do not have training as interpreters for medical and legal procedures.

Vertical Advocacy

Vertical advocacy means continuity of care from beginning to case closure, providing client wrap-around services, coordination, and case management by a single advocate. The rape

crisis center provides advocacy to the survivor throughout the process beginning with the first contact for assistance. Vertical advocacy includes: crisis intervention counseling; accompaniment services at the hospital and during the investigative and prosecution procedures; follow-up counseling; assistance with logistical problem solving (e.g., childcare, employer relations, schools and teachers, family members); and assistance engaging systems outside the criminal justice system.

Other Advocacy Roles

Rape crisis centers assist survivors in many circumstances such as:

- providing individual or group counseling and advocacy services when the survivor resides in juvenile hall, an adolescent group home, a nursing home, a psychiatric facility, and regional centers serving the developmentally disabled;
- assisting survivors to obtain temporary restraining orders;
- providing accompaniment services to civil as well as criminal proceedings;
- assisting survivors in obtaining on-going medical follow-up; and
- providing assistance in the preparation of written and verbal victim impact statements at sentencing hearings. [Preparation and submission of victim impact statements is often a highly therapeutic process in which the survivor describes the impact of the sexual assault upon her life. The process can enable the survivor to release feelings and begin the healing process.]

Information and Referral Services

Centers respond to requests for information from survivors, the general public, and schools. They also provide referrals to a broad range of community resources needed by survivors.

Community Education and Sexual Assault Prevention Programs

Rape crisis centers provide community outreach, education, sexual assault prevention programs, and self-defense programs. These programs are offered routinely throughout the year. Such programs are also offered at times of a community crisis such when a serial rapist is at large. In this situation, there is considerable fear in the community and at the schools. Rape crisis centers respond by providing immediate community education programs, large and small group meetings, and self-defense classes.

System Advocacy and Training for Professionals

The history of rape crisis centers is to identify needs for system change on behalf of survivors and to train professionals on these issues. Rape crisis center advocates see the system through the eyes of the survivor and propose ideas to improve the system for the benefit of all survivors. Rape crisis centers help public agencies gain and maintain a “client or victim centered” perspective. In addition, rape crisis centers provide training for law enforcement officers, prosecutors, medical professionals, and others about a range of topics (e.g., myths and facts about rape, rape trauma syndrome, survivor needs).

Professional Organization for Rape Crisis Centers

California Coalition Against Sexual Assault (CALCASA)—CALCASA provides technical assistance to rape crisis centers; training to rape crisis centers on crisis intervention, counseling, advocacy, non-profit management and leadership, and a range of issues relating to sexual assault; a comprehensive library; media advocacy and support; and public policy and legal advocacy.

Training Resources

CALCASA—Publications available at <http://www.calcasa.org/resources/publications> include *Support for Survivors Training Manual and Updates* | *Student Safety, Justice and Support: Policy Guidelines for Campuses Addressing Sexual Assault, Domestic/Dating Violence, and Stalking* | *Counseling Tools for the Prevention and Reduction of Post Traumatic Stress Disorder* | *Sharing Our Strengths* | *Sexual Assault Training Standards: A Trainer’s Guide* | *CALCASA’s Information Packet Series* | *Cal OES Service Standards for Rape Crisis Centers*.

California Clinical Forensic Medical Center—*Compassionate Care: An Overview of the Sexual Assault Forensic Medical Examination for Criminal Justice Professionals and Advocates* is a training DVD produced by CCFMTC. It can be obtained at www.ccfmtc.org.

Relevant State Laws for Rape Crisis Centers

Summaries of these laws are provided below. Actual statutory language can be obtained by typing the phrase “California Penal Code” followed by the section number into an Internet

search engine. Since statutes are subject to legislative amendments, it is best to review the actual code section to be aware of updates.

- ***Statutory requirements for rape crisis centers funded by the California Office of Emergency Services***—Penal Code section 13837 requires sexual assault services programs funded by the California Office of Emergency Services to provide these services: crisis intervention 24/7; follow-up counseling services; in-person counseling including group counseling; accompaniment services; advocacy services; information and referral to victims and the general public; community education presentations; rape prevention presentations; and self-defense programs.
- ***Notification of rape crisis center by law enforcement and provision of client support during medical/evidentiary exam***—Penal Code section 264.2 requires law enforcement to immediately notify the local rape crisis center when any victim of sexual assault is transported to a hospital for a sexual assault medical evidentiary or physical examination. Victims of sexual assault have the right to have a victim advocate and a support person of their choosing present during the medical evidentiary examination. Victims must be notified of this right prior to the commencement of any medical evidentiary examination. A support person may be excluded from a medical evidentiary or physical examination if the law enforcement officer or medical provider determines that the presence of that individual is detrimental to the purpose of the examination
- ***Sexual assault victim counselor defined***—Evidence Code section 1035.2 defines a sexual assault victim counselor as a person who is engaged in any office, hospital, institution, or center commonly known as a rape crisis center for purposes of providing advice or assistance to sexual assault victims *and* who received a certificate evidencing completion of the 40-hour training program issued by a counseling center that meets the criteria for the award of a grant pursuant to Penal Code section 13837. Minimum training is specified in Penal Code section 13835.10. The person must be supervised by an individual who qualifies as a counselor pursuant to this statute or is a master’s level clinician with one year of counseling experience, at least six months of which is in rape crisis counseling.

- ***Counselor client privilege***—Evidence Code sections 1035–1036.2 provide a client confidentiality privilege or “confidential communication” between the sexual assault counselor and the victim. The victim is the holder of the privilege. Eligibility to participate in the client confidentiality privilege is conferred upon those who are employed or who volunteer at a rape crisis center, have completed 40 hours of training certified by Cal OES, and have received a certificate evidencing completion of the required training program.
- ***Provision of client support at interviews***—Penal Code section 679.04 provides that a victim of sexual assault has the right to have a sexual assault victim advocate and a support person of the victim’s choosing present at any interview by law enforcement, district attorneys, or defense attorneys. Victims must be notified of this right prior to the commencement of any interview. A support person may be excluded from an interview if it is determined that the presence of that individual would be detrimental to the purpose of the examination. An initial investigation by law enforcement to determine whether a crime has been committed and the identity of the suspect(s) shall not constitute a law enforcement interview.

[A “victim advocate,” as defined in Penal Code section 679.04(a), means “a sexual assault victim counselor, as defined in Section 1035.2 of the Evidence Code, or a victim advocate working in the center established under Article 2 (commencing with § 13835) of Chapter 4 of Title 6 of Part 4.” A rape crisis center advocate has professional standing, is recognized in various state laws, and has received specified training prescribed by state law. The victim advocate provides crisis intervention, educational information regarding criminal justice and forensic medical exam procedures, advocacy, and emotional support. A support person means a friend or relative providing an emotionally supportive presence for the survivor.]

- ***Provision of client support at trial***—Penal Code section 868.5 provides that a victim is entitled to the attendance of up to two persons of his or her own choosing at the preliminary hearing and at trial, and during testimony. Only one of those support persons may accompany the witness to the witness stand and the other

may remain in the courtroom during the testimony. If the case is a juvenile court proceeding, the judge shall inform the support person or persons that the proceedings are confidential and may not be discussed with anyone. Support persons may not prompt, sway, or influence the witness in any way, and can be removed from the proceedings if it appears as though they are.

- ***Victim's Bill of Rights Act of 2008: Marsy's Law***—See California Attorney General Victims' Services Unit website at http://oag.ca.gov/victimservices/marsys_law for a description about how victims' rights have been expanded. Or use an Internet search engine with the phrase "Marsy's Law".

Chapter 8: Law Enforcement Component

Law enforcement is an essential SART partner and its role is to:

- be fully engaged and support SART at the patrol, investigative, and executive levels of the agency;
- attend regularly and actively participate in SART meetings and case review;
- participate in training SART partners; and
- develop policies, procedures, and agency cultural norms that institutionalize SART throughout the entire law enforcement system for the city and county.

Role and Responsibilities of Law Enforcement

Law enforcement's mission is to protect and serve the public, investigate crimes, identify and apprehend perpetrators, and prepare investigative reports. In California, there are more than 400 city police departments, 58 county sheriff's departments, 58 county district attorney's offices, and several city attorney's offices. Many have specialized sexual assault units.

Law enforcement officers evaluate sexual assault cases in the context of the criminal laws contained in the Penal Code. Their objective is to reassure the victim that she is safe, obtain a factual and comprehensive history of the assault, collect and preserve evidence, conduct investigations, prepare reports, and submit investigative reports to the district attorney's office. The district attorney's office makes the determination about whether to file criminal charges on the case.

The investigative objectives are to:

- determine if a sexual assault occurred;
- determine location and jurisdiction of the assault;
- determine who is responsible;
- collect and preserve evidence;
- identify and apprehend suspects;
- arrest where probable cause exists;
- assist the district attorney in the prosecution of cases; and
- provide testimony and evidence in court.

Victim Rights Requirements in State Law

Law enforcement officers shall:

- Apprise the victim of his or her legal right to have a victim advocate and a support person at any interview by law enforcement officers, district attorneys, or defense attorneys. *Note:* The initial investigation by law enforcement to determine whether a crime has been committed and the identifying of the suspects shall not constitute a law enforcement interview. (Pen. Code § 679.04(a).)
- Apprise the victim of her or his legal right to have her or his name kept confidential. (Gov. Code § 6254.)
- Immediately notify the local rape victim counseling center whenever a victim of any alleged violation of sexual assault is transported to a hospital or exam facility for any medical evidentiary or physical examination. (Pen. Code §§ 264.2 and 264(b)(1).)
- Notify the sexual assault victim of the right to have a sexual assault victim counselor and at least one other support person of the victim's choosing present at any medical evidentiary or physical examination. (Pen. Code § 264(b)(1).)

Federal VAWA and California Statute Regarding Victim Cooperation with Law Enforcement

The federal Violence Against Women Act (VAWA) legislation eliminates requirements for victims to cooperate with law enforcement agencies as a condition of receiving a sexual assault forensic medical examination at public expense. California law was amended and brought into compliance with VAWA effective January 1, 2012. (Pen. Code § 13823.95(b).)

Published in January 2012, Cal OES 2-924: Abbreviated Adult/Adolescent Sexual Assault Examination Forensic Medical Report was developed for use for these exams and only requires collection of perishable evidence. **Use of the Cal OES 2-924 form is optional, and the Cal OES 2-923 Forensic Medical Report form can be used for these exams as well.** Many law enforcement agencies have made the decision to use the Cal OES 2-923 for all exams to avoid any potential problems.

The Cal OES 2-924 Forensic Medical Report and instructions are available online at www.ccfmtc.org and www.caloes.ca.gov.

Payment for Collection of Forensic Medical Sexual Assault Evidence

California state law requires law enforcement agencies to pay for sexual assault forensic medical examinations. Penal Code section 13823.95 states that no costs incurred by a qualified health care professional, hospital, or other emergency medical facility for the examination of a victim of a sexual assault, as described in the protocol developed pursuant to sections 13823.5 and 13823.7 for the purposes of gathering evidence for possible prosecution, shall be charged directly or indirectly to the victim of the assault. These costs shall be treated as local costs and charged to the local governmental agency in whose jurisdiction the alleged offense was committed. Bills for these costs shall be submitted to the law enforcement agency in the jurisdiction in which the alleged offense was committed and which requests the examination. The phrase “indirectly charged” is defined in the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Assault Victims* as a third-party payer such as private or public insurance (e.g., Medi-Cal or Medicaid).

Basic Elements of Law Enforcement Investigation

Phase One: Immediate Intervention

Responsibilities of the patrol officers as first responders are to:

- ensure the victim’s safety;
- evaluate the need for emergency medical care;
- evaluate the need for additional units and supervisor;
- check for possible suspects and consider the need for a crime broadcast;
- locate and identify witnesses, including friends or family the victim might have called or contacted immediately after the assault;
- conduct a brief preliminary interview of the victim to determine whether and what crimes may have occurred, the location where the crime occurred, and the time/ time frame of the occurrence;
- arrange for a sexual assault forensic medical examination;
- notify hospital triage nurse or SAFE/SANE team (per local protocol);
- evaluate the need for response from investigations unit (detectives);
- evaluate the need for crime scene processing and arrange for the proper personnel to respond (i.e., photos, criminalist, and fingerprints);
- secure the crime scene, if indicated;

- document, collect, and preserve all crime scene related evidence at the earliest appropriate time (i.e., victim's clothing, bedding, video evidence, cellphone text messages, etc.);
- collect the first available urine sample if drug-facilitated sexual assault is suspected (if the victim must urinate prior to arrival at the hospital or exam facility; some jurisdiction's patrol cars carry urine cups for this purpose);
- transport the victim to the hospital or exam facility or permit the victim to be transported by family or a friend;
- request a private waiting area for sexual assault victim, if one is not designated;
- stand-by during the forensic medical exam or return to duty (per local protocol);
- ensure transportation for the victim home or to another residence after the completion of the exam (per local protocol); and
- receive the sexual assault evidence kit and deliver it to the crime laboratory (per local protocol) or ensure that evidence is placed in locked storage at the exam facility (preserving the chain of custody of evidence) for later pickup by a patrol officer or the crime laboratory evidence technician. Per local protocol, patrol officer may take other evidence (i.e., clothing, bags, shoes) to the law enforcement agency evidence storage facility.

The initial handling procedures for suspects, if immediately located, include:

- separating suspects when there are more than one;
- not permitting suspects into the crime scene area;
- preventing communications between all involved parties;
- informing persons of their rights, if questions are being asked about the crime and they are in custody;
- recording statements; and
- photographing suspects' physical appearance, physical injury, torn or stained clothing.

Follow local protocol for sexual assault suspect forensic medical examinations.

- Know how to access the SAFE/ SANE team or other contracted provider for suspect exams.

- Ensure that suspects are examined at locations separate from the victims, or that the exam facility is large enough to prevent them from seeing and having contact with one another.
- Ensure that victim and suspect exams are performed by different examiners, if your jurisdiction has sufficient resources and personnel.
- Follow local protocol for suspects who voluntarily agree to the exam, or obtain a search warrant for suspects who refuse the exam.
- Follow the Cal OES 2-950 Sexual Assault Suspect Medical Report form and protocol.

Phase Two: Coordinated Interview Process Prior to the Sexual Assault Forensic Medical Examination

- In a coordinated interview process, the law enforcement officer will have interviewed the victim and briefed the SAFE/SANE team examiner about the sexual assault.
- Joint law enforcement and SAFE/SANE team examiner interviews are no longer recommended in many counties based upon *Crawford v. Washington* (2004) 541 U.S. 36. Contact your local district attorney's office to learn their position on joint interviews.
- If requested by the victim, the rape crisis center advocate is present to provide vital emotional support during the law enforcement investigative interviews and the forensic medical exam, **but does not ask interview questions or answer for the survivor**. Adherence to these parameters prevents the advocate from becoming part of the investigation and jeopardizing client confidentiality. The advocate stays with the patient for the entire exam unless family or friends are preferred by the victim to provide support.
- The patrol officer either stands-by or returns to duty (per local protocol).
- The SAFE/SANE team examiner interviews the patient pursuant to the patient history sections on the Cal OES 2-923 Forensic Medical Report: Adult/Adolescent Sexual Assault Examination.
- The SAFE/SANE team examiner conducts the forensic medical examination, collects and preserves evidence, documents information on the Cal OES 2-923 Forensic Medical Report form, and provides the patient with written discharge instructions.

Discharge instructions provide information regarding follow-up medical care needed for further evaluation of injuries, forensic follow-up photography, prophylaxis given for sexually transmitted disease, and pregnancy prevention.

- If the SAFE/SANE examiner learns that additional crimes were committed and/or that additional evidence may be located at the crime scene, the examiner will notify law enforcement.

Victim transportation home or to another residence after the forensic medical exam requires discussion and planning. Some of these options include:

- family member or friend transports (optimal);
- rape crisis center advocate provides transportation, if the center has a liability policy for advocates;
- patrol officer waits on stand-by or another patrol officer is called to provide transportation (*Note:* It is important to discuss how a victim may feel about being transported in a patrol car to her neighborhood); and
- cab vouchers, which is the least desirable option since there is no accompaniment, but may be acceptable, if the victim is being transported to family or friends.

When preparing the preliminary investigation report, law enforcement needs to:

- memorialize statements made by victim and witnesses;
- describe distinctive characteristics about the suspect's identification and location—if known and suspect is not in custody;
- prepare a BOLO (Be On the Look Out) alert or an all points bulletin if the suspect is a stranger;
- document victim's condition;
- document condition of clothing (e.g., torn, stained);
- document outward appearance of the victim and other evidence of trauma;
- describe observations about the crime scene; and
- describe any evidence collected from the crime scene or other locations.

Phase Three: Detective Follow-Up

The detective or investigations unit supervisor is notified about the sexual assault.

Depending on the circumstances, a detective may respond to the scene or to the hospital or the sexual assault forensic medical exam facility. The job of the detective is to:

- review the crime report and the Cal OES 2-923 Forensic Medical Report and initial crime report;
- make contact with the victim, and provide support and transportation when necessary;
- interview the victim and verify or clarify the contents of the preliminary investigation, composite sketch, pretext phone call, etc.;
- interview witnesses;
- submit a request to the crime laboratory to analyze physical evidence.
- consult with the crime laboratory on the outcome of the analysis;
- check the crime scene and obtain appropriate photographs;
- attempt to identify the suspect, if the suspect is unknown;
- submit follow-up investigation report to the district attorney's office or city attorney's office, and follow procedures related to the arrest of a suspect, if the suspect is identified and the elements of the crime exist;
- prepare and submit all preliminary and follow-up investigation reports to the district attorney's office;
- provide assistance to the deputy district attorney and victim through the court process (*Note: In some jurisdictions, after the case is filed by the deputy district attorney, the case is assigned to an investigator in the district attorney's office for follow-up investigation, and the detective or law enforcement officer is involved by request*); and
- ensure that victims are informed about their legal rights, especially with regard to any medical attention and the right to have an advocate present.

Law Enforcement Training

Law enforcement officers receive basic academy training prior to working in a law enforcement agency, which covers a broad range of training. Penal Code section 13516 requires that law enforcement personnel have specialized training in the investigation and interview process for sexual assault.

In California, POST (Peace Officers Standards and Training) provides basic and advanced officer training on the investigation of sexual assault on the following topics:

- physical evidence unique to sexual assault cases;
- techniques for interviewing rape victims and the victim's emotional needs;
- techniques for interviewing suspects;
- California sexual assault laws; and
- sexual assault forensic medical examination.

Law enforcement officer training should include information on Rape Trauma Syndrome, also called Post-Traumatic Stress Disorder, and the roles of the SART members. Some California law enforcement agencies provide specialized "first responder" training to patrol officers. The FBI's National Center for the Analysis of Violent Crime (NCAVC) and the FBI National Academy also provide training programs for law enforcement professionals.

Professional Organizations

- California Police Chiefs Association
- California State Sheriffs' Association
- California Sexual Assault Investigators Association

Chapter 9: Crime Laboratory Component

The role of the crime laboratory on the SART is to:

- participate as an active partner in SART by attending monthly meetings;
- provide routine feedback to the SAFE/SANE team regarding quality of forensic medical evidence and completion of “rape kits”;
- provide training regarding the practicalities of evidence collection and preservation, trends being discovered in drug-facilitated rape, and the latest forensic science trends and developments;
- re-evaluate the five-day window for collection of forensic evidence in sexual assault cases together with colleagues statewide to expand this time frame to 7–10 days;
- provide local leadership regarding the performance of suspect forensic examinations to ensure sound procedures; and
- work with colleagues statewide to agree upon a standard rape kit for California, especially given advances in forensic knowledge, experience, and technology.

Role and Responsibilities of the Crime Laboratory

There are 40 public crime laboratories in California—23 city and county laboratories and 13 California Department of Justice, Bureau of Forensic Services laboratories that serve 48 counties. There are also 22 privately operated crime laboratories with similar capabilities. Visit the California Association of Criminalists at www.cacnews.org for contact information for the forensic laboratory serving your community.

The crime laboratory analyzes and interprets evidence collected by medical and law enforcement personnel. Its objective is to provide information useful for identifying or eliminating persons suspected of committing the crime, and reconstructing the events in question. Criminalists also respond to crime scenes, and document and collect evidence.

Forensic scientists evaluate biological evidence, such as semen, saliva, and blood; foreign materials such as hair and fibers; clothing or other evidence from the scene of the crime; and analyze urine and/or blood for the presence of intoxicating substances. The crime laboratory communicates its results to law enforcement investigators through written reports and to

the courts through testimony. Because the recipients of the results are often not scientifically trained, the laboratory bears a special responsibility to provide complete, technically accurate information that is understandable to a lay audience. Forensic scientists are also involved in training law enforcement and medical personnel on evidence-related topics.

Relationships to Law Enforcement Agencies and SAFE/SANE Teams

The crime laboratory has close working relationships with law enforcement agencies and district attorney's offices. In 10 large counties, the crime laboratory is a part of the police or sheriff's department or the district attorneys office.

Sexual assault forensic medical exam teams and hospitals must develop a close working relationship with the local crime laboratory to obtain training and feedback on proper collection and preservation of evidence. An important role of the crime laboratory is to train SAFE/SANE teams and hospitals within their jurisdictions regarding their preferences for evidence collection—what options are available and methods for collection of toxicology and reference samples—and providing feedback forms on the quality of the sexual assault evidence kits.

Types of Evidence Analyzed by the Crime Laboratory

- Clothing and bedding.
- Biological stains and secretions (e.g., semen, blood, saliva).
- Oral, vaginal, rectal samples collected from the victim.
- Foreign bodies used to penetrate victim.
- Hair combings (head and pubic).
- Fingernail scrapings.
- Trace evidence, sometimes called foreign materials (e.g., fibers, vegetation).
- Urine or blood for toxicology.
- Photographs of injuries (including bite marks) and crime scene.
- Potential weapons, bindings, restraints and ligatures used to restrain the victim.
- Evidence materials collected from the suspected assailant.

Why Does the Crime Laboratory Want to Know the Answers to Such Personal Questions?

Previous Consensual Sexual History

This history is relevant for accurate suspect identification. For example, the forensic medical examination requires the collection of vaginal swabs, if there is a history of vaginal penetration. If the victim had consensual intercourse in the past five days and was sexually assaulted by vaginal penetration, the criminalist must be able to distinguish between the seminal contribution of the consensual partner and the alleged perpetrator. The history helps explain seminal collection outcomes and focuses the analysis on the potential suspect. The question is relevant to the following time frames: within the five-day period after the alleged incident for vaginal and anal intercourse, and 24 hours for oral copulation.

Previous and Post-Assault Drug/Alcohol Use

Blood and urine for toxicology are now required to be collected from every patient and specimens submitted to the crime laboratory. Analyze as indicated by the investigation.

The presence of alcohol or drugs in the victim's blood or urine may have legal significance. Alcohol and numerous central nervous system (CNS) depressant drugs (including illegal, prescription, and over-the-counter preparations) have been used to prevent resistance from the victim or impair the victim's memory of the events during an assault. Assaultants can also take advantage of the victim's voluntary consumption of these materials to facilitate the assault. These substances may affect the victim's ability to make rational decisions, or cause the victim to lose consciousness or to have no recollection of events. Analysis of blood or urine may detect these substances, often for several days after the assault.

Collection of toxicology samples is always indicated if the patient shows any of these signs or symptoms: unconscious; exhibits abnormal vital signs; reports ingestion of drugs or alcohol; exhibits signs of memory loss, dizziness, confusion, drowsiness, impaired judgment; shows signs of impaired motor skills; describes loss of consciousness, memory impairment, or memory loss; and reports nausea and/or vomiting.

Hygiene Since the Sexual Assault

This information assists the medical examiner and the crime laboratory to evaluate and analyze information. If the patient showered or doused prior to the forensic medical examination, potential evidence from the body and vagina may be lost. The victim's post-assault cleansing does not mean that a forensic medical exam should not be performed because other types of evidence may be found and documented. Hygiene does not eliminate all evidence; however, there is a lower probability of recovery. *Note:* A Sacramento County case reported successful DNA analysis of underwear washed and dried in a clothes dryer, and a subsequent successful prosecution.

The Impact of DNA Typing

DNA typing has revolutionized the analysis of biological evidence. It is now possible to obtain very discriminating information from a wide variety of biological evidence. This information allows evidence collected from the patient, suspect, or crime scene to be linked. In addition, DNA testing is sufficiently sensitive that valuable genetic information can be routinely obtained from very small or old evidence samples. A much higher success rate is now possible from analyzing small evidence such as fingernail scrapings and saliva samples from bite marks due to DNA typing. At least, three connections can be made with a DNA match: identity of the suspect; bodily and/or sexual contact between suspect and victim; and linkage among the victim, suspect, and crime scene.

The other major advancement is the ability to use DNA typing results as an investigative tool to identify or exclude potential assailants in sexual assault investigations. The California Department of Justice DNA Laboratory maintains a data bank of DNA profiles from persons arrested or charged with a felony offense. It is possible to search a DNA profile from an evidence sample (collected from a victim or crime scene) against the data bank to help identify the perpetrator of a crime. This means that DNA typing results can be used much like fingerprints to help solve serious, violent crimes in California.

DNA Webinars for SAFE/SANE Teams Examiners and Other Professionals

CCFMTTC, the California Department of Justice Bureau of Forensic Services (BFS), and the Sacramento County Crime Laboratory have collaborated to produce several webinars on DNA for SAFE/SANE examiners and other professionals. Visit www.ccfmtc.org to view them in the electronic library.

Sexual Assault Victims' DNA Bill of Rights

Penal Code section 680 was amended to include the Sexual Assault Victims' DNA Bill of Rights, which goes into effect January 1, 2016. The law was enacted to recognize that DNA (deoxyribonucleic acid) and forensic identification analysis are powerful law enforcement tools for identifying and prosecuting sexual assault offenders. Section 680(b)(7)–(j)states:

- (b)(7) In order to ensure that sexual assault forensic evidence is analyzed within the two-year time frame required by subparagraphs (A) and (B) of paragraph (1) of subdivision (g) of Section 803 and to ensure the longest possible statute of limitations for sex offenses, including sex offenses designated pursuant to those subparagraphs, the following should occur:
- (A) A law enforcement agency in whose jurisdiction a sex offense specified in Section 261, 261.5, 262, 286, 288a, or 289 occurred, should do one of the following for any sexual assault forensic evidence received by the law enforcement agency on or after January 1, 2016:
- (i) Submit sexual assault forensic evidence to the crime lab within 20 days after it is booked into evidence.
 - (ii) Ensure that a rapid turnaround DNA program is in place to submit forensic evidence collected from the victim of a sexual assault directly from the medical facility where the victim is examined to the crime lab within five days after the evidence is obtained from the victim.
- (B) The crime lab should do one of the following for any sexual assault forensic evidence received by the crime lab on or after January 1, 2016.
- (i) Process sexual assault forensic evidence, create DNA profiles when able, and upload qualifying DNA profiles into CODIS as soon as practically possible, but no later than 120 days after initially receiving the evidence.
 - (ii) Transmit the sexual assault forensic evidence to another crime lab as soon as practically possible, but no later than 30 days after initially receiving the evidence, for processing of the evidence for the presence of DNA. If a DNA profile is created, the transmitting crime lab should upload the profile into CODIS as soon as practically possible, but no longer than 30 days after being notified about the presence of DNA.
- (C) This subdivision does not require a lab to test all items of forensic evidence obtained in a sexual assault forensic evidence examination. A lab is considered to be in compliance with the guidelines of this section when representative samples of the evidence are processed by the lab in an effort to detect the foreign DNA of the perpetrator.
- (D) This section does not require a DNA profile to be uploaded into CODIS if the DNA profile does not meet federal guidelines regarding the uploading of DNA profiles into CODIS.
- (E) For purposes of this section, a "rapid turnaround DNA program" is a program for the training of sexual assault team personnel in the selection of representative samples of forensic evidence from the victim to be the best evidence, based on the medical evaluation and patient history, the collection and preservation of that evidence, and the transfer of the evidence directly from the medical facility to the crime lab, which is adopted pursuant to a

written agreement between the law enforcement agency, the crime lab, and the medical facility where the sexual assault team is based.

(8) For the purpose of this section, “law enforcement” means the law enforcement agency with the primary responsibility for investigating an alleged sexual assault.

(c)(1) Upon the request of a sexual assault victim, the law enforcement agency investigating a violation of Section 261, 261.5, 262, 286, 288a, or 289 may inform the victim of the status of the DNA testing of the rape kit evidence or other crime scene evidence from the victim’s case. The law enforcement agency may, at its discretion, require that the victim’s request be in writing. The law enforcement agency may respond to the victim’s request with either an oral or written communication, or by email, if an email address is available. Nothing in this subdivision requires that the law enforcement agency communicate with the victim or the victim’s designee regarding the status of DNA testing absent a specific request from the victim or the victim’s designee.

(2) Subject to the commitment of sufficient resources to respond to requests for information, sexual assault victims have the following rights:

(A) The right to be informed whether or not a DNA profile of the assailant was obtained from the testing of the rape kit evidence or other crime scene evidence from their case.

(B) The right to be informed whether or not the DNA profile of the assailant developed from the rape kit evidence or other crime scene evidence has been entered into the Department of Justice Data Bank of case evidence.

(C) The right to be informed whether or not there is a match between the DNA profile of the assailant developed from the rape kit evidence or other crime scene evidence and a DNA profile contained in the Department of Justice Convicted Offender DNA Data Base, provided that disclosure would not impede or compromise an ongoing investigation.

(3) This subdivision is intended to encourage law enforcement agencies to notify victims of information which is in their possession. It is not intended to affect the manner of or frequency with which the Department of Justice provides this information to law enforcement agencies.

(d) If the law enforcement agency does not analyze DNA evidence within six months prior to the time limits established by subparagraphs (A) and (B) of paragraph (1) of subdivision (g) of Section 803, a victim of a sexual assault offense specified in Section 261, 261.5, 262, 286, 288a, or 289 shall be informed, either orally or in writing, of that fact by the law enforcement agency.

(e) If the law enforcement agency intends to destroy or dispose of rape kit evidence or other crime scene evidence from an unsolved sexual assault case prior to the expiration of the statute of limitations as set forth in Section 803, a victim of a violation of Section 261, 261.5, 262, 286, 288a, or 289 shall be given written notification by the law enforcement agency of that intention.

(f) Written notification under subdivision (d) or (e) shall be made at least 60 days prior to the destruction or disposal of the rape kit evidence or other crime scene evidence from an unsolved sexual assault case where the election not to analyze the DNA or the destruction or disposal occurs prior to the expiration of the statute of limitations specified in subdivision (g) of Section 803.

(g) A sexual assault victim may designate a sexual assault victim advocate, or other support person of the victim's choosing, to act as a recipient of the above information required to be provided by this section.

(h) It is the intent of the Legislature that a law enforcement agency responsible for providing information under subdivision (c) do so in a timely manner and, upon request of the victim or the victim's designee, advise the victim or the victim's designee of any significant changes in the information of which the law enforcement agency is aware. In order to be entitled to receive notice under this section, the victim or the victim's designee shall keep appropriate authorities informed of the name, address, telephone number, and email address of the person to whom the information should be provided, and any changes of the name, address, telephone number, and email address, if an email address is available.

(i) A defendant or person accused or convicted of a crime against the victim shall have no standing to object to any failure to comply with this section. The failure to provide a right or notice to a sexual assault victim under this section may not be used by a defendant to seek to have the conviction or sentence set aside.

(j) The sole civil or criminal remedy available to a sexual assault victim for a law enforcement agency's failure to fulfill its responsibilities under this section is standing to file a writ of mandamus to require compliance with subdivision (d) or (e).

Professional Associations

- California Association of Criminalists
- California Crime Laboratory Directors Association

Chapter 10: Prosecution Component

The role of the district attorney's office on the SART is to:

- provide leadership in the development of new SARTs;
- advocate for the enhancement or stabilization of existing SART teams with the county board of supervisors, city council, public agency and hospital executive level leadership in conjunction with other criminal justice agencies;
- provide leadership, together with the sheriff and chiefs of police and local hospitals, to institutionalize SAFE/SANE teams and help ensure stable funding;
- ensure regular prosecutor participation in and support for SART, including regular attendance at full SART meetings; and
- ensure participation in case review by prosecutors of both open and closed cases within the SART context to provide feedback on case outcomes and to provide a quality review component for continuous improvement.

Role of the Prosecutor (Deputy District Attorney)

Every county in California has its own district attorney's office. The role of the district attorney's office is to prosecute felony violations of law in the courts of the county.

Depending on the municipality, misdemeanor violations are either prosecuted by the district attorney's office or by the city attorney's office. Cases are referred by the law enforcement agencies within the county in whose jurisdiction the alleged offense occurred.

Law enforcement investigates the case and submits a written report to the district attorney's office for evaluation. An experienced prosecutor reviews the submitted materials and decides whether or not to file criminal charges. In some jurisdictions, the district attorney's office employs investigators to conduct further investigations into the cases after charges are filed. The professional association for district attorneys and their deputies is the California District Attorneys Association (CDAA).

Role of the Public Defender and the Defense Bar

The mission of the public defender and the private defense attorney is to protect the civil rights of the defendant, ensure that the prosecution meets the burden of proof, ensure a fair trial, provide adequate representation for the defendant, and be a guiding hand for the defendant through the criminal justice system. Persons charged with a crime are entitled

to a legal defense and protection of their constitutional rights. If they can afford their own attorney, they engage one. The indigent defendant is usually represented by the public defender's office, or depending on the county, a private law firm is contracted by the county to serve as the public defender. The two professional associations for defense attorneys are the California Public Defenders Association (CPDA) and the California Attorneys for Criminal Justice (CACJ).

Role of the Judge

The role of the judge is to determine, interpret, and apply the law to the case before the court, and to be the impartial trier of fact in court trials and hearings. There are two agencies involved with the administration of justice and judicial performance in California. The Judicial Council of California is the constitutionally mandated body responsible for improving the administration of justice. The Council is involved in state policy making and undertakes new initiatives. The California Commission on Judicial Performance is the independent state agency responsible for investigating complaints of judicial misconduct, judicial incapacity, and for disciplining judges. The Commission's jurisdiction includes all active California state court judges. Anyone may submit a complaint to the Commission.

Role of Probation and Parole

Probation officers have a role after the defendant is convicted of a crime. They conduct an investigation of the defendant's background and prepare a pre-sentencing report. The pre-sentencing report contains recommendations regarding proposed time in state prison, county jail, and/or probation. Probation is not an option for every defendant, and depends upon the types of crimes for which the person was convicted. Defendants who are convicted of crimes and not sent to state prison are typically placed on probation for various lengths of time, often in conjunction with a term in county jail. Persons placed on probation are supervised by the probation department in an attempt to monitor their success in complying with the terms of their probation.

After a person is released from state prison, he or she is assigned a parole officer. The role of the parole officer is to help the person transition into the community and monitor whether the individual is in compliance with the terms of parole.

Victim's Rights in the Criminal Justice System

For years, crime victims were forgotten within the criminal justice system. In an attempt to rectify this situation, the California Legislature, as well as the voters of the state through the initiative process, have passed numerous laws to protect the rights of sexual assault victims:

- Rape shield laws preventing or regulating the introduction of a victim's prior sexual history. (Evid. Code § 1103.)
- Victims of sexual assault cannot be held in contempt of court in California for refusing to testify in the prosecution of a case. (Code Civ. Proc. § 1219.)
- Victims of sexual assault cannot be required to take a polygraph test. (Pen. Code § 637.4.)
- Victims of sexual assault cannot be forced to submit to a psychological evaluation. (Pen. Code § 1112.)
- Crime victims have the right to speak at the sentencing hearing. (Pen. Code § 1191.1.)
- Victims of specified sexual assault where there was a possible transfer of blood or other bodily fluids by the perpetrator, have the right to have a warrant issued for testing of the defendant's blood for AIDS-related conditions or may petition the court of said testing. Specified sexual assaults include Penal Code sections 220, 261, 261.5, 262, 264.1, 266b, 266c, 269, 286, 288, 288a, 288.5, 289, and 289.5. (Pen. Code § 1524.1 and Health & Saf. Code §§ 12055 et seq.)
- Laws have also been enacted to give victims certain rights when DNA evidence may be present in their case. These laws are commonly referred to the Sexual Assault Victims' DNA Bill of Rights. (Pen. Code § 680.)
- In November 2008, California voters approved Proposition 9, the Victims' Bill of Rights Act of 2008 (Marsy's Law). The 17 rights enumerated in the Victims' Bill of Rights acknowledged the vital role victims play in the administration of justice and focuses on ways to protect the victim's privacy and dignity, to keep a victim free of intimidation and harassment, and to provide procedures whereby a victim can be kept informed of the status of a case as it works its way through the criminal justice system. Marsy's Law makes victims an integral part of the criminal justice process. These rights are listed on the California Attorney General's Office of Victims' Services at www.oag.ca.gov. Pocket cards are available in 14 languages.

Basic Elements of Prosecution and Judicial Proceedings

Arrest and Arraignment at Municipal Court

A Suspect Is Arrested and Is in Custody

After the arrest of a suspect, there is an arraignment hearing within two court days of the arrest for all persons in custody. The district attorney's office then has two days to evaluate the case and make a filing decision. At the arraignment, the defendant is informed of the charges and, generally enters a plea of guilty or not guilty. If the defendant is in custody, bail will be set or the defendant can be released on his or her own recognizance (without bail).

Statutes of Limitations for Filing Charges if the Suspect Is Not Arrested

The statute of limitations refers to that time from when a crime was committed to that date after which criminal charges can no longer be filed. The laws dealing with statutes of limitations are complex and they vary depending on the nature of the offense, the potential sentence, and when the offense was committed, among other things. Generally, for sex crimes that occurred after January 1, 1995, the statute of limitations is 10 years. Recognizing the significance of the presence of DNA, for sexual assaults committed after January 1, 2001, if DNA was tested and entered into CODIS (Combined DNA Indexing System) within two years of the commission of the crime and, if after a CODIS hit, criminal proceedings are instituted against the defendant with one year of the hit, the statute of limitations is tolled for the intervening years. There are numerous exceptions that may toll the statute of limitations in any given case. For more definitive information, consult your local district attorney's office.

Bail

Bail is the money or bond put up by, or on behalf of, an arrested person to release him or her from jail pending the trial outcome. The primary purpose of bail is to ensure that the defendant returns for all court appearances. The amount of bail is determined by the seriousness of the crime, the suspect's previous record, flight risk, and any potential danger to the public. While every defendant generally has the right to reasonable bail, the court has the duty to set bail after consideration of all these factors, and reserves the right to revoke bail when circumstances warrant.

Case Filing Decisions

Law enforcement investigation reports are provided to the filing deputy district attorney. This deputy district attorney reviews the facts of the investigation and determines whether a case should be filed and what the charges should be. Cases can be filed as misdemeanors or felonies. The following factors are considered in determining whether or not to file a case:

- whether the facts, when considered in a reasonable light, establish all the necessary elements of the charge.
- the victim's ability and likelihood of proceeding with the prosecution, the victim's credibility, the suspect's statement (if any), witnesses' statements (if any), physical evidence supporting or refuting the allegations, and any corroboration supporting or refuting the allegations;
- whether there is reasonable likelihood that the evidence will persuade a jury of the suspect's guilt beyond a reasonable doubt.

Preliminary Hearing

The preliminary hearing is a bare bones presentation of the evidence by the prosecution to establish whether there is sufficient evidence to hold the defendant over for trial. The prosecution puts forth evidence to establish that a crime has been committed and that the defendant, more likely than not, committed the offense. The preliminary hearing is heard by a magistrate sitting as the trier of fact; there is no jury. If the defendant is in custody, he or she has the right to a preliminary hearing within 10 days. If the defendant is out of custody, he or she typically "waives time," and the preliminary hearing is set for a date that is mutually agreeable for the prosecutor and defense counsel. Preliminary hearings are often presented via hearsay testimony. This is especially true in sexual assault cases where the evidence, by its very nature, is often difficult for a victim to relate. While hearsay testimony is permissible, double hearsay is not. Hearsay can be complex issue; for more information, contact your local district attorney's office.

Since the preliminary hearing is an evidentiary proceeding, issues of admissibility of evidence (physical evidence collected by law enforcement, defendant's statement/confession, the results of a photo or other line-up shown to the victim or other witnesses) or requests to have the defendant's blood tested for AIDS-related conditions pursuant to Penal Code section 1524.1 or Health and Safety Code section 12055 et seq. are often heard

at this time. If, at the conclusion of the preliminary hearing, the magistrate determines that sufficient evidence has been presented to demonstrate that a crime has been committed and the defendant more likely than not committed the offense, a holding order will be issued and the defendant will be bound over for trial.

Grand Jury

In California, at the prosecutor's discretion, the preliminary hearing can be bypassed and the case can be presented to a grand jury (comprised of citizens) for an indictment. The grand jury process is typically used when the case presents unusual or extremely challenging or complex issues (e.g., an unusual amount of circumstantial evidence, no body, indirect linkages between the alleged perpetrator and the crime, a high-profile defendant). The grand jury is often used in gang cases where the witnesses may be extremely reluctant to testify due to fear of retaliation or the number of defendants may be unwieldy. In these cases, the district attorney's office may elect to proceed via grand jury rather than a preliminary hearing. The defendant is not present for the grand jury proceeding, nor is his or her attorney. If the grand jury believes sufficient evidence has been presented, it issues an indictment.

Arraignment in the Superior Court

After a holding order by a magistrate at a preliminary hearing or the issuance of an indictment by a grand jury, the defendant is arraigned in superior court. The arraignment is a proceeding before a judge to advise the defendant of the charges against him or her, enter the defendant's plea of guilty or not guilty, and set dates for future proceedings (e.g., pre-trial hearings, trial). Present for this proceeding is the deputy district attorney, the defendant, the defendant's counsel, and the judge and court personnel. The victim is not usually present, but can be. The arraignment must take place within 10 court days of either the holding order to the issuance of an indictment. The defendant has the right to a jury trial within 60 days of his or her arraignment. This right can be waived, and often is, to allow the defendant's counsel adequate time to prepare for trial. There are many variables that can effect the setting of the trial date.

Trial

Both the prosecution and the defendant have the right to have the case heard by a jury. If both waive that right, the case can be heard by a judge sitting as the trier of fact. At a jury trial, 12 citizens are chosen to serve from a pool of citizens who are summoned to the courthouse to serve as jurors. The jury is chosen after each side (prosecution and defense) has the opportunity to question them regarding their ability to be fair and impartial. The jury is the trier of fact, and has the obligation to listen to the evidence and, once presented, decide whether the defendant is guilty or not guilty. The judge sits as the trier of the law, and determines the admissibility of evidence and ensures the orderly flow of the trial. The standard of proof in a criminal trial is “beyond a reasonable doubt.” The prosecutor presents his or her evidence (witnesses and physical evidence) first, subject to cross-examination of each witness by the defense. When the prosecutor has presented all his or her evidence, the prosecution “rests.” The defense then has the opportunity to present evidence, but is under no obligation to do so. Trials can last a few days to several months. At the conclusion of all the evidence and the closing statements of both counsel, the case is “given” to the jury for their deliberation and ultimate decision. After the jurors have deliberated, they return to the courtroom and announce their verdict to the judge in front of the attorneys and the defendant. The victim has the right to be present at this time. If the defendant is found not guilty, he or she will be released. If found guilty, a date for sentencing is set. If the jury is unable to reach a unanimous decision, a mistrial is declared, and the case may be re-tried.

Common Defense Strategies for Sexual Assault Cases

In most rape cases, defense attorneys have three possible defenses: the acts were consensual, mistaken identification, and denying that the crime occurred. In the consent defense, the defense acknowledges that the accused engaged in sexual relations with the victim but argues that the victim consented. In the mistaken identification defense, the attorney acknowledges that the sexual assault may have occurred, but claims that the accused was not the attacker. In the denial defense, the attorney argues either that the alleged acts do not constitute sexual assault or that no such acts occurred.

Penal Code Definition of “Consent”

Consent is defined in Penal Code section 261.6 to mean “positive cooperation in act or attitude pursuant to the exercise of free will. The person must act freely and voluntarily and

have knowledge of the nature of the act and the transaction involved.” A current or previous dating or marital relationship shall not be sufficient to constitute consent where consent is an issue in a prosecution under sections 261, 262, 286, 288a, or 289. See Chapter 16: Affirmative Consent Standard for University and College Students, California Education Code Section 67386, for information relating to students.

Aspects of Sentencing

The defendant has the right to be sentenced within 28 days of the guilty finding, and can waive that right. Sentencing hearings typically occur four to six weeks after conviction due to many variables. The judge will receive sentencing recommendations from the prosecutor, the defense attorney, and a pre-sentence report from the probation officer.

Victims have a right to attend the sentencing hearing and to submit a victim impact statement or to give a verbal statement, although they are not required to do so. If the victim is **not** contacted by the probation officer, she can write a report directly to the judge. The victim may also request restitution.

Sentences can either be given consecutively for each charge for which the defendant is convicted, or the sentences may run concurrently. Sentences may involve a commitment to state prison or a term of probation that usually includes commitment to county jail. To obtain detailed information about California sentencing laws and laws requiring registration as a sex offender (Pen. Code § 290), contact the local district attorney’s office or probation department.

Appeals

If the defendant is found guilty, he can appeal. In an appeal, an appellate court reviews the case to determine whether any legal errors were made during the trial. An appeal can take months or years. The victim is not present during this process. The judge may release the defendant during the appeal, but this seldom occurs. If the defendant’s claims are upheld on appeal, the case will be sent back to the trial court for judicial action consistent with the ruling of the appellate court.

Role of the Rape Crisis Center Advocate During Judicial Proceedings

The role of the advocate is to provide support, accompaniment, and to answer questions about legal proceedings. An advocate can be present at any proceeding attended by the victim.

Specialized Sexual Assault and Child Sexual Abuse Prosecution Units

The concepts of specialized and “vertical” prosecution units began in the 1980s. A specialized unit may or may not be a vertical unit. A specialized unit is composed of highly trained prosecutors in the field of sexual assault or the designated specialty. With a specialized unit, one deputy district attorney handles the preliminary hearing and trial.

A vertical unit means both specialization and one deputy district attorney handling the case from start to finish (e.g., arraignment, preliminary hearing, and trial). In those district attorney’s offices not using the vertical concept, there are filing deputies and trial deputy district attorneys. In specialized fields such as sexual assault, domestic violence, child abuse, and gang violence, specialized teams have been found effective.

Some of the benefits for creating specialized sexual assault units include:

- enhanced prosecutorial expertise in sexual assault;
- increased familiarity with the sexual assault laws;
- increased knowledge about the psychology and methods of perpetrators;
- increased knowledge about the dynamics of victimization;
- improved rapport with victim that increases confidence and commitment to participating in the judicial process; and
- closer coordination between prosecutors, law enforcement agencies, rape crisis centers, hospitals, and crime laboratories.

Continuing Legal Education

The California District Attorneys Association provides continuing legal education for prosecutors. The California Public Defenders Association provides continuing legal education for public defenders. The California Attorneys for Criminal Justice also provides continuing legal education seminars.

Associations and Agencies

- California District Attorneys Association
- California Public Defenders Association
- California Attorneys for Criminal Justice
- Judicial Council of California
- California Commission on Judicial Performance

Chapter 11: Victim/Witness Assistance Center Component

The role of victim/witness assistance centers on the SART is to:

- participate regularly in SART meetings to ensure coordination; and
- inform victims and all professional disciplines about the California Victim Compensation Program that reimburses crime victims for out-of-pocket medical and mental health services, re-location expenses if indicated, including the benefits for primary and secondary victims of crime including non-offending parents and caretakers.

Role and Responsibilities of Victim/Witness Assistance Centers

The concept of providing governmental assistance to crime victims was formally established in 1965 when California developed the nation's first Victim Indemnification Program to financially reimburse crime victims for losses. In 1977, legislation was passed to establish six pilot centers for victims and witnesses using federal funds administered by the Governor's Office of Criminal Justice Planning. In 1980, the statute was expanded to establish the Victim Witness Fund as the fund source (fines and penalties collected from convicted offenders) and 30 centers were established. By 1989, victim/witness assistance centers were developed in all 58 counties in California, and in the Los Angeles City Attorney's Office.

Minimum Service Requirements for Victim/Witness Assistance Centers

(Pen. Code § 13835.5)

- Crisis intervention.
- Emergency assistance (e.g., food, housing, clothing, cash).
- Resource and referral counseling.
- Counseling on problems resulting from the crime.
- Assistance in the processing, filing, and verifying of crimes.
- Assistance in obtaining return of the victim's property when used as evidence.
- Orientation to the criminal justice system.
- Court escort.
- Training of criminal justice system agencies.

- Public presentations.
- Monitoring court cases to inform victims and witnesses regarding case status.
- Notification of friends, relatives, and employers of the occurrence of the crime, upon request of the victim.
- Intervention with employers to prevent loss of pay or other benefits resulting from the crime or participation in the criminal justice system, upon request of the victim.
- Assistance in obtaining restitution for economic loss and providing this information to the probation department, district attorney, and court prior to the imposition of the sentence, upon request of the victim.

The enabling legislation for victim/witness assistance centers recognizes that:

- crime victims' lives are disrupted emotionally, physically, and economically;
- criminal apprehension, prosecution, and incarceration are only three elements of the broad scope of issues to address; and
- crime victims and witnesses need specialized services not provided by established governmental agencies (e.g., social services and mental health treatment services).

Client Confidentiality

Confidentiality for victims receiving services from a victim/witness assistance center is a complex issue to summarize. Currently in California, 51 victim/witness assistance centers are located in district attorney's offices, three are located in probation departments, one is located in a sheriff's department, and three are non-profit organizations. For those located in a district attorney's office, the program is considered an "agent" for the district attorney. This means that information relevant to the prosecution must be given to the deputy district attorney by the victim/witness assistance center staff person. Once information is given to the deputy district attorney, the information is discoverable by the defense. Most programs try to facilitate the victim reporting the information to the deputy district attorney rather than the staff person.

Programs located in probation departments and the sheriff's department face a similar situation because they are public agencies. They are considered responsible for disclosure of relevant information. For more information about client confidentiality provisions and restrictions for these programs, contact the local victim/witness assistance center.

Complimentary Advocacy: Inter-agency Collaboration with Rape Crisis Centers

Each center has an important role in serving sexual assault victims. Some client services provided by victim/witness assistance centers and rape crisis centers are similar, some are unique, and all are complimentary. In some jurisdictions, there are close positive working relationships, which recognize that each advocacy organization has distinctive strengths and capabilities. Achieving collaboration means looking at the strengths and opportunities that each organization brings to the community table and adopting coordinating strategies.

What is the Difference Between Rape Crisis Centers and Victim/Witness Assistance Centers?

Rape crisis centers:

- are usually non-profit organizations with multiple funding sources;
- provide counseling services *both for sexual assault victims who report and sexual assault victims who do not report the crime* to law enforcement;
- provide a 24-hour telephone crisis line and crisis intervention services on 24 hours a day, 7 days a week;
- provide follow-up counseling, advocacy and supportive services based on the needs of the victim;
- provide hospital accompaniment services 24 hours a day, 7 days a week;
- provide accompaniment services during law enforcement investigations to interviews with deputy district attorneys and defense attorneys, and during judicial proceedings; and
- ensure client confidentiality for sexual assault victims pursuant to state statute.

Victim/witness assistance centers:

- serve all types of crime victims and witnesses to crime;
- provide crisis intervention, transportation, problem-oriented counseling (not mental health counseling), emergency assistance (e.g., food, housing, clothing, and cash, if needed), resource and referral counseling, orientation to the criminal justice system, and court accompaniment services;
- family notification, upon request of the victim;
- employee notification and intervention, upon request of the victim; and

- assistance in preparing the crime victim compensation application form.
- *Note:* Victim/witness assistance centers housed in governmental agencies cannot guarantee confidentiality for sexual assault victims.

Coordinating Strategies for Inter-agency Collaboration

The victim/witness assistance center is in a pivotal position to engage in collaboration with all victim service agencies in a community by:

- creating inter-agency networks and task forces including rape crisis centers, domestic violence shelters, child abuse councils, child abuse treatment programs, child advocacy organizations, and elder abuse programs to identify common issues and engage in problem solving;
- developing task forces together with local law enforcement agencies and the district attorney's offices to identify broad issues common to all victim advocacy groups and engage in problem solving;
- engaging in joint training programs with speakers and break-out groups to discuss topical issues to facilitate relationship and team building;
- participating in joint strategic planning for the community to identify service needs, to develop programmatic directions and financial strategies utilizing various funding streams;
- serving as the source of information regarding court dates and times;
- providing cross training (using each other's trainers) for each agency; and
- establishing an annual awards luncheon to recognize the contributions agencies and individuals make to the community with participation by elected officials.

Advocacy Organization for Victim/Witness Assistance Centers and All Types of Victim Assistance Organizations

- California Crime Victims Assistance Association
www.calvictimassistance.com
- National Organization of Victim Assistance (NOVA)
www.trynova.org

Chapter 12: California Victim Compensation Program (CalVCP)

Eligibility for Reimbursement of Expenses

- A California resident or non-resident injured in California who suffers physical injury, threat of physical injury, or death. Victims of sexual assault are presumed to have suffered physical injury.
- Family members (e.g., spouse, sibling, child, parent, foster parent, fiancé) are also eligible for benefits whether or not they are California residents. They are described as “derivative victims” for purposes of filing applications for the reimbursable expenses listed below.

Losses Covered

Medical and dental expenses, mental health treatment or counseling, physical therapy expenses, funeral and burial expenses, wage or income loss, loss of support, job retraining expenses for a disabled victim, home or vehicle modifications for a disabled victim, home security improvements, moving/relocation expenses, crime scene clean-up, medically necessary equipment such as a wheelchair, insurance co-payments, loss of support for dependents when a victim is killed or disabled because of a crime, childcare services when a caregiver is killed or disabled because of a crime, and more. Consult the CalVCP website for further description of benefits at www.vcgcb.ca.gov or www.victimcompensation.ca.gov. The website also has links to “Find a Therapist” and “Find a Psychologist.”

Reimbursable Expenses

Victims of crime are eligible to receive a maximum of \$46,000 if the crime occurred prior to January 1, 2001, and \$63,000 if the crime occurred after January 1, 2001. Each of the losses described above may have its own limit. Consult CalVCP for more information at (800) 777-9229.

Requirements

The crime must be reported to law enforcement or (in the case of child or elder/dependent adult abuse) to child or adult protective services. The victim must cooperate with law enforcement in the investigation and prosecution of any known suspects. If the victim is a

child who has been confirmed as abused, the child may qualify with or without the child's legal guardian's cooperation with the authorities, or the identification or prosecution of any known suspects. The victim must not have knowingly and willingly participated in the commission of the crime or engaged in conduct that caused or led to the crime. Eligibility for program benefits may be limited if the victim/claimant was convicted of a felony committed on or after January 1, 1989, and had not been discharged from probation, parole, or released from a correctional institution at the time losses were incurred.

Submitting an Application for Reimbursement of Expenses

Victims (18 years old or older at the time of the crime) must file an application within three years from the date of the crime. Victims (under 18 years of age at the time of the crime) must file an application with the Board before their 21st birthday.

Assistance in Filing Claims

Additional information on crime victim compensation may be obtained by contacting local county victim/witness assistance centers or CalVCP. Local programs provide assistance to victims in the preparation and submission of these claims to CalVCP, and check on claims status.

Victims may also be assisted by a private attorney in filing claims. Government Code section 13965(d) provides that the Board shall pay private attorney fees of 10 percent of the approved award up to a maximum of \$500. These fees are not deducted from the applicant's award.

A common misconception about eligibility for this program is that the case has to be prosecuted in order for the victim to be eligible for benefits. This is not accurate information; only proof of the crime in the form of a police report, a medical report, a children's protective services report, or an adult protective services report is needed.

Limitations

CalVCP is the “payer of last resort.” Other sources of reimbursement such as health or disability insurance must be used first. CalVCP does reimburse for co-pays required by health insurance companies since those expenses are considered “out of pocket.”

Appeals Process

If the Victim Compensation Board denies a claim, or partially denies a claim, a claimant can either request reconsideration and provide additional information or file an appeal in court (“petition for writ of mandate”) requesting a judge to find that the Board abused its discretion. Reconsideration requests or court appeals must be filed within 60 days of the denial.

Chapter 13: Cultural Competency

California is a highly diverse state, and non-Latino Whites are no longer the majority population. To be effective, a SART must be culturally competent, providing effective services to individuals of diverse ethnicities, sexual orientations, and cultural backgrounds. The concept of diversity has now become broader than race/ethnicity. It includes gender/sexual orientation, hearing/visually impaired, and developmental and physical disabilities.

Cultural competence is defined as a set of congruent attitudes, actions, behaviors, and policies that come together among professionals at all levels within an organization. The congruence enables the system, agency, team, and individual to work effectively in cross-cultural situations. Cultural competence should be viewed as a goal toward which agencies and individuals can strive. Becoming culturally competent is a developmental process (Guerrero, 2000). It is a journey with continual learning, personal and professional development, and self and organizational evaluation.

Agencies must become culturally competent at all levels of their system to truly move towards providing culturally competent services (Cross, 1989). The concept of cultural competence is larger than having a brochure translated into other languages, having a Spanish-speaking person on staff, or becoming familiar with how different cultures view sexual assault. These are, of course, valuable steps—but they do not represent the broad concept. Taking a piecemeal approach to providing culturally competent interventions is not considered acceptable. Cultural competence must be recognized as an intrinsic part of the overall quality of intervention.

Cultural competence is often divided into organization and/or systemic and individual provider levels.

Organizational Cultural Competence

- Agencies must embrace the process of cultural competence at all levels, including administrators, managers, supervisors, and front-line providers.

- Administrators need to understand the critical need to provide culturally competent intervention for individuals and families who come to their attention.
- Supervisors must know how to provide culturally appropriate supervision to their staff, including how and when to seek cultural consultation.

Individual Provider Cultural Competence

- Cultural competence at the provider level is conceptualized in three areas: knowledge, awareness, and skills in assessing clients and providing effective interventions.
- Cultural competence includes understanding the meaning of sexual assault in various cultures. True understanding exists on two levels: the manifest content (what is known or shared) and the latent content (the meaning and significance attached to the event). Part of cultural competency is to understand the meaning for the individual and the meaning for the individual in the context of the family (immediate and extended) and the person's community. With regard to the process of intervention, showing kindness and respect is effective in any culture.
- Optimally, services should be provided in the preferred language of the individual, or at least with a qualified interpreter. Agencies should seek to hire bilingual, bicultural workers. The rape crisis center advocate should not be used as the interpreter. Doing so creates role confusion, eliminates client confidentiality, and places the advocate into the role of investigator or medical examiner. The survivor deserves a person with the single mission of providing support, advocacy, information, and explanation of various procedures.

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

In general, the best approach to achieving cultural competency involves several steps.

- Ensure organizational leadership commitment and a clear, committed vision for achieving cultural competency.

- Cultural competency must be integrated into all aspects of the agency, not isolated as a separate component. Cultural competency should not become the responsibility of one person in the organization who speaks another language. Recruit a diverse workforce at all levels. Develop leadership capacity for employees from diverse groups. Agencies should encourage internal dialogue and training on multicultural issues.
- Identify cultural consultants within and outside the organization.
- Utilize internal and external consultants to develop a plan for the agency and establish a multicultural advisory committee. Seek diversity in the committee representation, utilizing individuals who have knowledge and experience with various ethnic cultural groups. Work with cultural consultants, community leaders, and community ethnic/cultural organizations in expanding the agency's cultural knowledge. Do not rely on a single consultant; hire a variety of cultural consultants.
- Develop an overall organizational plan to move the agency toward becoming more culturally competent.
- Conduct a cultural competency assessment of the organization and the community. Assess the cultural and linguistic competency of the staff. Examine what has already been done in the agency. Determine whether ethnic minorities are referred at disproportionate rates. Consider potential causes of disproportional rates, and how the organization and the individual providers can address them.
- Develop specific, short-term and long-term goals and objectives the agency can realistically accomplish. Incorporate cultural competency planning into existing strategic planning efforts.
- Take advantage of planned system change. Strengthen cultural competency by including it in any and all system-change strategic planning.
- Move the agency toward providing culturally competent services. Every agency training should include cultural competency as an intrinsic component. Agencies should provide cultural-specific training that is pertinent to the community each serves. Develop strategies to enhance the knowledge, awareness, and skills of providers. Providers should receive training on cultural differences in the ways in which communities view, address, and communicate regarding issues of sexuality and sexual behaviors. Providers should be respectful of these differences while ensuring client safety.

- Work with cultural consultants, community leaders, and community ethnic/cultural organizations in expanding the agency’s cultural knowledge. Do not rely on a single consultant; hire a variety of cultural consultants.
- Make every effort to serve individuals in their preferred primary language to avoid misunderstandings. Ensure that all materials are provided in languages spoken in the community, and that an effective and timely system for providing translation services is in place.
- Establish a plan to evaluate efforts and to monitor changes. Collect data about clients to enable systems to identify and address disparities.

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

This chapter is a summary of documents and represents the leadership of Terry Cross; Rachel Guerrero, M.S.W.; Jerry Tello, M.S.W.; Anthony Urquiza, Ph.D.; and Katherine Elliot, Ph.D., and many others on this important subject.

Selected Reading

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

NAMI, *Cultural Competence in Mental Health* <[http://www.nami.org/Content/NavigationMenu/Find Support/Multicultural Support/Cultural Competence/Cultural Competence.htm](http://www.nami.org/Content/NavigationMenu/Find%20Support/Multicultural%20Support/Cultural%20Competence/Cultural%20Competence.htm)>.

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U.S. Department of Health and Human Services, Office of Minority Health, *National Standards on Culturally and Linguistically Appropriate Services (CLAS), Final Report*, 2001.

Additional Resources

Jerry Tello, M.S.W.
Los Angeles, California
www.jerrytello.com

Terry L. Cross
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National Indian Child Welfare Association
Portland, Oregon
www.icwa.org

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California State Department of Mental Health
Sacramento, California

Chapter 14: Trauma Reduction

The psychological trauma experienced by survivors of rape and other forms of sexual assault was originally documented in the literature by Burgess & Holmstrom in *Rape: Victims of Crisis* (1974). They first described the concept as Rape Trauma Syndrome. Subsequent research and decades of experience have resulted in Rape Trauma Syndrome being classified as a subset of Post-Traumatic Stress Disorder (PTSD) (American Psychiatric Association, 1994).

Acute Post-Traumatic Stress Symptoms

Acute post-traumatic stress reactions that may be observed in survivors immediately following a sexual assault include the following:

- anxiety, difficulty sleeping, irritability, hyper-vigilance, exaggerated startle response, and problems with focus and concentration;
- dissociative symptoms such as numbness, detachment, depersonalization, or derealization; reduced awareness of surroundings (appears to be “in a daze”); emotional unresponsiveness (flat affect); dissociative amnesia (inability to recall an important aspect of the trauma); and outward calm and collectedness;
- preoccupation with the assault and persistent re-experiencing of the trauma (e.g., flashback, intrusive thoughts, images, dreams) or distress on exposure to reminders of the trauma (questions by law enforcement and medical personnel); and
- marked avoidance of stimuli that arouse recollections of the trauma (e.g., reluctance to participate in interviews with law enforcement and medical personnel).

Other psychological reactions commonly expressed by survivors in the immediate aftermath of a sexual assault include: shock and disbelief, hysteria, confusion and non-sequential recollection of events, fears about personal safety, and concerns about the consequences of reporting the assault and the reactions of others.

Long-Term Post-Traumatic Stress Symptoms

The diagnosis of PTSD is made if symptoms cause significant distress or disruption in the survivor’s functioning.

Post-Traumatic Stress Disorder symptoms include:

- persistent symptoms of anxiety, sleep disturbances, irritability, mood swings, difficulty with concentration, hyper-vigilance, and exaggerated startle response;
- panic attacks;
- depression;
- persistent re-experiencing of the trauma (recurrent, intrusive thoughts, distressing dreams, and nightmares);
- acting or feeling as if the sexual assault is happening again;
- extreme distress when exposed to something that resembles or is symbolic of the traumatic event;
- persistent avoidance of people or situations associated with the trauma; and
- numbing or reduced responsiveness, including diminished interest or participation in significant activities, inability to recall an important aspect of the trauma, feeling detached or estranged from others, restricted range of affect, and sense of a foreshortened future.

Additional symptoms commonly experienced by sexual assault survivors include: self-blame, guilt, shame, humiliation, loss of personal dignity, anger, suicidal thoughts or attempts, dangerous risk-taking behavior, sexual dysfunction, somatic complaints, loss of self-confidence, devaluation in regard to personal identity and self-esteem, inability to concentrate, difficulty attending to tasks at hand, and changes in the survivors' assumptions about themselves, others and their place in the world. Survivors may drop out of school or college, become unable to complete courses, become unable to work full or part-time at their jobs. School and work-related problems due to the sexual assault may cause them to feel as though they are failures. They may feel similarly about their ability to parent their children.

Factors That Can Exacerbate Psychological Trauma

- The relationship between assailant and survivor may exacerbate trauma because the survivor can experience profound betrayal of trust.
- If there was drug or alcohol used or administered, the survivor may have become immobilized and not had the ability to resist or get away. Or the survivor may have lost consciousness with a later intuitive unsettling feeling that something happened.

If this is confirmed later by a forensic medical exam, her reaction may be deep shock.

- The method of sexual assault (i.e., fondling or oral penetration) does not lessen the effect of sexual assault upon the survivor.
- The absence of physical injuries does not reduce the trauma of sexual assault.
- Whether or not the assault was attempted, but not completed, does not soften the trauma.

Impact on Adolescents

Additional symptoms demonstrated by adolescents includes: cutting school, inability to trust, outbursts of anger or rage, generalized self-destructive behavior, sexual promiscuity, beginning or increased drug/alcohol use, cutting and self-mutilation, exaggerated adult behavior, high frequency of suicide attempts, and persistent anger.

Adolescents and children raised in neglectful homes with drug and alcohol abuse are at risk for sexual assault by non-family members and chronic child sexual abuse by immediate and extended family members. The risk is especially high in drug-abusing/drug-manufacturing homes.

Impact on Children

Children may experience forcible rape or child sexual abuse (incest) and be diagnosed with PTSD. They may also experience dissociation; fear/anxiety; guilt/shame; depression; repressed anger/hostility; low self-esteem; poor social skills; inability to trust (if victimized by a known or trusted person); blurred boundaries and role confusion (incest); pseudomaturity coupled with failure to accomplish developmental tasks (incest); developmental delay (incest); and/or attachment disorder, i.e., the inability to bond or develop empathetic relationships (any type of child abuse and neglect).

Impact on the Elderly

The elderly are at risk for anxiety, depression, a sense of hopelessness, and PTSD. They are also at risk for declining health from injuries or from the psychological aftermath. Whereas, they might have lived independently in their own home or apartment, they may no longer be able to do so.

Survivors with Mental, Developmental, and Physical Disabilities

Survivors with mental, developmental, and physical disabilities are also at risk for anxiety, depression, and PTSD. The emotional impact of a sexual assault may exacerbate existing life challenges for persons with disabilities. If they had previously been living in an independent living situation, they may no longer be able to do so for various reasons.

Male Victims

Both homosexual and heterosexual men are also victims of sexual assault. Male survivors are reluctant to disclose sexual assault for several reasons:

- societal beliefs that a man should be able to defend himself, especially against a sexual assault;
- fear that his “manhood” has been lost or that his sexual orientation may become suspect or changed as a result of the assault;
- fear that disclosure will release overwhelming emotions (men are taught to be in control of their feelings);
- fear that no one will understand; and,
- fear that seeking help or that the assistance given will make them feel weak or vulnerable.

Male survivors are more likely to show a highly “controlled” style of reaction after a sexual assault. This is likely to mask significant hidden psychological trauma. This traumatic experience may produce acute and longer-term stress disorder symptoms. Male survivors tend to act out their feelings with a great deal of anger toward those close to them. However, the targets of their anger may not understand why.

What is the Difference Between Rape Trauma Syndrome and PTSD?

Rape Trauma Syndrome was recognized and documented by Ann Wolpert Burgess, D.N.S.C., and Linda Lytle Holmstrom, Ph.D., in *Rape, Victims of Crisis* (1974). Dr. Burgess was an associate professor of Nursing and Dr. Holmstrom was an associate professor of Sociology at Boston College in Massachusetts at the time. Their first publications conceptualized Rape Trauma Syndrome as having an acute phase and a long-term reorganization process. The authors recognized that the time of onset of the second phase varied from individual to individual, and commonly began about two to three weeks after the attack.

Later researchers began to conceptualize three stages: the short-term or acute stage, an intermediate stage, and a long-term reaction. A range of traumatic symptoms such as somatic complaints, sleep disturbances and nightmares, fear, suspiciousness, anxiety, major depression, and impairment in social functioning characterizes the acute stage. According to these writers, the acute symptoms remain relatively stable for two or three months. Three months to one year, during the intermediate phase, the diffuse anxiety experienced about the world in general becomes rape-specific. Women may then experience depression, and social and sexual dysfunction.

The longer-term reaction, one year following the assault, typically involves anger, hypervigilance to danger, sexual dysfunction, decreased work performance, and relationship problems. Hope for the future is negatively affected, and victims experience a diminished capacity to enjoy life (Ellis, 1983). According to a study by Renner et al., (1988), 45 percent of women are able to readjust themselves; however, 55 percent of the victims suffer from lasting effects.

PTSD is one of the anxiety disorders listed in the American Psychiatric Association's *Diagnostic and Statistical Manual (DSM)*. The *DSM-V* (fifth edition) is a standardized psychiatric and psychological diagnostic manual for describing mental health problems. In addition to its universally used definitions for diagnosis, it is used for insurance reimbursements and for the CalVCP reimbursements. The *DSM-V* was published in 2013.

Sexual assault is one of the recognized traumatic events that can trigger PTSD. A PTSD reaction can be caused by natural disasters such as earthquakes, tornadoes, floods, or volcanic eruptions. It can be precipitated by tragic accidents (air and car crashes); man-made catastrophes such as war, concentration camps, torture, bombings, and kidnapping; by violent crime such as sexual and physical assault; and by child physical and sexual abuse. Abused children can demonstrate anxiety symptoms to the extent that clinicians are challenged to sort out whether the child has PTSD or ADHD (Attention Deficit Hyperactivity Disorder). In the literature, the PTSD descriptions conceptualize the experience in a two-phase process, e.g., acute and long-term.

The decision over which terminology to use appears to be one of preference since neither term contradicts the other. Briefly, during the 1980s, Rape Trauma Syndrome was attempted for use as a strategy to prove that rape occurred. This resulted in the 1984 court decision in *People v. Bledsoe* (1984) 36 Cal.3d 236, which stated that, *by itself*, Rape Trauma Syndrome could not be used to make the legal determination as to whether rape occurred or not.

Not long after that, PTSD gained recognition with the reactions of the returning Vietnam War veterans. Most of the early research on PTSD was based upon the experiences of Vietnam combat veterans. PTSD was subsequently included in the *DSM* to describe the reactions of individuals exposed to a life-threatening event, and sexual assault was included in the scope of possible events.

There may have been a shift to using PTSD by some in the field because it had the stature of inclusion in the *DSM*. *DSM*-diagnosed psychotherapeutic services are reimbursed by health insurance companies and the CalVCP Program. The PTSD diagnosis may also have provided a vehicle for distancing from the court decision on Rape Trauma Syndrome. There was a great deal of misinformation at the time about the *Bledsoe* decision. Again, the decision did not say that Rape Trauma Syndrome did not exist; only that, by itself, it could not be used to make a legal determination that rape occurred.

Resources on Post-Traumatic Stress Disorder (PTSD)

PTSD has become a very extensive subject for research and publication. The National Institute of Mental Health has an excellent informational website with booklets and fact sheets that can be downloaded or ordered. One in particular is called "Post Traumatic Stress Disorder (Easy to Read)" and another is called "Anxiety Disorders." In addition, there are research reports on current studies and clinical trials. The NIMH website is www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml.

There is also a National Center for PTSD and a *PTSD Research Quarterly* providing reviews of trauma research. And there is a PILOTS database (Published International Literature on Traumatic Stress). The website for the organization and database is <http://www.ncptsd.org>.

Chapter 15: Sexual Assault By a Person Known to the Victim

Acquaintance Rape, Date Rape, and Predator Date Rape

The terms are frequently used interchangeably in various publications. For the sake of clarity, it would be useful for the field to clearly differentiate between the terms. The term “acquaintance” can cover a broad range of casual relationships, whereas a “date” implies an invitational focused interaction between two people.

Acquaintance rape means the assailant is someone the victim recognizes by sight or someone known fairly well. This could be the next-door neighbor, an ex-boyfriend, the friend of a friend, a gardener, or someone who knows the victim’s environment. Acquaintance rape can be a spontaneous act of opportunity, or planned days or hours in advance.

Date rape means there is a social engagement or agreement that has social and/or romantic overtones or expectations. Alcohol and drugs are often a significant factor in date rape. Date rape can be a spontaneous act, or planned days or hours in advance.

Predator date rape deserves recognition as a method or strategy for sexual assault, and involves “grooming” behavior. Grooming behavior is well recognized in the multi-disciplinary field of child sexual abuse intervention. However, it is not well recognized in the field of sexual assault.

Unfortunately, in some jurisdictions, the victim’s credibility is automatically compromised if there was a relationship, albeit brief. Recognition must be given, however, to the reality that some men initiating a new dating relationship may be sexual predators. They have a need to assert their prowess, conquest, and power over women. Importantly, they have no recognition of another person’s boundaries or body integrity. Just “saying no” does not work because they push beyond “no.”

Predators initiate a dating relationship for the purpose of sexual assault and view the woman as a “throw away.” They may use sophisticated strategies to entice women to date them, such as sport or luxury cars, luxury apartments, event tickets, and promises to buy clothing, shoes, jewelry, and small electronic equipment. Predators may also use seductive

strategies such as promises of a modeling or artistic career, and take photographs of the victim in varying stages of undress. Then they use the photographs to claim that “consent” was involved.

The consent defense is the common response to criminal apprehension or prosecution for date rapists. Two interesting comparisons are:

- financial abuse of elderly victims by a person known to them (no one would consider dropping the investigation of this crime because there was a prior relationship and the older person gave the other person large sums of money); and
- it is accepted in the field of child sexual abuse that perpetrators purposely form the relationship as a means of sexually abusing the child.

Survivors of date rape and acquaintance rape experience stress and trauma as a result of the sexual assault. Due to the nature of date rape in which there is a social interaction and a possible (albeit temporary) trust bond developed, the trauma can be exacerbated. Feelings of betrayal intensify the emotional reactions and create fears about trusting others and their own judgment. It is a myth that if the victim knows her assailant that somehow the experience is “not so bad.”

Sexual Assault on College Campuses

The U.S. Congress, the President, and California Legislature and Governor are focusing national attention on the frequency of sexual assault on campuses by. A recommended documentary to watch is the CNN-produced *The Hunting Ground*, a film about sexual assault on American college campuses, which has been nominated for an Academy Award for Best Feature Documentary. Use Internet search engines and the CALCASA website (www.calcasa.org) to stay current on this issue.

Related Situations

Dating Violence

This is a broader term most commonly used in the literature on domestic violence. This term can mean physical assault, emotional or verbal abuse, and sexual assault.

Stalking

Stalking generally refers to harassing or threatening behavior that an individual engages in repeatedly, such as following a person, appearing at a person's home or place of business, making harassing phone calls, leaving written messages or objects, or vandalizing a person's property. These actions may or may not be accompanied by a credible threat of serious harm, and may or may not be a precursor to an assault or murder. Stalking is against the law in all 50 states and the District of Columbia. In this technological age, stalking also involves repeatedly sending text messages, emails, installing spyware on a victim's computer to detect keystrokes, and installing hidden cameras in the home for remote viewing and monitoring the victim.

Sex Trafficking/Human Trafficking/Trafficking in Persons

Sex trafficking is a form of modern slavery that exists throughout the United States and globally. Sex traffickers use violence, threats, lies, debt bondage, and other forms of coercion to compel adults and children to engage in commercial sex acts against their will. Under U.S. federal law, any minor under the age of 18 years induced into commercial sex is a victim of sex trafficking—regardless of whether or not the trafficker used force, fraud, or coercion.

The situations that sex trafficking victims face vary dramatically. Many victims become romantically involved with someone who then forces or manipulates them into prostitution. Others are lured in with false promises of a job, such as modeling or dancing. Some are forced to sell sex by their parents or other family members. They may be involved in a trafficking situation for a few days or weeks, or may remain in the same trafficking situation for years.

Victims of sex trafficking can be U.S. citizens, foreign nationals, women, men, children, and young LGBTQ individuals who have become homeless due to rejection by parents. Vulnerable populations are frequently targeted by traffickers, including runaway and homeless youth, as well as victims of domestic violence, sexual assault, war, or social discrimination.

Sex trafficking occurs in a range of venues including fake massage businesses, via online ads or escort services, in residential brothels, on the street or at truck stops, or at hotels and motels.

Human Trafficking Resources

- FBI—Human Sex Trafficking — www.leb.fbi.gov
- Sex Trafficking Polaris Project — www.polarisproject.org

Unlawful Sexual Intercourse

The most common type of unlawful sexual intercourse is between a female minor under the age of 18 (typically 15–17 years old and sometimes younger) and a young adult male typically in the 18–21 age range. This is against the law in California, and the adult male can be charged and prosecuted for unlawful sexual intercourse.

Other types include the immature older male, the exploitative older male, and the predatory older male. The primary motivation for the immature or exploitative older male is a social/sexual relationship. For the predatory older male, the motivation may include obtaining financial resources. Once the minor is impregnated, the older man may live off of the minor's welfare benefits. With the birth of the child, the young woman can become an emancipated minor. These men have been known to maintain several of these relationships concurrently and live with each young woman until the monthly check is depleted. Once the range of exploitative relationships became more widely identified in the 1990s, funding was made available to establish special prosecution units in district attorney's offices.

A consensual sexual relationship between two older minors, (e.g., 16- and 17-year olds) is against California law because minors (under the age of 18) cannot legally consent to sexual intercourse. If there is an age differential between two minors, such as a 13-year-old and a 17-year-old, the child sexual abuse laws and intervention procedures become applicable. Unlawful sexual intercourse involves a broad range of issues, including female perpetrators. Handling of these cases varies between jurisdictions. The best approach is to understand the laws and consult with local law enforcement agencies, the district attorney's office, and children's protective services.

Charging cases involving sexual intercourse with a person (not the spouse of the perpetrator) under the age of 18 years is dependent on several variables.

- Less than three year age difference — misdemeanor
- More than three year age difference — wobbler (can be charged as a felony or a misdemeanor)
- Over 21 years old and under 16 years old — felony

Note: Consent is not a defense to these charges but mistaken belief as to age is.

Marital Rape or Intimate Partner Sexual Assault

Marital rape is defined in the literature as any unwanted intercourse or penetration (vagina, anal, or oral) obtained by force, threat of force, or when the wife/partner is unable to consent (Bergen, 1996; Pagelow, 1984; Russell, 1990). Force, threat of force, and inability to consent due to incapacitation are the key elements of the crime. The concept in the literature has been expanded to Intimate Partner Sexual Assault.

Emotional pressure, verbal coercion, or “sexual pressure” are not elements that meet the legal definition of the crime. These methods of coercion are recognized in the literature. If the objective is action by the criminal justice system, it is best to focus on the legal elements of the crime in discussions with these officials. If the objective is to change interactions between males and females and to address the emotional coercion that results in acquiescence to sexual acts, other forums are needed (e.g., prevention programs, school education, books, movies, popular magazine articles).

Studies using clinical samples of battered women show that between one third and one half of battered women are raped by their partners (Bergen, 1996; Browne, 1993; Campbell, 1989). Rape also occurs in marital relationships without the context of a battering relationship; however, the rates are not as high.

Researchers generally categorize marital rape or intimate partner sexual assault into three types:

- **Force-only rape** — One partner uses only the amount of force necessary to coerce the victim.
- **Battering rape** — This type of rape occurs in the context of a battering relationship.
- **Sadistic/obsessive rape** — One partner uses torture or perverse sexual acts. Pornography is frequently involved.

Women who are at risk for being raped by their partners are:

- married or living with domineering men who view them as “property”;
- involved in physically violent relationships;
- pregnant;

- ill or recovering from surgery; and
- separated or divorced from their husbands or partners.

The literature suggests the reason for being at risk during pregnancy or when ill or recovering from surgery is that the woman is less sexually and emotionally available to her husband/partner. The husband/partner is unable to tolerate the unavailability and reacts with frustration and aggression.

Marital rape survivors experience a higher number of assaults within the marital relationship, and research indicates that they are more likely than women raped by acquaintances to experience unwanted oral and anal intercourse (Peacock, 1995). Some researchers have found that compared to batterers, men who batter and rape are especially dangerous, and are more likely to severely injure their wives and have the potential to escalate the violence to murder (Browne, 1987; Campbell, 1989). Finkelhor and Yllo (1985) found that two-thirds of the women in their sample were sexually assaulted at the end of the relationship. Other researchers have found that women who are separated or divorced from their partners appear to be at high risk for sexual assault (Dobash & Dobash, 1992; Kurz, 1997; Russell, 1990). Marital rape survivors also suffer severe and long-term psychological consequences. Research indicates that the marital rape survivors report flashbacks, sexual dysfunction, and emotional pain for years after the violence (Bergen, 1996; Whatley, 1993).

Need for Training

Law enforcement officers, healthcare providers, social workers, psychologists, and religious advisors need information about marital/partner sexual assault to increase responsiveness to the problem and decrease judgmental attitudes, and need training on sensitive interview methods to ask battered women about sexual violence.

Battered women's shelters and rape crisis centers need training on the incidence, dynamics, and emotional needs of marital rape survivors, and they need support groups tailored to address issues experienced by marital rape survivors.

Resources on Marital Rape

- Freedman, Estelle B., *Redefining Rape: Sexual Violence in the Era of Suffrage and Segregation*, Harvard University Press, 2013.
- Violence Against Women Online Resources
<http://www.vaw.umn.edu/Vawnet/marpe.htm>

Chapter 16: Affirmative Consent Standard for University and Community College Students, California Education Code 67386

California Penal Code Definition of Consent

Consent is defined in Penal Code section 261.6 to mean, “positive cooperation in act or attitude pursuant to the exercise of free will. The person must act freely and voluntarily and have knowledge of the nature of the act and the transaction involved.” A current or previous dating or marital relationship shall not be sufficient to constitute consent where consent is an issue in a prosecution under sections 261, 262, 286, 288.1, or 290.

California Education Code Definition of Consent

Section 67386 was enacted in 2015 in response to the high frequency of sexual assault on college campuses. Under the law, curriculum on affirmative consent is mandated for California colleges, universities, and high schools. Universities and colleges are working with local law enforcement agencies to establish procedures and protocols for implementing this statute. The statute is reprinted on the next page for convenience in interpreting and implementing the law.

Resources

- **How-To Guide Model Memorandum of Understanding**

The How-To Guide is a step-by-step resource for stakeholders to create an MOU that reflects local needs and capacity. It is intended to provide context, suggested supplemental content, and points of discussion to assist parties as they tailor the Template MOU to their unique circumstances. Available from the California Office of the Attorney General, www.oag.ca.gov.

- Informational Bulletin—Office of the California Attorney General
www.oag.ca.gov

California Education Code Section 67386

(a) In order to receive state funds for student financial assistance, the governing board of each community college district, the Trustees of the California State University, the Regents of the University of California, and the governing boards of independent postsecondary institutions shall adopt a policy concerning sexual assault, domestic violence, dating violence, and stalking, as defined in the federal Higher Education Act of 1965 (20 U.S.C. Sec. 1092(f)) involving a student, both on and off campus. The policy shall include all of the following:

(1) An affirmative consent standard in the determination of whether consent was given by both parties to sexual activity. "Affirmative consent" means affirmative, conscious, and voluntary agreement to engage in sexual activity. It is the responsibility of each person involved in the sexual activity to ensure that he or she has the affirmative consent of the other or others to engage in the sexual activity. Lack of protest or resistance does not mean consent, nor does silence mean consent. Affirmative consent must be ongoing throughout a sexual activity and can be revoked at any time. The existence of a dating relationship between the persons involved, or the fact of past sexual relations between them, should never by itself be assumed to be an indicator of consent.

(2) A policy that, in the evaluation of complaints in any disciplinary process, it shall not be a valid excuse to alleged lack of affirmative consent that the accused believed that the complainant consented to the sexual activity under either of the following circumstances:

(A) The accused's belief in affirmative consent arose from the intoxication or recklessness of the accused.

(B) The accused did not take reasonable steps, in the circumstances known to the accused at the time, to ascertain whether the complainant affirmatively consented.

(3) A policy that the standard used in determining whether the elements of the complaint against the accused have been demonstrated is the preponderance of the evidence.

(4) A policy that, in the evaluation of complaints in the disciplinary process, it shall not be a valid excuse that the accused believed that the complainant affirmatively consented to the sexual activity if the accused knew or reasonably should have known that the complainant was unable to consent to the sexual activity under any of the following circumstances:

(A) The complainant was asleep or unconscious.

(B) The complainant was incapacitated due to the influence of drugs, alcohol, or medication, so that the complainant could not understand the fact, nature, or extent of the sexual activity.

(C) The complainant was unable to communicate due to a mental or physical condition.

(b) In order to receive state funds for student financial assistance, the governing board of each community college district, the Trustees of the California State University, the Regents of the University of California, and the governing boards of independent postsecondary institutions shall adopt detailed and victim-centered policies and protocols regarding sexual assault, domestic violence, dating violence,

and stalking involving a student that comport with best practices and current professional standards. At a minimum, the policies and protocols shall cover all of the following:

- (1) A policy statement on how the institution will provide appropriate protections for the privacy of individuals involved, including confidentiality.
- (2) Initial response by the institution's personnel to a report of an incident, including requirements specific to assisting the victim, providing information in writing about the importance of preserving evidence, and the identification and location of witnesses.
- (3) Response to stranger and nonstranger sexual assault.
- (4) The preliminary victim interview, including the development of a victim interview protocol, and a comprehensive followup victim interview, as appropriate.
- (5) Contacting and interviewing the accused.
- (6) Seeking the identification and location of witnesses.
- (7) Providing written notification to the victim about the availability of, and contact information for, on- and off-campus resources and services, and coordination with law enforcement, as appropriate.
- (8) Participation of victim advocates and other supporting people.
- (9) Investigating allegations that alcohol or drugs were involved in the incident.
- (10) Providing that an individual who participates as a complainant or witness in an investigation of sexual assault, domestic violence, dating violence, or stalking will not be subject to disciplinary sanctions for a violation of the institution's student conduct policy at or near the time of the incident, unless the institution determines that the violation was egregious, including, but not limited to, an action that places the health or safety of any other person at risk or involves plagiarism, cheating, or academic dishonesty.
- (11) The role of the institutional staff supervision.
- (12) A comprehensive, trauma-informed training program for campus officials involved in investigating and adjudicating sexual assault, domestic violence, dating violence, and stalking cases.
- (13) Procedures for confidential reporting by victims and third parties.

(c) In order to receive state funds for student financial assistance, the governing board of each community college district, the Trustees of the California State University, the Regents of the University of California, and the governing boards of independent postsecondary institutions shall, to the extent feasible, enter into memoranda of understanding, agreements, or collaborative partnerships with existing on-campus and community-based organizations, including rape crisis centers, to refer students for assistance or make services available to students, including counseling, health, mental health, victim advocacy, and legal assistance, and including resources for the accused.

(d) In order to receive state funds for student financial assistance, the governing board of each community college district, the Trustees of the California State University, the Regents of the University of California, and the governing boards of independent postsecondary institutions shall implement comprehensive prevention and outreach programs addressing sexual violence, domestic violence, dating violence, and stalking. A comprehensive prevention program shall include

a range of prevention strategies, including, but not limited to, empowerment programming for victim prevention, awareness raising campaigns, primary prevention, bystander intervention, and risk reduction. Outreach programs shall be provided to make students aware of the institution's policy on sexual assault, domestic violence, dating violence, and stalking. At a minimum, an outreach program shall include a process for contacting and informing the student body, campus organizations, athletic programs, and student groups about the institution's overall sexual assault policy, the practical implications of an affirmative consent standard, and the rights and responsibilities of students under the policy.

(e) Outreach programming shall be included as part of every incoming student's orientation.

Implications for SART

It is important for SARTs to discuss the implications of this statute for SART operations and to review the *How-To Guide, Model Memorandum of Understanding* available from the California Office of the Attorney General at www.oag.ca.gov. This guide was developed by representatives from law enforcement, prosecutors, and CALCASA.

Chapter 17: Alcohol and Drug-Facilitated Sexual Assault (DFSA)

Alcohol

Alcohol is the most prevalent date rape drug. It is sometimes used for delivery of the drugs listed below. In the latter case, the victim is subjected to a polydrug episode.

Types of Drugs Used

The drugs listed below are sometimes taken voluntarily because they produce a “high” effect at social events. They are popular on high school and college campuses, raves, and nightclubs. In some circumstances, they are used to counter depression and withdrawal symptoms after a high on cocaine and heroin. They are also used surreptitiously to incapacitate a potential victim. It is illegal to manufacture, deliver, or possess these drugs in the United States.

GHB

GHB is most often administered as a clear liquid that tastes salty. This drug causes intoxication followed by a deep sedation that lasts up to eight hours. The victim may experience reduced inhibitions, nausea, convulsions, amnesia, and loss of consciousness. Mixed with alcohol, GHB can have a serious adverse impact upon the central nervous system. This may result in respiratory distress, coma, or even death. Once administered, the drug affect begins within 15–30 minutes.

GHB is a popular drug circulating at clubs, bars, and raves because of its euphoric effect. The drug was once sold in health food stores to bodybuilders because it was believed to help stimulate muscle growth. It was taken off the market in 1990 due to bad side effects.

Chemical Names

Gamma-hydroxybutyrate

Gamma-hydroxy-butylamine

Gamma hydroxybutyric acid

Street Names

Grievous Bodily Harm, Cherry Meth

Liquid G, Easy Lay

Somatmax, Gamma G, Liquid Ecstasy, Liquid X, G-juice, Scoop, Georgia Home Boy, Easy Lay, Growth Hormone Booster, Goop

Rohypnol

Rohypnol is a drug that leaves no detectable taste, odor, or color. It is illegal to manufacture, sell, or use rohypnol in the United States. This drug is legal in more than 60 countries for treatment of insomnia. It is also used as a sedative. Rohypnol is many times more potent than its related drug valium. Its effects are impaired judgment, lowered inhibitions, dizziness, motion difficulty, respiratory depression, amnesia, muscle relaxation, and a slowing of psychomotor responses.

The drug effect begins within 15–60 minutes, peaks in about two hours, and can last eight hours depending on the dosage. Rohypnol stays in a person's system for up to 72 hours. Victims report not being able to remember what happened or where they have been. When combined with alcohol, marijuana, or cocaine, it produces a rapid and very dramatic high. Even when rohypnol is used alone, users can appear extremely intoxicated, with slurred speech, impaired coordination, swaying, and blood-shot eyes. When taken repeatedly, it can lead to physical and psychological dependence, which is thought to increase with both doses and duration of use. When manufactured in pill form, it is an oblong olive green tablet imprinted with the number "542." The pill form can also be crushed and snorted.

Chemical Name
Flunitrazepam

Street Names
Being "roached" or "roached out," rope, ropies, roopies, ruffies, roaches, R-2, mind erasers, Roche' (the manufacturer is Hoffman-LaRoche), forget pills, circles, rib and rope

Ketamine

Ketamine is a fast-acting general anesthetic used for both humans and animals. In recent years, veterinary clinics have reported thefts of ketamine to law enforcement agencies.

This drug is also popular in clubs, bars, and raves because of its euphoric effect. Ketamine causes impaired judgment, paranoia, numbness, amnesia, convulsions, and respiratory depression. Large drug doses can lead to oxygen starvation to the brain and muscles. The drug effects typically last for about an hour; however, it is not uncommon for the effects to last for 4-6 hours. The user will not completely recover from the long-term effects until 48 hours after administration.

<u>Chemical Names</u>	<u>Street Names</u>
Ketaset	Cat Valium
Vetalar	Keller, Ket, K, Special K, Vitamin K, Kit Kat, Purple C, Super C

“Ecstasy” or MDMA

The club drug “ecstasy” has also been used to commit sexual assault.

<u>Chemical Name</u>	<u>Street Names</u>
MDMA	Ecstasy or Molly

Soma

Soma, a commonly known trade name of the drug carisprodol, is a prescription muscle relaxant and central nervous system depressant.

<u>Chemical Name</u>	<u>Street Names</u>
carisprodol	D, D’s, DAN5513, Dans, Danz, Somas

Resources on Drug-Facilitated Rape

- National Drug Intelligence Center, U.S. Department of Justice
Drug-Facilitated Sexual Assault Fast Facts
www.usdoj.gov/ndic
- RAINN: Rape, Abuse and Incest National Network
www.rainn.org/get-information/types-of-sexual-assault/drug-facilitated-assault
- *MedicineNet.com*, December 1, 2015

Chapter 18: Other SART Considerations

Gang Rape

Gang rape, by definition, is about men or boys who rape in groups. The National Crime Victimization Survey by the Bureau of Justice Statistics is the only national source of statistics on gang rapes. In 2010, the Bureau found that gang rape was reported in 10 percent of the cases. Of the multiple-offender rapes, the victim reported knowing at least one of the offenders in 37 percent of the cases. Gang rapes typically involve young male perpetrators, either young adolescents (13–17 year olds), older adolescents (18–21 year olds), and young men in their 20s and early 30s. These groups of men or boys usually have a close affiliation either through school, work, or a social group. There are increased numbers of reported cases of girls' involvement in gang rape by luring and setting up the victim for sexual assault.

Considerations for SART

The primary challenge for a SART is to allocate sufficient investigative, medical, and rape crisis center advocates to the case in the event of multiple perpetrators and multiple victims.

Prisoner Rape—Sexual Assault of Male and Female Inmates

Sexual assault occurs in both male and female correctional institutions. In 2001, the California Department of Corrections and Rehabilitation (CDCR) developed a “first responder” protocol and training program. Under the protocol, inmates are taken to the nearest local hospital with a sexual assault forensic medical examination team or a team on contract that responds to the prison. CDCR reimburses hospitals and medical forensic exam teams for the exams. CDCR also has investigation protocols for sexual assault of male and female inmates in state prison. Sexual assault of inmates in county jails is the responsibility of the local sheriff's department. Local protocols exist for case investigation and the provision of sexual assault medical forensic exams for male and female inmates in the county jail.

Chapter 19: Review of Jurisdictional Issues

Jurisdictional issues are important to understand because where the crime began and occurred determines which law enforcement agency has the authority to investigate the case. Establishing working relationships with all of the possible investigative authorities in the region is essential to smooth operations of a SART.

Sexual Assault in State Buildings, Parks, and Lands

If a sexual assault is committed in a state park, the investigation is the responsibility of the state park ranger. If a sexual assault is committed in a state building or state parking lot, the California Highway Patrol has legal jurisdiction. The California Highway Patrol and the state park ranger have the option of investigating the crime, or contacting the local city police department or sheriff's department. This is done in recognition of the experience these agencies have with sexual assault investigations. In these cases, victims are typically brought to the designated hospital in the county jurisdiction for the forensic medical examination.

Sexual Assault in Federal Parks and Lands

The National Park Service has legal jurisdiction over crimes committed on federal parks and lands. The park ranger will turn the case over to the Bureau of Land Management Criminal Investigations Unit. Most often, they contact the sheriff's department in the county where the national park or lands are located to conduct the sexual assault criminal investigation. Under some circumstances, the Federal Bureau of Investigation (FBI) may be called upon for the investigation. Victims are typically brought to the designated hospital for that California county nearest the national park or wilderness area.

Sexual Assault on Native American Lands

Criminal offenses committed on Native American lands are investigated by the local law enforcement agency having jurisdiction. (Public Law 280.) This is usually the sheriff's department. Tribal police officers are not usually sworn peace officers. Victims are typically brought to the designated hospital for that California county nearest the reservation lands.

Sexual Assault on Military Bases

The military police have legal jurisdiction over crimes committed on a military base. If the assailant is a member of the military, the crime is investigated and prosecuted in the military courts. If the suspect is non-military and the assault takes place on a military base, the suspect is turned over to the local authorities. Some military bases have a base hospital and trained personnel to perform sexual assault forensic medical exams. Other bases make arrangements with the designated hospital in the California county nearest to the military base for the performance of sexual assault forensic medical examinations. Some military bases have arrangements with local rape crisis centers to provide counseling services for victims. Other bases use their own counseling centers. As a result of increased attention and focus by the U.S. Congress and the President, sexual assault in the military is recognized as a serious problem. Refer to the Department of Defense Annual Report on Sexual Assault in the Military for updates.

Sexual Assault on University of California, State University, Community College, and Private College Campuses

The University of California and State University police have jurisdiction over their campuses. There are 10 campuses in the University of California system, 23 campuses in the California State University system, and more than 100 public community colleges. The University of California and State University campus police departments have the option of investigating the case or calling upon the local city police department or the county sheriff's department (if the university is not located within a city jurisdiction). Private colleges and community colleges (public and private) do not have police departments, and refer the case to the local city police department or county sheriff's department.

Other Jurisdictional Issues

There are many other possibilities involving jurisdictional issues (e.g., cruise ships at sea, sexual assault of U.S. citizens in adjacent countries, and so forth). Consult the local district attorney's office for information regarding these questions.

Chapter 20: Data Collection and Evaluation

Sound planning, decision-making, internal management, and allocation of resources are dependent on generating reliable data. Decisions made by intuition, anecdotal information, experience, or protocol can only take the decision-maker to a certain point. These information sources do not compare to the level of confidence that sound data can provide.

SART operations benefit from solid data to evaluate their operations and responsiveness to the community. Survivors and the community benefit from a planned and organized system for responding to sexual assault that has reliable feedback mechanisms in place. An individual's recovery from sexual assault and the ability to move forward and lead a productive life is priceless. The recovery has exponential benefits as well for family members (parents, spouses, partners, siblings, children) who are also able to move on with life if the victim can. Otherwise, a great deal of human resources and energy stay tied to a tragedy.

Uses of Data

The primary uses for data in the fields of health and human services, criminal justice, and advocacy organizations are to enhance and improve services and outcomes through:

- problem identification and description;
- program management;
- program evaluation;
- cost-effectiveness and/or cost-benefit analysis; and
- fund development.

Problem Identification

Data serves to identify, describe, and quantify the nature and scope of a problem; to describe it in statistically meaningful ways; and to show whether the problem is increasing or decreasing. This can include forecasting whether the problem will increase or decrease due to the presence or absence of certain factors.

Program Management

Program management may focus on the organization as a whole, individual programs, departments, processes (e.g., investigations/dispositions), teams, or individuals. The emphasis is on producing services or products that are typically measured by a data unit or multiple data units.

Typical questions answered include:

- How many clients received services?
- What is the demographic and geographic profile of the clients receiving services?
- What services are provided?
- What services are used?

Increasingly, funding entities and policy leaders are asking questions about program service outcomes, effectiveness, and efficiency. Above all, the fundamental questions agencies must be able to answer are:

- Who has benefited and how?
- What outcomes have been achieved?
- What are the costs of the program?

Program Evaluation

Program evaluation is designed to assess the performance of a program or the impact of a service. In the field of sexual assault, there are two sets of outcomes: patient centered and criminal justice. Typical questions answered through program evaluation are:

- Did the services and activities have the intended impact?
- Did the services and program reach the intended target population?
- How can service outcomes be improved?
- What adjustments and refinements to services, training, staffing, and other variables are needed to improve the services?
- Is the service or program cost-effective (e.g., serves the intended number of clients)?

Process Evaluation

Process evaluation describes procedures and the sequencing of interactions. In the case of a SART, the best process evaluation involves both descriptive information and diagramming

the process through a procedural flow chart and writing descriptive procedures in outline format. Diagramming a process or flow chart helps the stakeholders to visualize the system and to evaluate how smoothly and cohesively the system functions.

External and Internal Program Evaluation

Program evaluation can be conducted either internally or externally. Internal evaluation usually consists of descriptive data collection (e.g., number of clients served, number of reports, number of investigations, number of exams, number of plea bargains, and number of trials resulting in conviction and acquittal) by internal staff.

External program evaluation is considered to be the most objective. The costs of hiring a program evaluator, however, can be quite high. Formal program evaluation is usually done if the funding sources (e.g., foundation, state, or federal government) require it and agree to fund it. Evaluations conducted by independent evaluators are typically performed on a higher, more complex scale than internal evaluations, and involve both descriptive and outcome data. It is important that both providers and evaluators understand that the purpose of evaluation is to ensure sound program development and to assist the provision of quality client services. A good working relationship between evaluator and provider requires collaboration and input from the beginning of the process followed by mutual sensitivity to provider and evaluator issues, training, and technical assistance.

Cost-Effectiveness and Cost-Benefit Analysis

The purpose of cost-effectiveness and cost-benefit analysis is to determine whether the benefits of the programs are equal to or are greater than the costs involved. Sometimes, the benefits do not measure up to the costs of the program, and decisions may be made to either reduce operating costs or to discontinue the program.

There are several ways to measure effectiveness and benefits. For example, the cost of a sexual assault forensic medical exam team may be high if measured simply on a per patient basis. Other benefits, however, need to be factored in to evaluate the full scope of the impact. Examples such as patrol officer waiting time (sometimes 6–8 hours in communities without a forensic medical exam team) and poor-quality forensic medical evidence can adversely

impact professionals' and administrative support staff's time spent on investigation and prosecution. These examples have costs associated with them. Taken together or analyzed separately, these costs may well exceed the expense of a forensic medical exam.

It is important to avoid simplistic evaluations of cost-benefit and cost-effectiveness. Reductionist thinking (reducing a concept to a negative phrase or a distortion) needs to be challenged. Sound analysis considers all the variables.

Types of Data

Descriptive Data

At a minimum, data needs to count the clients and types of services received. Data should provide demographic information (age, gender, race/ethnicity) about the population served.

Outcome or Performance Data

Outcome data addresses the impact of the services or intervention. Outcome measures can vary from simple to complex. Simple outcome measures include measuring the high school drop-out rate for students before and after receiving tutoring and social services. Another example is to measure knowledge acquired at a training program by using pre- and post-testing. Examples of complex outcome measures include measuring changes in human behavior or mental health status before and after an intervention. Complex outcome measures typically require multiple tools or testing instruments in order to capture the range of data necessary to draw conclusions.

Surveillance Data

There are various types of surveillance data (e.g., health, criminal justice, vital statistics, and sexually transmitted disease). Surveillance data is used to track various trends either relevant to or affecting the general population.

Collaborative Trend Analysis

Collaborative trend analysis involves the collection, aggregation, and analysis of data from a variety of sources in order to identify trends and patterns.

Considerations in Developing Data Systems

Developing a sound data collection system requires careful planning and ongoing monitoring. Consideration for planning a data collection system include the following:

Database Application (Software Program)

Select the appropriate software program. There are basic database creation tools used by non-profit and governmental organizations. There are database kits that give the user tools to create database applications. For discussion of database design use, refer to Nonprofit Genie at <http://search.genie.org/geni>.

Type of Data

Determine what information is needed for program managers, planners, and decision-makers.

Quality of Data

Devote time and attention to ensure consistent and reliable data collection and data entry. Otherwise, data analysis will be incomplete and inaccurate. Clear definitions, procedures, and staff training is critical.

Flexibility

Adopt a flexible data system that can accommodate changes. A rigid and difficult to modify data collection process may not suit long-term program needs. Over time, and sometimes in response to data and evaluation, programs revise services or targeted clients. As programs change, data systems must be flexible to respond.

Access

Data must be accessible and easily retrievable. Systems designed to produce only periodic reports may not be sufficient for ongoing feedback and internal management.

User Friendly

Keep data collection simple and easy. Otherwise, it will not be used. Excessive time requirements and a complex data collection system may outweigh its value. It is important to

balance the magnitude of data with the ability to manage the system. One pitfall is the “camel syndrome,” e.g., a form devised by a committee whose members think they need every piece of data imaginable but will never use it.

Staff Training

A data collection system is only as reliable as the quality of data entered into it. Training for staff who will collect, enter, and manage the data is essential. Likewise, they must have sufficient time to properly and thoroughly complete data collection and entry requirements.

Pitfalls to Avoid in Data Collection

- Complex forms with easily misunderstood phrases and requirements, including forms designed to collect information that will never be used.
- Insufficient training or time for program staff to complete data collection requirements, resulting in inaccurate, incomplete, or falsified data.
- Inadequate training for staff as to how and why data should be collected, resulting in a lack of commitment to data collection and program evaluation.

Positive Results of Data Collection and Analysis

- Development of a knowledge base upon which to make informed client, program, and policy decisions.
- Information with which to create procedures and protocols, and set standards for the field.
- Understanding of whether or not a program or strategy “works,” and should therefore be replicated, abandoned, or revised.
- Support for making informed funding decisions or for encouraging funders to support the program.
- Ability to hold a program accountable for accomplishing what it promises.
- Information with which to evaluate program effectiveness, and analyze a program’s cost versus its benefit.
- Solid data leads to increase accountability, identification of trends, funding to solve a problem, and answering the fundamental question, “but does it work?”

SART Data

These are optimal recommendations for data elements to document the operations of a SART. All of these data elements are not necessary to operate or record the operations of a SART. It is better to select key data elements that can be reliably collected than to select several or all and not be able to reliably maintain the data system.

Rape Crisis Center

- Number of sexual assault (new clients only) reports to rape crisis centers.
- Number of clients accompanied to a forensic medical exam.
- Number of clients receiving accompaniment services.
- Number of clients receiving counseling services.
- Number of clients follow-up services.
- Number of clients receiving in-person counseling.

Law Enforcement

- Number of sexual assault reports received by law enforcement agencies.
- Number of first-responder law enforcement investigations by patrol officers.
- Relationship of assailant to victim; single offender or multiple offenders.
- Number of victims transported to hospital or by family/friends.
- Number of forensic medical exams.
- Time spent waiting for forensic medical exam to be performed.
- Time spent waiting at the hospital for exam to be completed.
- Number of crime reports assigned to detectives for investigation.
- Disposition information regarding law enforcement investigation outcomes.
- Number of cases referred to the district attorney's office for filing decisions.

District Attorney's Office

- Number of case reports submitted to the district attorney's office.
- Number of cases filed and the charges that were filed.
- Number of preliminary hearings.
- Number of plea bargains, charges/convictions, and sentences.
- Number of trials, charges/convictions, and sentences.
- Case characteristics compared to case outcomes.

Forensic Medical Exam Team

- Total number of sexual assault forensic medical exams performed.
- Number performed by each medical forensic exam team in the county.
- Demographic information about the patient (age, gender, ethnicity).
- Relationship of suspect to victim.
- Patient arrival time/start time of exam/completion time of exam (on the Cal OES 2-923).
- Duration of exam.
- Forensic findings plus random selection of charts for peer review.
- Hours and days elapsed between assault and exam (< 6 hrs, < 12 hrs, < 18 hrs, < 1 day, 1, 2, 3, 4).

Crime Laboratory

- Number of sexual assault evidence kits received for analysis.
- Number of kits analyzed.
- Forensic findings.
- Feedback to forensic medical exam team on quality of evidence kits.
- Results of Fast Track Projects.

Victim/Patient/Survivor Evaluation of Process and Outcomes

Simple, formal feedback form mailed (with permission) to the victim requesting feedback 30 days, 3, 6, and 12 months later rating three factors about SART team functioning: knowledge, competency, and attitude with a comments section. This type of feedback is valuable to examine team functioning. Survivor outcome data would be a valuable research project.

Research

Once the data elements and collection procedures are established, a SART can provide descriptive and outcome data. SARTs can also engage in comparative data analysis regarding outcomes and findings. Research can be done to compare SART jurisdictions with non-SART jurisdictions.

Chapter 21: Preventing Stress and Burnout

There are many published articles, books, workshops, and consultants available to address stress and burnout. There is literature on the subject of secondary victimization. Secondary victimization means the psychological impact of being exposed to repeated stories and first-hand exposure to victimization. This section summarizes the important points to consider in preventing burnout.

- Monitor the number of hours that staff and volunteers have worked so that no one is working a disproportionate number of hours.
- Monitor the types and complexity of cases that staff and volunteers are experiencing.
- Become acquainted with team building exercises to continue to build camaraderie within teams and between inter-agency teams.
- Make sure staff and volunteers take regular and periodic vacations and not embrace an annual pattern of saving up for the “big” vacation—then waiting an entire year before going on vacation again, year after year.
- Monthly meetings with other teams are useful to build camaraderie and reduce “we are in this alone” mentality.
- Sometimes teams get “down.” Hire a consultant to meet with the group to discuss what is going on and what changes could be made to improve matters.
- Make sure team members are apprised of positive outcomes. Information about convictions and prison sentences for convicted offenders enable team members to realize the positive outcomes. They see that the work is worthwhile, and not an endless stream of patients, clients, and victims in the middle of the night.
- Some teams promote social gatherings (e.g., potlucks with team members participating in game show activities, rafting trips, cross-country ski trips, hiking, picnics, for example).
- Ensure that procedures are in place to implement Critical Incident Stress Debriefing (many hospitals have this protocol) for serious, overwhelming, or complex situations.
- Identify ways of expanding benefits (e.g., flex time, discount tickets at theme parks, water-slide parks, ski areas, negotiated discounts for car repairs, and so forth).
- Rotate personnel to other duties and responsibilities or special projects.
- Organize award dinners and newspaper feature stories to ensure public acknowledgment of team members.
- Consider how to celebrate team success other than through prosecution, which sometimes has variables beyond anyone’s control or influence.

Chapter 22: Future Trends

The anti-rape movement, started in the early 1970s by committed, dedicated women, can be proud of its success. Sexual assault, historically a largely misunderstood crime, has gained substantial recognition as a crime by the public and by criminal justice and health care professionals. The perseverance of the anti-rape movement staff and volunteers, and the dedicated efforts of enlightened law enforcement officers, deputy district attorneys, judges, health care providers, and researchers deserve accolades.

Looking to the Future

- SART programs will continue to develop, strengthen, and improve the community response to sexual assault.
- Historic turf issues between agencies will subside with the recognition that no one agency can handle a sexual assault case by itself.
- Improved recognition of predator date rape will increase and gain acceptance by the criminal justice system in most jurisdictions.
- Sexual assault forensic medical exam teams will be developed in nearly every county, and adjacent rural counties will create multi-county teams.
- Technology will continue to impact the forensic medical exam field with direct entry of examination results onto tablets or desktop computers connected to a database.
- Internet-based computer networking systems have emerged to transmit high-quality digital images to experts for consultation on the interpretation of forensic exam findings that are HIPPA compliant. Internet-based computer-to-computer networking is not limited to desktop computers connected to a cable. WiFi allows participants to hold meetings and view images using smart phones and tablets.
- Use of colposcopes, considered state-of-the-art, will be replaced by high-powered magnification cameras with macro lens—a less expensive, but high-quality substitute.
- Standard database programs for recording forensic medical exam findings will advance the field with systematic data collection and for research purposes.
- Internet search engines will expand information about the crime of sexual assault and provide essential information to support the anti-rape movement, the criminal

justice system, and healthcare providers organizing sexual assault forensic medical exam teams.

- Research will be conducted on SART outcomes and effectiveness.
- Increased awareness will develop in schools and communities about sexual assault dynamics, prevalence, and prevention.
- Child abuse prevention and early identification will be established as an important link to prevention of many social problems (e.g., sexual assault, domestic violence, juvenile delinquency/development of conduct disorders, and alcohol and drug abuse).
- Cultural competency will be understood and implemented.
- Public awareness will increase about rape as a tool of war in today's world as well as historically.

Chapter 23: History of SART in California

Origin of SART: Memphis, Tennessee, 1975

The first program having key features of the SART model was established through a federal grant in Tennessee in 1975 by the Memphis Police Department. The program was called The Rape Crisis Center. In a 1986 formal report to the National Institute of Mental Health (NIMH), the program was described as having a director, three counselors, 10 nurse practitioners, a laboratory technician, a secretary, and 45 volunteers. The report states that the early focus of the program was on the medical examination and evidence collection. This program is recognized as the first Sexual Assault Nurse Examiner (SANE) team in the nation. The NIMH report, however, makes it clear that coordinated interviews took place between the city police, county sheriff's department, and the SANE team. In addition, the victims could receive forensic medical examinations without law enforcement agency involvement. Before the grant expired, the program was transferred and made a separate bureau under the City of Memphis Executive Division for reasons of budgetary protection. Although not formally identified as SART, this program had the components of the SART model.

California History of SART Begins 1980

Laura Slaughter, M.D., in collaboration with nurses at San Luis Obispo County General Hospital and with support of local law enforcement agencies, started California's first SART in San Luis Obispo County in 1980. This team, consisting of law enforcement officers, sexual assault advocates, and on-call physicians, conducted joint interviews. According to an early description, "the physician conducted the exam, gave the report to the officer, and testified in court."

In 1985, the team that galvanized the SART movement was started in Santa Cruz County. The Santa Cruz Women Against Rape and Women's Crisis Center and the Santa Cruz City Commission for the Prevention of Violence Against Women were both involved in the early vision for the program. Together with Santa Cruz County District Attorney Art Danner III, they formed a task force in 1985.

The task force invited Dr. Laura Slaughter from the nearby San Luis Obispo County SART to present their model at a meeting in Santa Cruz. Dr. Slaughter was an early advocate for training nurses to be sexual assault forensic medical examiners and became a nationally recognized trainer for forensic nurses. Dr. Slaughter convinced the task force that nurses could perform forensic medical exams and testify effectively in court. District Attorney Danner became a strong advocate for the SART model because he was reportedly concerned about losing sexual assault cases due to problems with forensic medical evidence. He favored the multi-disciplinary approach because it gave support to the victim and strengthened the criminal justice system approach to the crime of sexual assault.

The Santa Cruz Task Force also researched the Sexual Assault Nurse Examiner (SANE) Program in Houston, Texas. The Houston program used registered nurses with advanced training to conduct the forensic medical exam for patients 14 years of age and older. These nurse examiners were on-call to the hospital, collected the forensic evidence, provided a report to law enforcement officers, and testified in court as expert witnesses. After the research was completed, the Santa Cruz Task Force combined the two models and implemented SART for their county in 1985. The Santa Cruz team was awarded a grant to fund a part-time, then full-time coordinator. Sherry Arndt, R.N., M.P.A., the first coordinator, is credited with organizing and implementing the SART/SANE Program for Santa Cruz County.

A progressive state law (Pen. Code § 13823.5) enacted in 1984, established standardized procedures for a forensic medical examination for victims of sexual assault and child sexual abuse, and required healthcare providers to use the standardized form to perform the examination and document findings. This law moved the field of victim services strategically forward by mandating that every county with a population of 100,000 or more have trained sexual assault examiners either on call or on duty at a county-designated hospital. It further required that counties with a population of more than one million designate one sexual assault forensic medical examination team per one million population.

This state law inspired the launch of the clinical forensic medicine discipline for the field of sexual assault in California. It also formalized the sexual assault examination team

as a partner in SART and strengthened relationships between rape crisis centers, law enforcement agencies, prosecutors, crime laboratories, and forensic medical exam teams. The addition of the forensic medical component further galvanized the need for SART, and coordinated inter-agency partnerships

At the same time, law reform to improve and secure victims' rights was marching forward, and specialized law enforcement investigation and prosecution units were formed and grant funded by the state. Public policy at the Governor's Office, Legislature, and state agency level resulted in substantial grant funding directed toward improving victim services and increasing effectiveness by all involved disciplines.

In 1986, the Santa Cruz Task Force established the first SART Institute at Cabrillo College to train its SART and to offer training to other counties on this unique model. They were the first to offer continuing education credit for all disciplines involved. The early relationship with Cabrillo College establishing a training institute was an innovative and progressive approach to replicate the model. The Santa Cruz SART then began official operations in 1987.

The California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims and the required standard state forensic medical examination forms were first issued by the state in July 1987. Development of the statewide protocol and standardized forms was a work in progress from 1984–1987. A state training team comprised of physicians, nurse practitioners, nurses, law enforcement officers, prosecutors, and criminalists provided training at 13 locations throughout California to implement the new protocol. More than 1,500 professionals from all disciplines attended. A training video on the protocol and forms was also issued. These forms were updated and re-issued in 2001, and efforts are underway to update and re-issue an electronic version and accompanying database in 2016.

In 1995, the California Clinical Forensic Medical Training Center (CCFMTC) was established in state law to train physicians and nurses throughout California on how to perform medical/evidentiary examinations for victims of sexual assault, child sexual abuse, child physical abuse and neglect, domestic violence, and elder abuse. Continuous grant funding for the CCFMTC began in 1996 to present. The organizational home for the CCFMTC is the California District Attorneys Association.

Other collaborative training organizations for their respective disciplines include the California Coalition Against Sexual Assault (CALCASA), California Sexual Assault Investigators Association (CSAIA), California Crime Laboratory Directors Association (CCLDA), the California District Attorneys Association (CDAA), and California Network of Child Advocacy Centers (CNCAC). Together, they move the field forward for their respective disciplines and on a multi-disciplinary basis. The California Office of Emergency Services, California Department of Justice, and Peace Officers Standards and Training are important state agency partners. Website information about these organizations is located in the appendix.

SART Recognized in State Law

California State Assemblyman Jim Cooper introduced legislation to establish the concept of SART in state law with statutory objectives. The Governor signed it into law in 2015.

Penal Code Sections 13898–13898.2

13898

(a) Each county may establish and implement an inter-agency sexual assault response team (SART) program for the purpose of providing a forum for inter-agency cooperation and coordination, to assess and make recommendations for the improvement in the local sexual assault intervention system, and to facilitate improved communication and working relationships to effectively address the problem of sexual assault in California.

(b) Each SART program shall be established and implemented pursuant to the provisions of this chapter.

13898.1.

(a) Each SART may consist of representatives of the following public and private agencies or organizations:

- (1) Law enforcement agencies.
- (2) County district attorneys' offices.
- (3) Rape crisis centers.
- (4) Local sexual assault forensic examination teams.
- (5) Crime laboratories.

(b) Dependent upon local needs and goals, each SART may include representatives of the following public and private agencies or organizations:

- (1) Child protective services.
- (2) Local victim and witness assistance centers.
- (3) County public health departments.
- (4) County mental health services departments.
- (5) Forensic interview centers.
- (6) University and college Title IX coordinators.
- (7) University and college police departments.

13898.2.

The program established pursuant to this chapter shall have the following objectives:

- (a) Review of local sexual assault intervention undertaken by all disciplines to promote effective intervention and best practices.
- (b) Assessment of relevant trends, including drug-facilitated sexual assault, the incidence of predatory date rape, and human sex trafficking.
- (c) Evaluation of the cost-effectiveness and feasibility of a per capita funding model for local sexual assault forensic examination teams to achieve stability for this component of the SART program.
- (d) Evaluation of the effectiveness of individual agency and inter-agency protocols and systems by conducting case reviews of cases involving sexual assault.
- (e) Plan and implement effective prevention strategies and collaborate with other agencies and educational institutions to address sexual assault perpetrated by strangers, sexual assault perpetrated by persons known to the victim, including, but not limited to, a friend, family member, or general acquaintance of the victim, predatory date rape, risks associated with binge alcohol drinking, and drug-facilitated sexual assault.

Chapter 24: A Brief History of the Victimology Movement and Rape Crisis Centers

Very Early History

The term “victimology” was coined in 1947 by Benjamin Mendelsohn, a Rumanian, later an Israeli legal scholar at a congress in Bucharest, Hungary. In the very early victimology literature, the focus was on the part played by victims in precipitating crimes of violence through provocation. The German criminologist Von Hentig published an article, “Remarks on the Interaction Between Perpetrator and Victim” (1941) and a book *The Criminal and His Victim* (1948) that focused on the relationships and interactions between the offender and victim before, during, and after the crime. Victims were classified as to their level of involvement in the crime. It was believed that a study of the victim’s role might result in better prevention of crime.

By 1956, Benjamin Mendelsohn shifted to examine the dynamics of criminal behavior without any intent to implicate the victim. He later called for the establishment of “victim’s clinics” to address the personal, social, and cultural needs for rehabilitation after having been victimized.

Other authors continued down the pathway of victim responsibility. Publications by Stephen Schafer entitled the *Victim and His Criminal: A Study into Functional Responsibility* (1968); Essat Fattah, a Canadian criminologist, who published the book, *La victime: est-elle coupable? (Is the Victim to Blame?)*; and Menachem Amir, *Patterns of Forcible Rape* (1971) also focused on victim precipitation of the event.

According to later historians, the idea of victim precipitation also had its origins in the concept of “atonement” for the crime. The responsibility of the offender “to make good by compensating his victim” was related to the degree of responsibility the victim had for the event. The idea of compensation and “making the victim whole” was advanced by the Dutch criminologist W.H. Nagel in 1959 and 1963. This may have laid the groundwork for the early crime victim compensation funds in parts of the United States. For example, the California Victim Restitution Fund was established in 1965.

The criticism against the first generation of victimology researchers was “voiced most clearly” by feminist researchers according to Jan J.M. van Dijk, Ph.D., Professor of Criminology at the University of London and President of the World Society of Victimology at the Ninth Symposium of the World Society of Victimology in 1997.

In relation to violence against women, the issue of victim-precipitation is particularly sensitive. The notion that victims, by their provoking behavior, triggered their victimization by male victimizers—and in fact deserved to be victimized—is part of the patriarchal mindset (regarding culpability) which is at the root of many such crimes. By focusing on the victim’s involvement, attention is diverted from the structural causes of violence against women.

Modern History of Victimology and Victim Assistance

The modern history of victimology, or the study of victimization, is a field of scientific endeavor that began about 1970 (van Dijk, 1997). According to van Dijk, the second-generation victimologists became victim advocates and began to be linked to victim assistance.

The second-generation victimology researchers were influenced by the early feminist writers regarding the concept of “victim blame” and the newer concept of “victim’s rights.” Some of these early writers were Susan Griffin, “Rape: The All American Crime,” *Ramparts* (1971); Susan Brownmiller, *Women Against Rape* (1975); and many research publications by Diana Russell, Ph.D. Sutherland and Scherl published “Patterns of Response Among Victims of Rape” in the *American Journal of Orthopsychiatry* in 1970. Another early writer, Gail Abarbanel, L.C.S.W. published “Helping Victims of Rape” in the *Social Work Journal* (1976) and “Rape—What Your Hospital Can Do to Help” in the *Journal of the Association of Western Hospitals* (1976).

International activities are linked to the World Society of Victimology, which began holding international symposia every three years beginning in 1973. It should be noted that Burgess and Holmstrom presented their *Rape Trauma Syndrome* paper at the First International Symposium on Victimology (September, 1973). The *Victimology Journal* was first published

in 1976, and the World Society of Victimology was created in 1979. The purpose of the Society is to promote research in victimology and the development of programs, policies, or legislation favoring victims and the respect of their rights.

Another researcher/writer deserving recognition is Nicholas Groth, Ph.D., *Men Who Rape: The Psychology of the Offender* (1979) who conducted important research into sex offenders and traveled extensively throughout the United States lecturing during the late 1970s and 80s. His classification study of the anger rapist, the power rapist, and the sadistic rapist helped focus understanding of the crime onto the psyche of the rapist.

The feminist theorists and writers importantly pointed out the false premise and illogic of victim blaming, and linked it to a cultural mindset. Their work provided the inspiration for the anti-rape movement. The research of Ann Wolpert Burgess, D.N.Sc., Linda Lytle Holmstrom, Ph.D., and Nicholas Groth, Ph.D. provided the rocket boosters for the movement with early data to support the alternate point of view—away from victim blame.

Origins of Rape Crisis Centers in the Women's Movement

The first stages of the women's movement began in 1848 and culminated in 1923 when federal legislation was enacted giving women the right to vote and to own property. The Great Depression and World War II marked the next two decades. The labor union movement began in the 1940s and recognized that women received half the pay that men did for equal work. At this time in U.S. history, women went to work in the factories during WWII in large numbers. The labor movement created fertile ground for further evolution of the women's movement.

In the 19th and 20th centuries, rape was used as a tool to express racism. As early as the 1870s, African-American women began to organize anti-lynching campaigns. The Black Women's Club movement emerged in the late 1890s from this organizing effort. This movement was responsible for the inception of several national groups that organized against rape and the response to it in the culture of the United States.

The second stage of the women's movement was sparked by the civil rights movement in the 1960s with the enactment of the Civil Rights Act of 1964. Title VII of the Act banned race and sex discrimination. In October 1966, the National Organization for Women (NOW) was formed to champion the rights of women guaranteed by Title VII and to advocate for other issues and laws on behalf of women.

The women's movement, in turn, spawned two major social movements on behalf of women in the 1970s—the anti-rape movement and the social movement on behalf of battered women. The anti-rape movement developed out of “Speak Outs” in which women gathered and recounted stories of victimization by perpetrators and by individuals and systems responsible for helping them. The first “Speak Out” was held in New York City in 1969. BAWAR (Bay Area Women Against Rape), one of the first rape crisis centers, was established in 1971 in Berkeley, California. This center remains strong today.

What is the Difference Between the 1970s and Today?

In the beginning years of the anti-rape movement, advocacy for improved survivor care was focused on every discipline (e.g., medicine, law enforcement, prosecution, judiciary) to improve intervention practices. Nearly 50 years later, significant progress has been made; however, it is uneven. Many communities either have outstanding forensic medical exam teams, sexual assault investigation units in law enforcement agencies, sexual assault prosecution units in the district attorney's office, or high-profile, well-funded rape crisis centers. No community appears to have it all. The main difference between the 1970s and today is that rape crisis centers are sitting at the community table recognized as equal and integral partners in the SART model.

The early directors of rape crisis centers and the volunteers on the hotlines during the 1970s can be compared to field generals and the infantry in small and large communities throughout the United States. They sent the movement forward. They did this work with little money to operate, long hours, and their own gas. Some experienced severe burnout, and when they departed, others stepped forward to take their place.

Two important national organizations made great strides in the late 1970s and 1980s to move the victims' movement forward—the National Coalition Against Sexual Assault (NCASA) and the National Organization of Victim Assistance (NOVA). Both were started in 1975. A NOVA publication states, “in 1980, the concept of “victim rights” was merely that—a concept.”

In 1980, the Sexual Assault Branch was established by legislation in the Governor's Office of Criminal Justice Planning to provide funding for rape crisis centers. The statute also created the State Advisory Committee on Sexual Assault Victim Services. Earlier that year, the Victim/Witness Assistance Branch was established at OCJP, and five years later, the Domestic Violence Branch was created. Establishment of statewide programs reflects a strong state policy commitment by the California Legislature and the governors of California to fund these programs assisting crime victims and to initiate positive change on their behalf.

In 1984, the field of sexual assault clinical forensic medicine was established by state statute in California. The elements of a sexual assault forensic medical examination were codified in state law; each county with a population of 100,000 or more is required to have an examination team either on call or on duty, counties with populations of one million or more are required to have one examination team per million. This historic statute laid the groundwork for establishing the field of sexual assault clinical forensic medicine, and, added the SAFE/SANE team member to the community table.

In 1995, California state law was expanded further to establish the California Clinical Forensic Medical Training Center to train physicians and nurses to perform quality medical/evidentiary examinations using standardized curriculum, employing telemedicine technology for continued coaching and mentoring examiners, and facilitate the development of new and enhanced community multi-disciplinary SART programs (Pen. Code § 13823.93). Concurrently, in the field of mental health, Post-Traumatic Stress Disorder (PTSD)—which includes Rape Trauma Syndrome—became a diagnostic criteria in the manual published by the American Psychiatric Association and used by medical and mental health professionals throughout the United States. This gave weight and recognition to the psychological reactions experienced by sexual assault victims. Considerable research about PTSD has been underway for decades.

This speaks to the important interplay of victim assistance, victim advocacy, victimology, criminal justice, mental health, and forensic medical research and training. Each field of endeavor advances the other. Disciplines on the front line of intervention see first-hand what is going on in the field, the advocates and professional associations generate policy and legislative ideas to correct the problems and expand the field, and researchers provide strength through data to support ideas and best practice. Each field of work individually and collectively generates innovation. Victimology is an action, policy-oriented field of work that has changed the way entire systems (e.g., law enforcement, prosecution, judicial, medical, and mental health) treat victims.

CALCASA: Moving the Field Forward

The California Coalition Against Sexual Assault (CALCASA) was founded in 1980. It is the only professional organization dedicated to advocating on behalf of and supporting the work of rape crises centers, which operate independently throughout California. CALCASA is committed to ending sexual violence through a multifaceted approach of prevention, intervention, education, research, advocacy, public safety, and legislation.

The organization provides a critical bridge between the efforts made by advocates providing direct services to statewide and federal policy makers. CALCASA is able to relay the challenges and successes of local work to the state and national level; and at the same time convey information about trends emerging at the national level to local rape crisis centers.

Since CALCASA has a national and local perspective of emerging issues and is also familiar with the demographic and cultural makeup of California, it can recommend effective plans to integrate developing issues into direct service programs of rape crisis centers, and provide training and technical assistance. CALCASA has offices in Sacramento and Washington, D.C.

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Marilyn Strachan Peterson, M.S.W., M.P.A., was the director of the Yolo County Sexual Assault Center from 1976–1980. Ms. Peterson initiated the idea of forming the California Coalition of Rape Crisis Centers and, together with her colleagues, organized the first statewide conference held in May 1980. This early organization was the forerunner of CALCASA. Ms. Peterson also served on the Board of Directors for NCASA (National Coalition Against Sexual Assault) in the early 1980s.

Legislative ideas suggested by Ms. Peterson and subsequently enacted into state law include:

- establishing the crime of sexual battery;
- defining consent in the Penal Code for sexual assault using the same definition used in kidnapping;
- removing the term “lunacy” in the original sexual assault statutes;
- standardizing the requirements for sexual assault medical forensic exams into state law and requiring the use of standard protocol and state forensic medical report forms;
- establishing a statewide medical training center to train physicians and nurses to perform quality medical forensic exams and documentation of findings for victims of sexual assault, domestic violence, child abuse and neglect, elder abuse, and assault and abuse against disabled persons;
- establishing standardized medical forensic report forms for victims of domestic violence and elder/dependent adult abuse; and
- establishing the concept of SART in state law.

From 1980–1987, Ms. Peterson was the Chief, Sexual Assault Branch, Office of Criminal Justice Planning (OCJP) responsible for funding California rape crisis centers. During that period, she was assigned the responsibility of developing the California Medical Protocol for the Examination of Sexual Assault and Child Sexual Abuse Victims and the standard state forms (OCJP 923 and OCJP 925 Medical Forensic Report Forms for Sexual Assault and Child Sexual Abuse). This task was completed with the active participation of the Medical Protocol Advisory Committee. She was subsequently given responsibility by OCJP for the revision of the state protocol and forms published in July 2001, in conjunction with

advisory committees. Two additional medical forensic report forms (the OCJP 930 for acute child sexual abuse and the OCJP 950 for suspect exams) were developed. Through state government reorganization, OCJP became part of Cal OES.

From 1988 to 2010, Ms. Peterson was the director of the CAARE Diagnostic and Treatment Center, Department of Pediatrics, UC Davis Medical Center in Sacramento, California. For 16 years, the CCFMTC was part of the CAARE Center, and she had the dual responsibility as director of the California Clinical Forensic Medical Training Center (CCFMTC). The purpose of the CCFMTC, established by state law, is to train health care providers to perform quality medical exams and documentation of findings for victims of sexual assault, domestic violence, child abuse and neglect, elder abuse, and assault and abuse against persons with disabilities. Since 2011, the organizational home for CCFMTC has been the California District Attorneys Association (CDA), and Ms. Peterson is the program director.

Chart A: SART Call-Out Procedures: Law Enforcement Receives the Call First

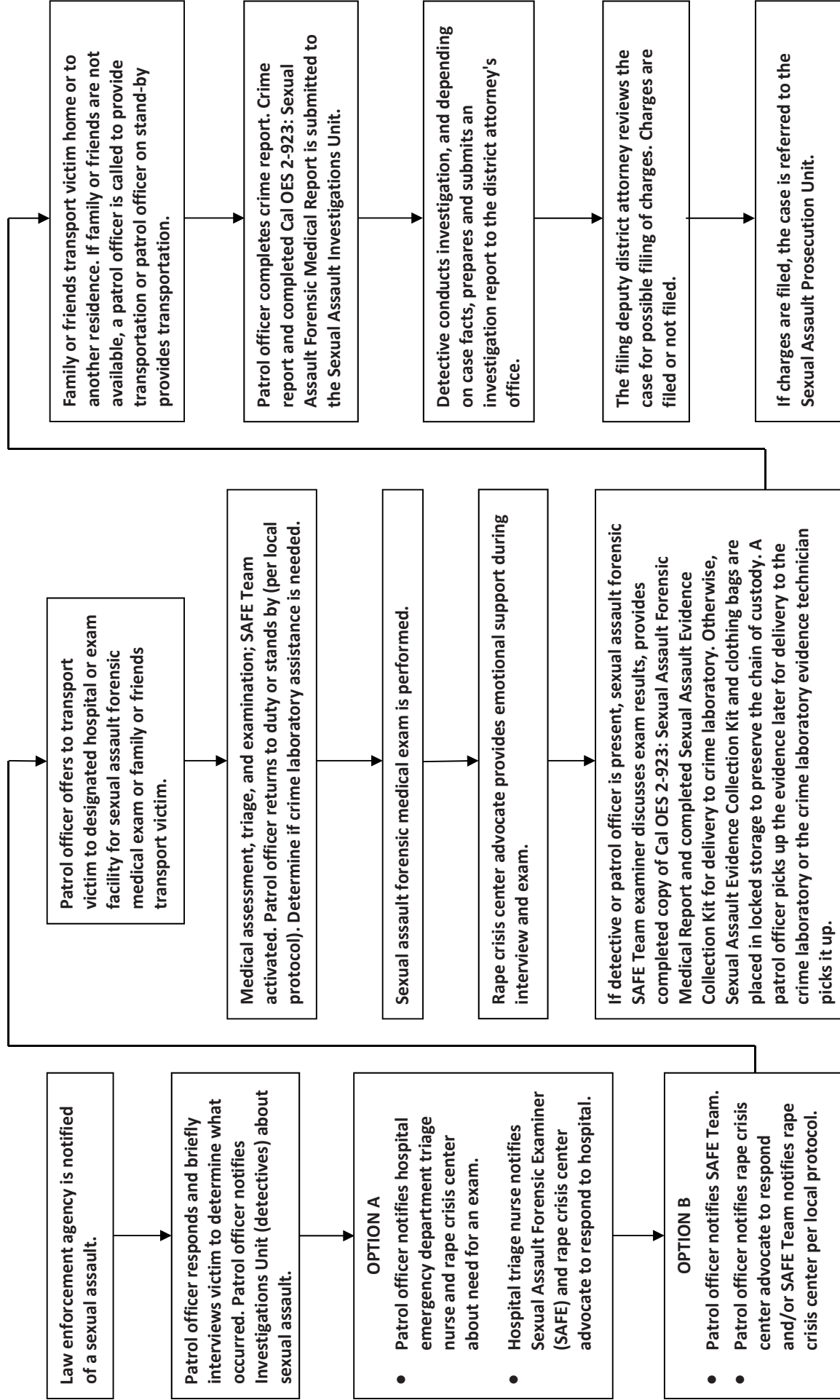


Chart B: SART Call-Out Procedures: Patient Presents at Emergency Department First

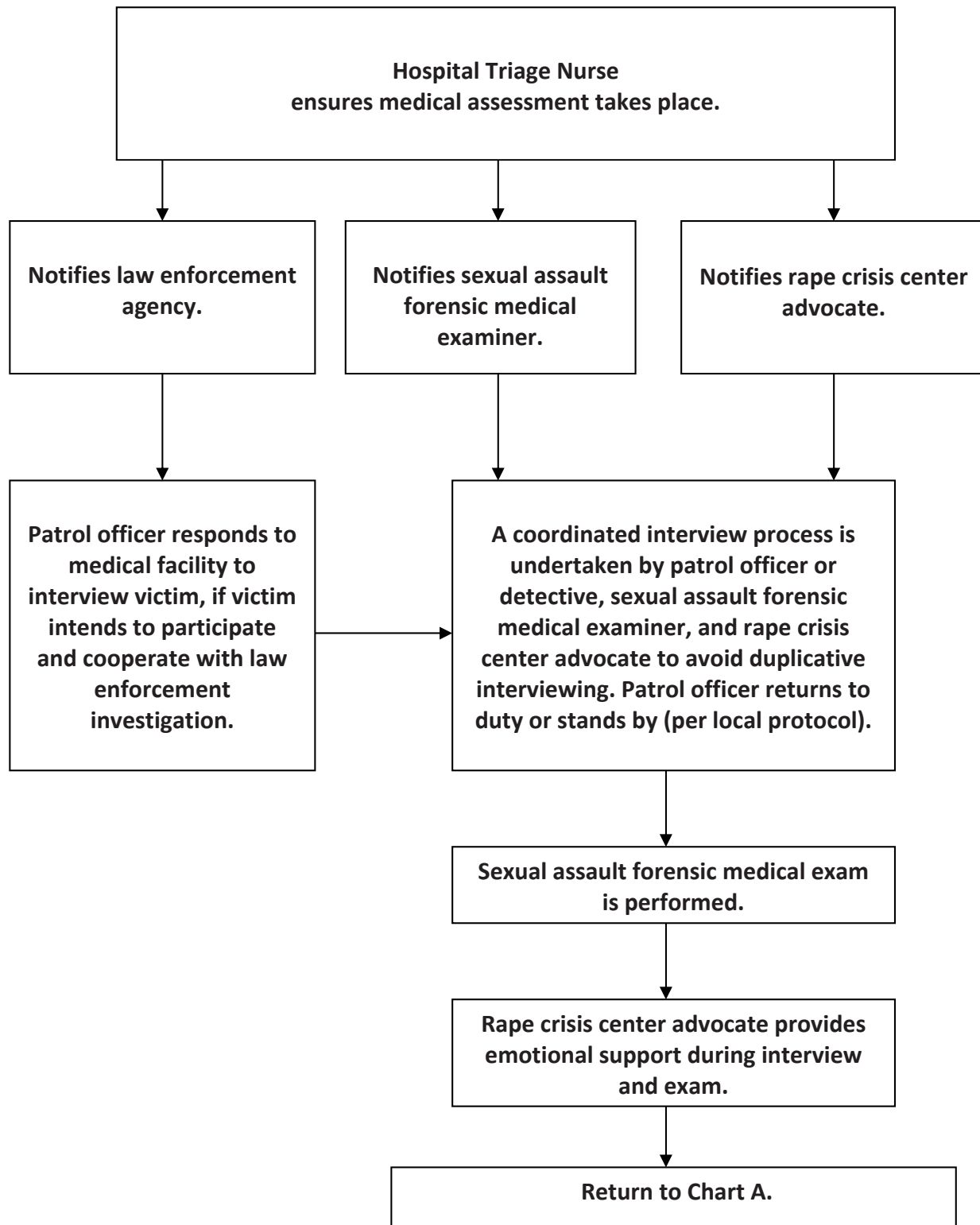


Chart C: SART Call-Out Procedures: Survivor Contacts Rape Crisis Center First

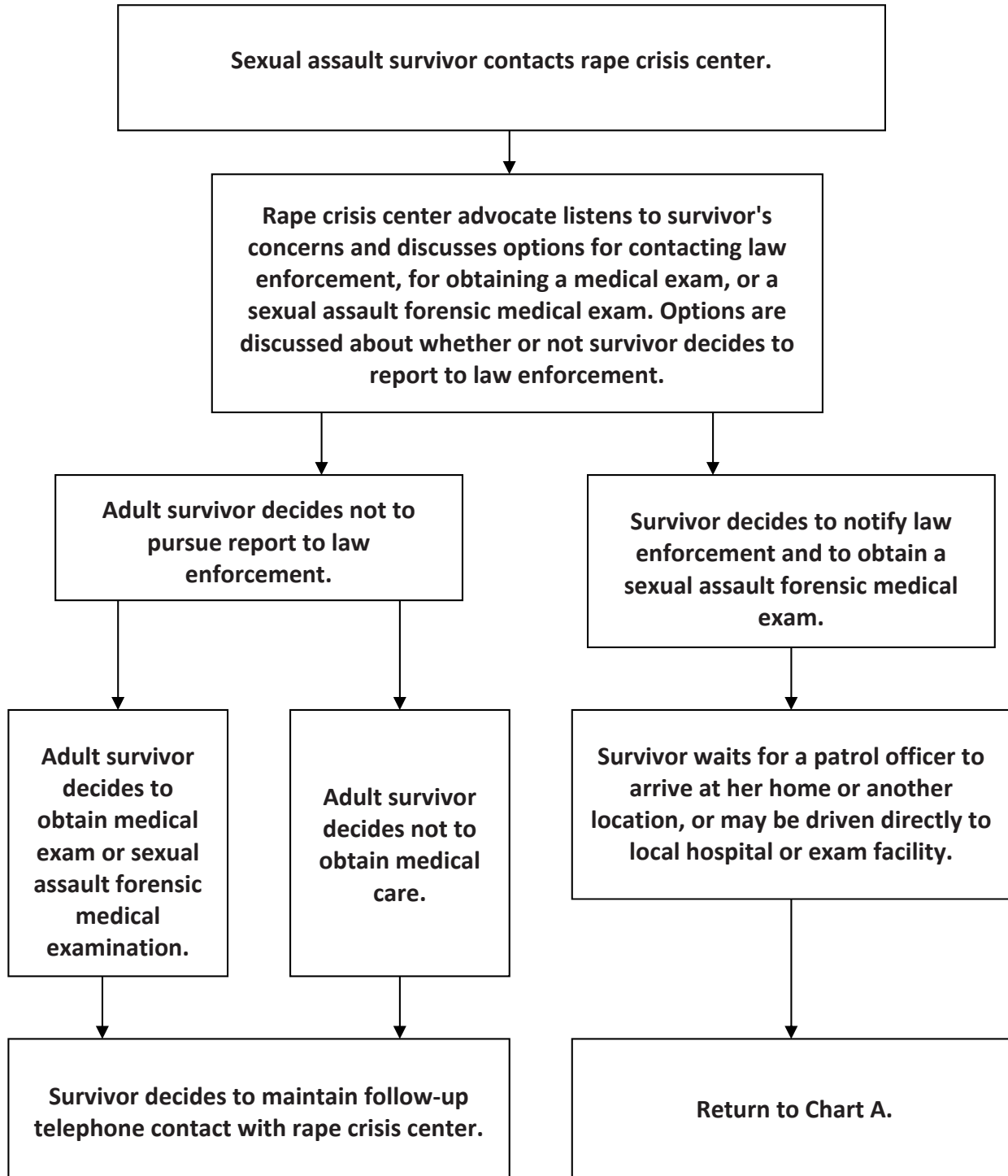


Chart D: Summary of Sexual Assault Forensic Medical Examination Procedures

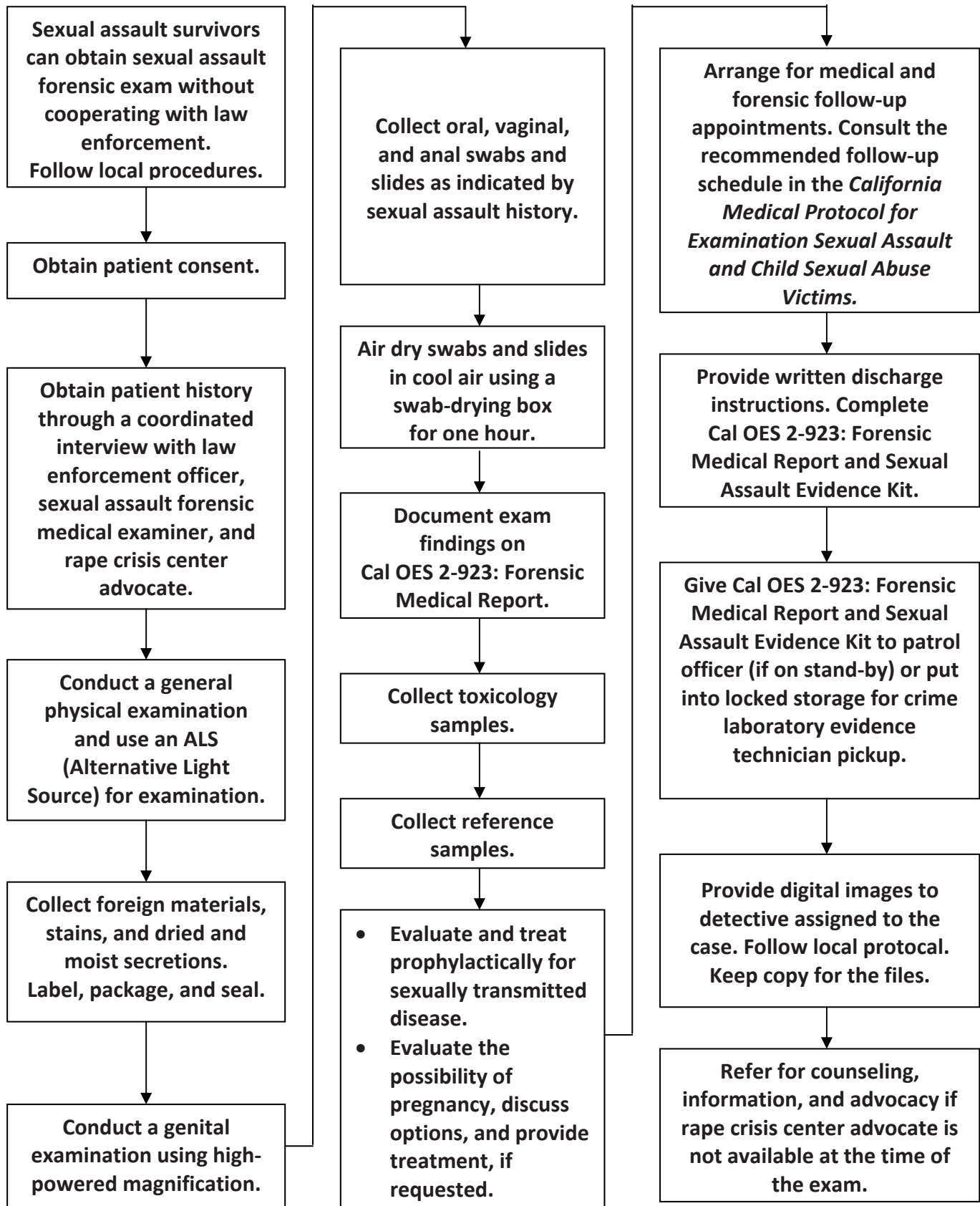
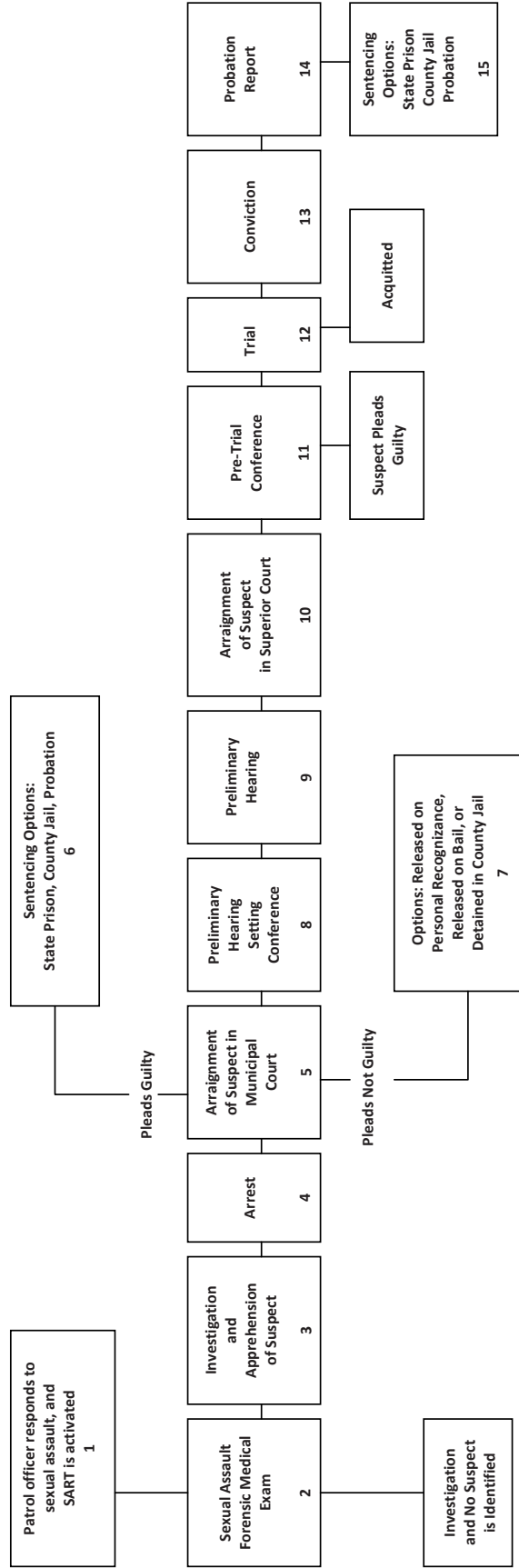


Chart E: SART in the Criminal Justice System



1. Patrol officer briefly interviews victim and activates SART.
2. Patrol officer, sexual assault forensic medical examiner, rape crisis center advocate, and victim meet at SART facility. Forensic medical exam conducted.
3. Investigation and suspect is apprehended.
4. Arrest is made. Deputy district attorney evaluates the case and decides whether to file charges.
5. Arraignment in Municipal Court. Suspect either hires an attorney or a public defender is appointed; informed of charges against him; and bail is set.
6. If suspect pleads guilty to the charges, case does not go to trial. Sentencing Hearing is scheduled.
7. If suspect pleads not guilty to the charges, there are three options. Suspect is released on personal recognizance; suspect is released on bail; suspect is detained in custody (considered dangerous or a flight risk).
8. Preliminary Hearing Setting Conference. Prosecutor and defense attorney meet in judge's chambers to discuss possible settlement (disposition) of case.
9. Preliminary Hearing is held approximately two weeks after the first court appearance. The primary purpose of this hearing is to determine whether there is sufficient evidence to bind the case over to trial.

10. Arraignment of suspect in Superior Court. Suspect is informed of original and any amended charges against him. Suspect can enter a plea. If plea is not guilty, judge will set date for a pre-trial conference and a trial date.
11. Pre-Trial Conference. Various motions can be filed and heard, special reports ordered, and discussion of evidence.
12. The prosecution and the defendant choose a court trial or a jury trial. If defendant is found guilty, a sentencing date is set. Before sentencing, the case is sent to the Probation Department for preparation of a pre-sentencing report.
13. Conviction. The suspect is placed into custody, if not already, pending the Sentencing Hearing.
14. Probation Department conducts background investigation, interviews defendant, and interviews victim to prepare a report to submit to the judge regarding a recommended sentence.
15. Sentencing Hearing is scheduled approximately one month after trial. At the Sentencing Hearing, victim can present written and/or verbal victim impact statement to Judge. Judge may accept or reject Probation Department recommendation and choose his or her own sentence. Sentences may involve commitment to state prison, or to a term of probation that usually includes commitment to county jail.

Appendix A

Sample SART Operational Agreement (OA) or Memorandum of Understanding (MOU)

This Operational Agreement stands as evidence of the commitment of the agencies listed below to implement SART (Sexual Assault Response Team) in this county.

It is hereby recognized that SART is an effective intervention method to ensure competent, coordinated, and effective intervention for victims of sexual assault. SART organizes an inter-agency, multi-disciplinary response to sexual assault for the benefit of the victim and the community. Each agency indicates their commitment to implementing and maintaining SART in the following ways:

- participating in SART planning and implementation;
- training patrol officers and detectives in the SART approach and by implementing first-responder training;
- training deputy district attorneys in the SART approach;
- establishing and obtaining training for the sexual assault forensic medical examiners;
- ensuring victim advocacy and continuity of care for survivors of sexual assault by involving rape crisis center advocates;
- involving the local crime laboratory in training sexual assault forensic medical examiners;
- ensuring coordination with the Victim/Witness Assistance Center to facilitate access to the Crime Victim Compensation Fund, and other services;
- participation by all SART agencies in a monthly SART meeting to ensure smooth operations, problem solving, and case review;
- development and maintenance of a database by each agency and a SART database;
- a commitment to positive, constructive problem solving for the benefit of the sexual assault victim and the community;
- a commitment to effective case review to identify trends, themes, and system problems; and
- ensuring a culturally competent system of care especially including the planning and availability of interpreters.

Rape Crisis Center

Hospital or Sexual Assault Forensic Medical Team

City Police Department

Crime Laboratory

County Sheriff's Department

Victim/Witness Assistance Center

County District Attorney's Office

Appendix B

Sample SART Operating Policies and Procedures

This is a general narrative description of the call-out procedures shown in the charts. Local procedures and protocols may vary.

Law Enforcement Procedures

A. Dispatcher/Communication Procedure

1. Identify the reporting party (R/P) by full name, address, and telephone number. Obtain any pertinent information including age, race, sex, and any other special considerations such as mental or physical disability, or non-English speaking. It may be necessary to obtain directions to the R/P's residence.
2. Attempt to determine if R/P is also the victim. If not, attempt to identify the victim by name, address, telephone number, and present location.
3. Determine if the victim has been physically injured and whether an ambulance is needed.
4. Inquire as to the identity of the suspect. Attempt to obtain a description of both suspect and, if applicable, suspect vehicle and weapon.
 - a. Obtain time of assault.
 - b. Put out crime broadcast, if appropriate.
5. In emergency situations, maintain telephone contact with the R/P or victim and advise that a unit is responding.
6. Log information obtained and action taken.
7. If required by agency procedures, notify watch commander and/or supervisor of the unit investigating sex crimes.
8. Advise the victim or R/P not to wash or remove or clean any clothing from the incident or touch any items at the crime scene.
9. To ensure that all pertinent information is available to investigators, anonymous reports of child or adult sexual assault should be taken, and the R/P and/or victim is encouraged to talk with sex crimes investigators.

B. Patrol Officer/Deputy Procedure

1. Respond to the scene and make contact with the victim.
2. Determine need for immediate medical treatment, need for ambulance, and whether there is a need for a Sexual Assault Forensic Exam (SAFE).
3. Ascertain if a crime occurred. It is sufficient that the victim alleges she was raped or that a suspicion of child abuse exists. Obtain as much initial information as is available for a basic crime report, crime scene search, and crime broadcast.
4. Notify rape crisis center about sexual assault victim (per state law) and where to meet you to provide emotional support for the adolescent/adult victim. A 24-hour hotline telephone service is available countywide.
5. Ensure that a rapid, thorough search for suspects is made, where appropriate.
6. Secure the crime scene and separate witnesses, victim, etc.
7. Transport the victim for a sexual assault forensic medical exam as soon as possible or ensure that a family member or friend can transport the victim. Advise the dispatcher of the estimated time of arrival to activate SAFE/SANE team.
 - a. Victim will be examined by a sexual assault forensic medical examiner within one hour of arrival at medical facility, per local protocol.
 - b. Efficiency is essential. The sooner the examination occurs, the more physical evidence can be obtained.
 - c. If the victim is at her residence or her residence is not too far away, secure a complete change of clothing for the victim unless she has changed prior to reporting the offense. Extra clothing may be available at the exam facility.
 - d. If she has changed, secure all items of clothing worn at the time of the attack as evidence. All clothing items must be packaged in paper bags. Follow crime laboratory protocol regarding wet evidence handling.
 - e. Request assistance of ID unit as appropriate for processing of the crime scene.
 - f. Upon arrival at the exam facility, the officer will sign the authorization on the Cal OES 2-923: Sexual Assault Forensic Medical Report Form.
 - g. The officer will brief the SAFE/SANE team examiner, and then wait outside the exam room while the physical evidence is collected by the examiner. Upon completion of the exam, the examiner will provide the officer with the Sexual Assault Evidence Kit, and both examiner and officer will sign off, thereby maintaining chain of custody.
 - h. Prepare crime report with all available information.

C. Suspect in Custody

1. Separate and isolate multiple suspects.
2. Note all spontaneous statements.
3. Advise sexual assault investigator of situation.
4. Provide *Miranda* admonishment.
5. Arrange for Sexual Assault Suspect Forensic Medical Exam per local protocol even if suspect reports that he bathed. Use Cal OES 2-950 for recording findings.
 - a. Obtain blood, hair (head and pubic), and saliva samples using the Sexual Assault Evidence Kit.
 - b. Obtain, mark, and package clothing in accordance with department policy.
 - c. Photograph suspect: mug shot, any injuries, overall photo of the suspect prior to obtaining clothing.
6. Note characteristics of suspect.
 - a. Under the influence of alcohol/narcotics?
 - b. Physical condition (injuries, etc.).

D. Sexual Assault Investigator

The assigned investigator is responsible for the implementation of the investigative protocol. The investigator must be familiar with the responsibilities and protocols of all other concerned agencies.

1. Location and time of the interview will be dependent on many factors (e.g., medical and emotional factors, need for privacy, physical examination, etc.); however, it should be accomplished at the earliest possible opportunity.
2. If not handled by patrol officer, brief the SAFE/SANE team about the sexual assault history prior to the exam.
3. The victim should not be required to repeat details of the crime more often than is necessary to ensure a thorough investigation.
 - a. Use terminology the victim understands and with which she is comfortable.
 - b. Let the victim relate complete details before asking questions.
 - c. Be empathic and non-judgmental.
 - d. Reassure victim on continuing basis.
 - e. Explain steps to be taken from investigation through prosecution and provide avenues of support.

4. Typical guidelines for the first interview
 - a. Suspect description in depth.
 - (1) Complete physical description.
 - (2) Peculiarities, oddities, tattoos, scars, and marks.
 - (3) Odor: cigarettes, marijuana, alcohol, body, aftershave.
 - (4) Hair color, style, length.
 - (5) Dress: hat to shoes.
 - (6) Speech pattern, accent, slurs.
 - (7) Weapon used, if any.
 - (8) Vehicle used.
 - b. Method of attack.
 - (1) First thing perpetrator said to victim.
 - (2) Quote victim, if (s)he can remember.
 - c. First sexual act demanded or attempted.
 - (1) Method used to complete act.
 - (2) Anything said before or after act.
 - (3) Any tools or items used.
 - (4) Physical evidence left at the scene or with victim.
 - d. Additional sexual acts demanded or accomplished.
 - (1) Method used to complete act.
 - (2) Anything said before or after act.
 - (3) Any tools or items used.
 - (4) Physical evidence left at the scene or with victim.
 - e. Where applicable, obtain Identi-kit or artist drawing of suspect.
 - (1) Best done at end of interview.
 - (2) Consider artist if Identi-kit does not meet need.
 - (3) Circulate to patrol and other area law enforcement agencies.
 - (4) Newspaper release, if applicable.
5. Coordinate investigation with responding patrol officers, identification technician, SAFE/SANE team.
 - a. All evidence has been seized, marked, packaged, stored, and submitted to crime lab properly.

- b. All witnesses have been identified and questioned.
 - c. The victim, suspect, and crime scene have been photographed as needed.
 - d. All appropriate reports and statements are completed and made a portion of the case file. These reports should be checked against each other to ensure accuracy.
6. If the suspect is arrested:
- a. complete Sexual Assault Evidence Kit on him / her or contact local provider;
 - b. take all clothes;
 - c. search warrant for item(s) secured in residence, vehicle, etc.;
 - d. photo-document all injuries on suspect from victim, if any; and
 - e. make sure Cal OES 2-950 is complete.
7. Carry investigation to successful conclusion using accepted and appropriate investigative procedures.
- a. Check with other law enforcement agencies for any similar attacks:
 - (1) circulate information and M.O. to other law enforcement agencies per local protocol;
 - (2) Local parole office;
 - (3) CDCR—Division of Juvenile Justice;
 - (4) Department of Justice: Sex Crimes Unit/Penal Code section 290 registration;
 - (5) Multi-County or Multi-Agency (per local protocol) Investigators Association meetings and California Sexual Assault Investigators Association newsletter.
 - b. If assault fits a pattern (consider day, date, time, area, M.O., victim type):
 - (1) consider a stake out;
 - (2) operate a victim “agent” in the pattern;
 - (3) check pattern and method of operation with previous arrests by your agency and surrounding agencies.
8. Present investigative findings to the district attorney’s office for issuance of criminal complaint(s). Conduct necessary follow-up on as needed basis.

Sexual Assault Forensic Medical Examiners

The Sexual Assault Forensic Examiner (SAFE) responsibility is two-fold—to ensure medical treatment for the victims and to conduct forensic medical examinations using the Cal OES

2-923: Sexual Assault Forensic Medical Exam Report Form for sexual assault victims over age 14 (per local protocol) on a 24-hour basis. For young victims under age 14, specially trained pediatric examiners may be available and will use the Cal OES 2-925 (non-acute child sexual abuse) or Cal OES 2-930 (acute child sexual abuse) Forensic Medical Report forms.

A. Notification Procedure for SAFE/SANE Team:

1. Dispatcher will notify hospital triage or the on-call nurse examiner (SAFE/SANE team) providing the following information:
 - a. victim name, age, sex;
 - b. injuries;
 - c. any special needs: physical/mental/language;
 - d. number and sex of accompanying significant others;
2. Hospital triage nurse will contact the SAFE/SANE team, or the pediatrician or nurse practitioner, if the victim is under age 14 or if the victim is pre-pubescent, per local protocol.

B. Non-Injured Sexual Assault Victim

1. The SAFE team member on call or on duty will be notified by dispatch or triage nurse that a sexual assault forensic medical exam has been requested.
2. The SAFE team member will call the back-up physician, if there are injuries.
3. The SAFE team member will call rape crisis center advocate/counselor, if they are not already there.
4. The SAFE team member will be briefed by the law enforcement officer prior to performing the exam.

C. Injured Sexual Assault Victim

If the responding officer alone, in consultation with the triage nurse or SAFE team member, determines the need for medical attention, the patient will be seen in the Emergency Department, per local protocol.

D. Follow-Up Procedures: After Sexual Assault Forensic Medical Exam

1. Discharge client with written follow-up instructions.

2. SAFE team member will transport all non-crime lab evidence (e.g., pregnancy test, samples for STD testing) to the hospital laboratory or clinic, per local protocol.
3. Law enforcement officer or crime lab technician will transport Sexual Assault Evidence Kit to crime laboratory.
4. Lock SAFE exam area.

Rape Crisis Center Advocate/Counselor

The rape crisis advocate/counselor's role is to provide emotional support, information, and advocacy on behalf of the victim and her/his significant others. Services are provided according to the mandated standards set forth by the California Office of Emergency Services. The advocate also acts as a supportive team member.

A. General Role

1. Per state law, law enforcement is required to notify the rape crisis center. New state law requires hospital and/or SAFE team to ask the patient's permission to notify the rape crisis center if he or she is not already there or en route.
2. Initial contact requesting rape crisis services may also come from triage nurse or sexual assault forensic medical examiner. Identify yourself and give an estimated time of arrival. If requested, make yourself available to speak directly to the victim or significant others by phone.
3. Identify location of and any special needs the victim and accompanying party may have. Attempt to meet whatever special needs they may have.
4. Upon arrival, introduce yourself to all SART members and the victim and her/his significant others and explain your role, if it has not already been explained by the other team members.
5. Provide emotional support and information to the victim while the officer/deputy conducts the interview. Support the officer/deputy's need to ask specific and difficult questions.
6. Per state and federal law, a sexual assault victim may request a sexual assault forensic medical exam without cooperating or engaging with law enforcement.
7. Before the medical examination, inform the victim that you and/or a significant other can be with her during the exam to provide emotional support. If appropriate,

explain what the sexual assault forensic medical exam entails, and assist the examiner and officer in answering any questions the victim might have. The SAFE/SANE examiner most commonly interviews and describes exam procedures to the patient.

8. Give the victim the SART information packet, extra clothing, and address any additional concerns the victim may have.
9. Assure the victim and his/her significant others that they may call the rape crisis hotline anytime, 24 hours a day for support and information. Arrange for telephone or in-person contact. Provide on-going support to the victim and her/his significant others after the initial contact as appropriate.

B. Hospital or the SAFE/SANE Team Examination Site

1. Upon arrival at the site, SART advocates:
 - a. Notify registration that they have arrived.
 - b. Inquire about the whereabouts of the survivor.
 - c. Inquire about whether or not the survivor has been registered.
2. When meeting the survivor, SART advocates:
 - a. Introduce themselves and the organization they represent.
 - b. Explain why they were contacted, including the survivor's right to an advocate.
 - c. Offer to contact a support person if the survivor is alone.
 - d. Inquire if there is anything the survivor needs before beginning.
 - e. Inform the survivor that anything she or he says to the advocate in private is strictly confidential and cannot be repeated to anyone without her/his written consent.
 - f. Provide emotional and technical support.
 - (1) Reassure the survivor that she or is safe now.

- (2) Provide empathy and support.
 - (3) Validate the survivor's responses.
 - (4) Encourage the survivor to talk about what happened.
 - (5) Discourage feelings of guilt and self-blame.
 - (6) Listen.
- g. Explain to the survivor that she or he has the right to ask any questions at any time before, during, and after the medical exam.
- h. Be prepared to clarify any questions regarding the sexual assault forensic medical exam, if needed.
- (1) Explain why it is important that the survivor have a medical exam performed:
 - To determine if any physical injuries have occurred.
 - To evaluate the possibility of pregnancy and discuss treatment options.
 - To evaluate the possibility of contracting a sexually transmitted disease and provide prophylaxis.
 - To collect forensic evidence for possible prosecution.
 - (2) Generally describe the questions that medical personnel will ask and why it is important that the survivor answer them to the best of her/his ability.
 - (3) Understand and generally describe forensic medical exam procedures.
 - Explain the consent form allowing photographs to be taken.
 - Explain why the collection of clothing worn during the attack is important for forensic analysis and possible prosecution.
 - Explain that the first part of the exam is to check for any physical injuries and that it is important to tell the healthcare provider about any pain, tenderness, or discomfort the survivor feels.

- Explain that the second part of the exam will be to collect any physical evidence that may be present.

(4) Regularly inquire if the survivor has any questions.

- Provide clarifying information and reinforce explanations given by the SAFE/SANE team examiner regarding medical and forensic exam procedures. Consult the suggested follow-up schedule in the *California Medical Protocol for the Examination of Sexual Assault and Child Sexual Abuse Victims* and the chapters on the possibility of pregnancy and sexually transmitted disease.
- Encourage the survivor to make a follow-up appointment in two weeks with her/his personal physician.
- Refer the survivor to the local rape crisis center and other relevant community resources that can help with her/his healing process.
- Leave a business card and information about how to access rape crisis center services, including the 24-hour hotline number, and a card with case information and contact numbers.
- Inform the survivor about rape crisis center services, and that she or he will be contacted within 72 hours.
- Prepare a list of possible needs the survivor may have and which agencies and community resources can best aid the survivor with those needs.
- Within 72 hours, SART advocates:
 - Contact the survivor.
 - Explain why the survivor is being contacted.
 - Explain that the advocate is available for supportive services and follow-up interviews.
 - Provide emotional and technical support.
 - Inquire if there is anything else the advocate can do at this time.

C. Law Enforcement

1. At the exam site and with law enforcement present, advocates:
 - a. Introduce themselves and the organization they represent.
 - b. Explain why they were contacted.
 - c. Inquire as to whether or not the officer has any requests.
 - d. Provide information to assist the survivor in deciding whether to file a police report, if this decision has not been made. Explains the pros and cons of this decision:
 - (1) Explain the importance of filing a police report.
 - (2) Explain the questions that law enforcement personnel will ask and why it is important that the survivor answer them to the best of her/his ability.
 - (3) Offer to attend all follow-up interviews with the survivor.
2. Support the survivor's decision regarding whether or not to file a police report.
3. Follow up and inquire which detective is handling the case.
4. When requested by law enforcement to be present during follow-up interviews advocates:
 - a. Contact the survivor and let him/her know that you have been invited to attend.
 - b. Inquire if the survivor will feel comfortable with an advocate present.
 - c. Inquire if the survivor has any special requests.
5. When requested by the survivor to be present during follow-up interviews, advocates:
 - a. Contact the detective and inform her/him of the survivor's requests.
 - b. Inquire if the detective has any requests.

D. Court Proceedings

1. Advocates
 - a. Inquire as to which deputy district attorney is handling the case.
 - b. Inquire about prosecution decisions and outcomes.
 - (1) Inform the survivor if more follow-up investigation by law enforcement is required.
 - (2) Inform the survivor whether or not charges have been filed.
 - (3) Inquire as to the date, time, and location of the preliminary hearing.
 - (4) Be prepared to discuss why charges were unable to be filed.

2. When requested by the deputy district attorney to be present during interviews, advocates:
 - a. Contact the survivor and let her/him know that you have been invited to attend.
 - b. Inquire if the survivor will feel comfortable with an advocate present.
 - c. Inquire if the survivor has any special requests.
 3. When requested by the survivor to be present during interviews, advocates:
 - a. Contact the deputy district attorney and inform her/him of the survivor's request.
 - b. Inquire if the deputy district attorney has any special requests.
 4. Provide emotional and technical support at the preliminary hearing and throughout the trial.
 5. Provide support to the survivor, and offer guidance in writing the victim impact statement and requesting restitution.
- E. Follow-up Counseling Services and California Victim Compensation Program (CalVCP)
1. Describe counseling services offered by the rape crisis center.
 2. Provide options about seeking counseling from private therapists in the community.
 3. Describe the California Victim Compensation Program (VCP) benefits such as payment for out-of-pocket medical expenses, psychological counseling, and job rehabilitation.
 4. Offer to assist in completing the application to the Victim Compensation Program or refer them to the county victim/witness assistance center. An advantage to working with the victim/witness assistance center is that they can check on the status of the application and reimbursements. Survivors can also apply online to the state program; however, local support from the victim/witness assistance center can be very helpful.

Appendix C: Examples of SART Forms

SART CLIENT SERVICES

Client _____ *SART Advocate* _____

Address _____ City/State/ZIP _____

Phone No. _____ Message No. _____ Agency ID? No Yes

DOB _____ Age _____ Gender _____ Ethnicity _____ Interpreter? No Yes

Law Enforcement Case No. _____ Detective _____ Date Assigned _____

Family/Friend _____ Relationship _____

Hospital _____

Social Services _____

LE Initial _____

LE Detective Interview _____

LE Line-Up _____

Rape Crisis Center _____

Crisis Intervention _____

Accompaniment Services _____

Follow-Up Counseling _____

Logistical Support Services _____

Victim/Witness Assistance Center _____

DA Initial Interview _____

DA Follow-Up Interview _____

MDIC or CAC Interview _____

Preliminary Hearing _____

Trial _____

Sentencing _____

36-Hour Follow-Up _____

3-Month Follow-Up _____

6-Month Follow-Up _____

Other Court Proceedings: _____

Other Advocacy and Referrals: _____

SART CLIENT SERVICE LOG

<p>Client _____</p> <p>Address _____</p> <p>City/State/Zip _____</p> <p>Phone No. _____ Message No. _____</p> <p>DOB _____ Age _____ Gender _____ Ethnicity _____</p> <p>Interpreter? <input type="checkbox"/> No <input type="checkbox"/> Yes _____</p> <p>Family/Friend _____</p> <p>Relationship _____ Phone _____</p>	<p>Billing Source:</p> <p>_____</p> <p>_____</p>
<p>Date Case Assigned _____ Forensic Medical Report? <input type="checkbox"/> No <input type="checkbox"/> Yes _____</p> <p>Law Enforcement Case No. _____ Detective _____</p> <p>District Attorney Case No. _____ Deputy DA _____</p> <p>Court Case No. _____</p>	<p>Referral Source:</p> <p>_____</p> <p>_____</p>
	<p>Service Units:</p> <p>1 Hour = 1.00</p> <p>¾ Hour = 0.75</p> <p>½ Hour = 0.50</p> <p>¼ Hour = 0.25</p>
	<p>Follow-Up Assessments:</p> <p><input type="checkbox"/> 36 hours</p> <p><input type="checkbox"/> 3 Months</p> <p><input type="checkbox"/> 6 Months</p>
	<p>How Was Case Closed?</p> <p><input type="checkbox"/> Suspended _____</p> <p><input type="checkbox"/> NCF _____</p> <p><input type="checkbox"/> Conviction _____</p>

SART Services Provided					Case Disposition	
Date	Code*	Time	Units	Description	Date	Code*

SART Service Codes

Crisis Intervention

C101 Emotional Support
C102 Technical Support
C103 Other

Follow-Up

FU01 Phone Contact
FU02 In-Person Contact
FU03 Counseling Scheduled
FU04 Victim/Witness Appointment Scheduled
FU05 Other

Information

IF01 Hospital Process
IF02 Law Enforcement Process
IF03 District Attorney Process
IF04 Court Process
IF05 Case Update
IF06 Other

Agency Referral

AR01 Adult Protective Services
AR02 California Legal Services, Inc.
AR03 Children's Protective Services
AR04 District Attorney
AR05 Family Court Services
AR06 Health Services Agency
AR07 Law Enforcement
AR08 Rape Counseling Service
AR09 Victim/Witness Assistance Center
AR10 Crisis Center
AR11 Other

Agency Referral

AD01 Hospital
AD02 MDIC
AD03 Law Enforcement
AD04 District Attorney
AD05 Court Proceedings (Pre-trial to Sentencing)
AD06 Adult Protective Services
AD07 Children's Protective Services
AD08 Victim/Witness Assistance Center
AD09 Other

SART Case Disposition Codes

Case Disposition

Law Enforcement

CDL01 Law Enforcement Follow-Up Investigation
CDL02 Victim Refused/Unavailable to Participate
In Investigation
CDL03 Case Unfounded by Detective
CDL04 Case Suspended by Detective
CDL05 Suspect Arrested
CDL06 Referred to Prosecutor's Office for Filing

District Attorney

CDA01 No Charges Filed by the District Attorney
CDA02 District Attorney Follow-Up Investigation
CDA03 Victim Refused/Unavailable to Participate in
Prosecution
CDA04* Charges Filed
*a Felony
*b Misdemeanor
CDA05 Defendant Held to Answer at Preliminary
Hearing (Victim Testified)
CDA06 Defendant Referred to Municipal Court
(Penal Code Section 17)
CDA07 Defendant Held to Answer
(Proposition 115 Prelim)
CDA08 Defendant Not Held to Answer
CDA09 Conviction by Plea to Original Charges
CDA10 Conviction by Plea to Lesser Charges
CDA11 Conviction by Trial to Original Charges
CDA12 Conviction by Trial to Lesser Charges
CDA13 Defendant Found Not Guilty

EVALUATION FORM

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

Initial Contact	Location: _____	Date: _____			
	Staff Person: _____				
	Strongly Agree	Agree	Disagree	Strongly Disagree	Does Not Apply
The police officer(s) treated me with concern and respect when she/he interviewed me.					
The hospital staff and SAFE treated me with concern and respect during my examination.					
The SAFE explained to me what to expect during my examination.					
The rape crisis center staff treated me with concern and respect.					
The rape crisis center staff gave me valuable information about clothing, housing, and referrals.					
The rape crisis center staff helped me to feel supported instead of alone.					
The entire SART team encouraged me to seek counseling. <input type="checkbox"/> Yes <input type="checkbox"/> No					
Two Week Contact	Location: _____	Date: _____			
	Staff Person: _____				
	Strongly Agree	Agree	Disagree	Strongly Disagree	Does Not Apply
The police detective who handled my case treated me with concern and respect.					
The police detective handling my case listened to me.					
The police detective who handled my case kept me informed about the process.					
The SART staff person listens to me and supports me.					
I have seen a doctor for a follow-up visit. <input type="checkbox"/> Yes <input type="checkbox"/> No					
I still have experienced some of the following:					
<input type="checkbox"/> Anger	<input type="checkbox"/> Depression	<input type="checkbox"/> Guilt	<input type="checkbox"/> Physical Pain or Discomfort		
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Distraction	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Unable to Focus		
<input type="checkbox"/> Cry Easily	<input type="checkbox"/> Fear	<input type="checkbox"/> Nightmares			
	Yes	No			
I am currently seeing a counselor for individual therapy.					
My family is in therapy.					
I am currently in a support group for victims of sexual assault.					
I have been helped completing the application for Crime Victim Compensation.					

Three Month Contact		Location: _____		Date: _____	
		Staff Person: _____			
	Strongly Agree	Agree	Disagree	Strongly Disagree	Does Not Apply
The deputy district attorney and staff have been helpful and supportive.					
The deputy district attorney and staff have kept me informed of my case and informed me of my legal options.					
The deputy district attorney decided not to file charges against the perpetrator because:					
The deputy district attorney and staff gave me information in a sensitive and respectful manner.					
I have seen a doctor for a follow-up visit. <input type="checkbox"/> Yes <input type="checkbox"/> No					
I still experience some of the following:					
<input type="checkbox"/> Anger	<input type="checkbox"/> Depression	<input type="checkbox"/> Guilt	<input type="checkbox"/> Physical Pain or Discomfort		
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Distraction	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Unable to Focus		
<input type="checkbox"/> Cry Easily	<input type="checkbox"/> Fear	<input type="checkbox"/> Nightmares			
	Yes	No			
I am currently seeing a counselor for individual therapy.					
My family is in therapy.					
I am involved in a support group led by a counselor/ therapist.					
My family supports me (e.g., they are patient and understanding).					
My friends support me (e.g., they are patient and understanding).					
I am currently working with the Victim/Witness Assistance Center.					

Six Month Contact		Location: _____		Date: _____	
		Staff Person: _____			
	Strongly Agree	Agree	Disagree	Strongly Disagree	Does Not
The deputy district attorney and staff have been helpful and supportive.					
The deputy district attorney and staff have kept me informed of my case and informed me of my legal options.					
My physical trauma symptoms (e.g., pain, discomfort) are lessening.					
My emotional trauma symptoms (e.g., anxiety, fear, anger, depression) are lessening.					
	Yes	No			
My case has come to trial.					
My case has been dismissed.					
The SART staff is still working with me.					
The Victim/Witness Assistance Center is working with me.					
I am seeing a counselor for individual therapy.					
My family is in therapy.					
I am involved in a support group led by a counselor/therapist.					
My family supports me (e.g., they patient and understanding).					
My friends support me (e.g., they patient and understanding).					
I still experience some of the following:					
<input type="checkbox"/> Anger	<input type="checkbox"/> Depression	<input type="checkbox"/> Guilt	<input type="checkbox"/> Physical Pain or Discomfort		
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Distracted	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Unable to Focus		
<input type="checkbox"/> Cry Easily	<input type="checkbox"/> Fear	<input type="checkbox"/> Nightmares			

One Year Contact	Location: _____	Date: _____
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Looking back over the past year, what service(s) was most helpful to you?

What service(s) was most helpful to your family?

What was the least helpful experience you had?

What would you change?

Appendix D

Patient Rights, Consent, and Incapacity to Give Informed Consent

Patient Rights and Consent for the Sexual Assault Forensic Medical Examination

Patients have the right to refuse an examination for the purpose of collecting evidence. Consent for evidence collection, once given, can be withdrawn at any time during the examination. Patients have the right to refuse the collection of reference specimens, such as pubic and head hair; blood and/or saliva for typing; and blood and/or urine for toxicology.

There are four separate consent items on the Cal OES 2-923 Sexual Assault Forensic Medical Report:

- consent for the examination at public expense and release of the forensic medical report to law enforcement authorities;
- consent for photographing injuries including the genital area;
- general consent for a forensic medical examination; and
- collection of de-identified exam data for health and forensic purposes to persons with a valid educational or scientific interest for demographic and/or epidemiological studies.

Minors: Consent Issues

- Minors 12 years of age and older may give consent to the provision of medical care related to the diagnosis or treatment of a sexual assault and the collection of evidence (Fam. Code §§ 6927 and 6928). The reverse is also true; they have the right to refuse consent.
- Minors 12 years of age and older may give consent to the provision of medical care related to the prevention of treatment of pregnancy (Fam. Code § 6925).
- Minors 12 years of age and older may give consent to the provision of medical care related to the diagnosis or treatment of sexually transmitted diseases (Fam. Code § 6926).
- Consent given by a minor is not subject to disaffirmance because of minority (Fam. Code § 6921). This means that a minor's rights cannot be taken away by an adult.

- Family Code section 6500 defines a minor as an individual who is under 18 years of age.

Minors: Non-Consent Issues

- *Non-consent by minors:* Since California law clearly establishes a minor's right to consent, the reverse is also true; they have the right to refuse consent. Questions regarding minors' rights should be directed to the district attorney's office or to hospital counsel.
- *Non-consent by children under age 12:* The conventional and collective wisdom of child abuse experts is to never force a sexual abuse forensic medical examination upon a child. This can have the effect of terrorizing the child and rekindling the memories of victimization. It can also create fear of healthcare providers.

For a non-acute examination, reschedule the appointment and use the first visit to acquaint the child with the surroundings and the personnel. For an acute exam or a non-acute exam when there is suspicion of a foreign body in the vagina or other medical concerns, consider sedation and follow the established sedation protocol. Never hold a child down for an examination, and never allow anyone else to hold a child down for an examination.

Incapacity to Give Consent for a Sexual Assault Forensic Medical Examination

Patients may be considered temporarily incompetent for giving consent because of incapacitating injuries, sedation, alcohol or drug intoxication, hallucinations, delusions, mental retardation; acute organic brain syndrome from any cause; or permanently incompetent because of irreversible dementia.

For purposes of consent for medical treatment, competency is defined as the ability to understand the nature and consequences of the illness, the proposed treatment, alternatives to treatment, and the ability to make a reasoned decision in this regard.

For medical purposes, competency is required at the time consent is given. If consent or refusal was given by the patient during a period of competency, then that consent or refusal

remains valid even if the patient later lapses into incompetency. If a patient is assessed to be incompetent, the basis for this must be documented in the patient's chart. If the patient is not competent to give informed consent, then another authorized party must approve the proposed treatment on the patient's behalf.

In the case of sexual assault, and in the absence of state law on this subject, it is recommended that specific procedures be developed in conjunction with law enforcement agencies, the district attorney's office, and hospital counsel.

Without a protocol, obtaining sexual assault forensic medical evidence without appropriate consent procedures could subject an examiner or a hospital to serious legal liability. Some strong views have been expressed on this issue, particularly involving a temporary incapacity to give consent.

This issue is described more in depth with specific recommendations in the CCFMTC publication *Developing a SAFE/SANE Team*.

In general, the best approach is the following:

In a medical emergency, treatment may be provided even if the patient or his/her legal guardian or conservator is unable to give consent. However, the nature of the emergency and the need for treatment must be clearly documented in the medical progress note. Only the emergency condition may be treated. Once the patient's condition has been stabilized, informed consent or a court order for additional treatment must be obtained. Some institutions require signatures of two physicians or healthcare providers attesting to this circumstance. It is recommended that this documentation include information that evidence will be lost or will deteriorate unless it is collected immediately.

Definitions

Non-Emergency Medical Care — A non-emergency condition means that the patient is medically stable.

Emergency Medical Care— Emergency medical care or a medical emergency means that prompt treatment appears to be necessary to prevent deterioration or aggravation of the patients' condition.

Appendix E: List of Training Organizations by Discipline

California District Attorneys Association

921 11th Street, Suite 300

Sacramento, CA 95814

www.cdaa.org

POST (Peace Officers Standards and Training)

860 Stillwater Road, Suite 100

West Sacramento, CA 95605

www.post.ca.gov

California Crime Laboratory Directors Association

4800 Broadway, Suite 200

Sacramento, CA 95820

www.caclld.net

California Sexual Assault Investigators Association

712 Bancroft Road, Suite 151

Walnut Creek, CA 94598

www.csaia.org

California Clinical Forensic Medical Training Center

921 11th Street, Suite 300

Sacramento, CA 95814

www.ccfmtc.org

California Coalition Against Sexual Assault (CALCASA)

1215 K Street, Suite 1850

Sacramento, CA 95814

www.calcasa.org