

Module 2: What is Sexual Assault Advocacy/Counseling?

Purpose

This module is intended to help you understand your role and responsibilities as advocates, and the roles of others with whom you will work.

Lessons

1. Basic Tenets of Advocacy
2. Overview of Sexual Assault Response Teams (SARTs) and Sexual Assault Nurse Examiners (SANEs)
3. Roles of the Advocate
4. Maintaining Confidentiality

Learning Objectives

By the end of this module, you will be able to:

- Describe the composition of a SART.
- Identify the major roles of an advocate.
- Make appropriate decisions based on state reporting laws.

Handouts

- Handout 2.1, VAWA 2005 Reauthorization Forensic Compliance Mandates
- Handout 2.2, Victims of Sexual Assault HIPAA Privacy Rule

Participant Worksheet

- Worksheet 2.1, Confidentiality Scenarios

1. Basic Tenets of Advocacy

One of the things that advocacy does is provide victims with information about their options so they can make educated choices (Ledray 1999; Ledray, O'Brien, and Chasson 2011). Advocacy encourages victims to ultimately advocate for themselves while giving them a voice when they are too weak to speak. Advocacy should be trauma-specific, addressing only the current sexual assault and any consequences or issues that arise as a result of that crime (Young 1993). Young cautions not to ignore preexisting life problems; rather, address them in descending order only after the more pressing criminal issues are addressed. Issues such as an abusive relationship, substance abuse, mental health problems, or financial troubles affect recovery and are thus issues for the advocate. It is important to know when to make referrals and which community resources are appropriate for follow-up counseling (Young 1993).

Whatever the scenario, the overriding tenet of advocacy is to listen and believe. The healing power of this is extraordinary. Survivors do not need to prove they are suffering to win support; advocates give unconditional support while safeguarding the individual's right to be treated with respect, whatever the circumstance.

The unfortunate reality is that an advocate may be the only person who believes a victim without question, comment, or blame, which makes the words, "I believe you," and the corollary, "It wasn't your fault," that much more powerful. The rare case when a survivor is dishonest is relatively unimportant. Clearly, the survivor is suffering on some level and has most likely been victimized in some way. Having the wool pulled over our eyes on that rare occasion is a small price to pay for extending the healing power of unconditional belief that has helped so many survivors.

Another advocacy maxim is neither to investigate nor judge. Asking questions so the account makes sense can jeopardize the advocate's relationship with the survivor. Leave the investigation to the investigators. This means no note-taking while the survivor talks about the assault. Keeping one's hands free nonverbally communicates to the survivor that the advocate is not interested in "taking" anything (including a report) but rather is present as a trusted ally. Advocates are the only first responders who have no other responsibilities and no pressing agenda.

In addition to these basic tenets, participants must keep the word "teamwork" in mind. As advocates, they will work with other professionals, from law enforcement officers to medical professionals, to meet the needs of sexual assault victims.

2. Overview of Sexual Assault Response Teams and Sexual Assault Nurse Examiners

No single agency can meet all of the needs of the sexual assault survivor. Rape crisis centers, medical professionals, law enforcement, and prosecutors have recognized the benefits of collaborating in their work with sexual assault survivors. In addition to learning to work effectively with victims of sexual assault, advocates must learn to work cooperatively and effectively with those with whom they will collaborate.

In many communities, the group of individuals from different agencies who work with rape survivors is referred to as the SART. Demonstrated to be an effective model for providing better services to sexual assault victims, the SART concept includes crisis intervention and long-term counseling, investigation and evidence collection, and a more sensitive initial medical response to rape victims (Ledray 1999; Ledray, O'Brien, and Chasson 2011).

SART membership varies depending on the community and the needs of a particular rape survivor. At a minimum, it should include the rape crisis advocate, medical personnel, law enforcement, prosecutor, and crime laboratory specialist. It may also include domestic violence victim advocates, clergy, and other social service agency personnel. In some communities, a core group of SART members may respond together in the emergency department, or they may simply work cooperatively to meet the needs of sexual assault survivors and their families/significant others.

The medical professional who participates in a SART is often a SANE. SANEs are specially trained nurses who are on call to specified emergency departments, medical clinics, community agencies, or independent SANE facilities.

SANEs are trained to complete a medical-legal examination of rape victims, taking into account specific medical and emotional needs of the victims, as well as the importance of properly collecting forensic evidence that can be used in legal proceedings. The SANE concept has been shown to be an effective model for providing better evidence collection and a more sensitive initial medical response to rape victims (Ledray, O'Brien, and Chasson 2011).

Medical professionals developed the first SANE programs in the mid-1970s after recognizing the need for better care for sexual assault victims in the emergency department.

Previously, when rape victims came to the emergency department for care, they often had to wait as long as 4 to 12 hours in a busy public area, their wounds considered less serious than those of other trauma victims, as they competed unsuccessfully for staff time with the critically ill or injured (Halloway and Swan 1993; Sandrick 1996; Speck and Aiken 1995). Often, they were not allowed to eat, drink, or urinate while they waited, for fear of destroying evidence (Thomas and Zachritz 1993).

Doctors and nurses were often insufficiently trained to do medical-legal exams, and many lacked the ability to provide expert witness testimony as well (Lynch 1993). Even trained staff often failed to complete a sufficient number of exams to maintain any level of proficiency (Lenehan 1991; Tobias 1990; Yorker 1996). When the victim's medical needs were met, emotional needs all too often got overlooked (Speck and Aiken 1995) or even worse, the survivor was blamed for the rape by the emergency department staff (Kiffe 1996).

There are many published and anecdotal reports of physicians being reluctant to do the exam. Many factors contributed to this, including their lack of training and experience in forensic evidence collection (Bell 1995; Lynch 1993; Speck and Aiken 1995); the time-consuming nature of the evidentiary exam in a busy emergency department with many other medically urgent patients (DiNitto 1986; Frank 1996); and the potential of being subpoenaed and taken away from the emergency department to be questioned by a sometimes hostile defense attorney while testifying in court (DiNitto 1986; Frank 1996; Speck and Aiken 1995; Thomas and Zachritz 1993).

As a result, documentation of evidence could be rushed, inadequate, or incomplete (Frank 1996). Many physicians simply refused to do the exam (DiNitto 1986).

Advocates must work cooperatively with other members of a SART or, if there is no formal SART in their community, with other first responders. Strategies and considerations for working effectively with SART members will be explored throughout this training.

Rape crisis centers, advocacy, specialized training, and teamwork have greatly improved the quality of care for rape victims. Advocates have provided and continue to provide a range of services to address the needs of victims and their families/significant others. The next section will examine in detail the various roles of the advocate.

3. Roles of the Advocate

Advocates most commonly provide any or all of the following services:

- Crisis telephone line staffing, which involves giving victims of rape immediate support and information about what to do after an assault.
- Medical-evidentiary exam response, during which an advocate's primary functions are to provide the victim with information about options, answer questions, provide support and crisis intervention, and advocate on the victim's behalf with the medical personnel providing care.
- Law enforcement statement accompaniment, which involves the advocate accompanying the rape victim to an investigator's office to give an official statement of the assault.

- Courtroom accompaniment, which involves accompanying the victim to attorney appointments, as well as to the courtroom.
- Family/significant other supportive counseling, which involves providing information and support to family members or significant others.

Procedures for each of these roles will be examined more closely later in this training. Advocates may also provide walk-in crisis intervention; individual, ongoing supportive counseling; or support group facilitation. However, these roles are less common for volunteers and will not be addressed in-depth in this training.

4. Maintaining Confidentiality

It is important to maintain confidentiality because it is the victim's right, it gives the victim control and the ability to make decisions about whom to tell, and it makes disclosure safe. Advocates have a responsibility to maintain confidentiality, to the limits of the law, about each and every case with which they are involved. A sexual assault is a loss of control over one's body and over the ability to choose with whom to be sexual. It is extremely important that the victim be able to retain control after the assault to the greatest extent possible. Deciding who will know about the rape is an important part of regaining control. Maintaining confidentiality is one way to help the victim regain control over who does and does not know that the rape occurred.

Only when victims know the limits of the confidentiality can they make a safe, educated choice about what to tell the advocate, SANE, or counselor. Rape crisis centers in many states have gone to great lengths to get state legislation passed to ensure that their conversations with sexual assault victims are completely confidential and that they cannot be subpoenaed to testify even if the case goes to court. Advocates must know the limits of confidentiality for rape crisis advocates in their state and communicate these to victims before the victims disclose information (Ledray, O'Brien, and Chasson 2011).

SANEs, on the other hand, are collecting evidence and expect that everything the victim tells them can be admitted into evidence and used in court. In other medical examinations, HIPAA requires the medical personnel to maintain all health-related information confidential.

However, because this is a medical-legal exam, the SANE will ask the victim to sign a release of information giving them permission to release all of the information gathered during this particular medical visit to law enforcement. The record of the visit and any physical evidence collected is an important part of the evidence that may be used in the investigation and prosecution of the reported sexual assault.

This release **ONLY** applies to health information collected in this particular visit. It **DOES NOT** apply to any other health records. The SANE is responsible for obtaining the consent and informing the victim about this lack of confidentiality.

One advantage of the SANE medical role is that the SANE can testify to things the victim says during the medical forensic examination. For example, if the victim tells the SANE information that establishes the sexual contact was forced, the SANE can testify to this in the courtroom as a medical exception to the hearsay rule, even if it was not an “excited utterance.”

Maintaining confidentiality means:

- Not talking to the media about the case without the victim’s permission.
- Not using the victim’s name when discussing the case with coworkers.
- Not discussing cases with your family.
- Not talking about cases on an elevator or in a public place.
- Not using any details of cases, even anonymously, for training purposes.

Especially in a small community, it is all too easy to breach client confidentiality unknowingly.