

Ohio Rape Crisis Advocate Training Manual

A PROJECT OF THE OHIO ALLIANCE TO END SEXUAL VIOLENCE (OAESV)

Developed in June 2013 in partnership with SARNCO, CRCC, BRAVO & ADWAS

This publication was supported in part by Grant No. 2015-VOCA-10201795.
The opinions, findings, conclusions, and recommendations expressed are those of the authors and do not necessarily reflect the views of the Ohio Attorney General's Office.



Table of Contents

I. **Purpose of Training& Audience** 3-35
- Background Reading Certification & Checklist
- Sexual Assault in Ohio Fact Sheet
- Ohio Age of Consent Fact Sheet
- Background Reading & Preparation

II. **Art of Advocay & Diversity** 36-77

III. **Specialty/ Underserved Populations** 78-353
- LGBTQI
- Deaf Advocacy
- Latinas/Hispanics & Sexual Assault
- Male Survivors
- Child & Adolescent
- Elder Population
- Stalking
- Drug Facilitated
- Human Trafficking
- PREA

IV. **Selfcare & Trauma** 354- 358

V. **Medical & Legal Advocacy** 359- 440

VI. **Collaboration & Services** 441- 454

VII. **Victims & Media** 455- 477

VIII. **Post-Training** 478- 546
- Checklist
- Follow-up assignments
- Needs Assessments
- Post Training Evaluation
- Core Standards

IX. **Appendix/Fact Sheets:** 547-554
- Ohio Statute of Limitations Fact Sheet
- Victim Rights on Ohio's Campuses
- Victim Rights in Ohio Regarding Untested Rape Kits

Purpose of Training and Audience

Purpose of Training & Audience

Training Objective: To give Ohio advocates working with sexual assault survivors (within rape crisis programs, dual sexual assault/domestic violence agencies, or other agencies) the background to be able to provide victim-centered advocacy to sexual assault survivors based on current best practices and OAESV's Core Standards for Rape Crisis Programs in Ohio.

Note about Language: In this manual you will notice the pronouns "he" and "she" often used. We recognize that anyone, regardless of sex, sexual orientation or gender identity may be a survivor of sexual violence. While that is the case, the majority of cases are a male perpetrator and a female survivor, so "he" and "she" will be used respectively throughout the majority of the manual.

Training Agenda: This training curricula was designed for a 40-hour certification to become a sexual assault crisis intervention staff advocate in Ohio. This training includes pre- and post-training requirements. The training is designed to be held during two consecutive days, with new advocates attending both days sessions and advocates with prior experience attending the intermediate session only on Day 2, to accommodate the training levels, needs and availability of advocates to attend an in-person training in Central Ohio.

Adapting this Training to Your Organization: While the information presented in this training is universally applicable, some of the background reading materials contain information that is specific to a particular agency or organization. Please verify your own organization's policies and procedures.

Background Reading Certification and Checklist

Background Reading/Preparation

- Sexual Assault in Ohio: Fact Sheet of Legal Definitions
- Ohio Age of Consent/Statutory Rape Fact Sheet
- Sexual Perpetrators Overview

- Anti-Oppression Theory
- History of the Rape Crisis Movement
- Rape Culture 101

- Understanding the Trauma of Sexual Violence
- Understanding PTSD in the Aftermath of Sexual Violence
- Supporting a Loved One Who's Been Victimized
- The Art of Providing Advocacy

- Six Fundamental Patterns of Cultural Differences
- Diversity Awareness and Sensitivity: Working with Survivors
- Survivor Rights & Resources: Fact Sheet for Advocates

- Three Steps Toward Empathetic Listening
- Listening Skills
- Crisis Intervention in an Acute Situation
- Mandatory Reporting of Sexual Violence: Best Practices for Advocates
- Management of Chronic and Abusive Calls
- Suicide Warning Signs & Intervention
- Facts about suicide, The Trevor Project
- Safety Planning

- LGBTQI Appropriate Terms/Language
- BRAVO Glossary of LGBTQI Terminology
- Power & Control in LGTB Relationships
- Domestic Violence and LGBT Relationships
- Kaleidoscope Youth Center Resources
- Trans-Specific Power and Control Tactics
- Working with LGBT Domestic Violence and Sexual Assault Survivors
- Creating a Trans-Welcoming Environment
- Why it matters: Rethinking Victim Assistance for LGBTQ Victims of Hate Violence and IPV
- A Report from the NCAVP LGBT Queer and HIV-affected IPV 2011
- Training Bulletin: DV in the LGBT Community
- Client Screening Assessment
- Screening and Assessment of Victims/Perpetrators of LGBT Domestic Violence
- Safety Planning: A Guide for Transgender and Gender Non-Conforming Individuals who are experiencing intimate partner violence

- abused Deaf women's advocacy services
- Existe Ayuda (Help Exists) Toolkit
    - English-to-Spanish Terms: Sexual Assault
    - Latinas and Sexual Violence
- No! The Rape Documentary discussion guide
- Male Survivors
- Male Sexual Victimization Myths & Facts
- Male Survivor Resources
- Child and Adolescent Sexual Assault Overview
- Teen Power & Control Wheel
- Sexual Violence in Later Life Fact Sheet

- Stalking Fact Sheet
- Stalking Response Tips for Victim Advocates
- Drug Facilitated Sexual Assault
- Identifying and Interacting with Victim/Survivors of Human Trafficking

- U Visa and T Visa Fact Sheet
- PREA & Working with Incarcerated Survivors: A Fact Sheet for Rape Crisis Advocates

- Self-Care and Trauma Work
- Tools for Watching Movies and Televisions Shows
- Rape Survivors' Experiences With the Legal and Medical Systems: Do Rape Victim Advocates Make a Difference?

- Ohio Protocol for Sexual Assault Forensic and Medical Examination
- Presence of Victim Advocate During Sexual Assault Exam: Summary of State Laws
- Criminal Justice Fact Sheet for Survivors
- Ohio Attorney General Sexual Assault Kit Commission Recommendations
- Civil Legal Remedies

- Building Stronger Sexual Assault Survivor Services Through Collaboration, p. 1-9

- Steubenville Rape Trial: Case Shows Social Media Can Be Positive and Negative
- Victim-Centered Stories: How to Work with the Media to Convey the Complexities of Sexual Violence
- Doubly Victimized: Reporting on Transgender Victims of Crime
- Developing Effective Responses to High-Profile Cases: A Factsheet for Rape Crisis Programs
- From the Front of the Room: A Survivor's Guide to Public Speaking

- Core Standards for Rape Crisis Programs in Ohio

Certification & Signature

The above information, to the best of my knowledge, certifies that I have completed the background reading prior to the training to become a certified Ohio Rape Crisis Advocate.

_____

_____

Signature of Rape Crisis Advocate Date

_____

_____

Signature of Rape Crisis Program Director/Manager Date

Please mail the completed form to OAESV at 526 Superior Ave. #1400, Cleveland, OH 44114 or email completed form to info@oaesv.org

Ohio Alliance to End Sexual Violence
Phone: 216-658-1381 / 888-886-8388 Email: info@oaesv.org

SEXUAL ASSAULT IN OHIO: FACT SHEET OF LEGAL DEFINITIONS

Ohio Statute	Definition:	Type of Offense:
§2907.01	**Sexual conduct:** • vaginal intercourse between a male and female; anal intercourse, fellatio, and cunnilingus between persons regardless of sex; AND • without privilege to do so, the insertion, however slight, of any part of the body or any instrument, apparatus, or other object into the vaginal or anal opening of another. • Penetration, however slight, is sufficient to complete vaginal or anal intercourse.	
§2907.01	**Sexual contact:** • touching of an erogenous zone of another, including the thigh, genitals, buttock, pubic region, or, if the person is a female, a breast; AND • for the purpose of sexually arousing or gratifying either person.	
§2907.02	**Rape:** • Offender has sexual conduct with another and o The offender substantially impaired the other in order to prevent resistance (through drugs, intoxicant, or controlled substance) by force, threat of force, or deception; OR o The other person is younger than 13 years old.; OR o The other person's ability to resist or consent is impaired due to mental or physical condition or advanced age, and the offender knows this OR • Sexual conduct where the offender uses force or threat of force	Rape: • 1st degree felony
§2907.03	**Sexual battery:** • sexual conduct with another AND o knowingly coercing someone to submit by any means that would prevent resistance by someone of ordinary resolution; OR o knowing that someone's ability to appraise the nature of or control their own conduct is substantially impaired; OR o knowing that someone submits because the other person is unaware that the act is being committed; OR o knowing that someone submits because the other person mistakenly identifies the offender as the other person's spouse; OR o offender has authority over someone (e.g. offender is a parent/guardian, has institutional authority, is a teacher, cleric, etc . . . See statute for full details.)	Sexual battery: • 3rd degree felony • 2nd degree felony *(if the person is younger than 13)*
§2907.04	**Unlawful sex with a minor:** • An offender who is 18 years or older who engages in sexual conduct with someone who is thirteen, fourteen or fifteen years old.	Unlawful sex with a minor: • 4th degree felony • 3rd degree felony *(offender is ten or more years older than the other person)* • 2nd degree felony *(offender previously convicted of this offense, sexual battery, or rape)*
§2907.05	**Gross sexual imposition:** A. having, causing another to have, or causing two or more other persons to have sexual contact through 1. forcible compulsion; OR 2. incapacity through force or threat of force; OR 3. knows the person is incapacitated; OR 4. One of the victims is younger than 13 years old; OR 5. the other person cannot consent due to mental or physical condition, advanced age, or substantial impairment	Gross sexual imposition: • 4th degree felony *(for all "A" offenses at left, except A(4))* • 3rd degree felony *(offense B at left, or offense A(4))*

SEXUAL ASSAULT IN OHIO: FACT SHEET OF LEGAL DEFINITIONS

	B. touching genitalia, not through clothing, to abuse, humiliate, harass, degrade, or arouse or gratify the sexual desire of someone less than 12 years of age (whether or not offender knows the age)	
§2907.06	**Sexual imposition:** • having, causing another to have, or causing two or more other persons to have sexual contact AND ○ knowing that the sexual contact is offensive to the other person, or is reckless in that regard; OR ○ knowing that the other person's mental abilities are substantially impaired; OR ○ knowing that the other person submits because of being unaware of the sexual contact; OR ○ The other person, or one of the other persons is thirteen, fourteen or fifteen years old, and the offender is at least eighteen years old and is at least four more years older than the other person; OR ○ Offender is a mental health professional and the other person(s) is a patient/client, who the offender has falsely represented that the sexual contact is necessary for mental health treatment purposes	Sexual imposition: • 3rd degree misdemeanor • 1st degree misdemeanor if previously convicted under this offense

This document in its entirety was published by the Ohio Alliance to End Sexual Violence (OAESV) through a Victims of Crime Act grant award administered by the Ohio Attorney General's Office

Ohio Alliance to End Sexual Violence
Phone: 216-658-1381 / 888-886-8388 Email: info@oaesv.org

OHIO AGE OF CONSENT/STATUTORY RAPE FACT SHEET

The legal age to consent to sex in Ohio is sixteen (Ohio Revised Code § 2907.04). Even if a teen and older individual claim they are both willing participants in the relationship or sexual encounter, in some situations it is still considered rape under the law. To determine whether a suspect has violated Ohio's age of consent laws (also referred to as "statutory rape" laws), refer to the chart below. *

In cases where a relationship does not violate Ohio's statutory rape laws, parents may intervene with other charges that are not sex offenses, such as contributing to the unruliness or delinquency of a child (ORC § 2919.24) or the charge of interference with custody (ORC § 2919.23).

Age Related Sex Offenses in Ohio

(See ORC §2907.04 - Unlawful Sexual Conduct with Minor)

Victim/Survivor's Age	Suspect's Age	Legal?	Penalty
Under 13 years old	18 or older	No	F1
13 years old	13-17	Yes**	--
	18-22	No	F4
	23 and older	No	F3
14 years old	13-17	Yes**	--
	18-23	No	F4
	24 and older	No	F3
15 years old	13-17	Yes**	--
	18	No	M1
	19-24	No	F4
	25 and older	No	F3
16 years old	13-17	Yes**	--
	18 and older	Yes**	--

*Even if a suspect does not violate an age related offense, if the sexual acts were forced or coerced, or the perpetrator is in a position of power over the victim, like a teacher, coach, parent and/or guardian, they are a violation of the law.

**The act is legal unless the act was forced, coerced, or the perpetrator is in a position of power over the victim, like a teacher, coach, parent and/or guardian.

This document in its entirety was published by the Ohio Alliance to End Sexual Violence (OAESV) through a Victims of Crime Act grant award administered by the Ohio Attorney General's Office

Minor's Consent to Rape Crisis and Healthcare Services

Generally, parents have the right to consent to the medical care their children will receive. However, there are some exceptions to this rule. The following chart lists instances in Ohio where minors may make decisions about their healthcare/mental health needs without a parent or guardian's permission. Note that if the minor is considered "emancipated" they are treated as adult under the law, and therefore they can make all decisions without a parent's input. (§2919.121 (A).) Ohio defines an emancipated minor as someone who is 1) married; 2) enlisted in the armed services, 3) self-employed and subsisting on their own; or 4) otherwise independent from the care of a parent/guardian/custodian.

Type of Care	May a Minor Consent?	Minor's rights	Limits	Ohio Statute
Sexual Assault Forensic Exam	Yes	• Minor can consent to an exam for purposes of gathering evidence • Minor should be informed of services for venereal disease, pregnancy, medical, and psychiatric care. • Minor cannot be charged for services • Parent cannot override minor's decision	• Hospitals are required to give written notice to parent, parents, or guardians that the examination took place.	§2907.28, §2907.29
Rape Crisis Center Counseling Services	Yes for minors 14 years old or older	• Can seek counseling at an out-patient center, such as a rape crisis center, as long as the services do not include medication. • The treatment is confidential and care providers cannot notify parents *(see exception to right)*	• The care is limited to six sessions or 30 days, whichever comes first. (After that, parent must give permission to continue services.) • Care provider can notify parents in situations where provider believes there is a substantial probability that the minor will harm themselves or others.	§ 5122.04 (A) and (B)

Further Resources:

- **ACLU of Ohio**, "Your Health and the Law: A Guide for Teens," available at http://www.acluohio.org/issues/TeenHealth/
- **Ohio American Academy of Pediatrics,** Fact Sheet, "Teen Health, Consent, and Ohio Law," available at http://www.ohioaap.org/files/TeenHealthConsent.pdf
- **Ohio Bar Association**, "The Law and You," 13th Edition, Chapter 10, available at https://www.ohiobar.org/General%20Resources/Law_and_You_010.pdf

Background Reading/Preparation

From the Sexual Assault Response Network of Central Ohio, OhioHealth's Survivor Advocacy Manual January, 2013

Sexual Perpetrators Overview [xxiii]

Sexual Predators in the Community

Research on sex offenders spans many decades and has contributed much to our understanding of the behavior and characteristics of rapists, their underlying motivations, and the developmental antecedents of sex offending.

Historically, one of the failings of this research literature is that it has been based exclusively on the study of captured, and typically incarcerated offenders. This is understandable – it is difficult to study sex offenders who have not been identified by the criminal justice system – but it carries with it potentially significant limitations. Since the vast majority of rapes are never reported, and the majority of rapists are never prosecuted, the largest population of rapists – those responsible for the vast majority of rape – were historically left out of the research literature. This limitation of the literature has been partially corrected in recent years with the study of "non-incarcerated" rapists (see below), which tends to show a convergence of findings with the older literature on incarcerated offenders.

The study of incarcerated rapists has produced notable and enduring findings about the perpetrators of sexual violence.

The three identified types of rapists are:

- Power Rapist was motivated by his need to control and dominate his victim, and inversely, to avoid being controlled by her.
    - Survivor Impact of Power Rape:
    - At the hospital, the survivor will have minimal or inconclusive evidence. The people she encounters are likely to be accusatory and express doubts about her efforts to resist.
    - Her fear continues since the offender usually learned a great deal about her such as address and living partners and the rapist may threaten to come back.
    - Her sense of helplessness is overwhelming. She has been totally controlled by another. She desperately needs to regain control and make decisions. Her guilt may be especially strong, because during the assault her primary goal may have been to resist the rape or to escape from the perpetrator, in this she may feel that she failed, that she should have done more.

- Anger Rapist was motivated by resentment and a general hostility towards women, and was more prone to inflicting gratuitous violence in the course of a rape. Not surprisingly, these types were rarely found in pure form. Most rapists were actually blends of power and anger motivations; however, a predominance of one or the other was often discernible.
    - Survivor Impact of Anger Rape:
    - The medical exam generally reveals considerable physical trauma.
    - Survivors report experiencing the rape as a life-threatening situation.
    - Despite the brutality, the psychological trauma may not be prolonged, for several reasons:

        - Her visible injuries evoke sympathy and validate use of force.
        - There is usually much concrete evidence of an assault.
        - There is generally little suspicion of either a false accusation or victim participation.
        - The survivor generally receives support and comfort from those she encounters immediately after the rape.
        - The survivor's goal was probably to survive the attack, and because she has done so, she can go on with her life.
        - Her feelings of guilt may be minimal.
        - Her feelings of anger may be strong, which is healthy and could lead to a quicker recovery.

- Sadistic Rapist. This rapist was motivated by the sexual gratification he experienced when he inflicted pain on his victim. The sadistic rapist has become a staple of the American media, but these, once again, extremely rare cases.
    - Survivor Impact of Sadistic Rape:
    - The victim of a sadistic rapist may not survive the attack. For some offenders, the ultimate satisfaction is gained from murdering the victim.
    - These assaults have a high incidence of serious physical injuries.
    - If the victim survives, she will usually need extended psychological care. She may suffer from severe depression, and her risk of suicide is high. She may display other compulsive behaviors as well.
    - Although sadistic rape is the least common form, because it is the most sensational, it usually receives the most media attention. Unfortunately, it consequently becomes the standard some people apply to judge whether or not a woman/man has actually been raped.

Groth's identification of anger and power as the primary motivations behind rape has endured, and has become the basis for attempts at defining more refined taxonomies of rape. These efforts have largely yielded modest results, and have focused on identifying blends of power and anger motivations, and on distinguishing developmental antecedents for the various types. Not surprisingly, among those developmental antecedents, one of the most prominent is a history of childhood abuse. Sexual abuse, physical abuse and neglect are all significantly more prevalent in the backgrounds of rapists than in the backgrounds of non-offending men.

Sexual Predators on Campus

Beginning in the 1980's, social science researchers began to systematically expose the reality of interpersonal violence in America. The first step in this process was the onset of a new generation of victimization research that documented the true prevalence of both sexual and domestic violence. Shunning the traditional data collection methods of the Federal Bureau of Investigation, these researchers revealed three fundamental realities:

1) most interpersonal violence is perpetrated by individuals who in some way are known to the victim;
2) most of this violence is never reported to authorities; and
3) most perpetrators of this violence are never prosecuted.

In the realm of adult sexual violence, these revelations spawned new, and ultimately unfortunate terms, such as "date rape." Much of this research was focused on college populations, not only because of their convenience, but because college students fall within the age range of maximum vulnerability to sexual violence – 18 to 24 years. As this new generation of victimization research was disseminated, it revealed with increasing clarity an enormous gap in the research on sex offenders. There were studies of incarcerated rapists, but there was almost no research on the men who were actually committing the vast majority of rape – non-stranger rapists whose victims rarely report, and who were almost never subject to prosecution.

This gap began to close with research that began in the mid-1980's, and that focused on non-incarcerated rapists. Researchers discovered that it was possible to gather accurate data from these men because they did not view themselves as rapists. They shared the very widespread belief that rapists were knifewielding men in ski masks who attacked strangers; since they did not fit that description, they were not rapists and their behavior was not rape. This has allowed researchers to study the motivations, behaviors and background characteristics of these so-called "undetected rapists."

Motivations and Characteristics

Many of the motivational factors that were identified in incarcerated rapists have been shown to apply equally to undetected rapists. When compared to men who do not rape, these undetected rapists are measurably more angry at women, more motivated by the need to dominate and control women, more impulsive and dis-inhibited in their behavior, more hyper-masculine in their beliefs and attitudes, less empathic and more antisocial.

These undetected rapists:

- are extremely adept at identifying "likely" victims, and testing prospective victims' boundaries;
- plan and premeditate their attacks, using sophisticated strategies to groom their victims for attack, and to isolate them physically;
- use "instrumental" not gratuitous violence; they exhibit strong impulse control and use only as much violence as is needed to terrify and coerce their victims into submission; use psychological weapons – power, control, manipulation, and threats –backed up by physical force, and almost never resort to weapons such as knives or guns;
- use alcohol deliberately to render victims more vulnerable to attack, or completely unconscious.

xxiii David Lisak, Ph.D. "Understanding the Predatory Nature of Sexual Violence", University of Massachusetts- Boston, 2009.

Anti-oppression Theory

JANELLE L. WHITE

SEXUAL ASSAULT IS A TACTIC OR TOOL OF OPPRESSION. Most frequently, sexual assault is used by men to dominate women and by adults to dominate children. Sexual assault has also been used as a weapon of oppression against people of color, people with disabilities, and lesbians and gay men. Because sexual assault is a weapon of oppression, we must understand oppression if we hope to end sexual violence. This chapter examines oppression, explains how different forms of oppression work together, and explores the ways that oppression may stand in the way of efforts to end sexual violence.

Oppression and what Keeps It Going

Oppression is the *systematic* and *pervasive* mistreatment of individuals on the basis of their membership in a disadvantaged group. Institutional and interpersonal imbalances in power contribute to this mistreatment. Oppression involves the systematic use of power to marginalize, exploit, silence, discriminate against, invalidate, deny, dismiss, and/or not recognize the complete humanness of those who are members of a disadvantaged group.

In the United States, there are systems of oppression based on race, class, gender, sexual orientation, religion, ability, age, body size, and citizenship. Privilege is given to those who are white, male, middle-class or "well-off" economically, heterosexual, Protestant, able-bodied and of able mind, middle-aged, thin, and a U.S. citizen. This means that some *groups* of people are oppressed, and some are not. For example, men, *as a group,* are not oppressed. Men do not face systematic and pervasive mistreatment because they are male. An individual man *may* face oppression based on another identity characteristic, such as race or disability. We all have multiple identities, because we all have a gender, race, class, and so on. This means we can be privileged because of one identity while at the same time facing oppression because of another.

Stereotypes, prejudice, and *discrimination* support oppression and keep it going. Stereotypes are generalizations about groups of people. They do not take into account the difference within groups. Like stereotypes, prejudice is based on incomplete or inaccurate information. Prejudice is a preference or bias toward or against a group. Both stereotypes and prejudice have negative or detrimental effects. They assert that groups of individuals are all the same (that is, "Those people are...," "That group can't...," "They all act..."). They fail to recognize uniqueness, which is an important part of every person's humanity. It is true that prejudice and stereotypes are only attitudes, but these destructive attitudes, opinions, feelings, and ideas shape our actions and contribute to discrimination.

Discrimination is active; it is preferential or biased treatment based on stereotypes, prejudice, and/or historical practices. It results in unequal access and/or representation. Oppressive systems and ideologies—such as racism and white supremacy, sexism and male supremacy, and classism and capitalism—are maintained through discrimination. Institutionalized oppression involves enforcing discrimination in such a way that the

status quo is maintained (for example, when all the secretaries are women and all the supervisors are men) and inequality is made to seem legitimate (for example, when it is said that the workplace is structured this way because women who apply for supervisory positions lack the skills to hold these jobs but do possess the skills to be secretaries).

When oppression is enforced through everyday interaction between individuals, this is interpersonal oppression. Interpersonal oppression may take place in a variety of ways. For example, a shop clerk might follow Black customers, expecting them to steal and making them uncomfortable. Interpersonal oppression may occur among friends and relatives as well as among strangers. For example, family members may psychologically and/or physically abuse elder or disabled relatives. Interpersonal oppression is often supported by institutional oppression. For example, if a lesbian teen is harassed by her classmates because she is a lesbian, this is interpersonal oppression. If school authorities allow or condone the harassment, that is institutional oppression.

> *Each person is an individual, and comes to the event with their own religious, cultural, age, and experimental differences.*
>
> LINDA LIVINGSTON, COALITION TO END DOMESTIC AND SEXUAL VIOLENCE

Discrimination can take many forms, including unfair hiring practices, white flight and residential segregation, the educational "tracking" of students, and even violence. In fact, many people refer to violence (and the threat of violence) as a weapon of oppression because it protects oppression.

In doing anti-rape work, it is important to have a clear understanding of oppression and how it functions in the United States. *Oppression*, a political term often used in the anti-rape movement and other progressive U.S. social movements, must maintain its sharpness, its clarity; otherwise, it will be stretched to meaninglessness (that is, everyone calling themselves oppressed, regardless of their actual positions of privilege). Oppression is an abuse of power by a dominant group. Other interactions among people may be hurtful or unfair but not oppression. As a social movement, our goal is to challenge abuses of power—more precisely sexual assault, a specific power abuse—and we require language that can articulate why abuses of power occur.

Making the Connections

Audre Lorde writes, "There is no hierarchy of oppression."[1] What does this Black lesbian feminist, poet-activist mean? Ultimately she is saying that she will not choose between her identities or favor one identity over another. Any movement that fails to recognize her multiple identities or that asks her to recognize only her Blackness or her gender or her lesbian identity is a movement in which she refuses to participate. In fact, Lorde argues that such a movement holds the seeds of its own failure and destruction.

If we look deeply, we will see that *violence*—in the form of sexual assault, battering, lynching, genocide, and other hate crimes—*is a tactic of all forms of oppression.* Thus, violence is one area where all forms of oppression intersect. And, in fact, acts of bias violence or hate violence often involve more than one form of oppression. For example, lynching—most obviously an expression of racism—often included bizarre sexual mutilation of the victim. It seems clear that the white male perpetrators of such violence were expressing not only their racist ideology of white supremacy, but also their sexist fantasy of masculinity.

By the same token, rape—most obviously an expression of sexism—also often involves other forms of oppression. When women, regardless of their sexual orientation, are threatened with rape when they show affection toward other women, we see homophobia acting in concert with sexism. This all-too-common occurrence is a manifestation of these two forms of oppression interacting with and bolstering each other. Suzanne Pharr,

who co-chaired the National Coalition Against Domestic Violence and its Lesbian Task Force, calls homophobia a weapon of sexism and connects homophobia and heterosexism to sexual and domestic violence perpetrated against women:

> *How many of us have heard battered women's stories about their abusers calling them lesbians or calling the battered women's shelter a lesbian place? The abuser is not so much labeling her a lesbian as he is warning her that she is choosing to be outside society's protection (of male institutions), and she therefore should choose to be with him, with what is "right." He recognizes the power in woman-bonding and fears loss of her servitude and loyalty: the potential loss of his control. The concern is not affectional/sexual identity; the concern is disloyalty. The labeling is a threat. . . . Our concern with homophobia, then, is not just that it damages lesbians, but that it damages all women. We recognize homophobia as a means of controlling women, and we recognize the connection between control and violence.*[2]

The intersection of oppressions also affects how acts of bias violence are perceived. The feminist legal scholar Kimberlé Crenshaw notes that rape is "racialized."[3] In the United States rape has been historically racialized in the image of the white female victim and the Black male rapist, and our social problem of rape has grown to be racialized in the rapist as a man of color. This does two things. First, women of color are absolutely invisible in this equation. Women of color come to be seen as "unrapeable." Second, white men are protected by this mythology. They are let off the hook; they are not seen as perpetrating rape. But we know that 90 percent of sexual assaults occur between individuals of the same race and socioeconomic class.[4] We also know that in 84 percent of all rapes the survivor knows her rapist.[5] Such a racialized image of rape obscures these facts as well as the everyday attacks that white women experience at the hands of white men. Therefore, this racist mythology harms, not only women and men of color, but also white women. Here, racism and sexism work together to hurt everyone but white men. Donna Landerman clearly articulates why it is of utmost importance that the anti-rape movement be anti-racist:

> *From both an ideological and practical point of view, it is essential for the anti-rape movement to investigate racism and incorporate an anti-racist perspective, because racism in major ways both causes and defines rape. If we are to successfully aid women who have been raped, prevent rape, and eventually eliminate rape, it is necessary to understand and attack rape in all its forms and at all its roots. Racism and cultural and class oppression are some of those roots of rape, and lead rape to take different forms in the lives of women of various races, cultures, and classes.*[6]

Angela Davis insightfully links rape to the capitalist class structure. She asserts that

> *those men who wield power in the economic and political realm are encouraged by the class structure of capitalism to become agents of sexual exploitation. Their authority (within this capitalist structure) guards them against punishment in all circles except one: they may not violate a woman of their own standing. . . . With this single exception, the man of authority can rape as he will, for he is only exercising his authority.*[7]

The highly publicized William Kennedy Smith rape case, which involved a rich and influential man from a well-known political family and a less-affluent women, shows that there is validity to what Angela Davis argues. But it may be inaccurate to say absolutely that economically privileged men cannot rape women of their economic class with impunity. Nonetheless, the power of Davis's analysis is her awareness that capitalism is connected to violence against women.

Capitalism is based on competition rather than cooperation and therefore promotes conflict. In addition, capitalism has exploitation of one group of people by another "built

in," because profits can be achieved only by the exploitation of workers and/or consumers. Capitalism treats workers like objects to be used just as many perpetrators of sexual assault treat women and children like sexual objects to be used or consumed. Modern capitalism, in its advertising, also treats women like sexual objects to be used to sell products. Capitalism teaches those who are or who aspire to be of the owning class to dominate, exploit, and use workers. These are the same dynamics that the anti-rape movement has identified as contributing to sexual violence. And arguably it is capitalism that encourages us to believe that poor and working-class men are more likely to perpetrate sexual violence than economically privileged men. Classism works to the benefit of those at the top of the hierarchy, protecting them from being accountable for the sexual violence they perpetrate against women of their economic class and against those women who have less economic privilege.

All of this demonstrates that considering sexism and male supremacy as the only important forms of oppression involved in sexual assault is not only inaccurate but self-defeating. This is, in part, because we cannot neatly separate sexism from homophobia or sexism from racism or classism. Over time, forms of oppression have become intertwined. Movements that fail to take this into account cannot fully succeed and may cause more harm. I think Kimberlé Crenshaw, writing about the anti-rape movement, says it best: "This movement inadvertently participates in exclusionary politics because some of us fail to comprehend the anti-violence movement as an anti-oppression movement."[8]

Thinking about all of the different forms of oppression and how they work together can feel overwhelming and depressing. With so many forces against us, how can we hope to make a difference? Although the task is challenging, it is not impossible. From the anti-lynching movement in the United States to the anti-apartheid movement in South Africa, history is filled with examples of women leading and contributing to successful collective efforts at social change. Working with and learning about other activists can be educational, inspirational, and transforming.

Oppression in the Anti-rape Movement

Because oppression is, by nature, pervasive, it is not surprising that social change organizations—including the anti-rape movement—are sometimes hampered by oppression. Obviously, those in power seek to hold on to their power, so the oppressive forces against which social change organizations struggle often strike back. "Backlash" is an example of that. Less obviously, but still importantly, social change organizations sometimes have internal problems rooted in one form of oppression or another.

As social change agents of the anti-rape movement, we recognize the prevalence of oppression in our communities, whether it be sexism, racism, hatred of immigrants, heterosexism, anti-Semitism, or some combination of these or other forms of oppression. And we recognize the existence of a backlash, a reactionary response to our social change work. This backlash stems from the unwillingness of institutions and individuals to give up power and privilege.

Often it is easier for us to see oppression "out there," beyond our social movement or our agencies. But oppression is insidious and does find its way into anti-rape organizations. For example, a white-dominated organization might neglect the needs of survivors of color or a primarily heterosexual agency might ask its lesbian staff members to "act straight." Like many other institutions, anti-rape agencies may be inaccessible to people with disabilities or unfair in their treatment of workers.

One example of resistance to institutional and interpersonal oppression within social change organizations is the work of the Ann Arbor Coalition for Community Unity. This Michigan-based coalition formed in 1994 in the wake of a poorly handled serial rapist

investigation and committed itself to simultaneously addressing sexism and racism. During its work, it issued a statement to feminist agencies in the Ann Arbor area that stressed the importance of addressing abuses of power within women's agencies. Here is an excerpt from a letter written by the women of the coalition:

> *Audre Lorde told us that when we, as women, fall back on the same tactics that the patriarchy uses to control us, tactics of sexism, racism, silencing, and dismissal, we become self-defeating as a movement. Instead of working to end the conditions that create and perpetuate violence against women, we enable them. Every time we silence other women's criticism of our work, or punish dissent, we commit an act of violence. Violence, after all, is the abusive or unjust exercise of power. And when we perpetuate this kind of emotional and spiritual violence against women within our movement, we condition women to accept the physical and sexual violence we are fighting daily.*[9]

We have to meet all forms of oppression in our communities *and* in our movement head-on in order to progress and to ultimately end rape. This means that we cannot write enough about how racism, classism, and heterosexism and other forms of oppression reinforce sexism. This means that we cannot educate enough about how violence is rooted in oppression. And this means we must act!

Notes

1. Audre Lorde, *Sister Outsider: Essays and Speeches* (Trumanberg, NY: The Crossing Press, 1984), 20.
2. Suzanne Pharr, *Homophobia: A Weapon of Sexism* (Little Rock, AR: Chardon Press, 1988).
3. Kimberlé Crenshaw, "The Marginalization of Sexual Violence Against Black Women," *National Coalition Against Sexual Assault Journal* 2, no. 1 (spring 1994): 1–6, 15.
4. Angela Davis, *Women, Race, and Class* (New York: Random House, 1981).
5. Mary Koss, "Date Rape: The Story of an Epidemic and Those Who Deny It," *Ms Magazine* (October 1985).
6. Donna Landerman, "Breaking the Racism Barrier: White Anti-racism Work," in *Revealing the Web of Life: Feminism and Nonviolence*, ed. Pam McAllister (Philadelphia: New Society Publishers, 1982).
7. Angela Davis, "Rape, Racism and the Capitalist Setting," *Black Scholar* 9, no. 2 (1978): 24–30.
8. Crenshaw, "Marginalization of Sexual Violence Against Black Women," 6.
9. Ann Arbor Coalition for Community Unity, *Open Letter to Women's Community-based Organizations in the Ann Arbor Area*, 1996.

History of the Rape Crisis Movement

By Gillian Greensite

California Coalition Against Sexual Assault (CalCASA)

OUR WILLINGNESS TO BECOME INVOLVED in the anti-rape movement deserves support and praise. Whatever particular reason drew you to this most important work, the results will not only help survivors in significant ways but will also give you a connection to the thousands of women and supportive men whose actions have formed a movement of people determined to confront and change the conditions that encourage and support a rape culture. A knowledge of the history of this movement will help you deal with the frequent frustrations and the ever-present outrage and will give you broader shoulders as you listen to and help relieve the trauma of those who have been raped. An awareness that you are part of a movement will connect you with a broader perspective and will challenge you to keep the movement alive.

The history of the rape crisis movement in the United States is also a history of the struggle of African American women against racism and sexism. During slavery, the rape of enslaved women by white men was common and legal. After slavery ended, sexual and physical violence, including murder, were used to terrorize and keep the Black population from gaining political or civil rights. The period of Reconstruction from 1865 to 1877, directly following the Civil War, when freed slaves were granted the right to vote and own property, was particularly violent. White mobs raped Black women and burned churches and homes. The Ku Klux Klan, founded in 1866 in Tennessee, was more organized. The Klan raped Black women, lynched Black men, and terrorized Black communities. Propaganda was spread that all Black men were potential rapists, all white women potential victims. The results and legacy of such hatred were vicious. Thousands of Black men were lynched between Emancipation and World War II, with the false charge of rape a common accusation. Rape laws made rape a capital offense only for a Black man found guilty of raping a white woman. The rape of a Black woman was not even considered a crime, even when it became officially illegal.(1)

Perhaps the first women in the United States to break the silence around rape were those African American women who testified before Congress following the Memphis Riot of May 1866, during which a number of Black women were gang-raped by a white mob. Their brave testimony has been well recorded.(2)

Sojourner Truth was the first woman to connect issues of Black oppression with women's oppression in her legendary declaration, "Ain't I a woman," in her speech at the Women's Rights Conference in Silver Lake, Indiana, challenging the lack of concern with Black issues by the white women present at the conference.

The earliest efforts to systematically confront and organize against rape began in the 1870s when African American women, most notably Ida B. Wells, took leadership roles in organizing anti-lynching campaigns. The courage of these women in the face of hatred and violence is profoundly inspiring. Their efforts led to the formation of the Black Women's Club movement in the late 1890s and laid the groundwork for the later establishment of a number of national organizations, such as the National Coalition Against Domestic Violence. Although women continued individual acts of resistance throughout the first half of the twentieth century, the next wave of anti-rape activities began in the late 1960s and early 1970s on the heels of the civil rights and student movements.

The involvement of other women of color accelerated in the mid-1970s. Organizing efforts brought national attention to the imprisonment for murder of a number of women of color

who defended themselves against the men who raped and assaulted them. The plight of Inez Garcia in 1974, Joanne Little in 1975, Yvonne Wanrow in 1976, and Dessie Woods in 1976, all victims of rape or assault who fought back, killed their assailants, and were imprisoned, brought the issue of rape into political organizations that had not historically focused on rape. Dessie Woods was eventually freed in 1981, after a long and difficult organizing effort.

The earliest rape crisis centers were established around 1972 in major cities and politically active towns such as Berkeley, Chicago, Boston, Philadelphia, and Washington, D.C. As more and more women began sharing their experiences of rape in consciousness-raising groups, breaking the silence that had kept women from avenues of support as well as from seeing the broader political nature of rape, a grassroots movement began to take shape. The establishment of rape crisis centers by rape survivors brought large numbers of middle-class white women into political activism. Although women of color were still involved, their visibility and efforts were made largely invisible in the absence of critical attention to racism within the movement and by white women's taking the center stage. Gradually the rape crisis movement became to be and to be seen as a white women's movement.

During the latter half of the 1970s, with increasing frustration about the exclusion of women of color, a number of radical women of color and white women within the movement began arguing for and organizing for an anti-racist perspective and practice within the movement. Tensions increased and the dialogue was frequently bitter, but the groundwork was laid for confronting racism within the movement. These efforts are ongoing and need constant attention. The number of women of color in the movement grew visibly between 1976 and 1980. Women of color are now major figures and leaders within the movement, but the dominance of white women within the power structures of most rape crisis centers is still a reality.

The character of the early rape crisis centers was significantly different from that of their counterparts today. The early centers tended to be grassroots collectives of women, predominantly survivors of rape, which may or may not have had an actual building or center, with no outside funding, making decisions by consensus with no hierarchy or board of directors. Many saw their anti-rape work as political work, organizing for broader social change, increasingly making connections among issues of sexism, racism, classism, and homophobia. Many articulated a radical political perspective, which often unwittingly excluded all but younger white women who were neither mothers nor fulltime workers.

Tactics to confront rape were often creative. Confrontations, in which a woman supported by her friends would confront and hold a man accountable in a public setting, were a feature of the more radical collectives. Description lists of men who raped were published, and there was general suspicion toward the police—well deserved in many cases. Self-defense classes began to be offered and "take back the night" marches organized.The first march was organized in San Francisco in 1978, bringing together 5,000 women from thirty states. A huge march followed in 1979 in New York. This heralded the beginning of an event that has spread across the country. Today, "take back the night" marches are organized in many communities and at most major universities in the United States as well as in other countries.

The 1980s saw the beginnings of anti-rape education spreading into universities and an increase in feminist academic research around the issue of rape. Myths about rape were seriously critiqued and the facts supported by a growing body of research. A clearer picture of the extent and seriousness of rape began to emerge. Heated debates centered on a need for sensitivity in our language and awareness of the politics of language, as illustrated by the successful effort to replace the word victim with survivor. The hard work of so many dedicated feminists, most of them survivors, began to bear fruit. An understanding of the

reality of acquaintance rape grew. The extent and seriousness of child sexual abuse began to be uncovered. New laws were passed that attempted to better serve survivors; police departments were educated to improve their training and protocols; a few hospitals began to provide special examining rooms and trained nurse examiners.

Not everything was positive in the 1980s. The decade also saw a backlash against the reality of rape being exposed by the anti-rape movement. The media elevated to prominence those writers who challenged the research and statistics about acquaintance rape.3 Funding for rape crisis centers became scarce. Meanwhile, many of the politically active radical feminists had graduated, disbanded, or been forced to find paid work. The movement became more fragmented. Many centers moved politically to the center to secure support and funding from established sources.

A look at the anti-rape movement of the 1990s and a comparison of writings from the late seventies to the late nineties reveal some significant changes. The dominance of a shared political analysis of rape and a strategy for social change has eroded. It still exists, but in fewer and fewer places. In some ways it has been absorbed. For example, many aware students and other women and men assume that rape is an act of power without its having to be spelled out for them. The changes in the anti-rape movement also reflect a decline in the radical politics of all social activism.

The establishment of rape crisis centers across the nation is a testament to the hard work of countless women. The resources available to survivors from such centers is without question one of the most significant and tangible results of the anti-rape movement. As is common within all movements, the daily challenge of providing a critical service with limited resources makes maintaining a conscious political analysis very difficult. The existence of a national organization, the National Coalition Against Sexual Assault (NCASA), and a statewide coalition, the California Coalition Against Sexual Assault (CalCASA), from the early days has helped to keep a political edge and has provided critical resources and connections to often-struggling local programs and centers.

However, many within the movement feel there needs to be more discussion and debate at the local, state, and national levels around important political issues affecting the future direction of anti-rape work. Some examples of these issues that need careful analysis are the effects of the increasing state and federal legislation concerning rape; the redefinition of the issue of rape away from a political model toward a health model; the strategy for building a bigger movement toward the elimination of rape and the role of rape crisis centers within this effort; the impact of the growing number of males within the movement.

Notes

1. Deb Friedman, "Rape, Racism and Reality," Quest 1 (1979).
2. Gerda Lerner, ed., *Black Women in White America: A Documentary History* (New York: Pantheon, 1972).
3. Katie Roiphe, *Sex, Fear, and Feminism on Campus* (Boston: Little, Brown, 1993).

Rape Culture 101 -Posted by Melissa McEwan at Friday, October 09, 2009: http://www.shakesville.com/2009/10/rape-culture-101.html

Frequently, I receive requests to provide a definition of the term "rape culture." I've referred people to the Wikipedia entry on rape culture, which is pretty good, and I like the definition provided in *Transforming a Rape Culture*:

> A rape culture is a complex of beliefs that encourages male sexual aggression and supports violence against women. It is a society where violence is seen as sexy and sexuality as violent. In a rape culture, women perceive a continuum of threatened violence that ranges from sexual remarks to sexual touching to rape itself. A rape culture condones physical and emotional terrorism against women as the norm.
>
> In a rape culture both men and women assume that sexual violence is a fact of life, inevitable as death or taxes. This violence, however, is neither biologically nor divinely ordained. Much of what we accept as inevitable is in fact the expression of values and attitudes that can change.

But my correspondents—whether they are dewy noobs just coming to feminism, advanced feminists looking for a source, or disbelievers in the existence of the rape culture—always seem to be looking for something more comprehensive and less abstract: *What **is** the rape culture? What are its borders? What does it look like and sound like and feel like?*

It is not a definition for which they're looking; not really. It's a description. It's something substantive enough to reach out and touch, in all its ugly, heaving, menacing grotesquery.

Rape culture is encouraging male sexual aggression. Rape culture is regarding violence as sexy and sexuality as violent. Rape culture is treating rape as a compliment, as the unbridled passion stirred in a healthy man by a beautiful woman, making irresistible the urge to rip open her bodice or slam her against a wall, or a wrought-iron fence, or a car hood, or pull her by her hair, or shove her onto a bed, or any one of a million other images of fight-fucking in movies and television shows and on the covers of romance novels that convey violent urges are inextricably linked with (straight) sexuality.

Rape culture is treating straight sexuality as the norm. Rape culture is lumping queer sexuality into nonconsensual sexual practices like pedophilia and bestiality. Rape culture is privileging heterosexuality because ubiquitous imagery of two adults of the same-sex engaging in egalitarian partnerships without gender-based dominance and submission undermines (erroneous) biological rationales for the rape culture's existence.

Rape culture is rape being used as a weapon, a tool of war and genocide and oppression. Rape culture is rape being used as a corrective to "cure" queer women. Rape culture is a militarized culture and "the natural product of all wars, everywhere, at all times, in all forms."

Rape culture is 1 in 33 men being sexually assaulted in their lifetimes. Rape culture is encouraging men to use the language of rape to establish dominance over one another ("I'll make you my bitch"). Rape culture is making rape a ubiquitous part of male-exclusive bonding. Rape culture is ignoring the cavernous need for men's prison reform in part because the threat of being raped in prison is considered an acceptable deterrent to committing crime, and the threat only works if actual men are actually being raped.

Rape culture is 1 in 6 women being sexually assaulted in their lifetimes. Rape culture is not even talking about the reality that many women are sexually assaulted multiple times in their lives. Rape culture is the way in which the constant threat of sexual assault affects women's daily movements. Rape culture is telling girls and women to be careful about what you wear, how you wear it, how you carry yourself, where you walk, when you walk there, with whom you walk, whom you trust, what you do, where you

do it, with whom you do it, what you drink, how much you drink, whether you make eye contact, if you're alone, if you're with a stranger, if you're in a group, if you're in a group of strangers, if it's dark, if the area is unfamiliar, if you're carrying something, how you carry it, what kind of shoes you're wearing in case you have to run, what kind of purse you carry, what jewelry you wear, what time it is, what street it is, what environment it is, how many people you sleep with, what kind of people you sleep with, who your friends are, to whom you give your number, who's around when the delivery guy comes, to get an apartment where you can see who's at the door before they can see you, to check before you open the door to the delivery guy, to own a dog or a dog-sound-making machine, to get a roommate, to take self-defense, to always be alert always pay attention always watch your back always be aware of your surroundings and never let your guard down for a moment lest you be sexually assaulted and if you are and didn't follow all the rules *it's your fault*.

Rape culture is victim-blaming. Rape culture is a judge blaming a child for her own rape. Rape culture is a minister blaming his child victims. Rape culture is accusing a child of enjoying being held hostage, raped, and tortured. Rape culture is spending enormous amounts of time finding any reason at all that a victim can be blamed for hir own rape.

Rape culture is judges banning the use of the word rape in the courtroom. Rape culture is the media using euphemisms for sexual assault. Rape culture is stories about rape being featured in the Odd News.

Rape culture is tasking victims with the burden of rape prevention. Rape culture is encouraging women to take self-defense as though that is the only solution required to preventing rape. Rape culture is admonishing women to "learn common sense" or "be more responsible" or "be aware of barroom risks" or "avoid these places" or "don't dress this way," and failing to admonish men to *not rape*.

Rape culture is "nothing" being the most frequent answer to a question about what people have been formally taught about rape.

Rape culture is boys under 10 years old knowing how to rape.

Rape culture is the idea that only certain people rape—and only certain people *get* raped. Rape culture is ignoring that the thing about rapists is *that they rape people*. They rape people who are strong and people who are weak, people who are smart and people who are dumb, people who fight back and people who submit just to get it over with, people who are sluts and people who are prudes, people who rich and people who are poor, people who are tall and people who are short, people who are fat and people who are thin, people who are blind and people who are sighted, people who are deaf and people who can hear, people of every race and shape and size and ability and circumstance.

Rape culture is the narrative that sex workers can't be raped. Rape culture is the assertion that wives can't be raped. Rape culture is the contention that only nice girls can be raped.

Rape culture is refusing to acknowledge that the only thing that the victim of every rapist shares in common is bad fucking luck. Rape culture is refusing to acknowledge that the only thing a person can do to avoid being raped is *never be in the same room as a rapist*. Rape culture is avoiding talking about what an absurdly unreasonable expectation that is, since rapists don't announce themselves or wear signs or glow purple.

Rape culture is people meant to protect you raping you instead—like parents, teachers, doctors, ministers, cops, soldiers, self-defense instructors.

Rape culture is a serial rapist being appointed to a federal panel that makes decisions regarding women's health.

Rape culture is a ruling that says women cannot withdraw consent once sex commences.

Rape culture is a collective understanding about classifications of rapists: The "normal" rapist (whose crime is most likely to be dismissed with a "boys will be boys" sort of jocular apologia) is the man who forces himself on attractive women, women his age in fine health and form, whose crime is disturbingly *understandable* to his male defenders. The "real sickos" are the men who go after children, old ladies, the disabled, accident victims languishing in comas—the sort of people who can't fight back, whose rape is difficult to imagine as titillating, unlike the rape of "pretty girls," so easily cast in a fight-fuck fantasy of squealing and squirming and eventual relenting to the "flattery" of being raped.

Rape culture is the insistence on trying to distinguish between different kinds of rape via the use of terms like "gray rape" or "date rape."

Rape culture is pervasive narratives about rape that exist despite evidence to the contrary. Rape culture is pervasive imagery of stranger rape, even though women are three times more likely to be raped by someone they know than a stranger, and nine times more likely to be raped in their home, the home of someone they know, or anywhere else than being raped on the street, making what is commonly referred to as "date rape" by far the most prevalent type of rape. Rape culture is pervasive insistence that false reports are common, although they are *less common* (1.6%) than false reports of auto theft (2.6%). Rape culture is pervasive claims that women make rape accusations willy-nilly, when 61% of rapes remain unreported.

Rape culture is the pervasive narrative that there is a "typical" way to behave after being raped, instead of the acknowledgment that responses to rape are as varied as its victims, that, immediately following a rape, some women go into shock; some are lucid; some are angry; some are ashamed; some are stoic; some are erratic; some want to report it; some don't; some will act out; some will crawl inside themselves; some will have healthy sex lives; some never will again.

Rape culture is the pervasive narrative that a rape victim who reports hir rape is readily believed and well-supported, instead of acknowledging that reporting a rape is a huge personal investment, a difficult process that can be embarrassing, shameful, hurtful, frustrating, and too often unfulfilling. Rape culture is ignoring that there is very little incentive to report a rape; it's a terrible experience with a small likelihood of seeing justice served.

Rape culture is hospitals that won't do rape kits, disbelieving law enforcement, unmotivated prosecutors, hostile judges, victim-blaming juries, and paltry sentencing.

Rape culture is the fact that higher incidents of rape tend to correlate with lower conviction rates.

Rape culture is silence around rape in the national discourse, and in rape victims' homes. Rape culture is treating surviving rape as something of which to be ashamed. Rape culture is families torn apart because of rape allegations that are disbelieved or ignored or sunk to the bottom of a deep, dark sea in an iron vault of secrecy and silence.

Rape culture is the objectification of women, which is part of a dehumanizing process that renders

consent irrelevant. Rape culture is treating women's bodies like public property. Rape culture is street harassment and groping on public transportation and equating raped women's bodies to a man walking around with valuables hanging out of his pockets. Rape culture is most men being so far removed from the threat of rape that invoking property theft is evidently the closest thing many of them can imagine to being forcibly subjected to a sexual assault.

Rape culture is treating 13-year-old girls like trophies for men regarded as great artists.

Rape culture is ignoring the way in which professional environments that treat sexual access to female subordinates as entitlements of successful men can be coercive and compromise enthusiastic consent.

Rape culture is a convicted rapist getting a standing ovation at Cannes, a cameo in a hit movie, and a career resurgence in which he can joke about how he hates seeing people get hurt.

Rape culture is when running dogfights is said to elicit more outrage than raping a woman would.

Rape culture is blurred lines between persistence and coercion. Rape culture is treating diminished capacity to consent as the natural path to sexual activity.

Rape culture is pretending that non-physical sexual assaults, like peeping tomming, is totally unrelated to brutal and physical sexual assaults, rather than viewing them on a continuum of sexual assault.

Rape culture is diminishing the gravity of any sexual assault, attempted sexual assault, or culture of actual or potential coercion in any way.

Rape culture is using the word "rape" to describe something that has been done to you other than a forced or coerced sex act. Rape culture is saying things like "That ATM raped me with a huge fee" or "The IRS raped me on my taxes."

Rape culture is rape being used as entertainment, in movies and television shows and books and in video games.

Rape culture is television shows and movies leaving rape out of situations where it would be a present and significant threat in real life.

Rape culture is Amazon offering to locate "rape" products for you.

Rape culture is rape jokes. Rape culture is rape jokes on t-shirts, rape jokes in college newspapers, rape jokes in soldiers' home videos, rape jokes on the radio, rape jokes on news broadcasts, rape jokes in magazines, rape jokes in viral videos, rape jokes in promotions for children's movies, rape jokes on Page Six (and again!), rape jokes on the funny pages, rape jokes on TV shows, rape jokes on the campaign trail, rape jokes on Halloween, rape jokes in online content by famous people, rape jokes in online content by non-famous people, rape jokes in headlines, rape jokes onstage at clubs, rape jokes in politics, rape jokes in one-woman shows, rape jokes in print campaigns, rape jokes in movies, rape jokes in cartoons, rape jokes in nightclubs, rape jokes on MTV, rape jokes on late-night chat shows, rape jokes in tattoos, rape jokes in stand-up comedy, rape jokes on websites, rape jokes at awards shows, rape jokes in online contests, rape jokes in movie trailers, rape jokes on the sides of buses, rape jokes on cultural institutions…

Rape culture is people objecting to the detritus of the rape culture being called oversensitive, rather than people who perpetuate the rape culture being regarded as not sensitive *enough*.

Rape culture is the myriad ways in which rape is tacitly and overtly abetted and encouraged having saturated every corner of our culture so thoroughly that people can't easily wrap their heads around what the rape culture actually is.

That's hardly everything. It's merely the tip of an unfathomable iceberg.

UNDERSTANDING THE TRAUMA OF SEXUAL VIOLENCE

Sexual Violence is a Form of Trauma

As a survivor of sexual violence, you have endured a trauma, a significant event or series of events that fall outside the range of normal, everyday human experience. All forms of sexual violence are traumatic, including rape, attempted rape, sexual abuse, molestation, voyeurism, and many others. Other familiar types of traumatic events include combat conditions, natural disasters, vehicle accidents, and medical emergencies, or witnessing one or more of these events happening to someone else.

What makes a particular experience traumatic is that the survivor's ability to control what is happening to him or her is stripped away, often violently. The survivor feels that his or her health, safety and even life are directly threatened and he/she is rendered powerless to address that threat in the moment. Such an event overwhelms the brain's capacity to effectively respond and cope the way you would be able to in other types of situations. The extent to which a particular event is experienced as being traumatic by the survivor depends on many factors, which are unique to each person and each situation. Although you may feel out of sorts, or even that you're "going crazy," your reactions are *normal responses* to an abnormal event.

Sexual Violence is Unique

While the "brain impact" of sexual violence is similar to that of other types of trauma, sexual violence is unique. Unlike other types of trauma, sexual violence is a deliberate violation of your most personal space by one or more individuals that you likely knew and may have even trusted or loved. It is a personal crime of violence in which sex or sexuality is used as a weapon to harm and humiliate. Additionally, the stigma and sense of shame with which society regards such crimes makes it more difficult for survivors of sexual violence to seek and receive support than survivors of any other type of trauma. This stigma has the capacity to prolong feelings of distress and complicate the recovery process for some survivors. *It's important for you to know that what happened to you is not your fault. You did not cause this to happen to you*.

Common Reactions to Sexual Violence

While every survivor's experience and recovery process is different, most survivors experience some or all of the following reactions to the trauma of sexual violence:

- Physical: body aches/pains, fatigue, upset stomach/bowels, changes in eating and sleeping patterns
- Mental: difficulty with concentration and comprehension, confusion
- Emotional: disbelief, sadness, anxiety, anger, irritability, neediness, feeling numb, mood swings
- Behavioral: hypervigilence, avoidance of people or places, desire to change appearance, surroundings or tasks, difficulty maintaining intimate relationships

Recovery Takes Time

Recovering from any trauma, including sexual violence, takes time. The recovery process is as unique as each individual survivor and is impacted by countless factors. There is no right or wrong way to feel, and there is no established timeline to follow. The following describes a *general* process by which many survivors respond to and recover from the trauma of sexual violence. Not all survivors move through this process sequentially, and there is no predictable pace, but it may help to explain patterns of emotions and behaviors over time.

Acute Stage:

This stage typically lasts from a few days to a few weeks after the traumatic event and is characterized by intense physical and emotional symptoms. In the immediate aftermath of the trauma, the body and mind of the survivor are still reeling and are struggling to return to a sense of balance and normalcy. Some survivors are very expressive (crying, yelling), while others are very reserved (calm, in shock). Both reactions are normal responses to trauma, as is fluctuation between the two.

Underground Stage:

It is intolerable for the body and mind to continue to operate in the intensity described in the Acute Stage and so the survivor works to return to normal, everyday life. This stage can last from a few days or weeks to decades, and the survivor will often go to great lengths to distance him/herself from the trauma and any reminders of it. This might involve making subtle or profound changes to one's routine or surroundings. It is common to push thoughts of the trauma away, to deny it, or to think and speak of it as if it's "no big deal."

Reorganization Stage:

This stage often begins if/when the survivor experiences memories of the trauma and a return of intense emotions described in the Acute Stage. These memories and emotions are usually triggered by something that may or may not be directly related to the past trauma, including experiencing a sensory reminder of the trauma (sight, sound or smell), or experiencing a major life transition. Some survivors in this stage feel a need to examine the impact the trauma has had on their lives. Some survivors are not able or willing to examine the impact of the trauma, and return to the Underground Stage. For some survivors, this stage results in reaching a sense of resolution, where the trauma is understood and integrated within the context of the survivor's full life and experience. This can occur with or without formal assistance.

When to Seek Help

Help is both appropriate and available at any point in your recovery process. It is a sign of strength, not weakness, to seek help in recovering from the trauma of sexual violence. You do not need or deserve to suffer in silence. IMPORTANT: If you are experiencing physical or psychological symptoms that are interfering with your daily life, or if you are feeling suicidal, it is important that you seek help right away. (Please see our Survivor Series sheet on PTSD and related issues). You deserve to live a happy, healthy, fulfilling life.

UNDERSTANDING PTSD IN THE AFTERMATH OF SEXUAL VIOLENCE

What is PTSD and who gets it?

PTSD (Posttraumatic Stress Disorder) is a mental health condition suffered by many individuals who have experienced one or more traumatic events, including sexual violence. Not everyone who has experienced a traumatic event develops PTSD. About one-third of sexual assault survivors do. Whether or not an individual will develop PTSD depends on factors specific to the traumatic event, such as the intensity of the event, amount of control over circumstances during the event, and physical harm. It also depends on individual factors, such as other current mental health conditions, a family history of mental health conditions, the amount of stress in life not related to the trauma, and the quality of support received after the event.

It's important to remember that *the individual survivor's experience of sexual violence is more significant to the development of PTSD than the details of the trauma.* For example, an attempted rape can be just as traumatic for one survivor as a completed rape is for another survivor. Regardless of the circumstances, if a survivor develops PTSD, it is not a sign of weakness, nor does it mean that he/she is "crazy." PTSD is a serious, recognizable, and treatable condition in the aftermath of trauma.

What are the symptoms of PTSD?

PTSD is generally characterized by the presence of three types of symptoms:

- *Intrusive memories:* These include flashbacks and disturbing thoughts or dreams about the event. Flashbacks are intense, terrifying recollections of the event, such that the survivor actually feels as if the event is happening again.
- *Avoidance and emotional numbing:* This may include avoiding things that could elicit memories of the trauma, avoiding activities that used to be enjoyable, feeling emotionally disconnected, feeling hopeless about the future, having difficulty with memory and concentration, and having difficulty maintaining close relationships.
- *Anxiety and emotional arousal:* This may include irritability or anger, overwhelming guilt or shame, difficulty sleeping, seeing or hearing things that aren't there, being easily startled or frightened, and engaging in self-destructive behavior.

Symptoms of PTSD typically develop within three months following sexual assault, but may also develop months or even years later in response to a trigger (something that reminds you of the assault). The presence and severity of symptoms can come and go. For example, PTSD symptoms are more likely to worsen when you are experiencing more life stress, or if you see a news report or TV show describing sexual violence.

How is PTSD diagnosed?

Many of the symptoms described above are normal, expected responses to the trauma of sexual violence. What indicates the presence of PTSD is the duration of these symptoms and the extent to which they are interfering with your quality of life. Generally speaking, if these symptoms persist for longer than a month and are making you feel "out of control," then you may have PTSD. Only a doctor or trained healthcare or mental health professional can diagnose PTSD. He/she will conduct an evaluation or assessment, which includes questions about the trauma, about your recent thoughts, feelings and behaviors, and about any other problems you are experiencing. PTSD is usually diagnosed within one or two evaluation sessions.

When should I get help?

The right time to seek help is anytime you feel that additional support or assistance would benefit you in your recovery process. Whether the assault happened yesterday or years ago, help is available. If you think you may have PTSD, you should consider being evaluated by a doctor or mental health professional. No survivor needs or deserves to suffer in silence.

You must seek help right away if you are engaging in self-harming behavior, such as cutting yourself or abusing alcohol or drugs. While these things may seem to provide you with short-term relief from the emotional pain you're experiencing, they are dangerous to your health and safety, potentially resulting in serious physical injury, illness, or even death. Additionally, if you are contemplating suicide, you must seek help right away. It is possible to recover from sexual violence and to lead a fulfilling, productive life after trauma – but only if you are alive. Before considering suicide, consider talking to someone who can help you. A great place to start is by calling the National Suicide Prevention Lifeline, which is 1-800-273-TALK (8255).

How is PTSD treated?

PTSD is treated with mental health counseling/therapy, medication, or a combination of the two. There have been significant advances in the understanding and treatment of PTSD in recent years, and more survivors than ever before are receiving effective and timely diagnoses and treatment.

Examples of mental health counseling/therapy include Cognitive Behavioral Therapy (CBT), which usually involves meeting with a licensed mental health professional once per week for a few months. During CBT, survivors learn skills to better understand the trauma they've experienced, as well as the thoughts and emotions related to the trauma. Some survivors are guided by the therapist to speak about the trauma repeatedly until the memories no longer cause distress, referred to as "prolonged exposure." Another mental health counseling method is called Eye Movement Desensitization and Reprocessing (EMDR). This method involves having the survivor focus on distractions like hand movements or sounds while talking about the traumatic event. Over time, this can relieve the distress experienced from memories of the trauma, and can change the way the survivor reacts to those memories.

For additional information and resources for recovery from sexual violence, please visit www.oaesv.org.

SUPPORTING A LOVED ONE WHO'S BEEN VICTIMIZED

The Impact of Sexual Violence on You

The crime of sexual assault/abuse impacts not just the survivor, but also his/her friends, family members, intimate partners and acquaintances. Loved ones are often referred to as "secondary victims/survivors" because the crime has a significant impact on them as well. There are many common reactions and emotions one may experience in response to sexual victimization suffered by a loved one, including sadness, anger, shock, self-blame, fear, a desire for retaliation, wanting to protect your loved one, and wanting to "do something" or "fix things." Whatever thoughts and feelings you're experiencing, it's important to recognize them and how they may be influencing the way you react to and treat your loved one. While it's important for you to support your loved one who's been victimized, it's also important for you to recognize your needs and to seek support if needed. Rape crisis centers are available to help you as well.

The Impact of Sexual Violence on Your Loved One

Sexual assault is a crime of violence in which sex is used as a weapon to harm and humiliate the survivor. It is experienced by the survivor as a traumatic event, similar to combat conditions, natural disasters, or accidents. When someone experiences a traumatic event, it causes physical and psychological reactions that can be intense and confusing for both the survivor and his/her loved ones.

The trauma of sexual assault is uniquely difficult for survivors to recover from because it involves the violation of their most personal space, and it was likely committed by someone known to them, causing them to question their judgment and trust of others. Additionally, sexual assault is the only crime for which the victim is routinely blamed. Nearly all survivors fear not being believed, being blamed for the assault, and being made to feel ashamed by loved ones and authorities. Unfortunately, these fears are too often realized.

In the immediate aftermath of sexual assault, any of the following reactions are possible and are a normal response to a traumatic event:

- Physical: body aches/pains, fatigue, upset stomach/bowels, changes in eating and sleeping patterns
- Mental: difficulty with concentration and comprehension, confusion
- Emotional: disbelief, sadness, anxiety, anger, fear, irritability, neediness, feeling numb, mood swings
- Behavioral: hyper-vigilance, avoidance of people or places, desire to change appearance, surroundings or tasks, difficulty maintaining intimate relationships

For more detailed information about the possible reactions of sexual assault survivors over time, please see our factsheet on understanding the trauma of sexual violence.

How to Support Your Loved One

While there are helpful things to say, and things to avoid saying, there is no perfect blueprint or script to follow in supporting a loved one who has suffered sexual assault or abuse. Each survivor is unique, as is his/her recovery process. Supporting your loved one is a process that will take time and will include some trial and error, some good days and bad. No one expects you to have all the answers, nor should you expect to.

Helpful things to say:

- "I believe you": This may seem unnecessary, but it's an important message to convey. Even if you have questions or doubts about the circumstances surrounding the assault, it's vital that you interact with your loved one as though you fully believe him/her.
- "It's not your fault": Nearly all survivors question their own actions before, during and even after the assault. It's important that you let your loved one know that the only one responsible for the assault is the person who committed it. Your loved one neither caused nor deserved what happened.
- "I'm here for you": Even if your loved one does not want to talk to you about the assault or his/her feelings about it, it's important that you let him/her know that you are available anytime for support.
- "What can I do?/What will help you?" Many love ones are afraid of saying or doing something wrong. It's often helpful to simply ask your loved one what would be helpful for them.

Helpful things to do:

- Treat your loved one the same: Survivors need to know that their loved ones still love them, care about them, and think of them the same as always.
- Empower your loved one: Sexual assault is the ultimate loss of power and control over one's body, safety and well-being. One of the most impactful things you can do is to help restore your loved one's sense of control by allowing him/her to make decisions and to play an active role in his/her recovery.
- Maintain your focus: Many loved ones feel very strongly about seeking justice or even retaliation for the assault. While anger at an offender is appropriate, focusing on the offender takes your focus away from where it needs to be – your loved one.
- Follow their lead: Allow your loved one the time and space he/she needs to regain a sense of control and begin the recovery process. This will require an open mind and a lot of patience on your part.

When to seek outside help:

- If your loved one threatens to harm or kill him/herself, you must intervene. If the threat is imminent, call 911 right away. If it is less urgent, contact your local crisis hotline or call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255).
- Similarly, if your loved one is threatening to harm or kill the offender (or anyone else), you must intervene by calling 911 or your local police department's dispatch number.
- If your loved one is experiencing prolonged symptoms of distress that are interfering with his/her quality of life, encourage him/her to seek assistance. Please see our factsheet on understanding PTSD for more information.

Things to avoid saying or doing:

- Don't try to force your loved one into a certain course of action that he/she doesn't want to do, such as pressing charges or seeing a counselor. This may further traumatize him/her.
- Don't hold your loved one responsible for stopping the offender. If your loved one does not want to report the assault, it doesn't mean he/she is letting the offender get away with it or giving the offender the freedom to assault someone else. Only offenders themselves can prevent their own crimes.
- Don't smother your loved one. It's common and understandable to want to protect loved ones who have been victimized, but it's important not to smother them, unfairly restrict their activities, or make decisions for them. Survivors need to feel in control as much as possible.
- Don't try to minimize or change your loved one's recovery process. There is no specific timeline for a survivor to follow. To tell a survivor that he/she should be "over it by now" is not helpful.
- Avoid dwelling on hindsight. Do not tell your loved one what they should or should not have done before, during or after the assault. This is particularly challenging if your loved one was engaging in behavior that was risky or even illegal when the assault happened. Although your intention may be to protect your loved from future harm, he/she will interpret it as blame for the assault.

Specific Concerns

<u>The impact on physical and sexual intimacy:</u>

If you are an intimate partner of a sexual assault survivor, you likely have concerns about how the assault will impact many aspects of your relationship, including physical and sexual intimacy. In addition to potential exposure to sexually transmitted infections, you may be concerned about how your partner will respond to physical touch, as well as his/her comfort level with sexual contact. Each survivor responds uniquely to sexual assault – there is no right or wrong way to respond. Your partner needs to know that you are not afraid to touch him/her. Avoiding all physical contact may make your partner feel as though you're afraid of him/her, or that you no longer find him/her desirable because of the assault. At the same time, you don't want to be aggressive in initiating physical or sexual contact. As with all other aspects of an intimate relationship, it's important to communicate with each other. It's helpful to say, "I love you and want to be with you. That has not changed, but I want you to be comfortable. Tell me what you'd like me to do and not to do, and I will respect that." Keep talking to each other throughout your partner's recovery process.

<u>The assault happened a long time ago:</u>

Some survivors never tell anyone about sexual assault/abuse, some only tell certain individuals, and others only disclose the assault years later. If a loved one has told you about a sexual assault that they suffered a long time ago, it's important that you don't judge them or be upset with them for withholding this information until now. It's very difficult for survivors to talk about the victimization, especially with loved ones who are most affected by knowing about it. Tell your loved that you're glad they told you and be available to listen if they want or need to talk about it. Also understand that even though the assault may have happened a long time ago, it is likely still a very painful and emotional event for your loved one to think or speak about.

From the Sexual Assault Response Network of Central Ohio, OhioHealth's Survivor Advocacy Manual January, 2013

The Art of Providing Advocacy [i] [ii]

- Always let the survivor know that you believe and support her.
- Listen to the survivor talk about the incident repeatedly if she chooses, and conversely don't push her to talk if she does not want to. Let her know you are there if needed and desired.
- Assist the survivor to make her own decisions. Provide options; don't direct.
- Reinforce the survivor's feelings of strength and courage by pointing out what positive actions she took during the assault. Don't add to feelings of helplessness by instructing in what she should have done.
- Use whatever language the survivor uses to describe the assault.
- Be prepared to speak calmly and empathetically about embarrassing or painful subjects.
- Do not project or assume anything.
- Leave the survivor with a plan of action.
- Explain to the survivor what is involved in mandated reporting and what her options are so that she can make an informed choice.

Objectives:

- To assess the survivor's immediate health and safety needs
- To determine what the survivor wants from you
- To validate the survivor's feelings / assure survivor she is not to blame
- To let the survivor know she has a right to be safe
- To assist the survivor with a problem-solving action plan

Do Not:

- Assume anything
- Make promises you cannot guarantee
- Tell anyone anything without permission (i.e., confidentiality)
- Make decisions for the survivor
- Expect the survivor to act or react according to your values, your time frame or your ideas
- Be offended if a survivor vents her anger on you or tries to make you feel responsible
- Take it personally if the survivor rejects your offer of assistance
- Tell the survivor she will eventually have "closure" or that "time heals all wounds"
- Tell the survivor the importance of forgiveness. This is a personal choice
- Question the survivor's credibility if no emotion is displayed
- Tell the survivor you "understand what she are going through"

Do:

- Provide respect
- Provide privacy
- Provide control

i "The Advocacy Wheel", the Domestic Violence Project, Inc., Wisconsin
ii National Assault Prevention Center of Columbus, Ohio

From the Sexual Assault Response Network of Central Ohio, OhioHealth's Survivor Advocacy Manual January, 2013

Six Fundamental Patterns of Cultural Differences [ii]

Different Communication Styles

The way people communicate varies widely between, and even within, cultures. One aspect of communication style is language usage. Across cultures, some words and phrases are used in different ways. (For example, even in countries that share the English language, the meaning of "yes" varies from "maybe, I'll consider it" to "definitely so," with many shades in between). Another major aspect of communication style is the degree of importance given to non-verbal communication. Non-verbal communication includes not only facial expressions and gestures; it also involves seating arrangements, personal distance, and sense of time. In addition, different norms regarding the appropriate degree of assertiveness in communicating can add to cultural misunderstandings. For instance, some White Americans typically consider raised voices to a sign that a fight has begun, while some Black, Jewish and Italian Americans often feel that an increase in volume is a sign of an exciting conversation among friends. Thus, some White Americans may react with greater alarm to a loud discussion than would members of some American ethnic or non-White racial groups.

Different Attitudes Toward Conflict

Some cultures view conflict as a positive thing, while others view it as something to be avoided. In the U.S., conflict is not usually desirable; but, people often are encouraged to deal directly with conflicts that do arise. In fact, face-to-face meetings customarily are recommended as the way to work through whatever problems exist. In contrast, in many Eastern countries, open conflict is experienced as embarrassing or demeaning; as a rule, differences are best worked out quietly. A written exchange might be the favored means to address the conflict.

Different Approaches to Completing Tasks

From culture to culture, there are different ways that people move toward completing tasks. Some reasons include different access to resources, different judgments of the rewards associated with task completion, different notions of time, and varied ideas about how relationship-building and task-oriented work should go together. When it comes to working together effectively on a task, cultures differ with respect to the importance placed on establishing relationships early on in the collaboration. A case in point: Asian and Hispanic cultures tend to attach more value to developing relationships at the beginning of a shared project and more emphasis on task completion toward the end as compared with European-Americans. European-Americans tend to focus immediately on the task at hand, and let relationships develop as they work on the task. This does not mean that people from any one of these cultural backgrounds are more or less committed to accomplishing

the task or value relationships more or less, it means they may pursue them differently.

Different Decision-Making Styles
The roles individuals play in decision-making vary widely from culture to culture. For example, in the U.S., decisions are frequently delegated – that is, an official assigns responsibility for a particular matter to a subordinate. In many Southern European and Latin American countries, there is a strong value placed on holding decision-making responsibilities oneself. When decisions are made by groups of people, majority rule is a common approach in the U.S.; in Japan, consensus is the preferred mode. Culturally different survivors will be very concerned about "who" is making decisions on their behalf. Trust plays a big role when determining if advice or direction provided will be in their best interest.

Different Attitudes Toward Disclosure
In some cultures, it is not appropriate to be frank about emotions, about the reasons behind a conflict or a misunderstanding, or about personal information. When you are dealing with a conflict, be mindful that people may differ in what they feel comfortable revealing. Questions that may seem natural to you – What was the conflict about? What was your role in the conflict? What was the sequence of events? – may seem intrusive to others. Particularly in the area of sexual assault, there is concern about "how" information from the survivor will be used. Will judgments or assumptions be made to draw generalized conclusions? Will this information be used to help or hurt?

Different Approaches to Knowing
Notable differences occur among cultural groups when it comes to epistemologies – that is, the ways people come to know things. European cultures tend to consider information acquired through cognitive means, such as counting and measuring, more valid than other ways of coming to know things. Compare that to African cultures' preference for effective ways of knowing, including symbolic imagery and rhythm. Asian cultures' epistemologies tend to emphasize the validity of knowledge gained through striving toward transcendence.

ii "Working on Common Cross-cultural Communication Challenges", Marcelle E. DuPraw and Marya Axner, http://www.pbs.org/ampu/crosscult.html, 1997

From the Sexual Assault Response Network of Central Ohio, OhioHealth's Survivor Advocacy Manual January, 2013

Diversity Awareness and Sensitivity: Working with Survivors [iii]

There is no such thing as an average or typical rape/abuse survivor. Each survivor may identify in a number of ways: race, ethnicity, religion, gender, sexual orientation, student status, and mental, physical or financial challenges. These are only a few examples.

There is no one correct way to respond to a survivor of sexual or physical violence. There is also no one right way for a survivor to respond. Sometimes, cultural differences may affect both how a survivor responds, as well as what she may interpret as being helpful and supportive – or not.

It is important not to categorize someone because they happen to fall within a certain group. There are some cultural factors, which are common, associated particularly with racial and ethnic groups. It is crucial to not use this information to further stereotype the survivor and her response. It is important to deal with each individual as a unique human being. Use the information provided in this section, not to label survivors, but to act as a framework for your understanding of her experience.

Suggestions for Working with Survivors

- Understand that she may be wary of or apprehensive about service providers from a background different from her own.
- Be open and flexible.
- Do not second-guess or assume you understand her experiences and values.
- Do not ignore her under the assumption that she would prefer to interact with a staff person of her own culture.
- Do not attempt to relate to or serve the survivor if you do not want to or if you feel fearful or hesitant approaching her.
- Affirm the survivor's experience, even if her beliefs are different from yours.
- Be aware of verbal and non-verbal communication.
- When talking with the survivor, listen to how she communicates; make an effort to respond accordingly.
- If the survivor's beliefs or values are impeding treatment, seek options and alternatives within the context of her culture.
- Recognize that survivors may respond to you based on past experiences with service providers.
- Accept the survivor's interpretation of her experiences.
- Be aware of your own biases.
- Develop knowledge of cultural differences.
- Accept cultural differences.

- Develop knowledge of the survivor's cultural background.

Educational Issues

- Recognize that your own beliefs about women, men, sexuality, sexual orientation, race, culture, religion, and sexual assault may differ from the beliefs of others.
- Seek out information about the cultures in your community to build an awareness and appreciation of different cultures.
- Learn to recognize stereotypes and dispel myths as you encounter them.
- Recognize that sexual assault is a crime that can affect anyone – regardless of their age, gender, culture, or background.

What to Do When You Make Mistakes

- Check for understanding in both directions.
- Admit lack of knowledge and ask for help.
- Apologize for the "effect" of what you did, state your intent and ask how that could have been accomplished more effectively.
- Try to keep from getting defensive about mistakes.
- Explore the value of the particular aspect of diversity that caused the difficulty.
- Accept the idea that making mistakes is the only way you can learn (the only way to play it safe is not to try).
- Make it clear that it is OK for others around you to make mistakes.

Issues within Your Organization

- Network with others in your organization from diverse cultures.
- Ask for help if you need it when working with a survivor who has a different background.
- Be sensitive to barriers and limitations, which may inhibit a survivor from getting treatment (e.g., no elevators for persons in wheelchairs).
- Encourage and receive training on multi-cultural approaches.
- Your organization's staff, volunteers and board should strive to be representative of your community (regarding age, socio-economic levels and ethnicity).

Language Issues in Interviewing Survivors

- Learn tolerance and patience of others' language skills and communication barriers - especially in a crisis.
- Don't presume someone doesn't speak English or was born in another country because of their appearance.
- Clarify terms if there seems to be confusion.
- Recognize that discussing sexual assault or sexual terms may be associated with shame and embarrassment in some cultures.
- Expressing feelings to a stranger may cause a conflict, which could inhibit a survivor from responding to you.
- Prepare adult interpreters to ensure an awareness of sexual assault,

confidentiality and cultural issues when necessary to facilitate communication.

- Eye contact or lack of eye contact may be a cultural communication of respect (not of guilt or deception).
- Take cues from the survivor regarding issues of touch and proximity (distance). ALWAYS ASK before touching and inform the patient prior to the actual exam.
- Recognize and respond to verbal and non-verbal cues. If unsure, seek clarification.

iii "Project Safety Newsletter, Volume II, Issue III" and "Ohio Protocol for the Treatment of Adult Sexual Assault Survivors: a Training Guide for Medical Personnel", Ohio Department of Health: Division of Prevention- Women's Health Section/Rape Prevention Program, revised 1999

Ohio Alliance to End Sexual Violence
Phone: 216-658-1381 / 888-886-8388 Email: info@oaesv.org

SURVIVOR RIGHTS & RESOURCES: FACT SHEET FOR ADVOCATES

Survivors with Limited English Proficiency (LEP)	**The Rights:** Survivors who have Limited English Proficiency (LEP) have the right to request a court-appointed interpreter, free of charge. The Supreme Court of Ohio administers a certification program for court appointed interpreters, to ensure that they are trained and qualified for the task. Interpreters must be more than simply bilingual and instead must have the requisite training and experience. Additionally, children, relatives and friends should never be used to interpret, and neither should judges, attorneys or court personnel. Non-certified interpreters may be used, but a judge must assess their skills and training to ensure they are adequately prepared for the task. To request an interpreter, alert the court staff or judge about the need for interpreter services. The judge is allowed to ask the individual to answer questions in order to assess their skill level with English. If it isn't clear whether the individual needs an interpreter, the Supreme Court of Ohio urges Ohio judges to err on the side of allowing one. **Resources:** • Supreme Court of Ohio and the Ohio Judicial System - Interpreter Services Program: ○ **Phone:** (614) 387-9403 ○ **Website:** http://www.supremecourt.ohio.gov/JCS/interpreterSvcs
Survivors with disabilities	**The Rights:** Survivors who are deaf, deaf-blind, or hard of hearing have the right to request a court-appointed interpreter (or other assistive service), free of charge. The Americans with Disabilities Act (ADA) entitles individuals who are deaf, deaf-blind, or hard of hearing to have equal access to the courts. Under the ADA, survivors with disabilities have the right to "effective communication" in a court. What constitutes effective communication depends upon the individual circumstances, but may mean the right to an interpreter or other form of accommodation, such as assistive listening devices or specialized interpreter services. Under Title II of the ADA, the court is obligated to ask the individual with the disability what type of accommodation they need. A judge may ask the survivor on the record what would allow for the best communication, and if an interpreter is needed. The National Association for the Deaf (NAD) suggest that individuals requesting accommodation be as specific as possible about the type of accommodation they need, and to explain why that form of accommodation would be most effective. While the court is not obligated to use the preferred

SURVIVOR RIGHTS & RESOURCES: FACT SHEET FOR ADVOCATES

Survivors with disabilities *(cont.)*	accommodation, this may be more likely when requests are specific. Additionally, NAD recommends that the request be made as early as possible, because it can take time to find a qualified interpreter. **If Rights are Denied:** If a court denies a request, individuals should file a Title II complaint with the Department of Justice. Forms and information can be found at http://www.ada.gov/enforce.htm#anchor218282, or by calling the ADA Information line at (800) 514-0301 (TTY: 800-514-0383). **Resources:** • Ohio Legal Rights Service ○ **Phone:** (800) 282-9181 ○ **Website:** http://www.olrs.ohio.gov/communicating-with-courts • ADA.gov ○ **Phone:** (800) 514-0301 (TTY: 800-514-0383) ○ **Website:** http://www.ada.gov • Midwest Center on the Law and the Deaf: ○ **Phone:** (800) 894-3653 (TTY: 800-894-3654) ○ **Website:** http://mcld.org • National Association for the Deaf: ○ **Phone:** (301) 587-1788 (TTY: 301-587-1789) ○ **Website:** http://www.nad.org/issues/justice
Rights for survivors and the use of Polygraph Tests	**The Rights:** Under Ohio law (§2907.10), survivors of sexual offenses* have the following rights regarding polygraph tests: • Survivors cannot be asked or required to submit to a polygraph examination in order for the criminal investigation to proceed; and • A survivor's refusal to submit to a polygraph cannot prevent the investigation of the sexual offense, the filing of criminal charges, or the prosecution. * Ohio defines sexual offenses as any of the following: rape, sexual battery, unlawful sexual conduct with a minor, gross sexual imposition, sexual imposition, importuning, voyeurism, or public indecency.

This document in its entirety was published by the Ohio Alliance to End Sexual Violence (OAESV) through a Victims of Crime Act grant award administered by the Ohio Attorney General's Office

From the Sexual Assault Response Network of Central Ohio, OhioHealth's Survivor Advocacy Manual January, 2013

Three Steps Toward Empathetic Listening [iiiiv]

1. Give the survivor your full attention
This is not a time to multitask. If you are doing something else, then your attention is diverted and is not focused on listening to the survivor. For example, if you're writing notes and the survivor wants to tell you something, stop what you're doing and focus on the survivor. If you need a few minutes to finish that project or email before comfortably beginning your shift, then make the time to find a comfortable stopping point. Create the space you need to be able to listen completely. This empowers you to take control of your interruptions and to choose what you focus on in any given moment.

2. Refrain from talking while the other person is talking
Your job is to hear what survivors are saying and listen for the heart of the message, which may be deeper than the words themselves. The fact is that many people have difficulty getting their thoughts out in a cohesive way. Be curious. What is the point they are trying to make? What do they want you to know? What do they need from you? Only speak to ask questions that will clarify what you are hearing so that you can better understand them, and so they can better understand themselves.

3. Summarize what you heard
This is important because it shows them that you are listening and that you really get what she is saying. If you didn't hear correctly or completely, let the survivor provide additional information and then repeat your understanding of what she has said. It sounds simple and it is, but like any change, it will require diligent attention, practice, and continued development and improvement. You will need to exercise self-control and muster patience especially if you have bad communication habits.

Some unhelpful habits you may need to replace:
As you begin to pay closer attention to your behavior, you may find that you have developed some really unhelpful habits when it comes to listening. Since awareness is the key to change, here are several common habits that you may recognize:

- Interrupting with your own ideas and thoughts.
- Finishing the person's sentence for them as if you know what they are saying or to hasten the conversation.
- Changing the subject to focus on a thought you had so the conversation shifts to you and away from them.
- Focusing on solving their problem rather than simply listening and discovering what they need from you.
- Thinking about something other than what the person is saying-having your mind drift away to other subjects, thinking about how you will respond, or

doing something else while the person is speaking so your attention is elsewhere.

Sometimes, you don't want to hear what the person is telling you and you become defensive. This should signify that there is a lesson here for you. What are you defending? Are you too attached to your ideas or to being right? Are you taking something personally? Use this emotion as a message for self-discovery. What is this message of "defensiveness" trying to communicate to you?

Empathetic listening is about uncovering and experiencing for yourself what other people are experiencing. Remember, you don't have to agree; just step into their shoes to see the world from their perspective. When you focus your attention on understanding, acknowledging the individual, and helping the person to express their own truth, you build credibility and make them feel that they matter. When people feel accepted and respected, they are more productive, more willing to cooperate, and more amenable to change.

Suggestions for the Use of Empathy:

- Remember that empathy is ideally a way of being and not just a professional role or communication skill.
- Attend carefully to the survivor's point of view.
- Set your judgments and biases aside for the moment and walk in the survivor's shoes.
- As the survivor talks, listen for the core messages.
- Listen to both the verbal and nonverbal messages and their context.
- Respond fairly frequently and briefly to the survivor's core messages.
- Be flexible and tentative enough that the survivor does not feel pinned down.
- After responding with empathy, attend carefully to the cues that either confirm or deny the accuracy of your response.

iii "The Art of Asking Questions", Dorothy Leeds, American Society for Training and Development. Alexandria, Virginia, 1993
"The Business of Listening", Diane Bone. Crisp Publications, Menlo Park, California, 1988
"Calming Upset Customers", Rebecca Morgan. Crisp Publications, Lost Altos, California, 1989
"Delivering Knock Your Socks Off Service", Ron Zemke and Kristin Anderson, AMACOM. 1991
"Front-Line Customer Service", Clay Cart. John W'fiey & Sons, 1990
Information and Referral Center Training Manial, FIRSTLINK. Columbus, Ohio, 1995
"People Skills", Robert Bolton. Simon & Schuster, New York, 1979
"Strawberry Communications. Let's Make Friends and Not Lose Customers", Audio Cassette Training. Zig Coprorations, 1987
"Tune in Empathy Training Workshop", Donald and Nancy Tubesing. Listening group, Duluth, MN, 1977
iv "Three Steps to Empathetic Listening", Julie Fuimano, MBA, RN, Nurturing Your Success Inc. www.hodu.com/empathic.shtm, 2009

Listening Skills [v]

TYPES OF QUESTIONS

Closed-ended Questions. Closed ended questions take the initiative away from the survivor with the burden of talk remaining on the advocate. If you sense the survivor is feeling discomfort or revealing too much, you can slow down and help her regain composure by using some closed questions. This is helpful with survivors who begin crying. (Silence may work also).

- Can be answered with a few short words
- Can focus the discussion
- Limit the number of potential responses
- Provide information that is factual
- Are not probing
- Often begin with, “Is,” “Are,” “Do,” “Can,” and “Did.” For example, "Are you married?" or "Do you have children?"

Open-ended Questions. “Could” questions are considered maximally open and contain some of the advantages of closed questions in that the survivor is free to say, “No, I don’t want to talk about that.” “Could/would” questions contain less control and command than others do. “Could/would you give me a specific example?”

- Encourage an unlimited number of responses
- Asks for subjective information
- Encourage survivors to continue talking, elaborate
- Provide focus
- Provide clarity
- Provide maximum information
- Facilitate free discussion
- Communicate care and concern/helps to develop trust
- Elicit feelings
- Often begin with “What,” “How,” “Could,” “Would,” and “When”
- “What” questions lead to facts. “What” calls for an explanatory description. “What happened?”
- “How” questions often lead to discussions about processes, sequences or feelings. “How do you feel about that?”

Indirect Questions. Skilled advocates use very few direct questions and do very little talking. Indirect questions produce situations that are as open as possible and permit a higher level of trust. Indirect questions are open questions that are even broader. They usually are not actually a question, however it is evident that a question is being asked and an answer is sought. They do not sound like a question. Closed-ended question: “What do you think of our new telephone system?” Indirect question: “You must have some thoughts about the new telephone system.”

Problematic Questions

- Bombardment/Grilling Questions. Asking a survivor too many questions at one time can put them on the defensive. They may just stop talking and will become distrustful. This type of questioning is not well received in non-western cultures.
- Multiple Questions. Multiple questions are asking several questions at once. Ex: “When does that happen and how do you feel when it does?” One sentence may set the context for the

question, explain the reason for it or prepare the survivor. “I want to be sure I understand you correctly.” “Could you tell me more about the...?”

- Questions As Statement. This is using questions as a way to express your (the advocate) point of view. They are leading questions indicating what the answer should be. You are not asking a question, you are soliciting a confirmation. For example, “Don't you think it would be more helpful if you studied more?”
- Questions That Have Another Agenda. Avoid using questions that imply blame, advice, antagonism, etc. For example: “Haven't you been taking your medicine?” (Blame), “What is that suppose to mean?” (Antagonism), “Have you talked with your doctor about this?” (Advice). Advice is not a part of advocating. Friends and family give advice, helping professionals do not. The difference between giving information and advice is that advice provides survivors with specific actions to perform. Information consists of facts, and additional options that survivors may find useful in decision making.
    - Example:

        Survivor: “I'm having trouble with my boyfriend.”
        Advocate: “Have you tried talking with him?” (Advice and premature problem solving).
        Rephrased: “Tell me about the trouble you are having” (Encourages elaboration).
- Double Questions. Double questioning is asking two questions within one question. “Do you wish to live with your father or your mother?” This question limits the survivor to one choice out of two. The survivor may have another option in mind. This type of questioning can be confusing.
- Why Questions. Questions that begin with WHY can sound blaming and may put the survivor on the defensive or cause discomfort. WHY questions call for self-analysis and people do not usually know why they feel the way they do. “Why do you have difficulty telling your husband about the things he does that annoy you?” Rephrased: “What do you think would happen if you told your husband about the things he does that annoy you?” or “Tell me about the trouble you are having.”

DEVELOPING ACTIVE LISTENING SKILLS

- Stop talking: If you really want to be an effective advocate, stop what you are doing. Eliminate distractions. Give your full attention and show the survivor that you really want to listen.
- Put the survivor at ease: Get relaxed yourself. Use door openers like, “Anything I can help you with?” Don't rush; give the caller time to gather her thoughts. Be alert to posture and nonverbal cues.
- Don’t Interrupt: Allow the survivor to vent, as needed. Remember that it's only words. Be patient.
- Empathize: Make a statement of regret. Be genuine. Ask her for help. “I'd like to understand your problem; will you help me?”
- Paraphrase: Try to summarize what you've heard and restate it to the survivor to her satisfaction. This often helps defuse tension. It also aids in showing a survivor that you are trying to understand her situation.
- Ask open-ended questions: Use questions for clarification and understanding; “What do you suggest we do?”

- Use silence: Don't be afraid of tension. If tension exists, your perceptions of time can get terribly distorted.
- Allow reflection: In many cases the best role we can play is that of a sounding board for survivors. This often allows for a little pressure release.

Attentive Silence

For most beginning advocates silence can be frightening. It seems to focus all of the attention on us, revealing our weaknesses as specialists. As a result, we have a tendency to say something - anything - to fill the silence. It is not necessary to always keep the survivor talking. Use of silence is a good use of time and can be therapeutic. Learning the art of silent responsiveness is essential to good listening.

Silence allows the advocate and survivor time to think, feel and express themselves. It provides the survivor time to deal with any ambivalence about sharing. By using silence the advocate may send such messages as "I want us to move more slowly." "I want you to think about what you just said." "I care very much about you and your feelings in this moment." Silence is an excellent tool to use with survivors who are quietly crying or have said something profound.

You can use silence to pace your time especially in the initial phase of the conversation when you are building trust. Silence allows more complete expression and lets the survivor determine the pace.

Sometimes survivors will present with emotions that belong to other people or situations. You may be tempted to help give the survivor insight. This may be a moment when the potential for awareness is high. Use silence as your response. There are times when a survivor will need to stop, catch her breath or process and review the implications of what was just said. This can help the survivor open up a door to awareness. The survivor may make an irrational statement or acknowledge a significant insight. By using silence you give the survivor time to absorb the impact of the moment.

Advocate: "This is _____, may I help you?
Survivor: (Silence)
Advocate: "This is _____, may I help you?"
Survivor: (Continued silence)
Advocate: "It's OK to talk, or not. You are troubled tonight. Take your time."
Survivor: (Audible breathing; pause)
Advocate: "Take your time. Perhaps you just want someone to be with you so you won't feel so alone. I'll just be here." (A long silence)
Survivor: (Very faintly and without expression) "I want to talk."

The skill demonstrated in the initial stages of this call was sensitivity in listening to the speechlessness of another, "hearing" the difficulty the survivor was having and tuning in to those feelings.

Non-Distracting Environment

Active listening involves giving the survivor your undivided attention. As an advocate, you need to

make every attempt to keep environmental disturbances to a minimum. Active listening requires the advocate to avoid distractions: for example, don't read the newspaper or a book as you listen. Although difficult, you need to screen out inner distractions. Enter every conversation with the commitment to focus on the other's frame of reference.

It is even possible for an advocate to become a distraction to the survivor. By interrupting, asking too many questions and making too many statements, you divert the survivor from the real reason they have sought out help. An advocate's goal should be to listen for the survivor's need from their frame of reference.

Door Openers

A door opener is a non-coercive invitation to talk. Sometimes a survivor plunges right into the need or problem and sometimes you will sense that she wants to talk but needs some encouragement. At other times a survivor will be in the midst of talking and will suddenly show signs that she is unsure about continuing. A door opener like this may help the survivor to proceed – "I'm interested in hearing more about it." Often survivors begin with, "I'm not sure you can help," or other unsure thoughts. People are often uncomfortable asking for help. An effective advocate will address this anxiety by the use of door openers: "I am glad you called", or "I am glad you came to the hospital", "I am here to help", "please, go ahead."

Minimal Encourages

Leading responses, or minimal encourages, are simple responses that encourage the survivor to tell her story in her way, yet allow the advocate to remain active in the process. These words and phrases aid the survivor in continuing to speak. Just a few words can let her know you are listening without interrupting the flow of talk or breaking the mood. It is an encouragement to talk, elaborate or to explain more.

Minimal encourages do not imply either agreement or disagreement with what the survivor said. They let her know she has been heard and that the advocate will try to follow her meaning if she will continue talking.

Examples of minimal encourages:
Tell me more. Really?
Yes. Go on.
I see. Right.
Then? Oh?
For instance... Mm-hm.

Focusing

Survivors often present their story like pieces of a jigsaw puzzle - disconnected - with significant items embedded in a great deal of irrelevant talk. They often talk in circles and in generalities, viewing their problems simplistically. They talk about other people not seeing their own involvement. Often the presenting problem turns out to be one of several unresolved issues. The advocate's task is to assemble the items, put the pieces of the puzzle together so they create a comprehensive picture and organize them in the survivor's mind.

Focusing is a skill that:

- Narrows to a single problem or need that is chosen from an array
- Helps the survivor to be in touch with her feelings
- Concretely identifies one problem or theme
- Breaks down large problems into more manageable pieces
- Reduces confusion
- Teaches problem solving, independence, and self-reliance

When you are focusing, you need to follow at the survivor's pace using a warm, expressive tone and directly follow the survivor's comment. Do not interrupt or change the subject.

Along with the focusing technique, the advocate will need to help the survivor prioritize needs. This is another technique that helps the survivor to concretely understand the situation, relieve confusion and begin to resolve the situation. The survivor decides the priority.

Start with the problem that is present, primary or most important for the survivor to resolve. Often this is the problem that is causing her the most pain or discomfort. Working with the issue(s) most important to the survivor will most likely lead to change. The relief of presenting the problem may help improve the survivor's ability to function.

"We have been discussing several (many) topics, (problems, needs) for the last few minutes. Tell me which one is the most important to you today?" Focus on the here and now, today.
"Of all the problems we have been discussing which one is more important to you today?" (Or bothers you the most?)
"How much relief would you experience if this issue were resolved?"
"Of these concerns, which is the most stressful or painful for you?"

Clarification

- Encourages elaboration
- Clears up vague and confusing messages
- Checks for accuracy

A beginning response: "Are you saying that...?" or "Could you describe what you mean by...?" plus a rephrasing of the message.

It is important, especially during the beginning of a conversation that you do not charge ahead without stopping to check the accuracy of what was said, this allows you to understand and encourage the survivor to talk. Be careful not to rush to assumptions, draw conclusions, and/or prematurely problem solve. Clarifying is used when needed throughout the entire discussion and is one technique that helps to keep the conversation open.

Examples of clarification:
"What specifically do you mean by...?"
"Will you clarify what you mean by...?"
"What I think you said was...?"
"As I understand it, the problem is...? Am I hearing you correctly?"

Paraphrasing

Paraphrasing is restating in your own words (not parroting) the content portion of the survivor's verbal message. Content refers to a situation, event, fact, person, object or idea.

- To determine whether you have accurately received the verbal message(s) sent to you
- To give the survivor the opportunity to correct you if your paraphrased statement is incorrect in order to clear up any misunderstanding
- To acknowledge that you have heard the survivor
- To demonstrate that you are interested in what the survivor is telling you
- Effective paraphrasing is a caring behavior that increases accuracy between the survivor and the advocate and produces a degree of mutual understanding.

The Following Are Some Classic Paraphrase Stems:
Let me repeat what I am hearing...
Let me check this out...
What I hear you saying is...
I understand you to say...
You're telling me...
You are saying that...

Direct Expression of Feelings

This skill identifies and directly names the survivor's (advocate) own feeling(s). Direct expression of feeling is sending an "I" (first person) message in which the survivor (advocate) owns their feeling. Indirect expression of feeling is sending a "you" message, which puts the burden on the other person. It is confusing and hurtful to the other person when feelings are described indirectly rather than directly.

Indirect: "Quiet! Not another word out of you!"
Direct: "I am really annoyed by what you just said."

For difficult, manipulative and resistant survivors, the direct expression of feeling approach teaches effective communication. It helps explain to the survivor how they are making us (advocates) feel, the reason, and what they can do to remedy the situation. "I feel (emotion) when you (behavior) because (reason)."

Summarization

Summarization is two or more paraphrases or reflections that condense the survivor's message.

- Focus the conversation by identifying common themes, patterns that are repeated over and over.
- Tie together multiple elements of the message.
- Use a technique to stop excessive rambling.
- Moderate the pace when moving too fast – "Let's stop for a moment and review what you are saying, you need help with..."
- Review progress.
- End discussion.

Avoid adding new ideas to the summary and use your voice so summarization sounds like a statement and not a question.

SURVIVOR REACTIONS

Angry Survivors

There are Three Levels of Anger:

- Complaining (disappointment).
- High voice, speaking faster, possible profanity or just the opposite - lowered voice, very controlled, keeping feelings in check, very definite speech.
- Out of control, crying uncontrollably, irrational, demanding.

Some Techniques That Help Calm Down an Angry Person:

- Use their name. Start out a sentence using their name. It gets their attention.
- Lower your voice somewhat; slow down your speech. Be careful not to overdo this technique as it could sound patronizing.
- To get their attention, carefully and slightly raise your voice and then gradually lower it.
- Ask a close-ended question and follow that with a second closed-ended question. This gives you more control and forces them to stop and think before answering.
- Use time-oriented action words – "I'm giving this my immediate attention", "today, right now, right away."
- Avoid all internal and external distractions. Give the person your undivided attention. Avoid the following labels that block effective communication:
    - Interrupting, finishing sentences
    - Not checking to understand
    - Criticizing the survivor
    - Focusing on how the survivor is talking instead of what the survivor is saying
    - Listening for facts not feelings
    - Faking attention
    - Creating distraction
    - Tuning out difficult or confusing information
- Do not overload the person with too much information or too many referrals.
- You can diffuse anger by smiling and offering a friendly greeting.
- You can diffuse angry survivors by managing your stress. Survivors may berate you with intense anger and soon you may begin to feel frustrated, angry and combative. If you are stressed out when you interact with a survivor, the result can be disastrous for both you and the survivor.
- With an angry survivor, you will spend about 80% of your time massaging feelings and 20% of your time on a solution. Stay calm. Lower your voice. Slow your speech. Do not fight back.
- Listen. Listen. Listen. Work at making sure the survivor feels understood. Take time to clarify - did I hear the survivor correctly? One way to diffuse anger is to be sure the other person knows you understand how they feel (listening is a good way to diffuse your own emotions). Work hard on connecting with the survivor.
- Empathize. Convey that you can sense the reason the survivor is upset. Acknowledge the survivor's right to feel the way they do. Do not ignore their feelings. Confirm that you understand or are trying to understand their feelings. Use feeling words:

- *"I can sense how you feel."*
- *"I can understand."*
- *"I see."*
- *"I can see how you'd be upset."*

- Be a team. You and the survivor need to work together to come up with a solution. You are on the same team. It is not "them vs. you." Use the survivor's name and tell them your first name.
  - *"I want to help find a solution."*
  - *"Let's see what we can work out together."*
- Remember this is the survivor's problem, not yours. Your responsibility is to act as the professional using your skills and knowledge to link the survivor to the appropriate community resources. Maintain your professional perspective. Think: What do I want to accomplish with this survivor?
- An angry survivor doesn't care how much you know until they know how much you care!

Crying Survivors

- Use silent pauses. It reflects that you care very much about their feelings at the moment.
- Use verbal assurances. "Take your time. I will wait". Be patient and reflect that in your voice.
- Permit the survivor to cry and validate that it is ok to let the emotions or feelings out. Let the emotion run its course.
- Don't rush the survivor into talking. Deal with the emotion and then the cause.

Depressed Survivors

- Establish rapport. Let the survivor know that you are listening.
- Be patient. Do not rush to identify or solve the problem. Deal with the feelings first. Paraphrase or reflect what you think you hear. *"I hear sadness in your voice."*
- Check your perception. *"I sense that you are feeling sad. Am I right?"*
- Listen for statements that reflect suicidal thoughts or intentions. *"I just feel like I don't want to live."*

Silent Survivors

- Silent calls or when no one answers.
- Do not hang up; be patient and remain calm.
- Encourage them to talk and wait for that to happen. *"It's ok if you want to talk."*
- Give them permission to be silent until they are ready to talk and use silence yourself. *"You feel too badly to talk at the moment. Take your time. Perhaps you just want someone to be with you so you won't feel so alone. I'll just be here." (Silence) and then wait.*

v "FIRSTLINK Information on Listening Skills", Angela Rountree, Director of Information Services at FIRSTLINK, 1997

From the Sexual Assault Response Network of Central Ohio, OhioHealth's Survivor Advocacy Manual January, 2013

Crisis Intervention in an Acute Situation

Assess the Caller's Physical Safety:

- Ask the caller if they are in a safe location.
- Ask where the perpetrator is at (if temporarily out of the home, ask when she is expected to return).
- If the caller is not in a safe location or if the threat of the perpetrator returning is present, brainstorm possible options with the caller by:
    - Asking if the caller feels comfortable calling 911 or if the caller would like for you to call. Ask the caller if they would like for you to call law enforcement if the perpetrator returns or if the call is disconnected, if so collect identifying information immediately. [varies by agency]
    - If at home, asking the caller if there is a neighbor's house that she could go to and then call the hotline back.
    - Asking the caller if she has a friend or family member's house she could go to and then call the hotline back, or (depending on safety concerns) if a friend or family member could come and stay with the caller.

Assess the Caller's Medical Condition:

Ask the caller if she is hurt and needs immediate medical attention. Some callers may not be aware of how badly injured they are, so it is imperative that you ask direct questions. For example, if the caller was raped vaginally or anally, you could ask, "Are you having any vaginal or rectal bleeding?"

If the need for immediate medical attention exists, brainstorm possible options with the caller by:

- Asking the caller if she feels comfortable calling 911, or if the caller would like for you to call. Try to obtain identifying information in the event that the call is disconnected. [varies by agency]
- If at home, asking if the caller has a neighbor that could transport her to the hospital.
- Asking the caller if she has a friend or family member that could transport her to the hospital.

Mandatory Reporting of Sexual Violence: Best Practices for Advocates

WHO This factsheet is for **advocates** who work with sexual violence survivors.

WHAT There are instances when advocates are required to report an incident of sexual violence to protective services and/or law enforcement personnel. This sheet details when an advocate is mandated to report.

WHY If you are obligated to report and fail to report, it is a violation of the law.

For example, the failure to report a felony could result in the charge of failure to report a crime, a misdemeanor of the fourth degree. It could also result in ethics violations for you professionally and/or loss of funding for the agency with which you are employed or affiliated.

WHEN There are two instances when advocates who work with sexual violence survivors may be required to report the incident of sexual violence:

1. **The advocate is a mandatory reporter of child abuse or maltreatment due to their profession** (such as licensed social workers, health care providers, school employees, etc.) (ORC § 2151.421).
2. **The advocate is mandated to report under Ohio's felony reporting law.** This law (ORC § 2921.22) requires individuals who know of an already committed felony, or a felony about to be committed, to report it to law enforcement. The law does exclude certain individuals from reporting, such as licensed counselors or drug treatment workers or those who work under those programs.

☞ **Advocates may need to report under one, both, or neither of the above laws.**
See pages 3– 6 to determine whether the incident must be reported.

WHERE Reports should be made to either child protective services (CPS) or to law enforcement in the county where the sexual violence took place or in the county where the minor resides.

HOW Report like an advocate. Keep the client's needs in mind as you abide by mandatory reporting laws. Only report the minimally necessary information in order to satisfy the law and protect your client.

☎ <u>Details on How to Report:</u>
A report may be made by telephone or in person with either the county where the assault occurred or the county where the child resides. CPS or law enforcement may request that you follow with a written report. Be prepared to provide:

1. the names and addresses of the child and the child's parents or the person or persons having custody of the child, if known;
2. the child's age and the nature and extent of the child's injuries and sexual abuse that is known or reasonably suspected or believed to have occurred or the threat

of injury or sexual abuse that is known or reasonably suspected or believed to exist (including any evidence of previous injuries/sexual abuse).

3. Any other information that might be helpful in establishing the cause of the injury, abuse, or neglect that is known or reasonably suspected or believe to have occurred or of the threat that may exist.

☆ Best Practices for Reporting:

- **Ensure the survivor has informed consent.**
  - Disclose your reporting obligations to the survivor and discuss them *before* she/he disclose any information.
  - Don't assume the survivor is familiar with the state and federal laws. The survivor may have moved from another state and may not understand the state of Ohio's law.
- **Abide by VAWA requirements**. If you are mandated to report, make reasonable attempts to notify the survivor and do what you can to protect the privacy and safety of the persons affected by disclosure.
- **Help the survivor anticipate the outcomes of reporting.**
  - Tell the survivor how CPS works.
  - Remind the survivor about how you can support her/him.
  - Prepare the survivor for potential unintended consequences of reporting (i.e. that parents are likely to find out about the assault/abuse, even if the survivor doesn't want them to)
  - Remind the survivor that he/she can also contact CPS directly for guidance and support, as can loved ones

Additional Resources

Ohio Child Protective Services:

- **Website:** http://jfs.ohio.gov/ocf/childprotectiveservices.stm or
- **Telephone:** (866) 886-3537, option 4.

Am I required to report under Ohio's child abuse and maltreatment law?

① ***Are you a mandatory reporter of child abuse and maltreatment?***

Under Ohio Revised Code § 2151.421(A)(1)(a), a number of professions and workplaces are required to report child abuse and maltreatment. For purposes of this fact sheet this includes the following:

- Anyone providing healthcare services (this includes dentists, nurses, physicians, hospital interns, hospital residents, podiatrists, coroners, speech pathologists, audiologists, psychiatrists)
- Any person engaged in the practice of social work or professional counseling
- School authorities, employees and teachers and day care personnel and child care workers [note that this may impact advocates who work in college campus settings that may host minors for summer camps or other events]
- Professionals working in a county Department of Jobs and Family Services and who work with children and/or families
- Anyone working for their local Board of Developmental Disabilities;
- Anyone holding licensure naming them a mandatory reporter (including Animal Control Officers/Agents, attorneys, child care workers, day care personnel

✖ ***No, I do not meet any of the above requirements.***

<u>You are not mandated to report.</u> Unless you meet one of the above requirements, you are not required by law to report child abuse or maltreatment. You might inquire as to whether others involved in the minor's care *are* mandated reporters. (Note: You do not have to be a mandated reporter to report suspected or actual child abuse or maltreatment. Anyone can make a report).

✓ ***Yes, I meet one of the requirements above.***

<u>You are a mandatory reporter.</u> You must then determine whether the incident is the type you must report to authorities. See step two to determine whether you must report.

② ***Is the survivor a minor (under the age of 18), or a mentally retarded, developmentally disabled, or physically impaired person under 21?***

✖ ***No.*** The incident does not need to be reported under the child abuse and maltreatment statute. NOTE: You may need to report the incident under the felony reporting statute. See page 5 of this document for next steps.

✓ ***Yes.*** You may need to report. See the next page for instances when you must report.

③ ***If the survivor is a minor, is the incident of sexual violence one that needs to be reported?***

✓ ***Yes,* if the minor is under the age of 13 and:**

- If the perpetrator had sexual conduct (see definition below) with another person under the age of 13, this is the offense of *rape* and must be reported. ☎
- If the perpetrator caused another individual to have sexual contact (see definition below) with someone 13 or younger, this is the offense of *gross sexual imposition* and must be reported. ☎
- If the minor is younger than 12 years old, and the perpetrator touched genitalia, not

through clothing, to abuse, humiliate, harass, degrade, arouse or gratify, this is the offense of *gross sexual imposition* and must be reported. ☎

✓ ***Yes,* if the minor is 13, 14, or 15 years of age and:**

- If the offender is 18 or older and engaged in sexual conduct with a minor who is 13, 14, or 15 years old, this is the offense of *unlawful sex with a minor* and must be reported. ☎

✓ ***Yes*, if the perpetrator is in a position of power or has institutional authority over the minor, such as:**

- **a teacher, a coach, a cleric, a scouting troop leader, or anyone with temporary or occasional disciplinary control over the minor**
- **a parent, guardian or person entrusted to the care of the child.**

If a perpetrator with power or authority over the minor engaged in sexual conduct with a minor, it is the offense of *sexual battery* and must be reported regardless of the minor's age or the perpetrator's age (assuming this is correct, should it be added?). ☎

Important definitions	
Sexual conduct (ORC §2907.01): • vaginal intercourse between a male and female; anal intercourse, fellatio, and cunnilingus between persons regardless of sex; AND • without privilege to do so, the insertion, however slight, of any part of the body or any instrument, apparatus, or other object into the vaginal or anal opening of another. • Penetration, however slight, is sufficient to complete vaginal or anal intercourse.	**Sexual contact (ORC §2907.01):** • touching of an erogenous zone of another, including the thigh, genitals, buttock, pubic region, or, if the person is a female, a breast; AND • for the purpose of sexually arousing or gratifying either person.

Am I required to report under Ohio's Felony reporting law?

① Are you required to report under Ohio's felony reporting law?

✓ ***Yes,*** if . . .
If this is the case, see step 2 to determine whether the incident is one that needs to be reported.

✖ ***No,*** if . . .

- **Note:** while this fact sheet focuses on reporting for **advocates**, the law also exempts some professionals from felony reporting in some circumstances (impacting attorneys, clerics, counselors, drug treatment workers, and others). If you are serving in a capacity other than an advocate, you may want to consult with a supervisor or legal staff for more information about these exemptions. Also, some colleges/universities require certain personnel, such as resident advisors, to report specific crimes to the school's dean, disciplinary board, or other authoritative body, whether or not they would be required to report the crime by law and even if the survivor is an adult. (Not sure if it's important to even mention this).

② Is the incident a felony, and therefore a crime which must be reported?

✓ ***Yes,*** if the perpetrator had sexual conduct (see definition chart below) with the survivor and:

- The offender substantially impaired the other in order to prevent resistance (through drugs, intoxicant, or controlled substance) by force, threat of force, or deception; OR
- The other person is younger than 13 years old.; OR
- The other person's ability to resist or consent is impaired due to mental or physical condition or advanced age, and the offender knows this; OR
- Sexual conduct where the offender uses force or threat of force

This is the offense of rape and it is a 1st degree Felony. It must be reported. ☎

✓ ***Yes,*** if the perpetrator had sexual conduct (see definition chart below) with the survivor and:

- knowingly coerced someone to submit by any means that would prevent resistance by someone of ordinary resolution; OR
- knowing that someone's ability to appraise the nature of or control their own conduct is substantially impaired; OR
- knowing that someone submitted because the other person is unaware that the act is being committed; OR
- knowing that someone submitted because the other person mistakenly identifies the offender as the other person's spouse; OR
- offender has authority over someone (e.g. offender is a parent/guardian, has institutional authority, is a teacher, cleric, etc . . . See statute for full details.)

This is the offense of sexual battery and is a 2nd or 3rd degree felony. It must be reported. ☎

Continued…

✓ ***Yes,*** if the perpetrator engaged in sexual conduct (see definition chart below) with someone who is thirteen, fourteen, or fifteen years old. *This is the offense of unlawful sex with a minor and it is a 2nd, 3rd, or 4th degree felony. It must be reported.* ☎

✓ ***Yes,*** if someone caused another to have, or caused two or more other persons to have sexual contact (see definition chart below) through

- forcible compulsion; OR
- incapacity through force or threat of force; OR
- knows the person is incapacitated; OR
- One of the victims is younger than 13 years old; OR
- the other person cannot consent due to mental or physical condition, advanced age, or substantial impairment

Or, if someone touches genitalia, not through clothing, to abuse, humiliate, harass, degrade, or arouse or gratify the sexual desire of someone less than 12 years of age (whether or not offender knows the age).

This is the offense of gross sexual imposition and it is 3rd or 4th degree felony. It must be reported. ☎

Important definitions	
Sexual conduct (ORC §2907.01): • vaginal intercourse between a male and female; anal intercourse, fellatio, and cunnilingus between persons regardless of sex; AND • without privilege to do so, the insertion, however slight, of any part of the body or any instrument, apparatus, or other object into the vaginal or anal opening of another. • Penetration, however slight, is sufficient to complete vaginal or anal intercourse.	**Sexual contact (ORC §2907.01):** • touching of an erogenous zone of another, including the thigh, genitals, buttock, pubic region, or, if the person is a female, a breast; AND • for the purpose of sexually arousing or gratifying either person.

✘ ***No,*** if the sexual violence is <u>not</u> classified as a felony, you do not have to report under the felony reporting statute. For instance, **some age-related sexual offenses are misdemeanors.** (For example, if the suspect is 18 and the minor is 15, it is a misdemeanor offense rather than a felony). And, some sexual conduct between minors is <u>not</u> a sexual offense. (For instance, if a minor between the ages of 13-16 has sexual conduct with another individual who is between the ages of 13-17, this is not illegal.) See OAESV's **Age of Consent Fact Sheet** for more details.

When in doubt about your reporting obligations regarding a specific client, you can contact a caseworker or intake specialist with your local CPS office and present a "hypothetical" situation (i.e. not revealing client information). The CPS worker should be able to guide you as to the appropriate course of action in terms of reporting.

From the Sexual Assault Response Network of Central Ohio, OhioHealth's Survivor Advocacy Manual January, 2013

Management of Chronic and Abusive Calls [i]

Although most callers utilizing the Helpline are actively seeking emotional support, information and/or referral services, some callers use the Helpline on a chronic basis or in an abusive manner. Dealing with a repeat caller or someone using the line disrespectfully can be a challenging experience. The following guidelines will provide assistance when working with chronic or abusive callers.

Documentation

Most agencies have a form for hotline advocates to use to documents chronic or abusive calls, and a system in place to alert other hotline advocates know about such callers. It is through these structured procedures that chronic callers can best benefit from the use of the hotline, abusive callers can be discouraged from calling, and advocate burnout can be reduced.

Specific Considerations – Chronic Callers

Setting boundaries with a caller after promoting dependency can lead to feelings of rejection; therefore it is important to set boundaries early. The following information is designed to assist advocates who are talking with chronic callers when a "recommended action" caller profile form has yet to be developed or when additional support is needed in working with existing recommended actions. This material does not supercede the recommended action for any chronic caller, but can be utilized in working through difficult calls.

Characteristics

- The caller utilizes the Helpline several times during one shift, several times during a 24-hour period and/or numerous times over the course of months or years.
- The caller may utilize the line for companionship and/or to vent frustration, but appears not to benefit from repeat interactions.
- The caller is not receptive to related information, community referrals, action plans, etc.
- The caller presents with multiple needs/problems, and is unable to focus on any one issue.
- The caller may change details of assault or presenting need in order to keep utilizing the line.
- The caller may use suicidal ideation as a means of keeping the advocate on the line.
- The caller responds negatively to information and/or referrals provided.

General Guidelines

- Encourage a positive response to the caller's problem by helping her to focus on one issue and the here and now.
- Work with the caller's problem-solving ability by helping the caller choose options for which there is an immediate chance of success.
- Listen for positive steps the caller has taken in the past, and explore these options. Validate the

progress the caller has made. Confirm the importance of each small step in resolving a problem.

- Listen for negative responses that will also guide you in helping the caller.
- Summarize what has been discussed in the call to move toward meeting the caller's goal.
- Explain to the caller the purpose of the Helpline, "This Helpline is a 24-Hour service that provides emotional support, information and/or referrals to those affected by sexual and domestic violence." Stress to the caller that Helpline advocates can provide emotional support, but are not trained counselors.
- If no Caller Profile form is in place, use your own judgment on the length of time to spend working with a caller. Consider such elements as how many times you have spoken with the caller and the caller's response to information and/or referrals.
- During shift change, notify the succeeding advocate about the characteristics of the chronic caller.

Detailed Guidelines

Eighty-ninety percent of chronic callers are linked to a social service support system (i.e., a therapist or mental health team). Explore whether a chronic caller has a mental health support system, and if so, utilize that system by referring her back to their therapist or mental health contact for more in-depth intervention. For instance, it could be helpful to suggest that a caller journal her questions and concerns in order to follow-up with their mental health contact. If the caller is unsatisfied with their current mental health support, brainstorm other options such as a new therapist or trying a support group. Continue by helping the caller identify other support people, such as friends, family, coworkers, etc.

Chronic callers who are manipulative and need a lot of attention could have Borderline Personality Disorder (BPD), which is characterized by, among other things, the experience of rejection and abandonment in childhood that is often re-created in adult relationships. People with BPD tend to have intense and conflicted relationships and will often put others in no-win situations. They may say they are calling for help, but have unreasonable expectations about what help involves. When the caller does not get what she or he wants it is interpreted as another rejection. That said, the caller will continue to call the line back to test the commitment of the person or the service. Chronic feelings of emptiness will prompt them to reach out to others, though they have a limited ability to sustain healthy relationships.

Other callers may have a need for connection, but either are not ready for help or simply do not possess the necessary social skills to seek it appropriately or follow through on any suggestions.

When one of these two types of chronic callers is identified, there are several ways to initially respond. After the caller has identified the issues, the advocate might respond with "How can I be helpful to you right now?" or "What do you think might be helpful to you right now?" This holds the caller responsible for stating what she wants. At this point the advocate would be incorporating the caller's response with the recommended action on the profile form (if applicable), and proceeding accordingly.

If the caller identifies a need that is unreasonable, an advocate could state "I wish I could help you with that, but that is out of the scope of what the Helpline provides." Continue by following the recommended action on the profile form (if applicable), or by exploring counseling options in

order to provide an appropriate referral or referring back to an existing therapist. The broken record technique could be helpful, "I can't help you with that," I understand your concern, but I can't help you with that..."

With "yes, but..." callers it is helpful to state any of the following: "I am hearing the reasons that you cannot..., let me know one reason that you can," "As evidenced by your repeat calls to the line, you are a very determined person. How can we use this determination to assist you?" and "I am sensing that the information and referrals I'm providing are not helpful, however, I hear you are determined to get help."

It is helpful to use the analogy of throwing the ball back into the caller's court. Encourage callers to develop an action plan, with minimal involvement on your part.

Recognize that when talking with chronic callers, some will use suicidal ideation as a means of manipulation. This awareness does not diminish the need to access for lethality, but can restore some sense of control over the call, and reduce overwhelming feelings.

Being consistent helps the caller process the information that is being discussed, and reduces advocate anxiety by not having to brainstorm additional responses.

Asking callers for a date that they will follow-up with the recommended actions assists with accountability and call resolution.

Feel good about being there for the caller, even if the caller did not respond as you hoped she would. Keep in mind that if the caller were able to move forward and resolve her problems, she would not be repeatedly calling the line for help.

Specific Considerations – Abusive Callers

Characteristics

- The caller may use vulgar or obscene language.
- The caller may make racial, cultural, and/or gender slurs.
- The caller may make disrespectful comments related to the abuse of women/men.
- The caller may make disrespectful comments about feminists/people that support sexual assault survivors.

When talking with an abusive caller do not let him detect a reaction from you, such as fear, disgust, anger, or surprise, thereby reducing any perceived power the caller may feel. Do not encourage the caller by talking to him. State in a calm and disinterested voice that "The language you are using and/or what you are saying is inappropriate and if you continue, I will terminate the call." Terminate the call immediately if the language and/or content of conversation continue. If the same caller calls again during your shift and seems to be apologetic, you can either determine if the caller is sincere and proceed with the call, or state, "I must open the line to other callers" and terminate the call.

Specific Considerations - Abusive Callers Seeking Sexual Stimulation

Characteristics

- The caller often speaks quietly, as if trying to sound sexy.
- The caller may compliment you for having a nice, sexy-sounding voice.
- The caller may ask personal information about you.
- The caller will often ask to have her confidentiality assured.
- The caller may exhibit heavy or irregular breathing.
- The caller will often ask sexually explicit questions.
- The call's content is primarily descriptive and detailed, focusing on physical qualities and clothing.
- A masturbating caller tends to avoid responding to empathy statements and to exploring feelings. His preference is to proceed, describing a fantasy.
- A caller may be open about masturbating.
- A caller will sometimes stay on the phone only a minute or two.

When talking with a sex offender do not let him know you are upset and do not engage in a conversation, thereby reducing any perceived power the offender may feel. Provide answers that the caller does not want. Redirect toward feelings, which causes the caller to feel less in control and uncomfortable. Once the call is terminated, realize that what you may be feeling is what the caller intended you to feel and work at releasing those feelings, along with the caller's power.

Do not offer sexual information or advice.
Do not disclose your sexual behaviors or anything personal about yourself.
Do not agree to talk in a way the caller requests you to do.
Do not debate with the caller after you've said you're hanging up. Hang up.
Do not personalize or judge the call; end the call because of its nature.

When dealing with a call in which a perpetrator states that she just raped someone, access the survivor's safety and focus only on providing information that will assist the survivor.

Specific Considerations – Heavy Breathing Callers

Give the caller the benefit of the doubt as someone who has been crying may be breathing heavy and may need a few minutes before being able to speak. Communicate availability by saying, "I am here to listen when you feel ready to talk," then allow the caller time to calm down and speak. If the heavy breathing continues and you feel this is a legitimate call, say, "I would like to talk, but perhaps it is too difficult for you now. I am glad you took the first step in getting some help by calling. This line is available 24-hours a day, please try calling again." If, on the other hand, the heavy breathing continues and you do not feel this is a legitimate call, inform the caller that you are going to terminate the call and then hang-up.

Specific Considerations - Hang-up Callers

Try to stay relaxed. If a caller calls every few seconds, take the receiver off for one or two minutes to break the pattern. If that doesn't work, inform the caller that you are documenting the date and time of each call and if he continues to abuse the line in this manner, [insert whatever policy program has in place].

Self-care

It is helpful to be mindful of a "workable" call verses a "non-workable" call. There is strength to be found in all chronic callers, and focusing on this strength may alleviate feelings of frustration. Comfort can also be found in providing links that will assist callers when their needs are beyond the hotline's scope.

Advocates have the right to protect themselves and are encouraged to utilize self-care when answering the hotline. Below are some options that advocates may find helpful when dealing with chronic and abusive callers:

- Terminating an abusive call or a chronic call when exhaustion has surfaced.
- Transferring the line to the voice mailbox system during a series of calls from the same chronic caller or during a series of hang-ups.
- Transferring the line to the voice mailbox system when needing to process a particularly difficult call.
- Utilizing a co-advocate or other staff member for comfort and feedback.

i Adapted from Talking with the Caller: Guidelines for Crisisline and Other Volunteer Counselors by Jason Millman, et al. Thousand
Oaks: Sage Publications, 1998.

From the Sexual Assault Response Network of Central Ohio, OhioHealth's Survivor Advocacy Manual January, 2013

Suicide Warning Signs & Intervention [i]

Because most suicidal people are ambivalent about dying, want to be rescued and want someone to help them, eight out of ten give warning signs, either intentionally or inadvertently.

Suicidal warning signs include:

1. The person's situation in life at this time, e.g., death or loss of significant other, financial catastrophe, diagnosis of terminal or chronic illness, any situation which severely affects one's self worth or sense of self-esteem. When a person feels a loss of a sense of connection to something important or feels a loss of control over what is happening, the situation might be suggestive of suicide possibility.

2. Signs of depression (Out of 100 people who are depressed and 100 people who are not, those who are, are more likely to become suicidal than the group who are not).

- Change in sleep: insomnia or excessive sleep
- Loss of appetite, anorexia, weight loss or gain
- Inability to concentrate
- Socially withdrawn
- Loss of interest in personal appearance
- Feeling worthless, hopeless, helpless
- Easily discouraged, low frustration tolerance
- Increased use of alcohol and/or drugs
- Crying frequently for no apparent reason
- May not want to talk, gives terse replies when questioned
- Apathy
- Lethargy and fatigue
- Preoccupation with death, morbid thoughts
- Morbid thoughts, dwells on problems, very negative
- Agitation, anxiety, restless, feels bad

3. Verbal warnings

Direct Statements:
"I'm going to kill myself."
"I wish I were dead."
"If such & such happen, I'm going to kill myself."
"You'll read about me tomorrow."

Indirect Statements:
"I hate my life, I hate everything."
"My family would be better off without me."

"If I don't see you again, thanks for..."
"I'm the cause of everything that's gone wrong."
"I can't go on living like this."

4. Behavioral warnings – direct and indirect:

- Any suicide attempt, gesture, or self-destructive behavior
- Giving away cherished possessions
- Making final arrangements, wills, funeral plans, insurance changes
- Sudden inexplicable recovery from profound depression
- Previous suicide attempt (this is a very important warning sign!)
- Poor adjustment to recent loss of loved one
- Resigning, quitting for no apparent reason
- Purchasing a gun, stockpiling pills
- Writing a suicide note
- Saying "goodbye" to loved ones, suddenly reconciling

Because most people have some ambivalence about killing themselves, many give clues such as the aforementioned verbal and behavioral warning signs. It is crucial for the helper to listen for these clues and act accordingly.

What To Do If You Believe Someone Is Suicidal:

Listen - Establish rapport, be accepting, non-judgmental, empathic, and supportive. When possible, do not leave the person alone without human support.

Express Concern – "I care about you." Be confident, address the person's feelings, and let them vent. Reassure the person you will get them help. Calm them.

Assess Suicide Risk – "Are you thinking about hurting yourself? Are you thinking about suicide?" (You will not induce a suicide by asking about it...that's a fact.) Ask about how they would do it. The more specific the plan: time, location and having the means available, the higher the risk. Try to distance the person from the means. Lock up guns, knives, car keys, pills. If attempt is in progress, call 911 for help.

Criteria for Determining Risk:

Low Risk

- Says she is not suicidal and you have reason to believe it.
- Has a history of suicidal thoughts but tells you they won't do it.
- Admits to thoughts, but the plan is vague and suicide is not directly part of the presenting problem.

Moderate Risk

- When there is more than one predictor of suicide, or when single predictor is intense – such as

a drinking relapse or sudden loss.
- Has potential to become increasingly at risk (e.g., awaiting HIV test results).

High Risk
- She has already begun the attempt (e.g., has taken the pills, cut themselves, etc.).
- She will not distance self from the means (e.g., keeps the gun in hand while talking).
- When several high-risk variables are present and she will not agree to getting help. She insists on remaining anonymous and staying alone.

Identify Primary Concern – "What happened today that has made you feel so bad?" Try to have the person talk about it a little bit. Don't judge or offer remedies. Encourage person to focus on one issue.

Assess Resources - Check out who is significant to this person - especially in a positive way. Check family, friends, and neighbors who might be supportive. Ask about previous coping strategies. Who has been helpful in the past?

Mobilize The Resources and Devise a Plan Of Action - Try to get as many people involved as possible in a plan to provide monitoring, support, and care. It is important to connect the suicidal person with a professional: social worker, psychologist, counselor, pastor, psychiatrist, or nurse. The helping person should be licensed to practice counseling. Friends and loved ones can be very helpful, but sometimes they are too close to the suicidal person's problems to be helpful in an objective way. An action plan is simply, "Who is going to do what?" "Within what time period?" "Is the plan achievable within a brief time span?" Make sure to keep these questions in mind as you help devise a plan of action with the suicidal person. You want for her to be able to achieve the plan and not fail as that might be seen as one more failure in her life.

Remember - Never ignore a cry for help! Always provide assistance until you are positive the person is safe to be alone. **You do not have to do this alone, if possible, get help. If you need more information or assistance, call the Suicide Prevention Services Hotline (614) 221-5445.**

i Adapted from *Talking with the Caller: Guidelines for Crisisline and Other Volunteer Counselors* by Jason Millman, et al. Thousand Oaks: Sage Publications, 1998.

From the Sexual Assault Response Network of Central Ohio, OhioHealth's Survivor Advocacy Manual January, 2013

Safety Planning i

If you or someone you know has been sexually assaulted or is in an abusive relationship, there are things to consider when thinking about safety. It may be helpful to create a safety plan or to think about some ways to stay and feel safer. Depending on where you live, there may be unique circumstances to think about. The following information is divided up into rural, suburban and urban, and college campus safety tips. There is a lot of overlap but there are also things that are unique to each location. Please review the one that is closest to your situation.

The Trevor Project is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender, and questioning youth.

If you need support, please call the **Trevor Lifeline: 866 488 7386**

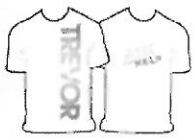
Suicide Prevention

Facts About Suicide

DID YOU KNOW?

- Suicide is the 3rd leading cause of death among young people ages 10 to 24 and accounts for 12.2% of the deaths every year in that age group. [CDC. (2009). 10 leading causes of death by age group – United States, 2009. Retrieved from http://www.cdc.gov/Injury/wisqars/pdf/10LCD-Age-Gp-US-2009-a.pdf.]
- LGB youth are 4 times more likely, and questioning youth are 3 times more likely, to attempt suicide as their straight peers. (2011, CDC, "Sexual Identity, Sex of Sexual Contacts, and Health-Risk Behaviors Among Students in Grades 9-12: Youth Risk Behavior Surveillance")
- Suicide attempts by LGB youth and questioning youth are 4 to 6 times more likely to result in injury, poisoning, or overdose that requires treatment from a doctor or nurse, compared to their straight peers. (2011, CDC, "Sexual Identity, Sex of Sexual Contacts, and Health-Risk Behaviors Among Students in Grades 9-12: Youth Risk Behavior Surveillance")
- Nearly half of young transgender people have seriously thought about taking their lives, and one quarter report having made a suicide attempt. (2007, Suicide and Life-Threatening Behaviors, Grossman, D'Augelli, "Transgender Youth and Life-Threatening Behaviors")
- LGB youth who come from highly rejecting families are 8.4 times as likely to have attempted suicide as LGB peers who reported no or low levels of family rejection. (2009, Family Acceptance Project™ "Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults")
- 1 out of 6 students nationwide (grades 9-12) seriously considered suicide in the past year. (2011, CDC, "Youth Risk Behavior Surveillance – United States, 2011")
- Suicide attempts are nearly two times higher among Black and Hispanic youth than White youth. (2011, CDC, "Youth Risk Behavior Surveillance – United States, 2011")
- Each episode of LGBT victimization, such as physical or verbal harassment or abuse, increases the likelihood of self-harming behavior by 2.5 times on average. (2010, American Journal of Public Health, "Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths")

TREVOR space
TREVOR TREVOR
TREVOR text
Like 263,626 people like this.
Follow @trevorproject 139K followers
We're on Follow
YouTube Tumblr Flickr
BE INFORMED
first name last name
e-mail zip
TrevorProject
CLICK HERE FOR MORE



national corporate partners
eHarmony esurance Google KIMPTON
Terms of Service + Privacy Policy Copyright ©2010 The Trevor Project. All rights reserved.
CHARITY NAVIGATOR ★★★★ Four Star Charity

SAFETY PLANNING IN URBAN OR SUBURBAN AREAS

Things to Think About:

How to get away if there is an emergency

- Be conscious of exits or other escape routes
- Think about options for transportation (car, bus, subway, etc.)

Who can help

- Friends, family
- Support centers if there are any in your area
- National Sexual Assault Hotline at 1-800-656-HOPE(4673) or, if you are in a dating or domestic violence situation, the National Domestic Violence Hotline 1.800.799.SAFE(7233)

Where to go

- Friend's house
- Relative's house
- A domestic violence or homeless shelter (if there are not any domestic violence shelters in your area, and you are contemplating leaving the town, you may want to consider going to a homeless shelter)
- The police
- **Important Safety Note:** If the dangerous situation involves a partner, go to the police or a shelter first.

What to bring

- Important papers and documents: birth certificate, social security card, license, passport, medical records, lease, bills, etc.
- House keys, car keys, cash, credit cards, medicine, important numbers, cell phone
- If you are bringing children with you, remember to bring their important papers and legal documents
- Keep all of these things in an emergency bag
- Hide the bag—best if not in house or car
- If the bag is discovered, can call it a "hurricane", "tornado" or "fire" bag

How to anticipate and respond to a perpetrator's actions

- Be conscious of places the perpetrator frequents (work schedule, favorite places to go, etc.)
- Plan what you would say and do if you came into contact with him or her

Traveling Safety:

Walking

- Make sure your cell phone (if you have one) is easily accessible
- Take major, public streets and paths rather than less populated shortcuts
- Avoid dimly lit places and talk to authorities if lights need to be installed in an area
- Avoid walking alone whenever possible

- Carry a small noisemaker (like a whistle) and/or flashlight on your keychain
- Remain mentally alert and aware of your surroundings
- Plan your route and know what "safe" places are on it (police stations, hospitals, etc.)

Driving

- Keep your doors locked
- Have extra car necessities (oil, jumper cables, etc.)
- Try not to wait until the last minute to fill your gas tank; always keep it at least half full if you can
- Have your keys ready when you go to unlock your car
- Plan your route and know what "safe" places are on it (police stations, hospitals, etc.)

Taking the bus or subway

- Be alert at bus or subway stops when waiting for them to arrive
- Use the bus or subway schedule to avoid waiting for a long time at a stop
- Plan your route to use the busiest, best-lighted stop possible
- If someone is bothering you on the bus or subway, tell the driver or use the emergency signal
- If you feel uneasy about getting off at your usual stop, stay on until the next stop or wait until the safest stop

Home Safety:

- Change the locks on doors and windows
- Keep house doors locked, even when you are at home
- Install a security system
- Install outside lighting system (with motion detectors)
- Do not prop doors or windows
- Close blinds/curtains at night
- Keep car doors locked, even in your own driveway or garage

Tips to Remember:

- Keep change/cash with you at all times
- Memorize all important numbers/have important numbers easily accessible on your cell phone (if you have one)
- Establish a code word so that family, friends, etc. know when to call for help
- Have a backup plan in case the first fails
- Be aware of your daily routine and try to alter it sometimes, if possible
- Keep in contact with people/organizations who are helping you
- Trust your instincts. If you feel uncomfortable or threatened, leave the situation and go to a safe place

SAFETY PLANNING ON A COLLEGE CAMPUS

Things to Think About:

How to get away if there is an emergency

- Be conscious of exits or other escape routes
- Think about options for transportation (car, bus, train, etc.)

Who can help

- Friends, family
- Support centers if there are any in your area
- Campus safety or local police
- National Sexual Assault Hotline at 1-800-656-HOPE(4673), the National Sexual Assault Online Hotline, or if you are in a dating or domestic violence, situation the National Domestic Violence Hotline 1.800.799.SAFE(7233)

Where to go

- Friend's dorm room or apartment
- Relative's house
- A domestic violence or homeless shelter (if there are not any domestic violence shelters in your area, and you are contemplating leaving the town, you may want to consider going to a homeless shelter)
- The police or campus safety (even if campus safety knows both you and the perpetrator—they are still responsible for doing their jobs)
- **Important Safety Note:** If the dangerous situation involves a partner go to the police or a shelter first.

What to bring

- Important papers and documents: birth certificate, social security card, license, passport, medical records, bills, etc.
- House or dorm room keys, car keys, cash, credit cards, medicine, important numbers, cell phone
- Keep all of these things in an emergency bag
- Hide the bag—best if not in house or car
- If the bag is discovered, can call it a "hurricane", "tornado" or "fire" bag

At parties

- Be aware of potential drug-facilitated sexual assaults
    - Try not to leave your drink unattended
    - Only drink from un-opened containers or from drinks you have watched being made and poured
    - Avoid group drinks like punch bowls
    - Cover your drink. It is easy to slip in a small pill even while you are holding your drink. Hold a cup with your hand over the top, or choose drinks that are contained in a bottle and keep your thumb over the nozzle
    - If you feel extremely tired or drunk for no apparent reason, you may have been drugged. Find your friends and ask them to leave with you as soon as possible
    - If you suspect you have been drugged, go to a hospital and ask to be tested
- Keep track of how many drinks you have had
- Try to come and leave with a group of people you trust

- Avoid giving out your personal information (phone number, where you live, etc.). If someone asks for your number, take her number instead of giving out yours

Traveling around Campus:

Walking

- Make sure your cell phone is easily accessible and fully charged
- Be familiar with where emergency phones are installed on the campus
- Be aware of open buildings where you can use a phone
- Keep some change accessible just in case you need to use a pay phone
- Take major, public paths rather than less populated shortcuts
- Avoid dimly lit places and talk to campus services if lights need to be installed in an area
- Avoid putting music headphones in both ears so that you can be more aware of your surroundings, especially if you are walking alone.
- Walking back from the library very late at night is sometimes unavoidable, so try to walk with a friend
- Carry a noisemaker (like a whistle) on your keychain
- Carry a small flashlight on your keychain
- If walking feels unsafe, try calling campus security. Many campuses offer safe ride programs

Driving

- Keep your doors locked
- Have extra car necessities (oil, jumper cables, etc.)
- Try not to wait until the last minute to fill your gas tank; always keep it at least half full if you can
- Have your keys ready when you go to unlock your car

Taking the bus

- Be alert at bus stops when waiting for the bus to arrive
- Use the bus schedule to avoid waiting for a long time at a stop
- Plan your route to use the busiest, best-lighted stop possible
- If someone is bothering you on the bus, tell the driver
- If you feel uneasy about getting off at your usual stop, stay on the bus until the next stop or wait until the bus goes around to your usual stop the second time

Dorm Safety:

- Lock your door when you go to sleep and when you are not in the room
- Keep your window locked (especially if it is easy to enter from the ground)
- If people constantly prop open the main dorm door, talk to an authority about it
- If your dorm has an elevator, try to stay near the button dashboard when are you riding in it so that you have easy access to the emergency button. Also, if you feel threatened, you can push the button for the next floor and leave immediately instead of waiting for the elevator to reach the floor where you live
- Avoid isolated areas (stairways, laundry rooms, basement, etc.) when you are alone

If you have been sexually assaulted there are some additional steps you can take to help feel safer:

How to anticipate and respond to perpetrator's actions

- Be conscious of places the perpetrator frequents (work schedule, class schedule, where she likes to eat, what club meetings she has, what sports practices she has, etc.)
- Know which people the perpetrator usually hangs out with and what social events she likes to attend
- Plan what you would say and do if you came into contact with him or her

General Tips:

- Use the resources that your campus offers (sexual assault services, psychological services, health services, campus police force, escort service, etc.)
- If you are concerned about anonymity, use any resources that the neighboring community provides
- Trust your instincts. If you feel uncomfortable or threatened, leave the situation and go to a safe place

SAFETY PLANNING IN RURAL COMMUNITIES

In rural communities, there are fewer services that provide support for survivors of sexual assault and dating and domestic violence. It can also be a challenge to maintain privacy due to the small community size.

Things to Think About:

How to get away if there is an emergency

- Be conscious of exits or other escape routes
- Think about options for transportation (car, bus, train, etc.)

Who can help

- Friends, family
- Support centers, if there are any in your area
- National Sexual Assault Hotline at 1-800-656-HOPE(4673), the National Sexual Assault Online Hotline (http://www.rainn.org/get-help/national-sexual-assault-online-hotline) or, if you are in a dating or domestic violence situation, the National Domestic Violence Hotline 1.800.799.SAFE(7233)

Where to go

- Friend's house
- Relative's house
- A domestic violence or homeless shelter (if there are not any domestic violence shelters in your area, and you are contemplating leaving the town, you may want to consider going to a homeless shelter)
- The police (even if the police know both you and the perpetrator—they are still responsible for

doing their job).

- **Important:** If the dangerous situation involves a partner, go to the police or a shelter first.

What to bring

- Important papers and documents: birth certificate, social security card, license, passport, medical records, lease, bills, etc.
- House keys, car keys, cash, credit cards, medicine, important numbers, cell phone
- If you are bringing children with you, remember to bring their important papers and legal documents
- Keep all of these things in an emergency bag
- Hide the bag—best if not in house or car
- If the bag is discovered, can call it a "hurricane", "tornado" or "fire" bag

How to anticipate and respond to a perpetrator's actions

- Be conscious of places the perpetrator frequents (work schedule, favorite places to go, etc.)
- Plan what you would say and do if you came into contact with him or her

Traveling Safety:

If you need to get away and there is no public transportation in your area, try to find someone who will allow you to use his or her car if you do not have one at your disposal.

Driving

- Keep your doors locked
- Have extra car necessities (oil, jumper cables, etc.)
- Try not to wait until the last minute to fill your gas tank; always keep it half-way full if you can
- Have your keys ready when you go to unlock your car
- Plan your route and know what "safe" places are on it (police stations, hospitals, etc.)

Home Safety:

- Change the locks on doors and windows
- Keep your doors locked, even when you are at home
- Install a security system
- Install outside lighting system (with motion detectors)
- Do not prop doors
- Close blinds/curtains at night
- Keep car doors locked, even in your own driveway

Tips to Remember:

- Keep cash with you at all times
- Keep some change accessible just in case you need to use a pay phone
- Memorize all important numbers/have important numbers easily accessible on your cell phone (if you have one)
- Establish a code word so that family, friends, etc. know when to call for help

- Have a backup plan in case the first fails
- Carry a small noisemaker (like a whistle) and/or flashlight on your keychain
- Be aware of your routine and try to alter it sometimes, if possible
- Have an extra copy of keys
- Try to keep in contact with people/organizations who are helping you

Finally... Remember it is not your fault.



LGBTQI

BRAVO
BUCKEYE REGION ANTI-VIOLENCE ORGANIZATION

LGBTQI Appropriate Terms/Language

YES	NO
Gay, Lesbian, Bisexual	Homosexual
Sexual Orientation	Sexual Preference
Gay Culture, Gay Community	Gay Lifestyle, Alternative Lifestyle
Trans, Transgender, Trans-Identified	Transvestite
Transgender Women, Transgender Man	A Transgendered, Transgendereds
Intersex	Hermaphrodite
You may also hear appropriate language such as: Gender Variant, Gender Non-Conforming (GNC), Transwomen, Transman	

BRAVO
MIDWEST REGION ANTI-VIOLENCE ORGANIZATION

Glossary of LGBTQI Terminology

ALLY: Someone who confronts heterosexism, homophobia, biphobia, transphobia, heterosexual and genderstraight privilege in themselves and others; a concern for the well-being of LGBTQI people; and a belief that heterosexism, homophobia, biphobia, and transphobia are social justice issues.

BIPHOBIA: The fear, discrimination of, or hatred, of bisexuals. Biphobia can be seen within the LGBTQI community, as well as in general society.

Bisexual: A person emotionally, physically, and/or sexually attracted to males/men and females/women. This attraction does not have to be equally split between genders.

***CLOSETED (IN THE CLOSET)*:** An LGBTQI identified person who will not or cannot disclose their sex, sexuality, sexual orientation, or gender identity to their friends, family, coworkers, or society. There are varying degrees of being "in the closet"; for example, a person can be out in their social life, but in the closet at work, or with family. *(Also known as "downlow" or "D/L").*

COMING OUT: The process by which one recognizes, acknowledges, accepts, and typically appreciates one's own sexuality, gender identity, or sexual identity.

CROSS-DRESSER: A person who, regardless of motivation, wears clothes, makeup, etc. that are considered by the culture to be appropriate for another gender but not one's own *(preferred term to transvestite).*

DISCRIMINATION: Differential treatment that favors one individual or group over another based on prejudice. Ongoing discrimination creates a climate of oppression for the affected group.

DRAG or **IN DRAG:** The performance of one or multiple genders theatrically.

DRAG KING: a person who performs masculinity theatrically.

DRAG QUEEN: a person who performs femininity theatrically.

FTM or **F2M:** Abbreviation for female-to-male transgender or transsexual person. *(Some reject this terminology, arguing that they have always been male or female and are only making that identity visible. Others feel that such language reinforces an either/or gender system).*

GENDER: The social construction of masculinity and femininity in a specific culture.

GENDER BINARY: The idea that there are only two genders – male/female or man/women and that a person must be strictly gendered as either/or.

GENDER EXPRESSION: How one chooses to express one's gender identity.

GENDER IDENTITY: A person's sense of being feminine, masculine, or other gendered.

GENDER VARIANT: A person who either by nature or by choice does not conform to gender-based expectations of society *(e.g. transgender, transsexual, intersex, genderqueer, cross-dresser, etc.).*

GENDERQUEER: A gender variant person whose gender identify is neither female nor male, is between or beyond genders, or is some combination of genders. *(Often as a political statement to challenge gender stereotypes and the gender binary system).*

GENDERSTRAIGHT: A person who by nature or by choice conforms to gender based expectations of society *(also referred to as 'gender normative').*

HETEROSEXISM: The societal/cultural, institutional, and individual beliefs and practices that privilege heterosexuals and subordinates people based on their sexual orientation. The element of institutional power to support these attitudes, actions, and/or practices differentiates this from other forms of prejudice and discrimination.

HETEROSEXUAL PRIVILEGE: Those benefits derived automatically by being heterosexual that are denied to people of other sexual orientations. Also, the benefits that non-heterosexuals receive as a result of claiming a heterosexual identity and denying their actual sexual orientation.

HOMOPHOBIA: The irrational fear or hatred of homosexuals, homosexuality, or any behavior or belief that does not conform to rigid sex role stereotypes. It is this fear that enforces sexism and heterosexism.

INTERSEX: A person whose combination of chromosomes, gonads, hormones, internal sex organs, and/or genitalia does not meet medical standard for either female or male *(Hermaphrodite – an out-of-date and offensive term for intersex)*.

MTF or **M2F:** Abbreviation for male-to-female transgender or transsexual person. *(Some reject this terminology, arguing that they have always been male or female and are only making that identity visible. Others feel that such language reinforces an either/or gender system)*.

OPPRESSION: The systematic exploitation of one social group by another for its own benefit. It involves institutional control, ideological domination, and the promulgation of the dominant group's culture on the oppressed. Oppression = Prejudice + Power.

PREJUDICE: A conscious or unconscious negative belief about a whole group of people and its individual members.

QUEER: An umbrella term some LGBTQI people have reclaimed as an inclusive, non-gendered, and positive way to describe themselves and their community *(Queer is also still used as a negative or derogatory slur to describe LGBTQI persons and community)*.

RACISM: The societal/cultural, institutional, and individual beliefs and practices that privilege white people and subordinates and denigrates people of color.

SEX: A medical term designation a certain combination of gonads, chromosomes, external genitalia, secondary sex characteristics, and hormonal balances. Because usually subdivided in to 'female' and 'male', this category does not recognize the existence of intersex bodies.

SEXISM: The societal/cultural, institutional, and individual beliefs and practices that privileges men and subordinates and denigrates women.

SEXUAL ORIENTATION: The desire for intimate, emotional, and/or sexual relationships with people of the same gender/sex, another gender/sex, or multiple genders/sexes.

TRANS or **TRANSGENDER:** An umbrella term for someone whose self-identification or expression challenges traditional notions of female and male. Sexual orientation varies and is not dependent on gender identity.

TRANSPHOBIA: The irrational fear, hatred, or intolerance of people who identify or are perceived as transgender.

TRANSSEXUAL: A person who identifies with a gender different than their biological gender. Transsexuals often undergo hormone treatments and gender reassignment surgery to align their anatomy with their core identity, but not all desire or can afford to do so.

TWO SPIRIT: A Native American/First Nation term for people who blend the masculine and the feminine. It is commonly used to describe individuals who historically crossed gender boundaries and were accepted by Native American/First Nation cultures *(preferred term to berdache)*. It is also often used by contemporary LGBTQI Native American and First Nation people to describe themselves.

GENDER NEUTRAL PRONOUN USAGE TABLE

	SUBJECT	OBJECT	POSSESSIVE ADJECTIVE	POSSESSIVE PRONOUN	REFLEXIVE
FEMALE	She	Her	Her	Hers	Herself
MALE	He	Him	His	His	Himself
GENDER NEUTRAL	Ze	Hir	Hir	Hirs	Hirself
SPIVAK	E	Em	Eir	Eirs	Emself

GENDER NEUTRAL PRONUNCIATION GUIDE

Ze	Hir	Hirs	Hirself	E	Em	Eir	Eirs	Emself
/zee/	/here/	/heres/	/hereself/	/ee/	/em/	/air/	/airs/	/emself/

Power & Control in Lesbian, Gay, Transgender & Bisexual Relationships



Transgender Clients

Barriers to Service

- Social discrimination, persecution
- Increased risk of being victims of violence
- Especially vulnerable to sexual assault (example: MTFs not experienced with sexual advancement by bio-males)
- Clients have an expectation of transphobia from service providers, legal, medical, and law enforcement personnel
- DV can be defined without reference to gender-variant abusers and survivors
- Survivors often cannot name the abuse occurring in their relationship as DV
- Services often segregated by gender, i.e. females as survivors, males as abusers. For a trans abuser or survivor in transition or a trans-person who doesn't identify as either gender, these services are inaccessible
- Few services for male survivors, most DV shelters will not work with male survivors, much less provide counseling or case management
- FTM survivors who present as female in order to access services can experience devastating psychological impact, also he may not be able to pass as female depending on the survivor's gender expression
- Heterosexual male batterer education programs are not appropriate for FTM batterers: an FTM may be justifiably frightened of potential abuse by other program participants
- Shelters often refuse admittance to MTFs alongside traditionally-gendered women
- If accepted into a shelter, many MTF survivors face emotional and physical abuse from other shelter residents

Intervention Considerations

- Do not pressure clients to come out or cross dress
- Client centered approach—build trust
- Narrative therapy/story telling: allow client to tell their story in order to deconstruct gender and heterosexism
- Counselors must be sensitive to the fact that medical and psychiatric establishments have long history of pathologizing transgender persons (note: Benjamin Standards 1979 "Standards of Care" dictate that hormonal and surgical candidates receive counseling and obtain official letters of recommendation by qualified mental health professionals, and to live as their desired gender for approximately one year prior to surgery. Also, counselor sometimes seen as gatekeeper to official letter and clients can be less open about issues like depression)
- Rethink your assumptions about gender, sexuality, and sexual orientation to adopt a trans-positive or trans-affirming disposition to clients
- Include the possibility of affirming an unique transgender identity
- Know local, regional, and national support networks for the transgender community

From: *Counseling, Transgendered, Transsexual, and Gender-Variant Clients* by Lynne Carroll, Paula J. Gilroy, and Jo Ryan. Journal of Counseling and Development, Spring 2002, Volume 80.

NATIONAL COALITION AGAINST DOMESTIC VIOLENCE

NCADV

Every Home A Safe Home

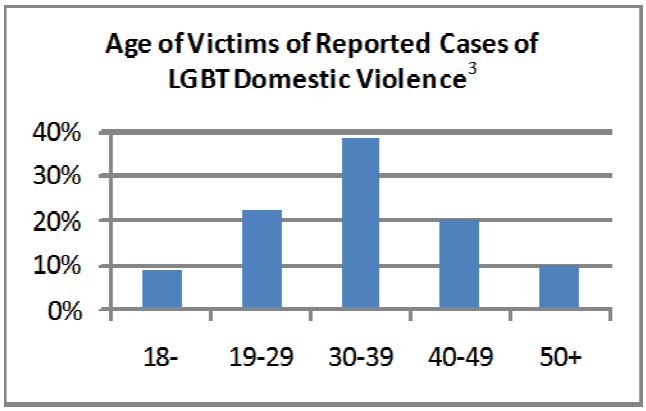
DOMESTIC VIOLENCE AND LESBIAN, GAY, BISEXUAL AND TRANSGENDER RELATIONSHIPS

WHY IT MATTERS

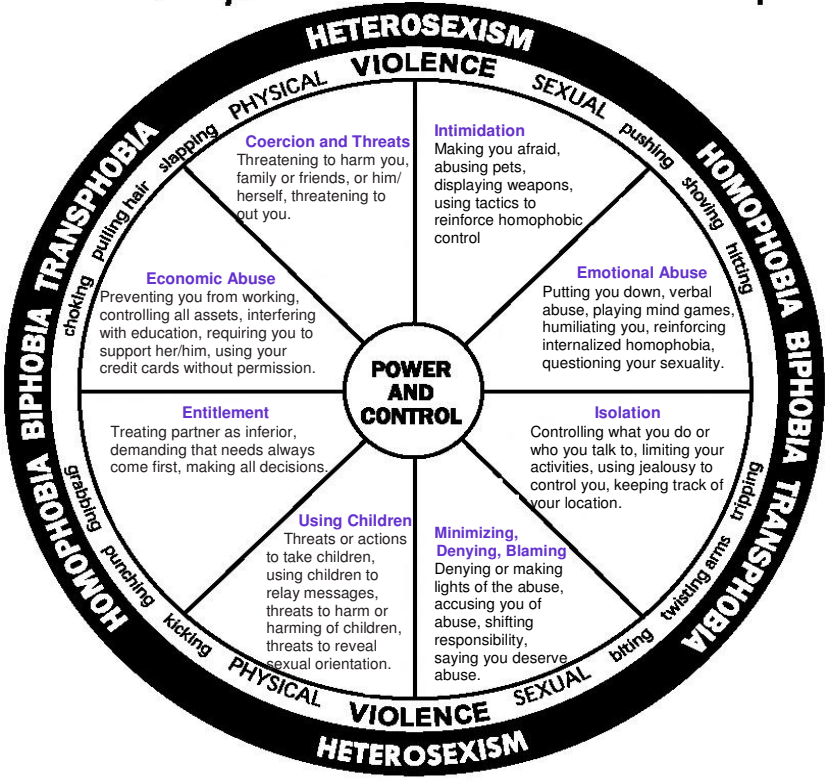
Domestic violence is defined as a pattern of behaviors utilized by one partner (the batterer or abuser) to exert and maintain control over another person (the survivor or victim) where there exists an intimate and/or dependent relationship. Experts believe that domestic violence occurs in the lesbian, gay, bisexual and transgender (LGBT) community with the same amount of frequency and severity as in the heterosexual community. Society's long history of entrenched racism, sexism, homophobia and transphobia prevents LGBT victims of domestic violence from seeking help from the police, legal and court systems for fear of discrimination or bias.[1]

DID YOU KNOW?

- In ten cities and two states alone, there were 3,524 incidents of domestic violence affecting LGBT individuals, according to the National Coalition of Anti-Violence Programs 2006 Report on Lesbian, Gay, Bi-Sexual and Transgender Domestic Violence.[1]
- LGBT domestic violence is vastly underreported, unacknowledged, and often reported as something other than domestic violence.[1]
- Delaware, Montana and South Carolina explicitly exclude same-sex survivors of domestic violence from protection under criminal laws. Eighteen states have domestic violence laws that are gender neutral but apply to household members only.[2]
- 30 states and DC have domestic violence laws that are gender neutral and include household members as well as dating partners.[2]



Power and Control Wheel for Lesbian, Gay, Bisexual and Trans Relationships



SURVIVORS

- Gay and bisexual men experience abuse in intimate partner relationships at a rate of 2 in 5, which is comparable to the amount of domestic violence experienced by heterosexual women. [3]
- Approximately 50% of the lesbian population has experienced or will experience domestic violence in their lifetimes.[1]
- In one year, 44% of victims in LGBT domestic violence cases identified as men, while 36% identified as women.[1]
- 78% of lesbians report that they have either defended themselves or fought back against an abusive partner. 18% of this group described their behavior as self-defense or "trading blow for blow or insult for insult."[4]

TYPES OF ABUSE[5]

- *Physical:* the threat of harm or any forceful physical behavior that intentionally or accidentally causes bodily harm or property destruction.
- *Sexual:* any forced or coerced sexual act or behavior motivated to acquire power and control over the partner. It is not only forced sexual contact but also contact that demeans or humiliates the partner and instigates feelings of shame or vulnerability – particularly in regards to the body, sexual performance or sexuality.
- *Emotional/Verbal*: any use of words, voice, action or lack of action meant to control, hurt or demean another person. Emotional abuse typically includes ridicule, intimidation or coercion.
- *Financial:* the use or misuse, without the victim's consent, of the financial or other monetary resources of the partner or of the relationship.
- *Identity Abuse*: using personal characteristics to demean, manipulate and control the partner. Some of these tactics overlap with other forms of abuse, particularly emotional abuse. This category is comprised of the social "isms", including racism, sexism, ageism, able-ism, beauty-ism, as well as homophobia. Includes threats to "out" victim.

TRANSGENDER ABUSE[1]

Specific forms of abuse occur in relationships where one partner is transgender, including:

⇒ using offensive pronouns such as "it" to refer to the transgender partner;
⇒ ridiculing the transgender partner's body and/or appearance;
⇒ telling the transgender partner that he or she is not a real man or woman;
⇒ ridiculing the transgender partner's identity as "bisexual," "trans," "femme," "butch," "gender queer," etc.;
⇒ denying the transgender partner's access to medical treatment or hormones or coercing him or her to not pursue medical treatment.

HIV/AIDS RELATED ABUSE[1]

The presence of HIV/AIDS in an abusive relationship may lead to specific forms of abuse, which include:

⇒ "outing" or threatening to tell others that the victim has HIV/AIDS;
⇒ an HIV+ abuser suggesting that she or he will sicken or die if the partner ends the relationship;
⇒ preventing the HIV+ partner from receiving needed medical care or medications;
⇒ taking advantage of an HIV+ partner's poor health status, assuming sole power over a partner's economic affairs, create the partner's utter dependency on the abuser;
⇒ An HIV+ abuser infecting or threatening to infect a partner.

BARRIERS TO SEEKING SERVICES[1]

Barriers to addressing LGBT intimate partner violence (both for service providers and survivors) include:

- The belief that domestic violence does not occur in LGBT relationships and/or is a gender based issue;
- Societal anti-LGBT bias (homophobia, biphobia and transphobia);
- Lack of appropriate training regarding LGBT domestic violence for service providers;
- A fear that airing of the problems among the LGBT population will take away from progress toward equality or fuel anti-LGBT bias.
- Domestic violence shelters are typically female only, thus transgender people may not be allowed entrance into shelters or emergency facilities due to their gender/genital/legal status.

FOR MORE INFORMATION

National Coalition of Anti-Violence Programs
212-714-1184
www.ncapv.org

GLBT National Help Center
1-888-843-4564
www.glbtnationalhelpcenter.org

Gay Men's Domestic Violence Project
1-800-832-1901
www.gmdvp.org

For more information or to get help, please call the
National Domestic Violence Hotline at 1-800-799-SAFE
National Sexual Assault Hotline at 1-800-656-HOPE

SOURCES

[1] National Coalition of Anti-Violence Programs. (2006) "Anti-Lesbian, Gay, Bisexual and Transgender Violence in 2006." www.ncavp.org
[2] National Gay and Lesbian Task Force. (2005) "Domestic Violence Laws in the U.S." www.thetaskforce.org
[3] Greenwood, Gregory, et. al. (2002) "Battering and Victimization Among a Probability-Based Sample of Men Who Have Sex With Men." *American Journal of Public Health*. 92 (12).
[4] Renzetti,C.M. (1992). "Violent betrayal: Partner abuse in lesbian relationships." *Violence Against Women*. Sage Publications.
[5] Gay Men's Domestic Violence Project. "Types of Abuse." www.gmdvp.org

NATIONAL COALITION AGAINST DOMESTIC VIOLENCE
NCADV
Every Home A Safe Home

The Public Policy Office of the National Coalition Against Domestic Violence (NCADV) is a national leader in the effort to create and influence Federal legislation that positively affects the lives of domestic violence victims and children. We work closely with advocates at the local, state and national level to identify the issues facing domestic violence victims, their children and the people who serve them and to develop a legislative agenda to address these issues. NCADV welcomes you to join us in our effort to end domestic violence.



Statistics

25-40% of youth who *become* homeless each year are LGBT.
(*Kruks G, Journal of Adolescent Health.*)

50% of homeless youth identify as LGBTQ.
(*Mallon, G, We Don't Exactly Get the Welcome Wagon: The Experiences of Gay and Lesbian Adolescents in the Child Welfare Systems.*)

26% of gay youth are forced to leave home because of conflicts with family members over sexual orientation.
(*Rhode Island Task Force on Gay, Lesbian, Bisexual and Transgender Youth.*)

23% of GLBT youth have been threatened with a weapon at school. 52% feel sad and hopeless. 48% have seriously considered suicide. GLBT youth are two-to-three times more likely to get pregnant or get someone pregnant than heterosexual youth.
(*U.S. Centers for Disease Control and Prevention.*)

30% of all completed adolescent suicides in the U.S. are by LGBT youth.
(*U.S. Department of Health and Human Services.*)

28% of LGBT youth drop out of school because of verbal or physical harassment by other students.
(*Savin-Williams, RC, Journal of Consulting Clinical Psychology.)*

78% of youth report that young people who are gay or thought to be gay are teased or bullied in their schools and communities. 93% hear other youth at school or in their neighborhood use words like "fag," "homo," "dyke," "queer," or "gay" at least once in a while, with 51% hearing them every day.
(*National Mental Health Association.*)

50% of gay males report negative reactions from their parents when they disclosed their sexual orientation and 26% were forced to leave home as a result of disclosing their sexual orientation to their parents.
(*U.S. Department of Health and Human Services.*)

33% of gay men and 34% of lesbians report suffering physical violence from family members as a result of their sexual orientation.
(*Philadelphia Lesbian and Gay Task Force.*)

50% of transgendered youth trade sex for money or a place to live.
(*Massachusetts Department of Public Health.*)

30% of young, black gay men in America are infected with HIV disease.
(*U.S. Centers for Disease Control and Prevention.*)

LGBT youth are twice as likely as heterosexual youth to abuse alcohol, and eight times as likely to use cocaine/crack.
(*Garofalo, R, MD, et al, The American Association of Pediatrics.*)

LGBT homeless youth are physically or sexually victimized on average by seven more people than heterosexual homeless youth; leave home an average of 12 times compared to seven times for heterosexual homeless youth; had nearly twice as many sexual partners in their lives than did heterosexual homeless youth; and used 11 of 12 substances more frequently during the previous six months.
(*University of Washington.*)

The following have adopted policies against discrimination based on sexual orientation:

- The American Psychiatric Association (APA)
- The American Psychological Association (APA)
- The National Association of Social Workers (NASW)
- The American Medical Association (AMA)
- The American Academy of Pediatrics (AAP)
- The American Counseling Association (ACA)
- The American School Health Association (ASHA)
- The Child Welfare League of America (CWLA)

The following have issued statements condemning attempts by child welfare and mental health professionals to alter a person's sexual orientation or gender identity through so called reparative or conversion therapies:

- The American Psychiatric Association (APA)
- The American Psychological Association (APA)
- The National Association of Social Workers (NASW)
- The American Counseling Association (ACA)

LESBIAN, GAY, BISEXUAL, and TRANSGENDER YOUTH STATISTICS

Lesbian, Gay, Bisexual and Transgender youth often feel invisible in their schools. Their invisibility is typically reinforced by heterosexism in their environment, which causes these young people to feel invisible, unsupported and isolated.

Sexual Self-Concept, Orientation and Identity:

- During adolescence, young people form their sexual identity.+
- Developing a sexual self-concept is a key developmental task of adolescence. +

LGBTQ Youth in School

- 41.7% of LGBTQ youth do not feel safe in their school. +
- 28% of gay teens drop out of school annually, three times the national average. +
- 69% of LGBTQ youth reported experiencing some form of harassment or violence. +
- 46% of LGBTQ youth reported verbal harassment, 36.4% reported sexual harassment, 12.1% reported physical harassment, 6.1% reported physical assault. +
- 86.7% of LGBTQ youth reported sometimes or frequently hearing homophobic remarks. +
- 36.6% of LGBTQ youth reported hearing homophobic remarks from faculty or school staff +
- LGBT high school students are seven times more likely than other students to be threatened or attacked at school. (Vermont Department of Health, 1995).
- 38.5 % of LGBT youth admitted to heavy drug use (compared to 22.5% of heterosexual peers). (Seattle, 1995)
- 20% of LGBT youth are forcibly institutionalized.
- 26% of LGBT adolescents are thrown out of their homes by parents. About half of these youth engage in "survival sex" to support themselves (University of Minnesota)
- 25-50 % of homeless youth are LGBT.

Suicide

- LGBTQ youth are 3 times more likely to attempt suicide than other youth.*
- 40% of LGBTQ youth attempted suicide compared to their heterosexual peers. +

Student Attitudes about LGBTQ issues

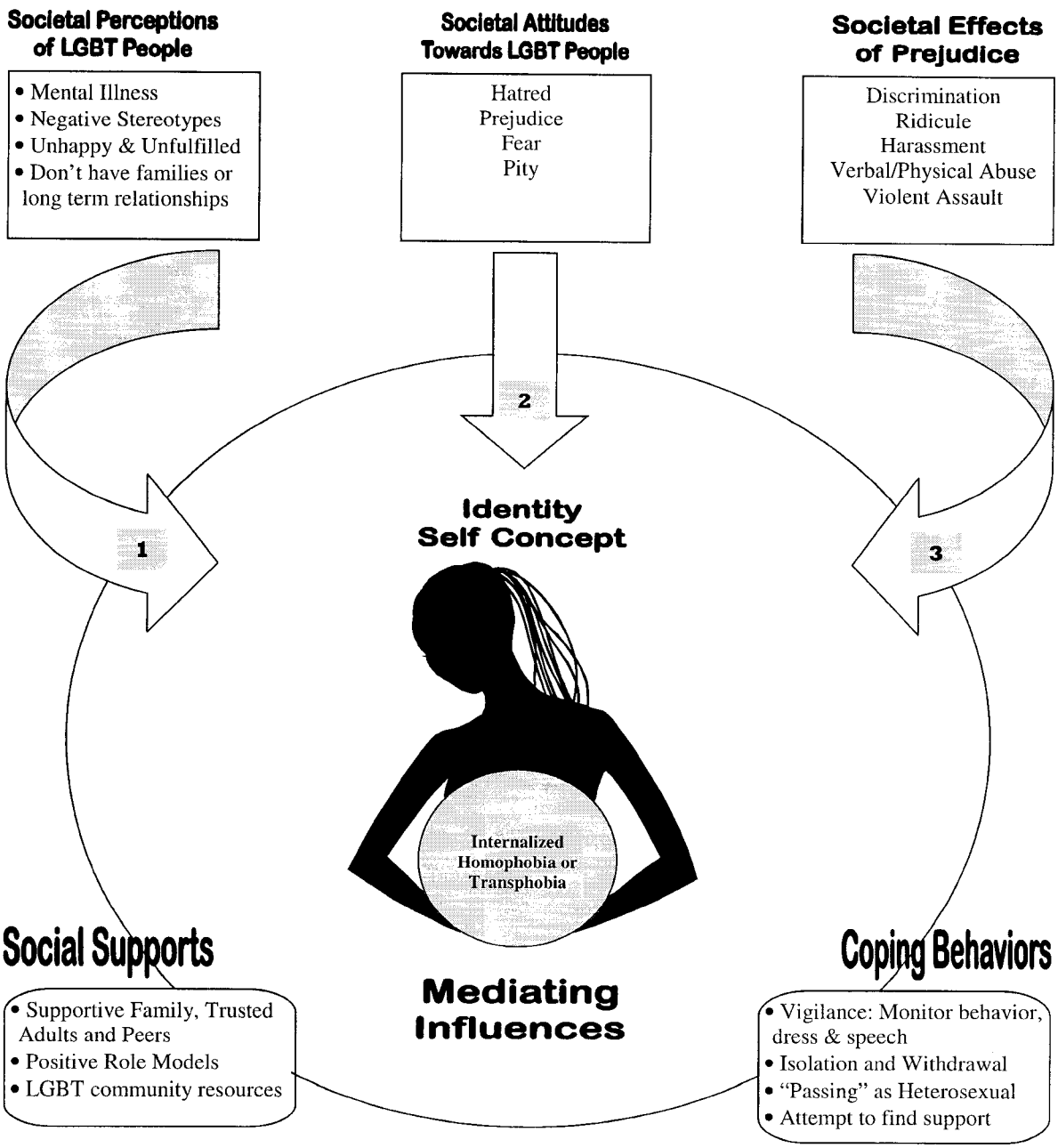
- 40% of high school students say that they are prejudiced against homosexuals. +

Teaching about Sexual Orientation in Schools

- In one study of LGBTQ adolescents, half of the students said that homosexuality had been discussed in their classes. 50% of the females and 37% of the males said it was handled negatively. +

‡Statements indicated with (*) derive from the National Mental Health Association website: http://www.nmha.org, and with (+) from the Sexual Information and Education Council of the United States: http://www.siecus.org.

Impact of Stigma and Prejudice on Lesbian, Gay, Bisexual and Transgender Identity



Misconceptions and negative stereotypes are used to justify negative attitudes or homophobia/transphobia, which leads to hostile behaviors, including discrimination, ostracism, and violence. These attitudes, stereotypes and experiences are also internalized as low self-esteem or self-hate. Adolescents must develop a range of coping behaviors and seek external support to learn to manage stigma and prejudice.

Kaleidoscope Youth Center PO Box 8104 Columbus, OH 43201 614.294.KIDS (5437) www.KYCohio.org

Creating Change With and For Youth...

Anti-bias and Leadership Programs Include:

Youth Activists Participating (YAP) is a community education program that provides youth-to-youth and professional development workshops to discuss the impact of homophobia, transphobia and heterosexism, and provide tools to create change that leads to safe, inclusive communities for LGBTQ individuals.

Youth Advisory Board members are young people given additional responsibilities to coordinate program activities. Supervised and supported by staff, these positions allow a focused way to develop and enhance professional, group and interpersonal skills.

Kaleidoscope's Board of Directors is committed to involving young people at the decision-making table. Seats on the Board of Directors are reserved for young adults and they work in close partnership with our Youth Advisory Board.

Social and Support Programs Include:

The **Drop-In Center** is a safe, youth-centered space for KYC programming. Age appropriate **Social Networking** and **Support Opportunities** help youth to develop positive, healthy peer relationships.

Individual **mentoring discussions** are integral aspects of creating a safe and supportive center. These services provide the link between support and advocacy, coordinating care among numerous systems (i.e. medical, mental health, legal, victim compensation, family, education, etc.).

Academic **Tutoring** and GED Preparation Support is provided by volunteers, focusing on academic performance without fear of negative perception and consequences of identifying as LGBTQ.

LGBTQ Young People at Risk...

Violence, harassment and homophobia make many places unsettling and unsafe for lesbian, gay, bisexual, transgender, and questioning individuals. Consequently, LGBTQ youth development and their ability to successfully transition to adulthood is negatively impacted.

The following statistics bear stark evidence of harsh realities:

- 78% of youth report that young people who are gay or thought to be gay are **teased or bullied** in their schools and communities. (*National Mental Health Association*)
- 26% of gay youth are **forced to leave home** because of conflicts with family members over sexual orientation. (*Rhode Island Task Force on Gay, Lesbian, Bisexual and Transgender Youth*)
- 48% of LGBTQ youth have seriously considered **suicide** and 29% have attempted suicide. 30% of all completed adolescent suicides in the U.S. are by LGBT youth. (*U.S. Centers for Disease Control and Prevention & U.S. Department of Health and Human Services*)
- 28% of LGBTQ youth **drop out** of school because of verbal or physical harassment by other students. (*Savin-Williams, RC, Journal of Consulting Clinical Psychology*)
- 30% of young, black gay men in America are **HIV-Positive**. (*U.S. Centers for Disease Control and Prevention*)
- LGBTQ youth are twice as likely as heterosexual youth to **abuse alcohol**, and eight times as likely to **use cocaine/crack**. (*Garofalo, R, MD, et al, The American Association of Pediatrics*)

Kaleidoscope Youth Center PO Box 8104 Columbus, OH 43201 614.294.KIDS (5437)

KALEIDOSCOPE Youth Center

About Us



www.KYCohio.org

"Kaleidoscope has helped me and our family understand the issues that LGBT youth deal with. I have learned how to be more supportive of my teen."





"Kaleidoscope is an awesome place because it is my home away from home, and a place I can always count on for someone to talk to."

"Trainings that Kaleidoscope has done for our staff have lead to a safer, more culturally inclusive environment for the young people we work with."





"Kaleidoscope is the one thing that kept me alive when I was coming out. I was so depressed and lonely. Today, I am doing great and will have the lead in the school play this year!"

One Sole, Necessary Mission....

Kaleidoscope Youth Center works in partnership with young people in Central Ohio to create safe and empowering environments for lesbian, gay, bisexual, transgender and questioning youth through advocacy, education and support.

Our Vision, Our Values, Our Youth

Our Vision

Kaleidoscope Youth Center's vision is to build a strong and vocal community of youth and their supporters in order to allow LGBTQ youth and their allies in Central Ohio to be heard, accepted and nurtured. The future we strive to create is one in which current prejudice against LGBTQ youth and their allies has been eliminated, and LGBTQ youth, young adults and their allies are empowered to live healthy, full lives.

Our Values

Kaleidoscope recognizes the essential nature of programs derived of youth-adult partnerships that combine elements of advocacy, support and empowerment. We understand the importance of empowering young people to make change and the necessity of supporting them in doing so. To that end, KYC sees youth development, leadership and organizing as fundamental elements to successful youth work. KYC encourages young people to be leaders within the organization and community, and partners with young people to develop programming to facilitate this process.

Kaleidoscope Youth Center administers an entire spectrum of programs free of alcohol, tobacco and other drugs, including a Drop-in Center, basic needs services, social support and activity programs, anti-bias programs, and leadership development opportunities.

Our Youth

Kaleidoscope offers opportunities for lesbian, gay, bisexual, transgender and questioning young people to explore their identity, family, leadership and community in a safe, respectful, and affirming environment. For most participants, their experience with the Center is the first in which they can talk, listen and support one another in an environment free of judgment or bias.

Their stories are compelling and profound and joyful and sad.

Connections at Kaleidoscope Youth Center make the isolation less overwhelming, the celebrations more exuberant, the hurt less deep, and the friendships lasting.

In short, Kaleidoscope Youth Center is a place where LGBTQ youth say to each other:

BE YOU, it's okay.

Kaleidoscope Youth Center is located at 1904 N. High St. Columbus, OH 43201 (Across from the Wexner Center)

FORGE
www.forge-forward.org

Trans-Specific Power and Control Tactics

	Tactics Used Against Trans Partners	Tactics used By Trans Partners
Safety. Outing. Disclosure.	▪ Threatening to "out" you to your employer, friends, or family members ▪ Threatening to take the children or turn them against you	▪ Threatening to tell your family, friends, employers that you aren't who you say you are (e.g. straight, lesbian...) ▪ Turning the children against you
Community attitudes	▪ Ridiculing or belittling your identity as bisexual, trans, femme, butch, genderqueer.... ▪ Claiming they are more "politically correct" and using their status as an L, G, B, and/or T person against you ▪ Stating you would harm the LGB and/or T community if you exposed what was happening	▪ Ridiculing or belittling your identity as bisexual, trans, femme, butch, genderqueer.... ▪ Claiming they are more "politically correct" and using their status as an L, G, B, and/or T person against you ▪ Stating you would harm the LGB and/or T community if you exposed what was happening ▪ Using "cisgender" as a slur and insult
Gender stereotypes (& transphobia)	▪ Telling you they thought you liked "rough sex" or "this is how real men/women like sex" ▪ Declaring you are not a real man/woman ▪ Telling you that nobody will ever love you ▪ Telling you that you don't deserve better and/or would never find a better partner ▪ Claiming they know what's best for you, how you should dress or wear makeup (or not) etc.	▪ Claiming they are just being "butch" or that "it's the hormones" (to explain their violent behavior) ▪ Telling you that there is no way to have safer sex with trans bodies, so you'll have to have unprotected sex ▪ Threatening suicide, especially while reminding you of how many trans people commit suicide ▪ Demanding greater share of clothing/grooming funds because their safety is at stake ▪ Claiming they make a better or more attractive man or woman than you do

Trans-Specific Power and Control Tactics

	Tactics Used Against Trans Partners	Tactics used By Trans Partners
Using or undermining identity	▪ Using pronouns not preferred by you or calling you "it" ▪ Calling you pejorative names ▪ Ridiculing how your body looks ▪ Telling you that nobody would believe you because you're transgender	▪ Accusing you of not allowing hir to have a "proper adolescence" ▪ Claiming that your identity "undermines" or is "disrespectful" of theirs ▪ Stating that trans people are superior because they don't limit themselves to a restrictive binary and sex role stereotypes
Violating boundaries	▪ Eroticizing/fetishizing your body against your will ▪ Touching parts of your body you don't want touched, or using terms about your body they know you find offensive ▪ Forbidding you to talk to others about transgender topics	▪ Denying that you are affected by transition or by being partnered with a trans person ▪ Charging you with "not being supportive" if you ask to discuss questions of transitioning timing and/or expense ▪ Forbidding you to talk to others about transgender topics
Restricting access	▪ Denying access to medical treatment or hormones, or coercing you to not pursue medical treatment ▪ Hiding or throwing away hormones, clothes, prosthetics, or other trans-specific items ▪ Negating your personal decisions ▪ Controlling finances to not allow for purchase of hormones, surgery, clothes, make up, prosthetics	▪ Not allowing you to talk to or see your friends ▪ Denying access to parts of the house or apartment (where hormones or clothes may be stored) ▪ Negating your personal decisions ▪ Controlling finances in order to prioritize paying for hormones, surgery, trans-related items (even if risking not paying for rent, food or mutual expenses)

© 2013 (updated)

Working With LGBT Domestic Violence and Sexual Assault Survivors

1. Whether on the phone or in person do not assume that every victim/survivor you come in contact with is heterosexual. Also be aware that sexual orientation and gender identity are not the same. A transgender person may be in a relationship with someone of the same or opposite gender.

- Be sensitive to word choice: the use of "lover" or "partner" or "roommate" as opposed to boyfriend or husband.
- Be aware of your own use of pronouns from the initial contact with any victim; do not assign a gender to their partner until they do.
- Practice use of non-gender-specific language

2. Do not pressure the victim/survivor to file a report or follow up on legal action.

- Know that it is a difficult and risky choice for the victim to be involved in the legal system, especially if they/their partner are not "out".
- If the victim does choose to take legal action, work with them on anticipating the reactions of family, friends, and employers.

3. Take special care in finding out what support systems exist in the survivor's life.

- Acknowledge that some victims may not have the support of their original family members.
- Do not assume that a victim has an "LGBT community" to which they can turn for support, and acknowledge that many of their friends may align with the abuser and not want to get involved.
- Provide the victim with information and referrals and let them know that they are not alone and that they are welcome in your program.

4. Respect their individuality and don't expect them to conform to stereotypes or your ideas of what LGBT people are.

- Don't assume that just because they're in a relationship with someone now that they've never been with other genders in the past.
- Don't assume that they are childless or don't have any children.
- Don't assume that they are politically active, a feminist, not a churchgoer, etc.

5. Advocate for them in situations where others may be insensitive or unsupportive; police, doctors, landlords, etc.

6. Know the counseling, medical, and legal resources available in the LGBT community in order to make appropriate referrals, but don't assume that just because they are LGBT that they will want an LGBT attorney, therapist, or doctor.

7. If an LGBT victim asks to speak to an LGBT advocate, and none are available, do your best to convey your knowledge and sensitivity to their needs and concerns, but do not automatically pass a LGBT survivor off to an LGBT counselor.

Creating a Trans-Welcoming Environment

A tips sheet for sexual assault service providers

"It takes no compromising to give people their rights.
It takes no money to respect the individual.
It takes no survey to remove repressions."
~ Harvey Milk

Language.

Everyone deserves respect. For transgender individuals, respect must be shown for their identity and history, for their personal style (clothes, accessories), for their bodily configuration, and for their name and pronoun. Respect extends beyond direct interactions to include what you say and how you behave even outside of their presence. If you are unsure which pronoun a client prefers, ask.

Manners.

If you wouldn't discuss your genitals with a colleague, it is probably inappropriate to ask a client about theirs. A person's genitals do not determine their gender for the purposes of social behavior, service provision, or legal status. Do not discuss a person's transgender status with others unless it is absolutely necessary to provide them with appropriate care or services.

Signage.

First impressions have a long-lasting impact. Having prominently displayed signs and posters of (LGB)T individuals, brochures specific to (LGB)T survivors, "Safe Space" stickers, and other overt signs of welcoming create an environment where survivors can immediately recognize that staff knows about and cares about (LGB)T survivors.

Client Resources.

Agencies often provide referrals and resources to clients. Preparing packets specific to transgender clients lets clients know you have vetted the resources and lets the survivor know ze is likely to receive respectful, competent care when pursuing the referral. If a specific resource packet is not possible, having a transgender survivor brochure validates transgender survivors by letting them know you are aware they exist and want to serve them.

Supplies.

Offering all clients a range of post-assault supplies (e.g. toiletry items, clothing) that can be used by people of all genders indicates that your agency serves multiple genders. When all individuals have options to choose from, they don't need to ask for specific items, which may add additional undue stress after an assault. Providing clothing in all genders and a wide range of sizes also encourages transgender clients to consider leaving their clothing for forensic evidence if they can find clothes that both fit and align with their gender identity.

Bathrooms.

Providing unisex, single stall, or gender neutral bathrooms supports all survivors who often feel a need for greater privacy. If it is not possible to make every bathroom gender neutral, find at least one option and have it clearly and prominently marked as gender neutral.

FORGE
po box 1272 | milwaukee, wi 53201 414-559-2123
AskFORGE@forge-forward.org | **www.forge-forward.org**

Paperwork.

Clients notice when intake forms only have two choices for gender, or have no option to check that captures their relationship. Make sure your intake forms, client history forms, body maps and other forms that clients may fill out, as well as those clinicians/ internal office staff may complete, are inclusive of all genders, a wide range of bodily configurations, and all sexual orientations.

Connect.

Connecting with the local transgender community will both provide your agency with valuable resources and let the transgender community know about your services and that your agency is open to and welcoming of transgender individuals. Consider advertising in (LGB)T press or having a section on your website devoted to (LGB)T individuals.

Train.

All agency staff should have regular diversity training, including on transgender issues. Training can be formal (conferences, speakers), or can take place in staff meetings. The goal is to have transgender issues and concerns brought to the attention of all staff so a transgender client will receive culturally competent care from the moment they call or enter your agency to the time they leave.

Follow the leader.

Many transgender individuals use nontraditional names for parts of their bodies (particularly genitals and other body features that are seen as sex-linked). These may be unique words (not found in any dictionary) or names usually used by "the other gender." Show respect for the transgender person's right to self-determination by also using the terms they use to refer to their body, life, relationships, or identity.

Be an advocate.

Although anti-transgender prejudice is still legal in many places, there are often basic rights that everyone is entitled to – the right to privacy, the right to access services, etc. – that you can refer to if the transgender person you're caring for is being mistreated. Don't let someone's gender identity be an excuse for poor or unprofessional treatment.

Be creative.

Transgender people may not fit into existing systems or forms. Respect the transgender person you are caring for by trying to get the form or system to adapt to their needs, rather than forcing them into a pre-determined and ill-fitting box.

This publication was supported by Grant No. 2009-KS-AX-K003 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

FORGE
po box 1272 | milwaukee, wi 53201 414-559-2123
AskFORGE@forge-forward.org | **www.forge-forward.org**

WHY IT MATTERS

Rethinking Victim Assistance for Lesbian, Gay, Bisexual, Transgender, and Queer Victims of Hate Violence & Intimate Partner Violence

A Joint Policy Report
by the National Center for Victims of Crime
and the National Coalition of Anti-Violence Programs

MARCH 2010

THE NATIONAL CENTER FOR Victims of Crime

NCAVP NATIONAL COALITION of ANTI-VIOLENCE PROGRAMS
National Advocacy for Local LGBT Communities

The **National Center for Victims of Crime** is the nation's leading resource and advocacy organization for crime victims and those who serve them. Since its inception in 1985, the National Center for Victims of Crime has worked with grassroots organizations and criminal justice agencies throughout the United States serving millions of crime victims.

The mission of the National Center for Victims of Crime is to forge a national commitment to help victims of crime rebuild their lives. We are dedicated to serving individuals, families, and communities harmed by crime. Working with local, state, national, tribal, and federal partners, the National Center for Victims of Crime:

- Provides direct services and resources to victims of crime across the country;
- Advocates for laws and public policies that secure rights, resources, and protections for crime victims;
- Delivers training and technical assistance to victim service organizations, counselors, attorneys, criminal justice agencies, and allied professionals serving victims of crime; and
- Fosters cutting-edge thinking about the impact of crime and the ways in which each of us can help victims of crime rebuild their lives.

The **National Coalition of Anti-Violence Programs** (NCAVP) is the nation's largest anti-violence coalition addressing the pervasive violence committed against and within the lesbian, gay, bisexual, transgender, queer (LGBTQ) and HIV-affected communities throughout the United States. NCAVP, coordinated by the New York City Anti-Violence Project, is dedicated to supporting local strategies addressing anti-LGBTQ violence and to fostering a national response to anti-LGBTQ violence. Members document and advocate for victims of anti-LGBTQ and anti-HIV/AIDS violence/harassment, domestic violence, sexual assault, police misconduct, and other forms of victimization. NCAVP and its members:

- Provide direct services to LGBTQ victims of violence across the country;
- Produce two annual reports: *Hate Violence against Lesbian, Gay, Bisexual, and Transgender People in the United States* and *Domestic Violence in the Lesbian, Gay, Bisexual, and Transgender Communities in the United States;*
- Provide training and technical assistance to mainstream and LGBTQ anti-violence organizations, law enforcement, hospitals, advocacy groups and allies;
- Advocate with local and national victim assistance providers to serve LGBTQ survivors ethically and competently through training and collaboration;
- Organize national and local responses to anti-LGBTQ hate violence; and
- Conduct outreach and prevention education to LGBTQ communities.

For more information about the partnership or this joint policy report, please contact:

Susan Smith Howley
Director of Public Policy
National Center for Victims of Crime
2000 M Street NW, Suite 480
Washington, DC 20036
showley@ncvc.org
202-467-8700
www.ncvc.org

Sharon Stapel
Executive Director
New York City Anti-Violence Project
240 West 35th Street, Suite 200
New York, NY 10001
sstapel@avp.org
212-714-1184
www.ncavp.org

The principal authors of this report are Mitru Ciarlante of the National Center for Victims of Crime and Kim Fountain, Ph.D., of the New York City Anti-Violence Project.

© 2010 National Center for Victims of Crime and the National Coalition of Anti-Violence Programs. All rights reserved.

TABLE OF CONTENTS

Table of Contents 3

Introduction 4

What We Know 6

What We Don't Know 9

What We Learned: Survey Findings 11

Recommendations 15

Conclusion: A Path Forward 18

Endnotes 20

INTRODUCTION

The National Center for Victims of Crime (National Center) is the nation's leading resource and advocacy organization dedicated to helping victims of crime rebuild their lives. The National Coalition of Anti-Violence Programs (NCAVP) is the nation's largest anti-violence coalition addressing the pervasive violence committed against and within the lesbian, gay, bisexual, transgender, queer (LGBTQ)[i] and HIV-affected communities throughout the United States.

In May of 2009, the National Center and NCAVP partnered to produce two related questionnaires surveying community-based organizations and victim assistance providers, including criminal and civil justice agencies, regarding their work with LGBTQ[ii] victims and survivors of violence. This survey is the first of its kind and sheds light on the important barriers faced by mainstream and LGBTQ service providers to adequately address the needs of LGBTQ victims of violence.

In releasing this joint policy report, the National Center and NCAVP announce their collaboration to identify and raise awareness about the gaps in victims' rights and services for lesbian, gay, bisexual, transgender, and queer victims of crime and present the results of their surveys. The ultimate goal of this partnership is to create equal access for LGBTQ victims of violence by fostering a better understanding of outreach, prevention, justice, and direct services for LGBTQ victims of crime and to forge a national commitment to better serve these individuals and communities whose victimization has largely been unseen, unreported, and unserved.

Thirty years ago, LGBTQ anti-violence programs began to offer local coordinated community responses to anti-LGBTQ victimization and to the lack of response from systems designed to aid victims of violence, including legal, medical, victims' assistance, and law enforcement. Several years later, these programs joined together to form the National Coalition of Anti-Violence Programs to strengthen and broaden their LGBTQ anti-violence work, support existing and help form additional local programs, and work

---

i In this report, the initialisms used, LGBTQ, LGBT, or LGB, vary based on the specific persons being discussed. Lesbians and gay men are individuals that develop intimate and/or sexual connections with members of the same sex. Bisexual people can experience sexual, emotional, and affectional attraction to their own sex and the opposite sex. Transgender individuals are broadly defined as people whose biosocial assigned sex is not congruent with the sex or the gender with which they identify. Queer has historically been used as a derogatory term against lesbian, gay, bisexual, and transgender people or those suspected of being L, G, B, and/or T. Currently, some people have reclaimed the term and self-identify as "queer."

ii The survey collected data on lesbian, gay, bisexual, transgender, and queer communities, but for the purposes of this paper, the authors chose to leave out the data on this final category. The data suggests the possibility that respondents, given the option to choose multiple categories for their answers, may have chosen queer in a manner that would inflate or conflate the data, as the term can be inclusive of the other four categories used. We have also elected to refer to the queer communities in the overall analysis, as these communities are representative of the populations for whom this paper advocates. Please note further that in other studies that collect data on sexual orientation, the category would remain, but transgender would be separately categorized as the term reflects gender identity.

with mainstream systems to provide culturally appropriate services to LGBTQ victims. Today, this work continues in the face of continued societal homophobia and heterosexism.

Inconsistent access: what victims experience*

In 2008, Davis, a gay man living on the west coast, was in danger when the abuser he had fled found him. Davis received a death threat on his car from the abuser, Jason. Davis had been with Jason for seven years. During that time, Jason was always controlling. He monitored Davis' phone calls, wanted to know where he was at all times, and controlled all of their money. Jason also sexually abused Davis and, after one particularly brutal incident, Davis fled. Davis stayed with a friend that Jason did not know and got a job. He was away from Jason for a month before he found a note on his car from Jason that was essentially written as a contract on his life.

Davis strategized to get to a domestic violence shelter. With help from a local anti-violence program, Davis developed an intensive safety and advocacy plan designed to keep him moving across the country to the east coast. Along the way, Davis contacted gay-friendly churches, local and statewide domestic violence programs, and a national domestic violence organization to find shelters that would accept men, and programs that would provide food, toll money, and gas cards. The national program provided information about local shelters that would accept men, but this information was not always accurate. Davis' calls to statewide coalitions and statewide domestic violence hotlines often resulted in the message "we don't shelter men." With the help of the coalitions or by talking to supervisors, Davis could sometimes get shelter for a night or two. This process happened repeatedly during the 12 days Davis traveled to the east coast.

When Davis could not get space in domestic violence programs, he looked for homeless shelters; however, due to the very recent sexual assault, Davis did not feel safe in a homeless shelter. After much advocacy, one particular shelter agreed to make arrangements to allow Davis to sleep in one of the beds that was in the staff offices; however, when Davis arrived, the staff person that greeted him told Davis that he thought that Davis didn't look gay and looked like he could take care of himself, so he would need to stay with the rest of the men.

**This compilation was provided by an AVP program advocate.*

As demonstrated by the findings in this report, the National Center and NCAVP found that, in 2009, LGBTQ victims of crime still did not have consistent access to culturally competent services to prevent and address the violence against them. Too often, mainstream victim assistance agencies cannot meet the needs of LGBTQ crime victims in culturally sensitive ways, while LGBTQ-specific anti-violence programs either lack the resources to do so or do not exist.[iii] Without access to culturally competent advocacy, intervention, and other critical services, LGBTQ victims will continue to suffer disproportionately from violence and the after-effects of victimization.

---

iii Throughout this paper, "mainstream" victim assistance provider refers to providers working primarily with heterosexual victims of crime; anti-violence programs are NCAVP's network of more than 35 anti-violence organizations that monitor, respond to, and work to end hate violence, domestic violence, and other crimes affecting LGBT communities.

This report makes recommendations and ultimately proposes collaboration between mainstream victim assistance agencies and LGBTQ-specific anti-violence programs to increase the efficacy and equity of services provided to LGBTQ victims of crime, particularly hate violence and intimate partner violence. The recommended strategies will be effective only when supported by the necessary changes in laws and policies to provide LGBTQ victims of crime with equal access to victims' rights and services.

The National Center for Victims of Crime and the National Coalition of Anti-Violence Programs make the following recommendations:

1. Build collaboration among LGBTQ anti-violence programs and mainstream victim assistance providers to increase the availability of culturally competent services for LGBTQ victims of crime by providing LGBTQ-specific training for criminal and civil justice system personnel and victim assistance providers.
2. Assess and evaluate the implementation of state and federal protections for victims of crime and implement policy and legislative changes to assure that LGBTQ victims have equal access to protections.
3. Increase public awareness of the extent and impact of victimization against LGBTQ individuals and communities and on crime victims' rights and services through national and local public awareness, education, and outreach campaigns.
4. Increase state and federal funding for collaboration, training, outreach, services, research, and data collection on the victimization of LGBTQ people.

About This Report

The National Center and NCAVP began this collaborative survey and report to gain a better understanding of the victim services provided to LGBTQ victims of crime throughout the United States. The focus of this joint policy report is on the crimes of hate violence and intimate partner violence against LGBTQ people, because these are the crimes that are most reported to NCVAP programs. This report confirms that gaps in services for LGBTQ victims of violence exist and shows the need for culturally competent service provision through LGBTQ and mainstream service providers' collaboration. These gaps in services compromise the safety of LGBTQ individuals, families, and communities.

This report first presents a brief overview of what we know through published literature on hate violence and intimate partner violence against LGBTQ people. Next, there is a discussion about why more is not known about the victimization of LGBTQ people and the responses to them. Existing research gaps reflect a dearth of information about the experiences of victim assistance agencies and anti-violence programs in responding to crime against LGBTQ people. To learn more about the current state of services provided to

LGBTQ victims, the National Center and NCAVP conducted surveys of victim assistance providers and LGBTQ anti-violence programs to begin to fill this knowledge gap. This report reviews key findings from the surveys as well as highlights relevant comments supplied by survey respondents.

The results made clear several pertinent steps, discussed in the recommendations, which must be taken to improve the response to LGBTQ victims of crime. Such an endeavor must include cross-training and collaboration; public awareness, education, and outreach on the scope and impact of crimes against LGBTQ people and the lack of options for victims; and improved data collection and research addressing the victimization of LGBTQ individuals, families, and communities. This work will require funding and relevant changes to laws and policies to ensure equal access to victims' rights and services for LGBTQ crime victims.

In the conclusion, allies are invited to embark on this journey forward to providing effective, relevant, and equitable victim assistance.

WHAT WE KNOW

Since the Stonewall Riots of 1969, which sparked the modern lesbian, gay, bisexual, transgender, and queer rights movement, LGBTQ individuals and communities have become more visible throughout the United States. However, these individuals and communities continue to experience significant degrees of discrimination and violence, ranging from government-sanctioned discrimination to a wide range of crime victimization, including assault, harassment, stalking, sexual violence, and homicide.[1] In focusing on hate violence and intimate partner violence in this report, the National Center and NCAVP address two prevalent and dangerous forms of violence experienced by LGBTQ individuals and communities.[2] This focus was also chosen because the needs of victims of these crimes may not be adequately addressed if the victim assistance providers do not know the sexual orientation and/or gender identity[iv] of the victim and if LGBTQ-sensitive services are not available.

Hate violence against LGBTQ people are crimes motivated by the offender's bias against the actual or perceived sexual orientation and/or gender identity of the victim. Hate-motivated violence is rooted in cultural bias. An attack against an individual or an act of property damage that clearly reflects bias motivation is also an attack against a community and may simultaneously incite community-wide fear and panic as well as frustration and anger. Such attacks send the message that a community and anyone as-

iv Sexual orientation is an enduring emotional, romantic, sexual, or affectional attraction toward others. Gender identity is the psychological sense of one's gender or lack thereof.

sociated with it is not safe, raising anxiety and fear for members of the community who may not even have known the victim.

Hate violence against LGBTQ people is on the rise. From 2006 to 2008, reports of anti-LGBT bias-motivated violence increased by 26 percent overall, with a 36 percent climb in crimes committed by strangers, a 48 percent increase in bias-related sexual assault, and an all-time high rate of hate violence resulting in murder. In 2008, medical attention was required by 46 percent of all victims of LGBT hate violence reported to NCAVP programs.[3] According to another recent study, approximately 20 percent of lesbians, gay men, and bisexual people experienced a crime against their person or property based on their sexual orientation and 50 percent experienced verbal harassment over their lifetime.[4] In addition, reports of anti-LGBT bias-related physical abuse at the hands of law enforcement personnel increased 150 percent from 2007 to 2008.[5]

The impact of hate violence harms members of the victim's community as well, and can leave them feeling isolated, vulnerable, and unprotected by the law.[6] A 2006 poll found that 54 percent of LGBTQ people responding were "concerned," "very concerned," or "extremely concerned" about being the victim of a hate crime.[7] According to studies by the National Institute of Mental Health (NIMH), hate crimes based on sexual orientation bias have more serious and long-lasting psychological effects than other crimes because of the link to core aspects of the victim's identity and community.[8]

Intimate partner violence against LGBTQ people, defined as a pattern of abuse in which one partner isolates, coerces, and dominates another in order to control the relationship. Abusers often capitalize on widespread bias directed at sexual orientation and/or gender identity by threatening to "out" (reveal the sexual orientation and/or gender identity of) the victim to family members, employers, landlords, or others in positions of power.[9] This threat is an effective tool of manipulation and control because once outed, people may lose jobs and homes, as well as custody of their children.[10]

Some studies suggest that intimate partner violence occurs in the relationships of LGBT people at about the same rate as in heterosexual relationships, or in approximately 25 to 33 percent of all relationships.[11] The National Violence Against Women Survey reported that slightly more than 11 percent of the women who had lived with a woman as part of a couple reported being raped, physically assaulted, and/or stalked by a female cohabitant.[12] Researchers also report a high rate of battering within gay intimate partnerships among men, with 39 percent of those studied reporting at least one type of battering by a partner over a five-year period.[13] Transgender people may experience a higher level of both intimate partner violence and sexual assault.[14]

The harm caused by anti-LGBTQ bias also poses additional barriers for victims of intimate partner violence. An LGBTQ victim may hesitate to disclose partner violence for fear that the abuse will be consid-

ered evidence that the victim's sexual orientation and/or gender identity is unhealthy. Seeking support from family members is especially difficult if the family disapproves of the relationship,[15] although studies reveal that even LGBTQ friends and community members are largely unprepared to support victims of intimate partner violence.[16] Additionally, criminal justice personnel and victim assistance providers often underestimate the physical danger involved in same-sex relationship abuse, or fail to recognize that a physically smaller partner may be the perpetrator. Victims may not be believed, or their concerns minimized, by service providers as well. Mainstream victim services and civil and criminal justice agencies may contribute to the appearance of bias by the lack of inclusive language or images used in outreach materials or even their program name. For example, a name that may seem innocuous, such as "The Women's Safeplace," may prevent men, transgender persons, or even lesbian or bisexual women, from seeking services.

There is a dearth of culturally competent victim services for LGBTQ victims of crime. Furthermore, many victim-serving agencies are not well trained to work with LGBTQ victims and survivors of crime.[17] Perhaps the most significant barrier to services for LGBTQ victims is the existence of bias attitudes: homophobia, biphobia, transphobia, and predominant heterosexism.[v] The history and prevalence of such attitudes means that LGBTQ victims may fear encountering bias, even if the service provider or justice agency has made efforts to increase their cultural competency.[18] Without training, providers often fail to consider and address the relevance of anti-LGBTQ bias in the victim's experience. An LGBTQ crime victim may experience bias repeatedly, from being targeted because they are LGBTQ to problems reporting the crime to lack of inclusive victim services. Failure to understand the significance of the victim's sexual identity and/or gender expression therefore presents a great barrier to LGBTQ victims of crime seeking services. While accessible support services can play an important role in preventing victimization and helping victims live free from victimization,[19] many LGBT victims and survivors do not feel that supportive services are readily accessible.[20] In fact, studies have shown that only one in five survivors of same-gender sexual assault and intimate partner violence received victim services.[21]

Despite the victimization experienced by LGBTQ individuals, there are fewer than 40 NCAVP-member LGBT-specific anti-violence programs in the country. Most are small, staffed largely by volunteers, generally under-funded, and lack the capacity to engage in the outreach, education, and advocacy necessary to raise awareness and increase reporting and help-seeking for these crimes. These programs' direct service departments are critically understaffed to meet current needs. As well, few national violence prevention

---

v Homophobia is any attitude or behavior predicated in the assumption that heterosexuality is both normative and desirable, resulting in the marginalization of lesbians, gay men, and queer people at personal, familial, and/or societal levels. Biphobia is any attitude or behavior predicated in the assumption that engaging in intimate/sexual behavior solely with those of the opposite sex is both normative and desirable, resulting in the marginalization of bisexuals at personal, familial, and/or societal levels. Transphobia is any attitude or behavior predicated in the assumption that biological sex and gender are binary and synonymous, resulting in the marginalization of transgender individuals at personal, familial, and/or societal levels. Heterosexism denotes negative attitudes, biases, and discrimination in favor of opposite-sex sexuality and relationships. It can include the presumption that everyone is heterosexual or that only opposite-sex attractions and relationships are valid and therefore superior.

or intervention organizations highlight the needs of LGBTQ victims and, while some federal agencies include LGBTQ populations among their concerns, federal laws do not recognize LGBTQ relationships or families. The federal Violence Against Women Act does not mention gender identity or sexual orientation in its definition of "special populations."[vi]

These disparities reflect widespread misconceptions about the need for victim services for LGBTQ communities. LGBTQ victims and survivors must know that relevant resources exist to assist them, and victim assistance providers must be trained and supported to develop competency in addressing LGBTQ victimization and addressing these unmet needs.

WHAT WE DON'T KNOW

Legitimacy in policy work is established in large part through data that justify the need for new policy or changes to existing policy. In the field of victim services, practical challenges have made it difficult to build a solid empirical foundation on which to base effective policies, particularly for underserved victim populations.[22] The available statistics are largely compiled through direct service and crime reporting data or studies that help to establish parameters such as definitions, prevalence, and demographics of victimization.

Statistics on historically marginalized communities as well as of highly stigmatized forms of violence (intimate partner violence or violence that relates to personal identity, such as hate violence) are under-reported. The U.S. Department of Justice advises policymakers "Homosexual victims may decide not to report hate crimes to police because of fears of reprisals or a belief that they will be forced 'out of the closet.' Such an 'outing' may cause repercussions to their career and

LGBTQ victimization is under-reported due to many risk factors:

Isolation inhibits full participation in society and exacerbates vulnerability to crime by creating less awareness of what constitutes a crime, crime victims' rights, and options for reporting.

Revictimization by homophobic and transphobic responders, lack of specific services, and environments which force victims to educate the providers contribute to fears of seeking help.

Shame in the face of societal stigma and victim blaming may be exploited by perpetrators. By targeting victims in highly stigmatized communities, perpetrators count on shame to keep victims from reporting the crime.

Discrimination and ***rejection*** are risks for victims "outing" themselves by seeking help. Being identified as LGBTQ means risking public rejection and stigma, discrimination in employment and housing, threats, and revictimization.

Within the LGBTQ community, risks include confidentiality being violated, retaliation by the perpetrator, and being perceived as betraying the community by taking problems to outsiders.

vi 42 U.S.C. §13925(a)(33) "The term "underserved populations" includes populations underserved because of geographic location, underserved racial and ethnic populations, populations underserved because of special needs (such as language barriers, disabilities, alienage status, or age), and any other population determined to be underserved by the Attorney General or by the Secretary of Health and Human Services, as appropriate."

relationships with family and friends. Some victims have little confidence that authorities will bring the perpetrators to justice."[23]

Taken individually, each of these issues presents an additional roadblock to reporting hate-motivated and intimate partner violence; taken as a whole, they become nearly insurmountable odds against seeking assistance.

Statistics reported by law enforcement agencies

In addition to the under-reporting of hate violence and intimate partner violence by LGBTQ victims and victim service agencies, there is also significant under-reporting by law enforcement agencies.

Large numbers of law enforcement agencies report zero hate crimes to the Federal Bureau of Investigation Uniform Crime Reporting (UCR) program, the national data collection system.[24] Despite growth in the total number of agencies participating from 1992 to 2004, approximately 84 percent of participating agencies reported zero bias incidents in each of these years.[25] This may accurately reflect the number of bias crimes coming to the attention of law enforcement personnel in some small jurisdictions, but it likely reflects a substantial under-reporting problem for many jurisdictions, particularly those in larger, more diverse communities. Using a national survey of police agencies, one study of note found that roughly 5,000 to 6,000 additional agencies investigated one or more crimes that could have been reported as bias crime incidents to the UCR.[26]

A factor that contributes to the underreporting of intimate partner violence against LGBT people is police failure to identify incidents as crime victimization. Studies suggest that police often fail to recognize that the incident has occurred in the context of an intimate partnership, or, because of a misconception among law enforcement that a determination of domestic violence is based primarily on the sex of the victim, many simply assign the label of "mutual abuse" and arrest both parties in incidents of violence in an LGBT relationship.[27]

Statistics reported by victim assistance agencies

As new LGBTQ-specific victim's rights laws are being considered and passed, it is imperative to learn more about the need for LGBTQ victim services, including the number of those who seek assistance, the number served, and the number referred or turned away. This data is crucial for developing support for services and advocacy, and for indicating how services may need to be adapted. We can only speculate how many LGBTQ victims of intimate partner violence are using victim assistance services because there are numerous challenges to obtaining this data, such as victim assistance providers not wanting victims to feel pressured to disclose sexual orientation and/or gender identity. Other issues in data collection reflect general mores concerning socially encouraged privacy around matters of sexuality, assumptions of heterosexuality and gender identity, lack of understanding regarding diversity among LGBTQ people, and the

need for data collection skills development. Misconceptions and assumptions about a victim's sexual orientation and/or gender identity, especially as they correlate to age or any additional identity-based marker, increase the risk that LGBTQ victims will fail to be identified and fail to receive culturally relevant services and advocacy.

Consequently, currently collected and available crime statistics, even those we cite in this report, are unlikely to represent the true extent of crime victimization against LGBTQ people. Nor do we know when or how LGBTQ victims are using victim assistance and if their needs are being met. In summary, LGBTQ people need relief from stigma, discrimination, and the threat of violence to help end their historic invisibility. This invisibility contributes to being uncounted and unserved. It is imperative for professionals to recognize and document crimes against LGBTQ individuals and communities, and to create safe and effective crime and victim services data collection systems.

WHAT WE LEARNED: SURVEY FINDINGS

In May of 2009, the National Center and NCAVP each conducted national surveys to assess the state of victim assistance for LGBTQ[vii] victims and survivors of crime. This survey is the first of its kind and sheds light on the current barriers to addressing the needs of LGBT victims of violence. The National Center surveyed its network of more than 10,000 legal system-based and community-based victim assistance agencies across the nation. NCAVP surveyed its member programs and their networks. There were a total of 648 survey responses. Responders were from a variety of victim assistance settings, including 40.5 percent nonprofit domestic violence centers, 38.7 percent nonprofit sexual assault centers, 26.6 percent prosecutors' offices, 16.5 percent law enforcement agencies, and 16.5 percent nonprofit organizations serving child victims. (In reviewing the survey findings, please note that data from multiple choice questions have been aggregated and reported in a range of numbers that may not equal 100 percent.)

Introduction to the findings

Overall, the results showed that LGBTQ-relevant victim assistance is generally lacking in every area included in the survey. Agencies expressed both a strong need and a willingness to receive culturally-specific training and technical assistance. The respondents also acknowledged the importance of LGBTQ-specific victim assistance and demonstrated a desire to better serve LGBTQ victims. Most respondents reported that their agencies:

- lack outreach to LGBT victims;
- lack staff LGBT cultural competence training;

---

vii The surveys collected data on lesbian, gay, bisexual, transgender, and queer communities, but for the purposes of this paper, the authors chose to leave out the data on the latter category. The data suggests the possibility that respondents, given the option to choose multiple categories for their answers, may have chosen "queer" in a manner that would inflate the data as the term can cross-cut the other four categories.

- did not implement LGBT-specific victim services policies and practices;
- did not collaborate with LGBT-specific service providers; and
- were under-resourced to correct these barriers to LGBT-specific services.

Lack of LGBT-specific services

While a strong majority of those surveyed reported a belief that it was important to serve LGBT victims, many agencies did not implement policies and procedures specifically for working with LGBT victims, including LGBT-friendly signs and materials, and gender-neutral intake forms. Most—from youth services to elder services and government agencies to nonprofits—face challenges in providing culturally competent services to LGBT survivors of violence. Obstacles range from general underlying staff homophobia to a perception that there is no need for specialized services for LGBT people. Victim service providers report they are overworked, under-funded, understaffed, and have limited options for offering a broad range of services in ways that are culturally specific. Thus, many providers have adopted a "one size fits all" approach to service provision, as illustrated by respondents' comments in the sidebar.

Respondents' comments on the lack of LGBT-specific services

We treat everyone the same.

How can we single out one section of the population and show favoritism?

Our population being served are predominantly women, ages 14 - 61, and sexual orientation has never been a concern when dealing with rape victims.

We primarily serve children.

Let's put criminals in jail regardless of who or what the victim likes to have sex with!

We are primarily a partner abuse intervention program – so maybe it doesn't apply.

The challenges to serve victims are immense and we endeavor to be available to all, to encourage their participation, and to provide services without categorization or preference, no matter who they are.

Only six percent of all survey respondents indicated that a majority of the victims they served (75 to 100 percent) identified as L, G, B, and/or T people. Further, the data suggests that the types of victim services available to each group differed. Of the NCAVP respondents, general victim services were more likely to be provided to lesbians than to gay men or transgender people. Nearly all the NCAVP survey respondents provided support groups that included lesbians and bisexual women, whereas the top service provided for gay male victims and survivors was referral (93.2 percent). Services provided to transgender victims and survivors included crisis intervention services (81.9 percent), individual counseling (79.4 percent), and shelter (58.1 percent).

Lack of culturally-specific outreach

One effective way to build an LGBT community's trust that an agency is inclusive is to have materials that are designed to encourage LGBT members to access victim services. Across the board, the top challenge

reported by service providers was a lack of outreach materials specifically designed for LGBT victims. The survey respondents indicated that most agencies do not provide such materials. In fact, 69.2 to 92.9 percent of all survey respondents reported that they lacked outreach specifically designed for LGBT victims.

Culturally specific outreach signals to LGBT victims that the available services will address their real-life needs and communicates that LGBT survivors' feelings, experiences, and concerns about the victimization are valid, and that someone else understands this. Victim assistance providers expressed a desire to increase their outreach to the LGBT community, let them know of the services available, and increase general awareness of the impact of LGBT victimization.

Lack of victim assistance provider training

Many victim assistance providers have little training in cultural competency regarding LGBT victims. Such training would help them become attuned to the concerns of LGBT victims, including victims' fear of encountering a homophobic or heterosexist response by the criminal and civil justice systems or victim service providers, fear of being "outed" if they were not fully public with their sexual orientation and/or gender identity, and the fear that they may be seen as betraying their community if the perpetrator is also LGBT. Training would also help victim service providers learn to recognize their own internal biases or actions that imply the existence of a bias.

National Center survey respondents identified a lack of training as one of their top challenges in serving LGBT victims; specific populations they need more training to help include:

- gay/bisexual men (66.3%);
- transgender people (51.3%); and
- lesbian/bisexual women (43.2%).

NCAVP respondents similarly reported a lack of training in issues specifically related to LGBT victims of violence:

- transgender people (93.3%);
- lesbians and bisexual women (70%); and
- gay and bisexual men (68.9%).

Many victim service providers responded to the National Center survey about training needs with statements that they strive to serve all victims equally or that they do not discriminate. While these are appropriate values in victim services, the statements indicate the perception that all victims' needs are the same, sexual orientation and gender identity do not matter, and, therefore, there is no need for cultural competency training or LGBT-specific services. Without additional training, victim assistance providers risk believing that they are delivering "equal" services to LGBT victims while delivering fewer or less than adequate services. Training in cultural competency would help victim service professionals achieve their

goal of being accessible and sensitive to all victims and support more effective identification of crimes, classification of crimes, safety planning, lethality assessment, and options counseling.[viii]

In the National Center survey, 56.4 percent of providers said that they would be very likely to use specialized training or technical assistance to better serve LGBT victims, and a total of 81 percent indicated that they would be very or somewhat likely to participate.

Lack of inclusive reporting forms

The surveys elicited a number of data-related issues regarding providers' reporting on work with LGBT victims and survivors of crime. The sidebar adds additional insights from some respondents' comments on the dilemmas encountered. If an LGBTQ victim receives services, data collection and reporting forms may not be written in an identity-inclusive way to capture the nature of a same-sex intimate partnership, the victim's sexual orientation, and/or gender identity, or the bias-motivated aspects of the violence. National Center respondents identified that the lack of specific LGBT-inclusive language on reporting forms was a top challenge in serving LGBT victims and survivors.[ix] Most victim assistance providers do not track these statistics. In fact, the majority of all survey respondents stated that their agencies did not have mechanisms to track the number of LGBT victims served.

Respondents' comments on the lack of data collection on LGBT victims

Even when we know the incident entails a same sex relationship, the victim will not acknowledge it as such and will refuse to be provided 'specific' assistance.

We have discussed tracking LGBTQ clients, with some in favor and some opposed at our agency. The pros are obvious, but the cons were that requiring orientation information to be disclosed at intake implies that if a client is not comfortable discussing their orientation, they are not welcome, and rather than set up that potential scenario, we opted not to collect LGBTQ data for any clients.

We cannot assume LGBTQ identity of crime victims who don't self identify. In some LGBTQ relationships, victims will not identify as intimate relationships; only as roommates when they believe a partner will be arrested.

Lack of LGBT-specific policies and practices

In the National Center survey, responses about LGBT-specific policies and practices varied by victim assistance setting; overall, 71.3 percent had written and adopted a non-discrimination policy covering sexual orientation, while 28.7 percent had not. In the NCAVP survey, 79.3 percent had written and adopted a

viii Another recent study revealed some common misperceptions among crisis center staff regarding same-sex intimate partner violence; they rated scenarios as less serious than opposite-sex intimate partner violence and judged same-sex intimate partner violence as less likely to get worse over time. M. J. Brown and J. Groscup, "Perceptions of Same-Sex Intimate Partner Violence Among Crisis Center Staff," *Journal of Family Violence* 24, (2009): 87-93.

ix Note though, that 77.4 percent of National Center survey respondents asked intake questions in a way that did not presume the gender of the victim, the victim's partner, or the offender.

non-discrimination policy regarding sexual orientation, and 46.1 percent had LGBT-related protocols that were enforced.

For some victim assistance agencies, advocating for prevention, outreach, justice, services, and policies that are inclusive of LGBTQ communities can mean risking one's job, agency funding, or general community support, and—especially without support from federal agencies and national organizations —can seem too great a burden for an individual victim advocate or local agency to bear. As the sidebar underscores, without adequate protections, individuals and organizations may opt not to push too hard for LGBTQ-inclusive practices.

Respondents' comments on homophobia's effect on victim assistance agencies

Most of our agencies are not even providing any sort of safe space for our LGBTQ employees, much less a safe environment for LGBTQ victims/survivors.

I believe the biggest issue for our office is the public stigma.

Our agency is in an extremely rural area with a strong Christian base. Unfortunately, there are extreme biases in this community, and even the mention of LGBT services creates uproar.

This is a huge mountain to climb.

Homophobia and transphobia are still quite prevalent in the workplace[28] and, in many states, protections for LGBTQ employees are not guaranteed.[29] According to the American Psychological Association, LGB individuals are less likely to suffer discrimination in organizations that have policies against LGB discrimination.[30] Such protections are imperative in victim assistance, as they allow and even encourage staff to advocate for inclusive and effective services for LGBTQ victims.

Lack of collaboration between LGBT and mainstream victim service providers

In the National Center survey results, 43 percent of sexual assault and intimate partner violence service providers said they did not collaborate with any LGBT organizations; neither did half of responding law enforcement-based victim assistance programs and nearly 78 percent of prosecutors' offices. Many respondents mentioned the difficulty of finding partner agencies to support or reach LGBT victims in areas that are rural or highly conservative and noted that a list of local LGBT resources would be helpful.

Those agencies that did report collaborations most commonly mentioned an LGBT community center or LGBT anti-violence project as a collaborating partner, while others included university-based programs, pride organizations, and chapters of PFLAG (Parents, Families, & Friends of Lesbians and Gays).

Lack of funding for LGBT-specific services

Across the board, the NCAVP survey respondents indicated that their services were not able to meet the needs of LGBT survivors of violence. Lack of funding and staffing were identified as majors concerns:

- 93.3% of the programs reported they lacked funding and staffing for services to transgender people,
- 91.0% of the programs reported that they lacked funding and staffing for services to lesbian/bisexual women, and
- 89.9% of the programs reported they lacked funding and staffing for services to gay/bisexual men.

NCAVP respondents also indicated that they needed funding for outreach to LGBT survivors. Specifically: 92.9 percent needed funding to outreach to transgender people, 71.8 percent to outreach to gay men, and 69.2 percent to outreach to lesbian/bisexual women. Many reported that they were not able to access funding for outreach because of an inability to establish the sufficient need based on the small number of LGBT victims who had sought services. This is a well-known conundrum in developing services for marginalized communities. Outreach is under-resourced and limited, which restricts access to the targeted community and in turn restricts the targeted community's participation in responses to the problems. This results in a failure to document a specific population's needs. Without being able to gather the required data or outreach outcome measures, developing programs are hard-pressed to make the case for increased funding, thereby creating a frustrating cycle that produces an inability to deliver increased and more focused services to particular communities.

A Closer Look: Shelter

Notable in addressing the needs of LGBTQ victims, is the particularly difficult issue of access to domestic violence shelter spaces. The dilemma facing providers in sheltering LGBTQ intimate partner violence victims runs the gamut of issues from adhering to mission statements and the fiscally-related need to fill beds, to creating harmony in the living spaces and having the necessary facilities to meet the needs of diverse residents. In New York City, there are 2,081 shelter beds for victims of domestic violence; four of them are LGBTQ-specific. Anecdotal reports from LGBTQ providers show that gay, bisexual, and transgender men cannot access shelter because most domestic violence shelters do not house men.

Perhaps that is why the issue of shelter access was not among the top three challenges listed by National Center respondents; the majority of responding domestic violence programs may not shelter men, therefore they did not identify this issue as a priority. When LGBTQ victims have been housed in mainstream shelters, there are reports of negative reactions from other residents. In fact, 90 percent of NCAVP respondents felt that other clients would have difficulty with transgender individuals in the shelter; 63.3 percent were concerned about reactions to gay or bisexual men, and 40 percent were concerned about reactions to lesbians.

Some shelters try to circumvent these difficulties by offering gay men and transgender people "hotel shelter" for short stays. While staying at a hotel or motel may attempt to address immediate needs, it does not offer male victims the same level of safety and security, nor inclusion into a community of survivors with access to a greater scope of services, such as support groups and short-term and transitional housing. It also does not challenge agency policies to rethink how services are provided and how to address the needs of survivors that do not fit providers' understanding of who may be victims of intimate partner violence.

This report underscores the need for national and local collaboration among victim assistance organizations, LGBTQ anti-violence programs, and victims/survivors to address this disparity. We must assess the emergency shelter needs of LGBTQ victims, study the dilemmas faced by local agencies in providing relevant shelter options, and generate practical recommendations that can be implemented in local communities to best ensure victims' safety, services, and rights.

RECOMMENDATIONS

LGBTQ victims of crime are not receiving the necessary services to address immediate victim needs nor the attention and awareness necessary to end violence against and within LGBTQ communities.[31] Victim assistance providers do not have adequate cultural competency to respond to LGBTQ victimization and LGBTQ-specific anti-violence programs are overburdened. An adequate response system involving law enforcement, victim services, and anti-violence programs that serves all LGBTQ victims is needed.

The National Center for Victims of Crime and the National Coalition of Anti-Violence Programs make the following recommendations:

1. **Build collaboration among LGBTQ anti-violence programs and mainstream victim assistance providers to increase the availability of culturally competent services for LGBTQ victims of crime by providing LGBTQ-specific training for criminal and civil justice system personnel and victim assistance providers.**

To improve our national response to LGBTQ victims, it is essential that the level of collaboration between LGBTQ anti-violence programs and mainstream victim service providers—including law enforcement agencies—increases. Such collaboration will foster LGBTQ-specific competency and sensitivity in mainstream first responders and providers and supply an important link between LGBTQ victims and the civil and criminal justice systems. Interagency coordination and collaboration will also result in a broader range of remedies for LGBTQ victims and communities, and assure that LGBTQ victims and communities receive the resources they need to survive the violence and engage in meaningful prevention.

State- and federally-funded programs, including law enforcement agencies, must be required to obtain meaningful training to increase cultural competency when working with LGBTQ victims. The overall majority of victim assistance providers who responded to the National Center and NCAVP surveys indicated that they needed additional training to help them reach and serve LGBTQ victims. Such training can help victim service providers better identify any underlying biases that may impair their ability to serve LGBTQ victims, or actions that create the appearance of bias.

Training for law enforcement personnel can help them to better distinguish hate crimes from crimes of opportunity, to discern a hate motivation in cases where there are multiple motivations for the offense, and to respond appropriately to LGBTQ intimate partner violence. Where the size of the jurisdiction or level of LGBTQ victimization so justifies, law enforcement and prosecution agencies should be encouraged to designate an LGBTQ crimes investigator or prosecutor.

LGBTQ anti-violence programs across the country have demonstrated the ability to develop and deliver a range of trainings to help law enforcement personnel address various biases in dealing with LGBTQ victims. Such sensitivity trainings include learning appropriate responses while working with LGBTQ victims, the proper use of language, identifying anti-LGBTQ hate violence, dismantling gay and transgender panic defenses, and assessing abusers and victims.[x]

Training and support to increase the cultural competence of law enforcement personnel and victim service providers must be prioritized, and increased state and federal funding must be available to carry out these trainings and to deliver follow-up technical assistance to providers.

---

x To learn more about these trainings, contact NCAVP or visit www.ncavp.org.

2. **Assess and evaluate the implementation of state and federal protections for victims of crime and implement policy and legislative changes to assure that LGBTQ victims have equal access to protections.**

Part of any strategy to improve our national response to crimes against LGBTQ victims will include legislative and policy changes to assure LGBTQ victims' needs are recognized, considered, and met. State and federal laws must include sexual orientation and gender identity as protected classes to assure equal access to justice for LGBTQ victims of violence. State and federal governments must understand that victims of violence include LGBTQ persons, and must ensure that support for domestic violence services, shelters, safe houses, and transitional housing is inclusive of same-sex and transgender victims, including men and male-identified people. To accomplish this, national, state, and local collaborations must be supported to assess the emergency shelter needs of LGBTQ victims, study the dilemmas faced by local agencies in providing relevant shelter options for LGBTQ victims, and generate practical victim-centered recommendations that can be implemented in local communities to resolve this disparity.

3. **Increase public awareness of the extent and impact of victimization against LGBTQ individuals and communities and on crime victims' rights and services through national and local public awareness, education, and outreach campaigns.**

The justice systems, social response systems, LGBTQ communities, and society at large must be made aware of the scope and effect of violent crimes against LGBTQ persons, as well as of victims' rights and services. Until this happens, LGBTQ victims will not receive adequate priority. Outreach materials and public awareness campaigns would serve to encourage the recognition and reporting of hate crimes, bias incidents, and LGBTQ intimate partner violence. As victims realize that they are not alone and others recognize that crimes against LGBTQ persons can happen even in their own communities, such crimes are more likely to be identified and reported. A national awareness campaign should also include local components to raise the profile of local LGBTQ-friendly services and allies. There is also a particular need for materials designed for friends and family of victimized LGBTQ persons so that they can be better prepared when victims turn to them for help.

4. **Increase state and federal funding for collaboration, training, outreach, services, research, and data collection on the victimization of LGBTQ people.**

State and federal funding must be provided to increase the capacity of local service providers to meet the need for LGBTQ victim assistance. To date, there are fewer than 40 LGBTQ-specific anti-violence programs existing in 20 states. More than half of the country lacks dedicated services for LGBTQ victims. Committing state and federal funding for victim services, outreach, and prevention within LGBTQ

communities is required to foster the development and expansion of these LGBTQ-specific programs and resources throughout the United States.

State and federal policies and practices must ensure that state- and federally-sponsored surveys of victimization include indicators that adequately address sexual orientation and gender identity as separate study dimensions. Efforts must also increase quantitative and qualitative research among LGBTQ persons and increase opportunities for publication and dissemination of scientific research of studies that illuminate the specific experiences and consequences of LGBTQ victimization. Ultimately, research and data will undergird evidence-based practices for outreach, prevention, and intervention.

State and federal victim services funding must be inclusive of LGBTQ victims and must hold funded programs accountable to report on the number of LGBTQ victims seeking services and the LGBTQ-specific services programs provide. Agencies that conduct national, state, or local crime data collection or reporting, including victimization surveys, must gather data on crimes against LGBTQ persons.

As is evident from the findings of this report and the limitations of LGBTQ victimization research, it is nearly impossible to measure the need for services for LGBTQ victims of violence. Even when victims do report, fear of revictimization or lack of knowledge on the part of responders may result in victims receiving services without being identified as LGBTQ. Service providers may not have the mechanisms to properly document LGBTQ relationships or sexual orientation and/or gender identity. Federal, national, state, tribal, and local programs need culturally competent technical assistance on the importance of and strategies for safely and ethically collecting and reporting this data.[xi]

CONCLUSION: A PATH FORWARD

With this report, the National Center for Victims of Crime and the National Coalition of Anti-Violence Programs have taken the first step in an initiative between mainstream victim assistance providers and LGBTQ-specific anti-violence programs to increase the efficacy of outreach, prevention, justice, and direct services for LGBTQ individuals, families, and communities harmed by crime. We invite federal, national, state, tribal, local, and individual collaborators to join us in this endeavor. This initiative must encompass cross-training and collaboration; LGBTQ-specific training for law enforcement and victim assistance agencies; more resources for LGBTQ anti-violence programs; public awareness, education, and outreach; and more consistent LGBTQ-focused research and data collection. Advocacy to change laws and policies that address the victimization of LGBTQ people is integral to this effort to provide LGBTQ victims with equal access to victims' rights and services.

---

xi For example, victims may be provided with anonymous feedback forms that also collect demographic information, including indicators of sexual orientation and gender identity.

Discriminatory policies that harm LGBTQ people and communities must be changed both to allow meaningful access to services required by LGBTQ victims and to end government-sanctioned discrimination that is at the root of bias-related anti-LGBTQ crimes. Additionally, the hard work of changing sociocultural biases against LGBTQ populations must become a much stronger and intentional part of crime prevention work.

LGBTQ-specific anti-violence programs must have resources and support to build their capacity to collaborate with and train law enforcement agencies and mainstream service providers to ensure inclusive and competent outreach and services. Funding interventions targeted for groups who experience identity-based violence is not a new concept. The violence against women movement, for example, established intimate partner violence and sexual assault laws, funding, and services based on this very premise.

The National Center for Victims of Crime and the National Coalition of Anti-Violence Programs will continue to advocate for the implementation of the recommendations made in this report and to seek opportunities to bring attention and resources to improving victim assistance for all victims of crime, including lesbian, gay, bisexual, transgender, and queer people.

ENDNOTES

1 Amnesty International, "Stonewalled: Police Abuse and Misconduct Against Lesbian, Gay, Bisexual, and Transgender People in the U.S." (New York): 2005; D. Saucier, J. Hockett, and A. S. Wallenberg, "The Impact of Racial Slurs and Racism on the Perceptions and Punishment of Violent Crime," *Journal of Interpersonal Violence* 23 (2008): 685 - 701; and D. G. Moon and T. K. Nakayama, "Strategic Social Identities and Judgments: A Murder in Appalachia," *Howard Journal of Communications* 16, no. 2 (2005): 87-107.

2 National Coalition of Anti-Violence Programs, "Hate Violence against Lesbian, Gay, Bisexual, and Transgender People in the United States: A Report by the National Coalition of Anti-Violence Programs," (New York: NCAVP, 2009), http://ncavp.org/common/document_files/Reports/2008%20HV%20Report%20smaller%20file.pdf. Annually, NCAVP members issue two reports, hate violence and intimate partner violence, focused on these issues because they consistently reflect the highest percentages of forms of victimization reported to the members of this coalition.

3 National Coalition of Anti-Violence Programs, "Hate Violence."

4 G. M. Herek, "Hate Crimes and Stigma-Related Experiences among Sexual Minority Adults in the United States: Prevalence Estimates from a National Probability Sample," *Journal of Interpersonal Violence* (2009).

5 Amnesty International, "Stonewalled."

6 International Association of Chiefs of Police (IACP), "Responding to Hate Crimes: A Police Officer's Guide to Investigation and Prevention," (Alexandria, VA: IACP, 1999), 4.

7 Harris Interactive, October 10, 2006, http://www.harrisinteractive.com/news/allnewsbydate.asp?News/D=1099 (accessed July 17, 2009).

8 G. M. Herek et al., "Psychological Sequelae of Hate Crime Victimization among Lesbian, Gay, and Bisexual Adults," *Journal of Consulting and Clinical Psychology* 67, no. 6, (1999): 945-51.

9 National Coalition of Anti-Violence Programs, "Lesbian, Gay, Bisexual, and Transgender Domestic Violence in the United States in 2007: A Report of the National Coalition of Anti-Violence Programs," (New York: NCAVP, 2008), 5-7, http://www.ncavp.org/common/document_files/Reports/2007%20NCAVP%20DV%20REPORT.pdf.

10 Stalking Resource Center, "Leaving No Victim Behind," *The Source* 3, no. 2 (Washington, DC: National Center for Victims of Crime, 2003), http://www.ncvc.org/src/main.aspx?dbName=DocumentViewer&DocumentID=37138.

11 P. Tjaden and N. Thoennes, U.S. Department of Justice, "Extent, Nature, and Consequences of Intimate Partner Violence: Findings from the National Violence Against Women Survey," (Washington, DC: GPO, NCJ 181867, 2000), http://www.ojp.usdoj.gov/nij/pubs-sum/181867.htm; G.L. Greenwood et al., "Battering Victimization among a Probability-based Sample of Men Who Have Sex with Men," *American Journal of Public Health* 92, (2002); D. Dolan-Soto and S. Kaplan, "New York Lesbian, Gay, Transgender, and Bisexual Domestic Violence Report," (New York: 2005), http://www.avp.org/publications/reports/2005nycdvrpt.pdf; A. J. Heintz and R. M. Melendez, "Intimate Partner Violence and HIV/STD Risk among Lesbian, Gay, Bisexual, and Transgender Individuals," *Journal of Interpersonal Violence* 21, no. 2, (2006): 193-208; J.M. Heidt, B.P. Marx, and S.D. Gold, "Sexual Revictimization among Sexual Minorities: A Preliminary Study," *Journal of Traumatic Stress* 18, no. 5, (2005): 533-40; and S. C. Turell and L. Cornell-Swanson, "Not All Alike: Within-Group Differences in Seeking Help for Same-Sex Relationship Abuses," *Journal of Gay & Lesbian Social Services* 18, no. 1, (2005): 71-88.

12 Tjaden, "Extent, Nature, and Consequences of Intimate Partner Violence."

13 Greenwood et al., "Battering Victimization."

14 S. Gentlewarrior, "Culturally Competent Service Provision to Lesbian, Gay, Bisexual, and Transgender Survivors of Sexual Violence," Applied Research Forum (Harrisburg, PA: VAWnet, a project of the National Resource Center on Domestic Violence/Pennsylvania Coalition Against Domestic Violence, 2009), http://www.vawnet.org; and R. L. Stotzer, "Violence Against Transgender People: A Review of United States Data," *Aggression and Violent Behavior* 14, no. 3, (2009): 171-72.

15 M. Aulivola, "Outing Domestic Violence: Affording Appropriate Protections to Gay and Lesbian Victims," *Family Court Review* 42, no. 1, (2004): 162.

16 S. Turell and M. Herrman, "Family Support for Family Violence: Exploring Community Support Systems for Lesbian and Bisexual Women Who Have Experienced Abuse," *Journal of Lesbian Studies* 12, nos. 2-3, (2008): 211.

17 G. M. Herek et al., "Hate Crime Victimization among Lesbian, Gay, and Bisexual Adults," *Journal of Interpersonal Violence* 12, nos. 2, 4, (1997): 195-215; T. A. Savage et al., "Applying Social Empowerment Strategies as Tools for Self-Advocacy in Counseling Lesbian and Gay Male Clients," *Journal of Counseling & Development* 83, no. 2, (2005): 131-37; M. D. Otis, "Perceptions of Victimization Risk and Fear of Crime Among Lesbians and Gay Men," *Journal of Interpersonal Violence* 22, no. 2, (2007): 198-217; K. B. Wolff and C. L. Cokely, "To Protect and to Serve? An Exploration of Police Conduct in Relation to the Gay, Lesbian, Bisexual, and Transgender Community," *Sexuality & Culture* 11, no. 2, (2007): 1-23; C. Fox, "Texts of Our Institutional Lives: From Transaction to Transformation: (En)Countering White Heteronormativity in Safe Spaces," *College English* 69, no. 5, (2007): 496-511; and R. Klitzman "Patterns of Communication between Gay and Lesbian Patients and Their Health Care Providers," *Journal of Homosexuality* 42, (2002): 65-75.

18 Stalking Resource Center, "No Victim"; Bornstein et al., "Understanding Experiences"; and Herek, "Hate Crimes and Stigma-Related Experiences."

19 Gentlewarrior, "Culturally Competent Service."

20 D. R. Bornstein et al., "Understanding the Experiences of Lesbian, Bisexual and Trans Survivors of Domestic Violence: A Qualitative Study," *Journal of Homosexuality* 51, no.1, (2006): 159-81; P. N. S. Rumney, "Gay Male Rape Victims: Law Enforcement, Social Attitudes and Barriers to Recognition," *International Journal of Human Rights* 13, no. 2/3, (2009): 233-250; and M. R. Sable et al., "Barriers to Reporting Sexual Assault for Women and Men: Perspectives of College Students," *Journal of American College Health* 55, no. 3.

21 J. McClennen, "Intimate Partner Violence Between Same-Gender Partners: Recent Findings and Future Research," *Journal of Interpersonal Violence* 20, (2005): 149; K. L. Bune, "Law Enforcement Must Take Lead on Hate Crimes," *Police Chief Magazine* (2004), http://www.policechiefmagazine.org/magazine/index.cfm?fuseaction=display_arch&article_id=270&issue_id=42004; and N. J. Sokoloff and I. Dupont, "Domestic Violence at the Intersections of Race, Class, and Gender: Challenges and Contributions to Understanding Violence Against Marginalized Women in Diverse Communities," *Violence Against Women* 11, (2005): 38- 64.

22 J. L. Lauritsen and E. Archkova, "Advancing the Usefulness of Research for Victims of Crime," *Journal of Contemporary Criminal Justice* 24, no. 2, (2008): 92-98.

23 U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance, "A Policymaker's Guide to Hate Crimes," (Washington, DC: GPO, 1999), xii.

24 Federal Bureau of Investigation, "Hate Crime Statistics, 2007," (Washington, DC: GPO, 2008), http://www.fbi.gov/ucr/hc2007/index.html.

25 Federal Bureau of Investigation, "Hate Crime Statistics 2004," (Washington, DC: GPO, 2005), http://www.fbi.gov/ucr/hc2004/openpage.htm.

26 J. Devitt et al., "Improving the Quality and Accuracy of Bias Crime Statistics Nationally: An Assessment of the First Ten Years of Bias Crime Data Collection," (Boston, MA: Center for Criminal Justice Policy Research, Northern University, 2000).

27 Amnesty International, "Stonewalled," 80-87.

28 American Psychological Association, "Testimony Submitted to the U.S. Senate Committee on Health, Education, Labor and Pensions for the Hearing on ENDA, Employment Non-Discrimination Act (2002)," http://www.apa.org/ppo/issues/penda202.html; and Amnesty International, "Stonewalled."

29 Amnesty International, "Stonewalled."

30 American Psychological Association, "Testimony Submitted to the U.S. Senate Committee."

31 Turell and Hermann, "Family Support."

A REPORT FROM THE

NATIONAL COALITION OF ANTI-VIOLENCE PROGRAMS (NCAVP)

LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER AND HIV-AFFECTED

INTIMATE PARTNER VIOLENCE

2011

2012 RELEASE EDITION

This report was written by the
NATIONAL COALITION OF ANTI-VIOLENCE PROGRAMS
A program of the **NEW YORK CITY ANTI-VIOLENCE PROJECT**
240 West 35th St., Suite 200
New York, NY 10001
www.ncavp.org

DATA COLLECTION, ANALYSIS, AND WRITING:

Tasha Amezcua, New York City Anti-Violence Project
Shelby Chestnut, New York City Anti-Violence Project
Ejeris Dixon, New York City Anti-Violence Project
Chai Jindasurat, New York City Anti-Violence Project
Nahima Ahmed, Strength in Numbers Consulting Group
Somjen Frazer, Strength in Numbers Consulting Group
Jonathan Rodkin, Strength in Numbers Consulting Group

DATA & REPORT DESIGN

Joyce Choi Li, New York City Anti-Violence Project
Kate Florence Traub, New York City Anti-Violence Project

ADDITIONAL WRITING AND DATA COLLECTION:

Laura Barton, United 4 Safety
LaDawn Best, L.A. Gay & Lesbian Center
Mary Case, CCDVC, L.A. Gay & Lesbian Center
Kelly Clark, Gay Alliance of the Genesee Valley
Kelcie Cooke, LMSW, Violence Recovery Program, Fenway Community Health
Elijah Davis, United 4 Safety
Aaron Eckhardt, MSW, Buckeye Region Anti-Violence Organization
Amanda Escamilla, Violence Recovery Program, Fenway Community Health
Kim Fountain, PHD, SafeSpace at the R U 1 2? Community Center
Lisa Gilmore, LCPC, Center on Halsted Anti-Violence Project
Anne Gingerich, Victim Response Inc./The Lodge
Cindy Guertin, Center for Women and Families
Gary Heath, Buckeye Region Anti-Violence Organization
Susan Holt, MA, CCDVC, L.A. Gay & Lesbian Center
Sally Huffer, Montrose Counseling Center
Elke Kennedy, Sean's Last Wish
Sandhya Luther, Colorado Anti-Violence Program
Lindsey Moore, Kansas City Anti-Violence Project
Rick Musquiz, LCSW, Montrose Counseling Center
Jessica Newman, Violence Recovery Program, Fenway Community Health
Brenda Pitmon, SafeSpace at the R U 1 2? Community Center
Marie Romeo, New York City Anti-Violence Project
Catherine Shugrue dos Santos, New York City Anti-Violence Project
Kristi Smith, Wingspan
Stacy Umezu, Community United Against Violence
Tre'Andre Valentine, The Network/La Red
Nusrat Ventimiglia, Equality Michigan
Rebecca Waggoner, OutFront Minnesota

Copyright © 2012 New York City Gay & Lesbian Anti-Violence Project, Inc. All Rights Reserved.
This report was produced in part with the generous support of the Arcus Foundation.

TABLE OF CONTENTS

4 MISSION

5 PREFACE

7 EXECUTIVE SUMMARY

10 INTRODUCTION

10 DEFINITIONS USED IN THIS REPORT

13 METHODOLOGY

15 MAJOR FINDINGS

- 16 TOTAL REPORTS
- 17 IPV-RELATED HOMICIDES
- 18 TOTAL SURVIVOR AND VICTIM DEMOGRAPHICS
- 25 MOST IMPACTED IDENTITIES
- 29 INCIDENT DETAILS

44 DISCUSSION

51 RECOMMENDATIONS FOR POLICYMAKERS AND FUNDERS

56 CONCLUSION

57 APPENDIX

- 57 LOCAL ORGANIZATION SUMMARIES
  - 58 BUCKEYE REGION ANTI-VIOLENCE ORGANIZATION
  - 60 CENTER ON HALSTED ANTI-VIOLENCE PROJECT
  - 62 CENTER FOR WOMEN & FAMILIES
  - 64 COLORADO ANTI-VIOLENCE PROGRAM
  - 66 COMMUNITIES UNITED AGAINST VIOLENCE
  - 68 EQUALITY MICHIGAN
  - 70 FENWAY COMMUNITY HEALTH
  - 72 GAY ALLIANCE OF THE GENESEE VALLEY
  - 73 KANSAS CITY ANTI-VIOLENCE PROJECT
  - 74 THE LODGE/VICTIM RESPONSE, INC.
  - 76 LOS ANGELES GAY AND LESBIAN CENTER
  - 78 MONTROSE COUNSELING CENTER
  - 79 THE NETWORK/LA RED
  - 81 NEW YORK CITY ANTI-VIOLENCE PROJECT
  - 83 OUTFRONT MINNESOTA
  - 86 SAFESPACE AT THE R U 1 2? COMMUNITY CENTER
  - 87 SEAN'S LAST WISH
  - 89 WINGSPAN ANTI-VIOLENCE PROGRAMS
  - 91 UNITED4SAFETY
- 93 2011 HOMICIDE NARRATIVES
- 100 NCAVP MEMBER & AFFILIATE DIRECTORY

MISSION

The National Coalition of Anti-Violence Programs (NCAVP) works to prevent, respond to, and end all forms of violence against and within lesbian, gay, bisexual, transgender, queer, and HIV-affected (LGBTQH) communities. NCAVP is a national coalition of local member programs, affiliate organizations, and individuals who create systemic and social change. We strive to increase power, safety, and resources through data analysis, policy advocacy, education, and technical assistance.

PREFACE

In October of 1997, the National Coalition of Anti-Violence Programs released *Lesbian, Gay, Bisexual, Transgender Domestic Violence*, the first-ever national report on LGBT intimate partner violence in the United States. At that time, 21 states had enforceable sodomy laws, which made it illegal to engage in consensual same-gender sexual activity, 7 states explicitly did not recognize domestic violence between people of the same gender, and the Violence Against Women Act (VAWA) of 1994, the federal law which provided billions of dollars of funding to support life-saving responses to domestic violence, dating violence, sexual assault, and stalking, was still in its infancy and years away from supporting LGBTQH survivors of domestic violence. In the fifteen years since that first release of NCAVP's groundbreaking report, lesbian, gay, bisexual, transgender, queer, and HIV-affected (LGBTQH) survivors of intimate partner violence have gone from being virtually invisible and silenced in both the LGBTQH movement and the intimate partner violence movement, to being featured stories in national media outlets, and at the center of national political debates about domestic violence services for survivors.

For the past three years, NCAVP has been the premiere national LGBTQH organization working to ensure that an LGBTQ-inclusive VAWA is passed.[1] As a result of NCAVP's legislative advocacy for the reauthorization of an LGBTQ-inclusive VAWA, NCAVP witnessed a sea change in the national dialogue on LGBTQH intimate partner violence. In 2011, Congress extensively and publically debated the inclusion of LGBTQ protections within VAWA, citing NCAVP's data exhaustively, and resulting in a sharp increase in media reports and public conversations on LGBTQH intimate partner violence. Our data and tireless advocacy resulted in Senate Bill 1925, a VAWA reauthorization bill that is the first piece of federal legislation that includes non-discrimination provisions on the basis of sexual orientation and gender identity to successfully pass through the Senate. Unfortunately, NCAVP's work is not done. The House of Representatives refused to acknowledge the pervasive experiences of domestic violence, sexual assault, dating violence, and stalking within LGBTQ communities and on May 16, 2012, the House passed a bill without protections, not just for LGBTQ survivors, but also for immigrant survivors, Native American survivors, and survivors from communities of color. As of the writing of this report, Congress must still reconcile these two bills in conference, and NCAVP remains committed to doing all we can to ensure that these LGBTQ provisions exist within the final bill and to ensure that LGBTQH communities will never again be left out of national conversations on intimate partner violence.

NCAVP continued several projects in 2011 to increase safety for LGBTQ survivors of violence including our multi-year policy advocacy with the Department of Justice (DOJ) to enact LGBTQ-specific non-discrimination provisions for DOJ grantees and to increase comprehensive data collection about the experiences of LGBTQ survivors of violence. This advocacy resulted in significant dedicated funding from the DOJ's Office on Violence Against Women (OVW) and the Office for Victims of Crime (OVC) to support national LGBTQ training and technical assistance projects. In 2011, NCAVP launched our National LGBTQ Training and Technical Assistance Center funded by OVW, providing critical support and tools to non-LGBTQ victim service organizations across the country to meet the needs of LGBTQ survivors. That same year, OVC awarded NCAVP a national training and technical assistance demonstration initiative, which will measure the impact of targeted training and technical assistance to increase LGBTQ competency within non-LGBTQ anti-violence organizations.

[1] For legislative and advocacy purposes, NCAVP uses the LGBTQ acronym for legislation and policy within the Department of Justice.

NCAVP also continued to work to increase options for LGBTQH survivors who face barriers to accessing the criminal legal system. NCAVP's 2011 data shows that more than half of the survivors who reported to NCAVP members did not call the police due to historical and current barriers. NCAVP members in 2011 and 2012 continued a series of discussions and workshops on community accountability and transformative justice. As a result of this project, NCAVP's membership has increased our analysis on responding to violence outside of the criminal legal system and our members are exploring implementing these strategies within their own organizations. Continuing our work to challenge government-based violence and discrimination, in the fall of 2011, NCAVP joined over 60 LGBTQH organizations across the nation to demand an end to the unjust federal "Secure Communities" immigration program, which has a chilling and dangerous impact on LGBTQH immigrants. Under this program, local law enforcement must share with federal immigration authorities fingerprint data for every person arrested, no matter how minor the charge, increasing deportations for immigrant communities. This program creates an alarming effect on LGBTQH immigrant survivors who may be discouraged from reporting their experiences of violence to law enforcement and to community-based organizations.

To support our national anti-violence agenda, NCAVP continued our Southern Project, to build capacity by identifying and creating specific strategies for anti-violence work in the under-resourced Southeast[2], which faces unique conditions and barriers to responding to and preventing LGBTQH violence. NCAVP continues to focus on the conditions that LGBTQH communities experience within the Southeast, particularly best practices for LGBTQH anti-violence organizing in rural communities, supporting programs to address violence within LGBTQH Southern communities of color, addressing LGBTQH violence within conservative and religiously intolerant political climates, and conducting anti-violence work with limited staff or funding. As a result of this project NCAVP's 2011 report includes new data from North Carolina and South Carolina and NCAVP increased its Southern membership by five new member organizations a 50% increase since the 2010 Intimate Partner Violence report.

NCAVP's annual reports on LGBTQH intimate partner violence are still the only reports of their kind, and the most comprehensive data available on LGBTQH intimate partner violence in the United States. Through the support of the Arcus Foundation, NCAVP continues to refine our data collection and analysis. This year's report includes the first national person-level data on LGBTQH intimate partner violence ever released. This report is a testament to the critical work of our membership, and a call to our communities and policymakers to join our efforts to build the power and resources needed to end LGBTQH intimate partner violence, and to create just and equitable communities. We hope that the findings, recommendations, and best practices within this report compel all of you to action—to join the movement to end LGBTQH intimate partner violence.

NCAVP'S GOVERNANCE COMMITTEE

Aaron Eckhardt
Lisa Gilmore
Ashley Marshall
Crystal Middlestadt
Terra Slavin
Darlene Torres
Rebecca Waggoner

[2] This project focused on building capacity in Alabama, Arkansas, Florida, Georgia, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia.

EXECUTIVE SUMMARY

Despite reflecting a 22.2% drop in reports of LGBTQH intimate partner violence (IPV), NCAVP's 2011 report documents nineteen homicides--the highest number of LGBTQH IPV homicides ever recorded. This represents an increase of more than three times 2010's six LGBTQH IPV homicides. This dramatic increase in reported IPV homicides illustrates the severity and deadly impact of LGBTQH IPV. Also in the 2011 report, NCAVP analyzes person-level data for the first time. Person-level data allows NCAVP to assess which LGBTQH survivors faced disproportionate rates of violence and service discrimination as compared to overall LGBTQH survivors. Within 2011's IPV report, data indicates that gay men, LGBTQH communities of color, LGBTQH youth and young adults, and transgender communities experienced the most severe forms of IPV. These findings continue to highlight the importance of IPV prevention, strategic responses to IPV, and the need for research and accurate documentation of LGBTQH IPV.

KEY FINDINGS

TOTAL INCIDENTS

- In 2011, NCAVP programs received 3,930 reports of intimate partner violence, **a decrease of 22.2% from 2010** (5,052 reports).
- **This decrease in reports was mainly due to a substantial decrease (42.7%) in reports from the LA Gay & Lesbian Center (LAGLC)** (1,433 less reports), which lost funding and staff for their IPV programming, reducing the number of LGBTQH intimate partner violence survivors from whom they collected reports.
- Excluding LA's reports, there was an **18.3% increase in reports of LGBTQH IPV nationwide.**

HOMICIDES

- **IPV homicides increased in 2011.** NCAVP documented **19 IPV homicides in 2011, more than three times the six documented homicides in 2010 and the highest ever documented by NCAVP.**
- **A majority (63.2%) of IPV homicide victims were LGBTQH men**. Of the 19 victims, 12 identified as men, seven as women, two of whom identified as transgender. This is a large shift from 2010, when 66.7% of LGBTQH homicide victims were identified as women.
- **In 2011, 42.1% of homicide victims were identified as people of color and 36.8% of homicide victims were identified as white**.
- **The majority of homicide victims identified their sexual orientation as gay (57.9%) and lesbian (21.1%).**

SURVIVOR AND VICTIM DEMOGRAPHICS

Women accounted for about half (50.5%) of IPV survivors who reported to NCAVP member programs in 2011, **while men accounted for more than a third (41.1%).** These numbers remained fairly consistent with 2010 numbers.

- **The majority of overall IPV survivors identified** their sexual orientations **as either gay (38.7%) or lesbian (31.3%)**. These numbers also remained fairly consistent with 2010 numbers.
- **More than a third of survivors were between the ages of 19 to 29 (38.5%),** remaining relatively close to 2010 (39.4%).
- **Survivors 60 and older only accounted for 5.1% of total survivors**, a slight increase from 2010 (3.36%).

- **People of color make up the majority of total survivors (66.8%),** which is a substantial increase from 2010 (58.3%).[3]
- **White survivors account for more than a third (40.8%) of total survivors,** which is a slight increase from 2010 (37.4%).

MOST IMPACTED IDENTITIES

LGBTQH youth and young adults, gay people, and LGBTQH men were more likely to experience injuries as a result of IPV. LGBTQH people under 30 were approaching two times (1.78) as likely to be injured as a result of IPV, gay identified people were more than two times (2.19) as likely to experience injuries, and LGBTQH men were about two times (2.04) as likely to experience injuries as compared to people who did not identify in these ways.

- **Transgender survivors and queer survivors were more likely to experience sexual violence within IPV.** Transgender survivors were almost two times as likely (1.81) and queer survivors were almost three times as likely (2.78) to experience sexual violence as compared to people who did not identify as transgender and queer.
- **LGBTQH youth and young adults, LGBTQH people of color, and LGBTQH youth and young adults of color were more likely to experience physical violence.** LGBTQH people under 30 were approaching two times (1.59) as likely to experience physical violence, LGBTQH people of color were approaching two times (1.77) as likely to experience physical violence, and LGBTQH people of color and under 30 were almost four times (3.98) times as likely to experience physical violence as compared to people who did not identify in these ways.
- **Bisexual survivors were more likely to experience verbal harassment from abusive partners.** Bisexual survivors were almost two times as likely (1.81) to experience verbal harassment as the overall sample.

INCIDENT DETAILS

- **Relatively similar amounts of survivors experienced IPV from current lovers and partners as compared to ex-lovers and partners. 35% of survivors indicated they experienced IPV with a lover or partner,** while 33.6% of survivors experienced IPV with ex-lovers and partners.
- **Fewer survivors in 2011 (23%) experienced physical violence from their abusive partners,** a substantial decrease from 2010 (46.5%). Physical violence remains the most reported type of LGBTQH IPV reported to NCAVP.
- **Largest proportions of abusive partners were reported to be gay, white, men, and young adults.** 35.5% of abusive partners identified as gay. 51.9% of abusive partners were reported to be white. 59.2% of abusive partners were reported to be men. 29.1% of abusive partners were reported to be between the ages of 19 – 29.
- **More survivors in 2011 (61.6%) were denied access to shelter than in 2010 (44.6%).**
- **More survivors called the police.** In 2011 45.7% of survivors called the police for support, a substantial increase from 2010 where 28.0% of survivors called the police.
- **The majority of survivors who sought orders of protection (78.1%) received them,** a slight decrease from 2010 (83.7%).

[3] Race is a category where people can select multiple identities leading the total percentage to be greater than 100%. This is why both white and people of color can increase for this year.

RECOMMENDATIONS IN BRIEF

- Congress should pass **an LGBTQ-inclusive Violence Against Women Act (VAWA)** to improve access to services for LGBTQ survivors of intimate partner violence, dating violence, sexual assault, and stalking.
- Policymakers and funders should **increase local, state, and national funding** to LGBTQH-specific anti-violence programs, particularly for survivor-led initiatives.
- Policymakers should support and fund **LGBTQH training and technical assistance programs** to increase the cultural competency of all victim service providers to effectively work with LGBTQH survivors.
- Policymakers and funders should fund **LGBTQH anti-violence organizations to conduct intimate partner violence prevention initiatives,** particularly prevention programs for youth and young adults.
- Policymakers and funders should support programs and campaigns **to prevent and increase public awareness** of LGBTQH intimate partner violence.
- Policymakers should ensure that **the federal government collects information on sexual orientation and gender identity,** whenever demographic data is requested in studies, surveys, and research including IPV.

INTRODUCTION

Intimate partner violence (IPV) is a devastating and deadly problem facing lesbian, gay, bisexual, transgender, queer, and HIV-affected (LGBTQH) communities**.** Violence within intimate relationships, known as domestic violence, intimate partner violence, dating violence, and/or partner abuse, has been documented as a national and international epidemic. While the definitions vary, within this report NCAVP defines IPV as an inclusive term that means: "a pattern of behavior where one intimate partner coerces, dominates, or isolates another intimate partner to maintain power and control over the partner and the relationship." Abusive partners may use a myriad of tactics and strategies to exert and maintain control over their partners, including: physical abuse, verbal abuse, sexual abuse, psychological/emotional abuse, economic abuse, isolation, and intimidation. IPV can occur in short or long-term relationships, with current or past partners, and affects all communities.

Research and literature on IPV began in earnest in the 1970's and 1980's with the emergence of the battered women's movement.[4] This movement was closely associated with the feminist movement of the 1970's, and focused on ending structural and cultural sexism that encouraged and allowed men to abuse their masculine privilege by battering the women and children in their lives. This movement successfully created some of the first resources to support IPV survivors, including the first domestic violence shelters in the country, to offer safe haven to survivors and their children. By valuing the experiences of survivors, the early organizers of this movement, many of them survivors themselves, identified power and control as the central dynamic in an abusive relationship. Power and control is a dynamic in which an abusive partner uses their power and privilege in society to control their partner in a relationship. This understanding of power and control became the bedrock of the modern understanding of what violence within relationships looks like. Because the battered women's movement was focused on sexism, patriarchy, and the abuse of male power and privilege in the context of heterosexual relationships between non-transgender people, our historical understanding of domestic violence largely excluded LGBTQH communities. Until the late 1980's, however, there was virtually no research or literature on IPV within the context of LGBTQH communities,[5] and even

Definitions In This Report

Intimate Partner Violence (IPV): a pattern of behavior where one intimate partner coerces, dominates, or isolates another intimate partner to maintain power and control over the partner and the relationship.

Gender Identity: A term that describes how a person identifies their gender. A person's gender identity may be different than social norms and/or sterotypes of the sex they were assigned at birth. There are a wide range of gender identities and expressions, including identifying as a man, woman, neither, and identifying as gender non-conforming.

Sexual Orientation: A term that describes a person's physical or emotional attraction to people of a specific gender or multiple genders. It is the culturally defined set of meanings through which people describe their sexual attractions. Sexual orientation is not static and can change over time.

Lesbian: A term that describes a person who identifies as a woman who is primarily or exclusively attracted to other people who identify as women.

Gay: A term that describes a person who identifies as a man who is primarily or exclusively attracted to other people who identify as men. It is also sometimes used as an umbrella term to describe LGBTQ communities.

Transgender: An umbrella term used to describe a group of individuals whose gender identity and how it is expressed, to varying degrees, are different than the sex assigned at birth. Transgender identity relates to a person's gender identity.

(Continued on next page)

[4] Martin, D. (1976). *Battered Wives*. San Francisco, CA: Glide Publications

[5] Kelly, E. E. & Warshafsky, L. (1987). *Partner abuse in gay male and lesbian couples.* Paper presented at the Third National Conference for Family Violence Researchers, Durham, NH; Island, D. & Letellier, P. (1991). *Men who beat the men who love them.* New York, NY: Harrington.; Richards, A., Noret, N. & Rivers, I. (2003). *Violence &abuse in same-sex relationships: A review of the literature*. In Social Inclusion & Diversity Paper No. 5, Research into Practice

now, in the majority of research on IPV, LGBTQH survivors are often invisible. Scholars often assume that bisexual and lesbian women are heterosexual, exclude transgender people from their analysis, or only offer binary gender identity categories (i.e. only men or women), which do not accurately capture the variety of gender identities within LGBTQH communities.

NCAVP's 2011 Intimate Partner Violence report contains the most comprehensive data available on IPV in LGBTQH communities in the United States to date, including detailed demographic data on survivors and victims of violence, information on abusive partners, and data on police, medical, and other direct service responses to LGBTQH survivors. NCAVP documents the impact of IPV within LGBTQH communities as a part of our continuing effort to prevent and end this violence. Federal data on LGBTQH communities in the United States is extremely limited, making it challenging for NCAVP to compare its data on LGBTQH survivors to overall LGBTQH communities. For example, the 2010 U.S. Census did not ask the sexual orientation or gender identity of its respondents. The 2010 Census did include for the first time the option for both same-sex partners and spouses to identify themselves as unmarried partners, or as husbands or wives. These new options for LGBTQH people within census reporting will allow for some documentation of same-sex relationships within federal data. However, the American Community Survey, one of the main data collection surveys for the federal government, continues to contain no questions on sexual orientation or gender identity. The National Crime Victimization Survey, the federal survey on violence in the United States, tracks minimal data on same-sex IPV, but this data is not specifically separated from its dataset and is not tracked annually, which substantially limits what this data can tell us about LGBTQH IPV.

Current research regarding the prevalence of intimate partner violence within LGBTQH communities in the United States does exist, but is limited. The UCLA Center for Health and Policy Research conducted a relatively large study in 2010, which shows that bisexual adults (40.6%) and gay or lesbian adults (27.9%) are almost twice as likely to experience intimate partner violence as heterosexual adults (16.7%). The study concludes that "high rates of IPV among sexual minorities . . . warrants further attention and exploration so that preventative measures may be undertaken." [6] Research also indicates that the risk for IPV and sexual violence are much higher for transgender people.[7] Transgender survivors also face pervasive institutionalized discrimination when seeking support from health care agencies, law

Definitions In This Report (continued)

Queer: A political and sometimes controversial term that some LGBT people have reclaimed. Used frequently by younger LGBTQ people, activists, and academics, the term is broadly inclusive, and can refer either to gender identity, sexual orientation or both. It is also sometimes used as an umbrella term to describe LGBTQ communities.

HIV- Affected: A term that describes HIV- positive people, people living with AIDS, and includes partners, friends, lovers, family members, and the community of people who are impacted by HIV/AIDS.

Gender Non-Conforming: A term that describes a person whose gender expression is different from the societal expectations based on their assigned sex at birth. This term can refer to a person's gender identity or gender role and refers to someone who falls outside or transcends what is considered to be traditional gender norms for their assigned sex.

Heteronormative: A viewpoint that expresses heterosexuality as a given instead of being one of many possibilities for a person's sexual orientation. Heteronormativity is often expressed subtly where heterosexuality is "accepted" as the default sexuality.

[6] Zahnd E.G., Grant, D., Aydin, M., Chia, Y.J. & Padilla-Frausto, D.I. (2010). Op. cit.
[7] Stotzer, Rebecca. (2009). *Violence against transgender people: A review of United States data*. Aggression and Violent Behavior, 14, 170-179.

enforcement, and domestic violence shelters. This discrimination is much higher for transgender survivors of color.[8] Survivors who identify as men are also far less likely to be able to access services, particularly domestic violence shelters, due to the heteronormative beliefs that many shelter providers hold, which understand IPV exclusively as non-transgender men abusing non-transgender women, erasing and ignoring the experiences of LGBTQH IPV survivors.[9]

Without comprehensive data about LGBTQH communities, policymakers, advocates, direct service providers, and organizers have less information about the dynamics of LGBTQH IPV and are less able to create programs that prevent violence and increase support for LGBTQH communities. Without national data on the prevalence and occurrence of LGBTQH IPV, service providers have less information with which to create LGBTQH-inclusive services, LGBTQH–specific violence prevention programs, and to use to accurately evaluate programs geared towards serving LGBTQH survivors.

Recognizing the unique and critical role that NCAVP's IPV report serves, NCAVP strives to ensure that this report is accessible to multiple audiences, reflects the current lived experiences of LGBTQH communities, and provides practical tools to assist anti-violence programs and policymakers working to end LGBTQH intimate partner violence. In this year's report, NCAVP included person-level data for the first time. Person-level data is analyzed at the individual level, allowing NCAVP to identify which communities are disproportionately impacted by IPV, and which LGBTQH survivors face the highest barriers to accessing support. This report also includes two new sections to assist readers in their efforts to address LGBTQH IPV: a *Discussion* section that compares our data with current research on LGBTQH IPV; and a *Best Practices* section that give anti-violence programs specific recommendations to tailor their programming to best support LGBTQH survivors.

As the nation begins to pay closer attention to IPV within LGBTQH communities, NCAVP will continue to support survivors and document their experiences. The 2011 report highlights trends grounded in contemporary research to give policymakers, LGBTQH communities, and anti-violence practitioners a wide-ranging view of the current dynamics within LGBTQH intimate partner violence. This report examines the intersections between LGBTQH IPV and various forms of oppression that affect LGBTQH communities, such as homophobia, biphobia**,** transphobia, racism, ableism, ageism, sexism, classism, anti-immigrant bias, anti-HIV bias, and many others. These forms of oppression can create barriers which can limit LGBTQH survivors' access to necessities such as safety planning, crisis intervention, supportive counseling, health care, law enforcement support, legal remedies, and shelter. This report is a vehicle to amplify the voices of LGBTQH survivors nationally and to examine strategies that will create safety within the LGBTQH communities and relationships.

[8] Grant, J., Mottet, L, and Tanis, J. (2011). *Injustice at every turn: A report of the national transgender discrimination survey.* Retrieved September 27th, 2012, from http://www.transequality.org/PDFs/NTDS_Report.pdf.

[9] National Center for Victims of Crime & the National Coalition of Anti-Violence Programs (2010). *Why It Matters: Rethinking Victim Assistance for LGBTQ Victims of Hate Violence and Intimate Partner Violence.* Washington, D.C. & New York. Retrieved Sepetmber, 20th, 2012,from http://www.avp.org/documents/WhyItMatters.pdf

METHODOLOGY

HOW ORGANIZATIONS COLLECTED THE DATA

This report contains data collected in 2011 by 19 NCAVP member and affiliate programs in 23 states.[10] Organizations collected this information from survivors and public sources. Survivors contacted LGBTQH anti-violence programs, either in person, by calling a hotline, filing out surveys, or making a report online. Most NCAVP member programs used NCAVP's Uniform Incident Reporting Form, revised in 2010, to document the violence that occurred to these individuals, while others have adapted and incorporated the form into other data collection systems. NCAVP then collected aggregate and person-level data from local organizations. Person-level data allowed NCAVP to anonymously analyze multiple facts about one victim or survivor. This allowed us to identify themes in intimate partner violence such as, whether or not types of violence varied across LGBTQH survivors' identities (i.e. "do women experience more physical violence?"). It also allowed NCAVP to examine survivors with multiple intersecting identities, such as gay youth, and the types of violence and/or law enforcement response that they received (i.e. "do gay youth report more to the police?").

HOW NCAVP COMPILED AND ANALYZED THE DATA

With support from the Arcus Foundation, NCAVP worked with the Strength in Numbers Consulting Group to provide each member program tailored support to submit data in ways that met their program's needs, yet provided consistency across all organizations. NCAVP local member organizations then submitted their local data to NCAVP and NCAVP aggregated the data and analyzed the differences between 2010's and 2011's data sets. In this report, NCAVP compares data proportionally for each variable between 2010 and 2011 when possible, allowing NCAVP to accurately assess increases or decreases in IPV, demographic changes for survivors, and changes in incident details over time. For the person-level data, NCAVP consultants coded 117 variables on 1,611 survivors. NCAVP selected statistics for publication based upon their relevance, statistical significance ($p<0.05$), and reliability. Additional data not included in the report may be available upon request by contacting NCAVP. In order to protect survivor confidentiality, not all information will be available to the public.

LIMITATIONS OF THE FINDINGS

This report is based upon information largely from LGBTQH-identified individuals who experienced IPV and who sought support from NCAVP member programs. Since NCAVP only measures data collected from individuals who self-reported and from other public sources, these numbers do not represent all incidents of LGBTQH IPV in the United States in 2011. NCAVP's data may particularly omit populations such as incarcerated people, people in rural communities, people who may not know about their local AVP, people who are not out, people who are not comfortable with reporting, and people who face other barriers to accessing services or reporting. Therefore, while the information contained in this report provides a detailed picture of the individual survivors who reported to NCAVP member programs, it cannot and should not be extrapolated to represent the overall LGBTQH population in the United States. NCAVP works to address this issue by constantly researching new data sources to expand and increase data for this report.

NCAVP members' capacity for data collection also varied based upon the programs' resources, staffing, available technology, and other factors. These considerations resulted in some programs submitting partial information in some

[10] Some member programs collected data from multiple states either through direct reports and / or through media sources.

categories creating incomplete and dissimilar amounts of data for different variables within 2011's data set. NCAVP continues to work with Strength in Numbers Consulting Group to ensure the highest level of data consistency possible within the resources available for NCAVP and its member programs. As with many reports, data inconsistency can also affect the data's accuracy. Individuals who completed the incident forms may have had different definitions and protocols for the same categories. These variations can exist between staff at the same program or staff at different organizations.

In addition, certain NCAVP members have more capacity to collect data, conduct outreach, and educate and inform LGBTQH survivors of their services, thereby increasing reporting. In particular, the Los Angeles Gay & Lesbian Center's data accounted for 48.8% of total survivors reporting to NCAVP, a decrease from 2010 (66.2%) resulting from a loss a staff due to funding cuts. LAGLC's data and the decrease that they experienced played a substantial role in all the major trends we see in this report. NCAVP is working to increase the capacity for all member programs throughout the United States to increase reporting.

Based on recommendations from NCAVP's consultants, NCAVP reorganized some sections of the 2011 report, particularly the variables on immigration, gender identity, race, and ability. Though this made comparing data between 2010 and 2011 challenging, it also allowed NCAVP to more accurately track, report, and analyze this data. When comparable data is not available, NCAVP documents this in the report. NCAVP also reorganized the data detailing the types of violence that LGBTQH IPV survivors experienced, in order to streamline these data categories. NCAVP increased the variables where survivors can report multiple identities within one variable. For example, within the gender identity category the 2011 report allows LGBTQH survivors to identity as both a women and as transgender. These adjustments may result in the totals for these sections that are larger than the total survivors within the report. NCAVP identifies where this occurs throughout the report. NCAVP also changed the gender identity category to use terms more inclusive of contemporary language on gender identity. NCAVP additionally changed how it reports on data within its variables in the 2010 report in order to promote best practices in data collection and reporting. As opposed to showing the percent of undisclosed (unknown) responses per variable, NCAVP now lists the *n* to indicate the total number of responses per category. In order to accurately compare data categories across years, NCAVP recalculated the data from 2010 removing the undisclosed amounts from 2010 when comparing 2011 data to 2010 data. This results in a more accurate depiction of LGBTQH IPV but also results in percentages that may not match 2010's report. NCAVP's efforts to improve and increase data collection among member programs and affiliates remain an ongoing process. Despite these limitations, this report contains the most detailed and comprehensive dataset to date on LGBTQH intimate partner violence nationally.

MAJOR FINDINGS

NCAVP's 2011 findings are based on analyzing aggregate and person-level data from reporting members. The findings include information on survivor demographics, incident details, most impacted identities, information about abusive partners, data on access to services for LGBTQH IPV survivors, and information on police response for LGBTQH IPV. This data can help us identify key gaps in survivor's access to support and trends in LGBTQH survivor demographics over time.

MAJOR FINDINGS CONTAINTED IN THIS SECTION

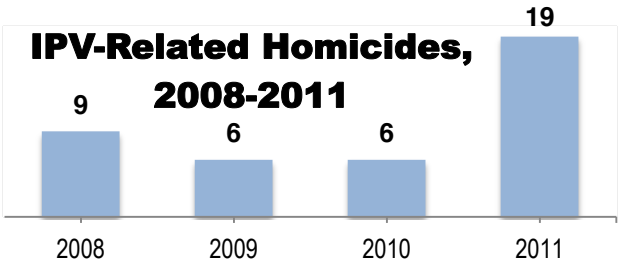
- **Overall IPV Incidents:** NCAVP member organizations received 3,930 reports of IPV in 2011, a 22.2% decrease from 2010 (5,052).
- **IPV Homicides:** NCAVP documented 19 homicide victims, more than three times the amount of homicides in 2010 (6 homicide victims), and the highest number of homicides ever recorded by NCAVP. Of the homicide victims, 63.2% identified as men (12 of 19 in 2011), and 36.8% identified as women (7 of 19, 2 of whom were transgender women).
- **IPV Overall Survivor and Victim Demographics:** Gay (38.7%) and lesbian (31.3%) survivors were the most represented sexual orientations reported among total survivors. Reports from lesbian survivors decreased slightly from 2010 (34.8%). White survivors represent 40.8% of total IPV survivors, which is an increase from 2010 (37.4%). Latina/o survivors represent the second largest amount of survivors (36.6%), an increase from 2010 (31.8%).
- **Most Impacted Identities:** People of color were more likely to report experiencing threats/intimidation and verbal harassment. Bisexual and transgender survivors were more likely to report experiencing verbal harassment, threats, and intimidation as a form of IPV. People of color under 30 were more likely to experience injuries, physical violence, and threats and intimidation. Youth and young adults were more likely to be injured and to experience physical violence.
- **Trends in LGBTQH IPV Tactics:** Less than a third (23.0%) of survivors experienced physical violence, a large decrease from 2010 (46.5%).
- **Characteristics of Abusive Partners:**[11] 35.5% of abusive partners were reported by survivors to be gay, while 27.2% of abusive partners were reported to be heterosexual, and 26.8% were reported to be lesbian.
- **Orders of Protection:** 78.1% of LGBTQH IPV survivors who sought orders of protection received them, a decrease from 2010 (83.7%).
- **Access to Shelter:** 61.6% of survivors who sought shelter were denied, as compared to 44.6% in 2010.
- **Police Response:** Police arrested survivors or both individuals in 28.4% of incidents involving the police, a slight increase from 2010 (21.9%).

[11] This information was not reported in 2010.

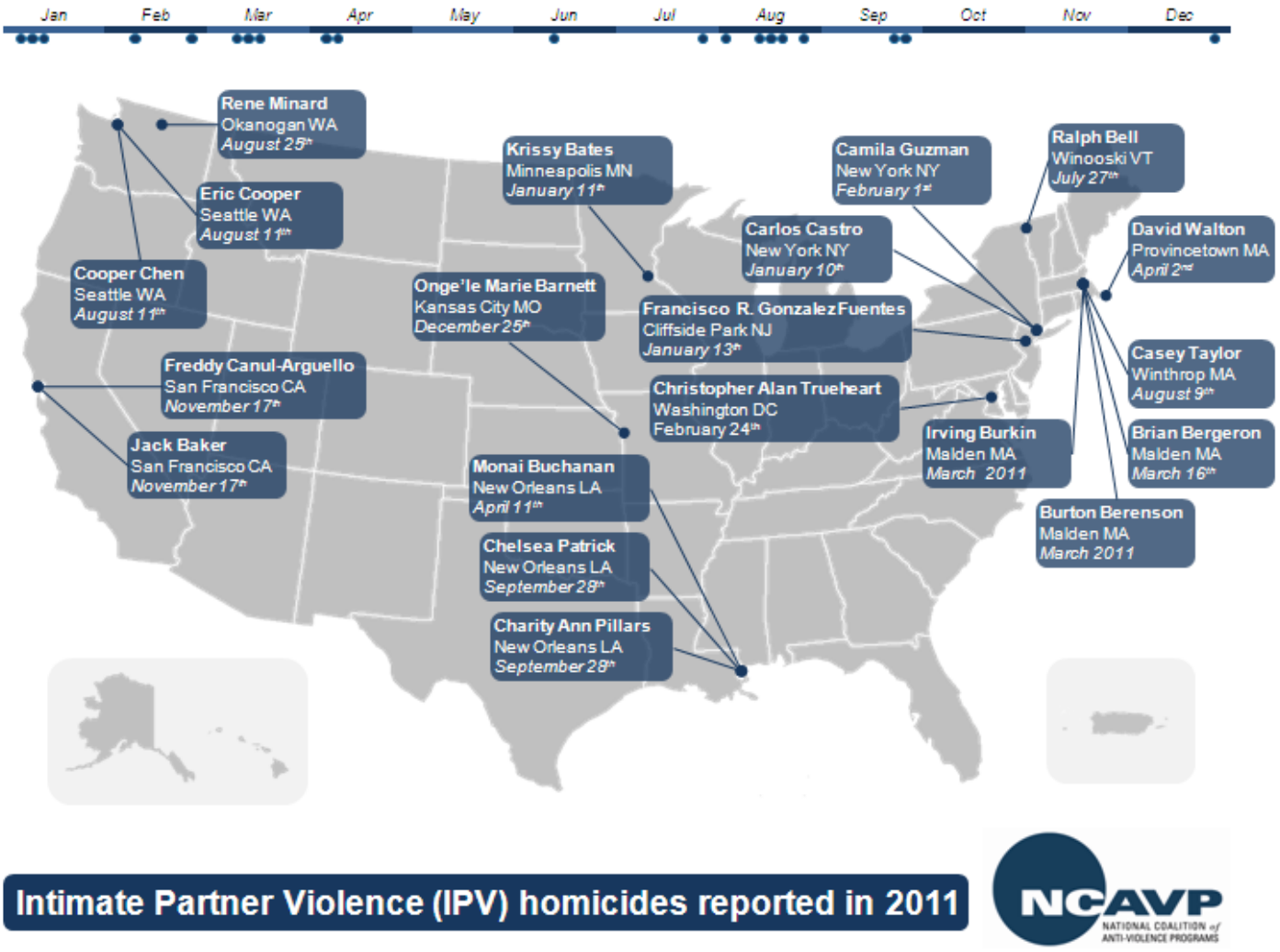
TOTAL REPORTS

In 2011, NCAVP programs received 3,930 reports of intimate partner violence, a decrease of 22.2% from 2010. This decrease was due to a substantial 42.7% decrease in reports from the Los Angeles Gay & Lesbian Center (LAGLC), which lost funding and staff for their IPV programming, reducing the number of LGBTQH intimate partner violence survivors from whom they collected reports. Excluding LAGLC's reports, there was an 18.3% increase in reports of LGBTQH IPV nationwide. This year's number of reports returns to levels similar to 2009 (3,658). Presently, NCAVP cannot fully separate the degree that this decrease in reports reflects decreased capacity to collect data within NCAVP's member programs or an actual decrease in violence.

IPV-RELATED HOMICIDES



In 2011, NCAVP recorded a large increase in IPV-related homicides[12], from six in 2009 and 2010 to 19 in 2011. Twelve of the nineteen victims identified as men (63.2%), while seven identified as women (36.8%) two of whom identified as transgender women (10.5%). This is a large shift from 2010, when the majority of homicide victims identified as women (66.7% or four of the six victims). In terms of sexual orientation, in 2011, 57.9% of homicide victims identified as gay, 21.1% as lesbian, and 21.1% of homicide victims had unknown sexual orientations. The majority of the homicides occurred in the Northeast with: three homicides in Massachusetts, two in New York, one in New Jersey, one in Rhode Island, one in Vermont, and one in Washington, DC. A substantial number of homicides occurred in the West, with three in Washington and two in California. Three homicides occurred in the South, all in Louisiana. The remaining homicides occurred in the Midwest, with one in Minnesota and one in Missouri.

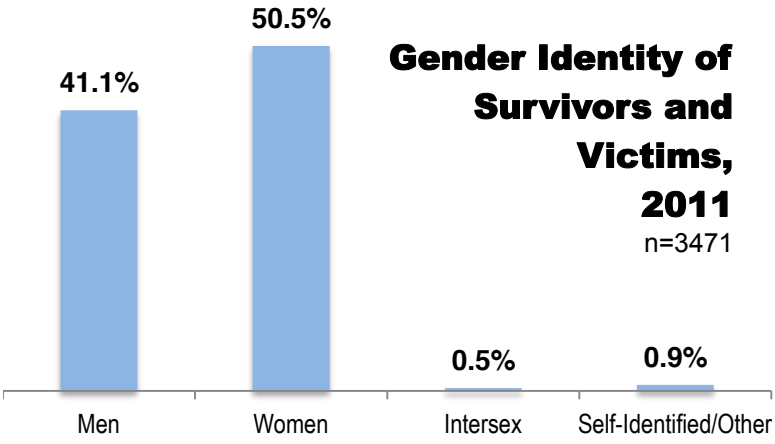


[12] Detailed information on each homicide is in the appendix.

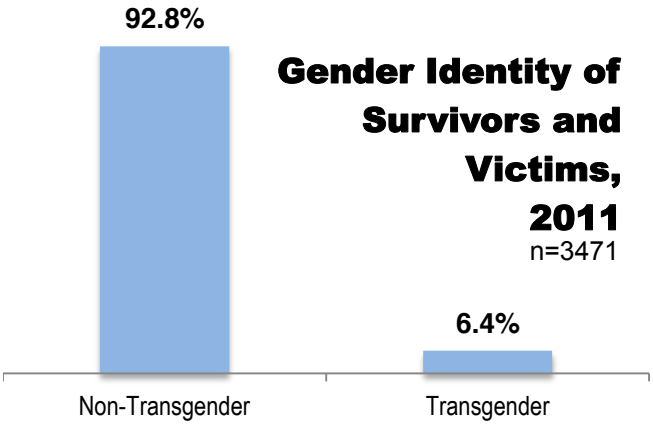
TOTAL SURVIVOR AND VICTIM DEMOGRAPHICS

The data in the following section describes the many identities of LGBTQH IPV survivors in 2011. LGBTQH people often have several intersecting marginalized identities, such as their racial identity, gender identity, socio-economic status, immigration status, and disability status. In this section NCAVP examines the identities of LGBTQH survivors who sought assistance from NCAVP programs, thus allowing NCAVP to better understand the diversity of LGBTQH IPV survivors in 2011.

GENDER IDENTITY



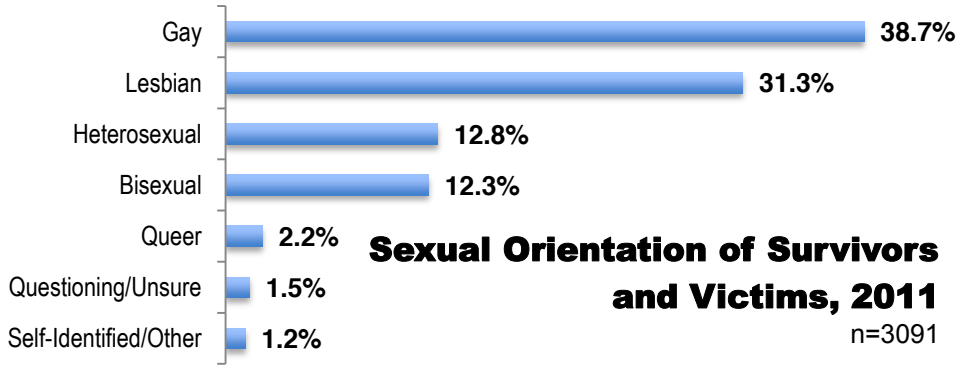
LGBTQH women IPV survivors accounted for nearly half (50.5%) of those who reported their gender identity[13] to NCAVP in 2011, with men IPV survivors accounting for more than one third (41.1%). Both of these remained relatively similar to 2010's reports, with women survivors representing 51.3% of total reports and men representing 41.3% of total reports. Intersex (0.5%) and self-identified/other (0.9%) survivors combined make up less than 2% of survivors who reported their gender identity to NCAVP members, remaining consistent with 2010 (0.6% intersex survivors and 1.9% self-identified survivors). Survivors who did not disclose their gender identity also remained consistent with 11% in 2010 to 11.7% in 2011.



The overwhelming majority of IPV survivors did not identify as transgender. Transgender survivors comprised 6.0% of total survivors. Among transgender survivors, 66.4% of transgender survivors also identified as women, 15.5% identified as men, and 22.1% identified solely as transgender. The proportion of transgender survivors (6.0%) increased slightly from 4.7% in 2010.

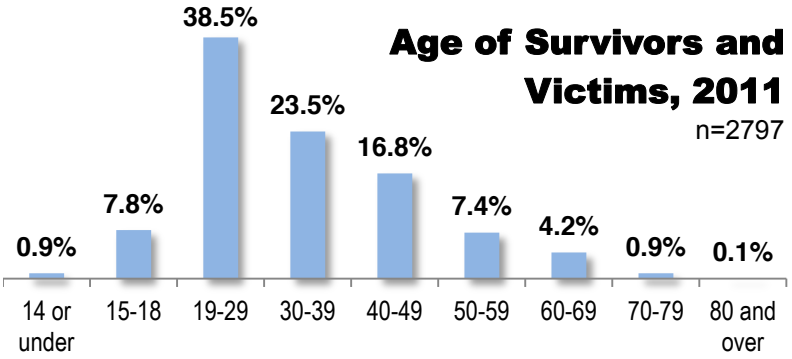
[13] Survivors can select multiple gender identities on NCAVP's reporting form.

SEXUAL ORIENTATION



Gay (38.7%) and lesbian (31.3%) survivors accounted for the majority of survivors who reported sexual orientation information to NCAVP in 2011. Bisexual survivors accounted for 12.3% of total reports, heterosexual survivors[14] accounted for 12.8% of total reports, and 21.4% of survivors did not disclose their sexual orientation. Questioning (1.5%), queer (2.2%), and self-identified (1.2%) survivors comprised less than 5% of the total reports. Lesbian survivors decreased slightly from 2010 (34.8%) to 2011 (31.3%), while gay (38.7%) survivors remained consistent with 2010 (38.6%). Bisexual survivors remained consistent from 2010 (11.4%) to 2011 (12.3%), as did self-identified survivors, from 2010 (1.5%) to 2011 (1.2%), while heterosexual survivors increased slightly from 9.9% in 2010 to 12.8% in 2011. 21% of survivors did not disclose their sexual orientation, a slight increase from 2010 (18.4%).

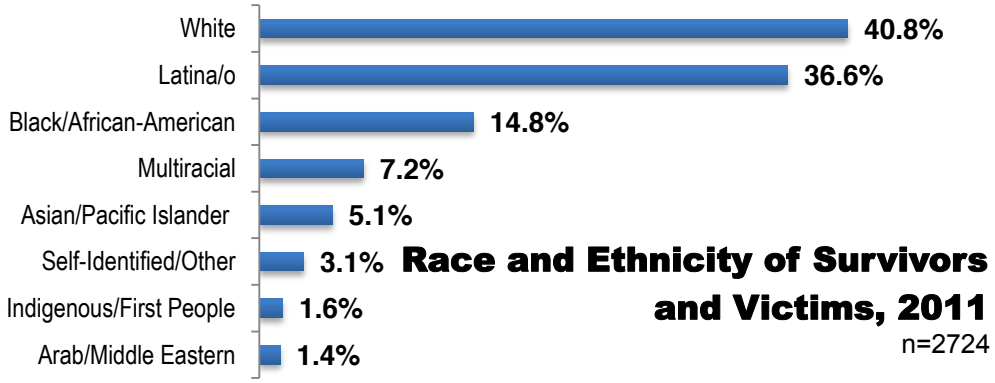
AGE



Over one-third of survivors reporting their age to NCAVP were between 19 – 29 (38.5%). Survivors between 30-39 accounted for almost a quarter (23.5%), survivors between 40 – 49 represented 16.8% of total reports. Survivors between 50 – 59 (7.4%), 60 – 69 (4.2%), and 15 – 18 (7.8%) each accounted for less than one tenth of the total reports each. Survivors from 70 – 79, 14 and under, and 80 and over accounted for a combined 1.8% of total survivors. 28.8% of survivors did not disclose their age, an increase from 2010 (15.5%).

[14] NCAVP's heterosexual survivors may also identify as transgender or HIV-affected. These may also represent survivors who are not LGBTQ but feel more comfortable reporting IPV to NCAVP.

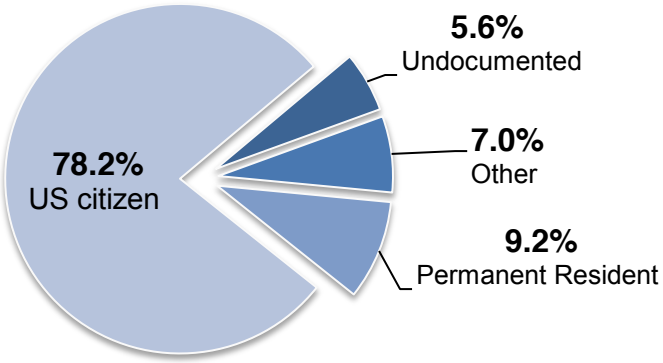
RACE/ETHNICITY



People of color made up more than half (66.8%) of survivors who disclosed their race to NCAVP, a substantial increase from 2010 (58.3%). Latina/o[15] identified survivors accounted for 36.6% of survivors who reported their race/ethnicity, an increase from 2010 (31.8%). Black/African American survivors made up 14.8% of survivors which is relatively consistent with 2010 (14.8%) and multi-racial survivors accounted for 7.2% of total survivors which is also relatively consistent with 2010 (6% of survivors). Asian/Pacific Islander survivors made up 5.1% of survivors and self-identified survivors accounted for 3.1%, both of these survivors remained relatively consistent with 2010 (5.3% Asian survivors, 4.3% self-identified survivors). Arab/Middle-Eastern (1.4%) and Indigenous/First People (1.6%) survivors comprised about 3% of the total data, relatively consistent with 2010 when these survivors collectively comprised 2% of the data. White survivors accounted for 40.8% of survivors, which is a slight increase from 2010 (37.4%). Survivors who did not disclose their race increased from 21.0% in 2010 to 30.7% in 2011.

[15] NCAVP recognizes that many Latin@ communities use Latin@ as a gender inclusive, non-gender binary term. In order to make this report as readable and accessible as possible we use the term Latina/o throughout the report. As its usage grows NCAVP will strives to use Latin@ in future reports.

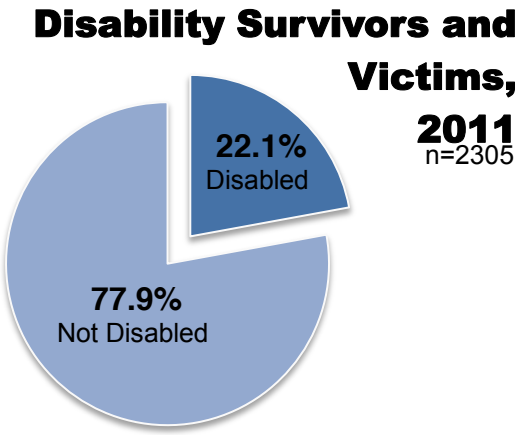
IMMIGRATION STATUS



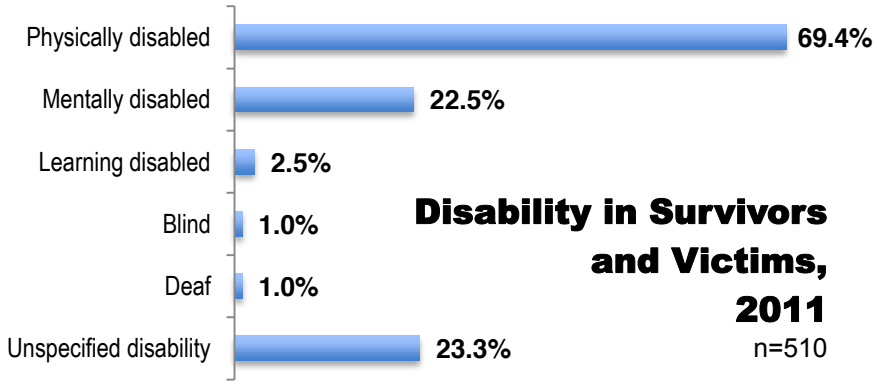
Immigration Status of Survivors and Victims, 2011
n=1958

In 2011, 78.2% of survivors who reported their immigration status to NCAVP identified as citizens. This is a slight decrease from 2010 (80.2%). Permanent residents accounted for 9.2% of survivors, and survivors who identified their immigration status in other ways represented 7.1% of total reports. Undocumented survivors represented 5.6% of survivors, a slight increase from 2010 (3.1%). Survivors who identified as citizens decreased slightly from 80.2% in 2010 to 78.2% in 2011. Half (50.2%) of total survivors did not disclose their immigration status, which increased from 45.2% in 2010 to 50.2% in 2011.

DISABILITY STATUS



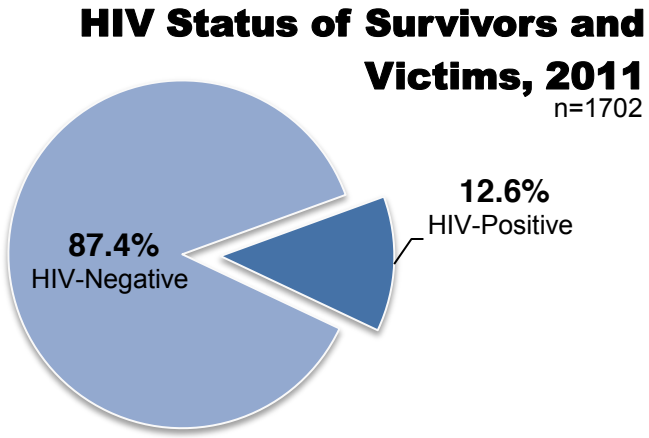
In 2011, 41.4% of all survivors did not disclose information about disabilities an increase from 30.8% in 2010. Of the 58.7% of survivors who did disclose this information, 22.1% reported having a disability while 77.9% reported they did not have disabilities. From 2010 to 2011, the number of survivors with disabilities increased from 13.6% in 2010 to 22.1% in 2011. Survivors without disabilities decreased, from 86.4% in 2010 to 77.9% in 2011. Survivors who did not disclose disabilities increased from 30.8% in 2010 to 41.4% in 2011. The increase in IPV survivors reporting to NCAVP is unlikely to represent an increase in IPV among this population. Instead it represents an increase in access to services for IPV survivors with disabilities.



Among survivors who disclosed disabilities to NCAVP in 2011, the majority of survivors (69.4%) reported physical disabilities.[16] This could be in part because obtaining information on survivor's physical disabilities is more routine for member organizations who must comply with the Americans with Disabilities Act (ADA) regulations. Survivors who reported unspecified disabilities represented 23.3% of survivors with disabilities, and survivors with mental disabilities represented 22.5% of those with disabilities. Survivors who were blind, deaf, or had learning disabilities represented a combined amount of 4.5% of IPV survivors with disabilities.

[16] Data on the specific disabilities that LGBTQH IPV survivors reported was not collected in 2010 so comparisons are not available.

HIV STATUS



The majority (56.7%) of IPV survivors did not disclose their HIV status in 2011, as compared to 93.6% in 2010. Of those who did disclose, 12.6% reported they were HIV-positive a decrease from 2010 where 40.8% reported that they were HIV-positive and 87.4% reported they were HIV-negative an increase from 2010 when 59.2% disclosed that they were HIV-negative. The large decrease between 2010 and 2011's proportion of HIV-positive IPV survivors most likely represents NCAVP's improved accuracy with tracking IPV survivor's HIV-status not a decrease in seeing HIV-positive survivors. NCAVP members are collecting this information more frequently in 2011 improving the accuracy of the data.

MOST IMPACTED IDENTITIES

NCAVP's person-level data allows us to highlight the survivors that are disproportionately impacted by various forms of IPV and which LGBTQH survivors experienced the highest barriers to support. This year's data suggests that LGBTQH people of color survivors, gay survivors, bisexual survivors, transgender survivors, and youth and young adults reported disproportionate experiences of IPV as compared to overall LGBTQH IPV survivors.

GENDER IDENTITY:

Transgender survivors are more likely to report experiencing sexual violence. Transgender survivors were almost 2 times (1.81) as likely to report experiencing sexual violence than people who were not transgender. 14.7% of transgender people experienced sexual violence, while 8.7% of non-transgender people experienced sexual violence.[17] Sexual violence is an under-recognized form of intimate partner violence that necessitates specific community education and direct support strategies to prevent and respond to this violence. The disproportionate impact of sexual violence against transgender survivors of IPV may reflect that transphobia contributes to an increased risk of sexual violence for these survivors.

Transgender people of color were more likely to report experiencing threats and intimidation from their abusive partners. Transgender people of color were almost 2 times (1.86) as likely to report experiencing threats or intimidation, compared to people who are not transgender people of color.[18] 61.7% of transgender people of color experienced threats or intimidation, while 46.4% of people who were not transgender people of color experienced threats or intimidation. Transgender people of color experience intimate partner violence while also experiencing transphobia and racism. Due to these experiences of racism and transphobia the use of threats and intimidation by abusive partners against transgender people of color can be a powerful tool of abuse within an abusive relationship.[19]

LGBTQH women were more likely to report experiencing physical violence and more likely to have police classify their incident as a domestic violence case. Women were almost 1.5 times (1.48) as likely to experience physical violence compared to those who did not identify as women.[20] 79.1% of women experienced physical violence, while 72.0% of people who did not identify as women experienced physical violence. This data likely indicates that women are more likely to seek assistance for physical violence from NCAVP member programs, rather than physical violence is higher among woman. This data also challenges sexist stereotypes can still allow non-LGBTQH providers to believe that women are not physically strong enough to be physically abusive. These stereotypes can create barriers for LGBTQH women IPV survivors who attempt to access competent and welcoming anti-violence support. NCAVP's data also suggests that women were more likely to receive IPV classification by the police. This could be due to the fact that police are more likely to identify IPV for LGBTQH women due to stereotypes that IPV survivors are women and abusive partners are men.

[17] .(95%, Confidence Interval =1.04, 3.16)
[18] .(95%, Confidence Interval =1.09, 3.19)
[19] Kae Greenberg.(2005). *Still Hidden in the Closet: Trans Women and Domestic Violence*. Individualized Study. pp 208
[20] (95%, Confidence Interval =1.13, 1.93)

LGBTQH men were more likely to report experiencing injuries from their abusive partners. Men were slightly more than 2 times (2.04) as likely to be injured as a result of IPV, compared to people who did not identify as men.[21] 68.1% of men were injured as a result of IPV, while 51.2% of people who did not identify as men were injured as a result of IPV. This data largely represents gay men with 83.4% of men also identifying as gay. Gay men could be experiencing more severe forms of IPV or gay men are more likely to reach out to an NCAVP member program after experiencing IPV-related injuries as a result of IPV. IPV injuries can escalate throughout the course of a relationship.

SEXUAL ORIENTATION

Queer people were more likely to report experiencing sexual violence as a form of IPV.
Survivors who identified as queer were almost 3 times (2.78) as likely to experience sexual violence compared to people who did not identify as queer.[22] 20.6% of queer people experienced sexual violence, while 8.5% of non-queer people experienced sexual violence. The term "queer" is a broad based category, and currently, only limited research exists on queer people's experiences of intimate partner violence. This data may be a result of the fact that "queer" communities may experience factors that make them more at risk for sexual violence that NCAVP has not yet fully discovered. NCAVP will continue to monitor this finding to explore it in future reports.

Gay survivors were more likely to report experiencing injuries as a result of IPV.
Gay survivors were more than 2 times (2.19) as likely to be injured as a result of IPV, compared to people who did not identify as gay.[23] 70.0% of gay survivors were injured as a result of IPV, while 51.6% of non-gay people were injured as a result of IPV. Within NCAVP's sample, 93.6% of gay survivors also identified as men. Similar to the disproportionate impact of homicide on gay men, gay men also experience more severe forms of IPV as compared to the sample. NCAVP believes this highlights the impact of the limited access to IPV services available to gay men. Without access to crisis intervention and prevention programs, violence can grow more severe and eventually lethal.

Lesbian survivors were more likely to report experiencing physical violence.
Lesbians were almost 2 times (1.89) as likely to experience physical violence compared to non-lesbians.[24] 84.7% of lesbians reported experiencing physical violence, and 74.5% of non-lesbians experienced physical violence. This is likely to be connected to the finding that showed that women had an increased risk of physical violence, since many people who identify as women within NCAVP's dataset also identify as lesbians. Lesbians can face discrimination and limited access to "mainstream" (non-LGBTQH) programs unless they are able and willing to pass as straight. Even when passing, lesbians may not receive support that is relevant to their experiences.

Bisexual survivors were more likely to report experiencing verbal harassment.
Bisexual survivors were almost 2 times (1.81) as likely to experience verbal harassment as compared to the overall survivors. 58.4% of bisexual survivors experienced verbal harassment, while 43.7% of non-bisexual survivors experienced

[21] (95%, Confidence Interval =1.34, 3.10)
[22] (95%, Confidence Interval =1.18, 6.56)
[23] (95%, Confidence Interval =1.41, 3.39)
[24] (95%, Confidence Interval=1.30, 2.77)

verbal harassment.[25] Bisexual people can experience biphobia (or anti-bisexual bias) within the broader society. Abusive partners can use bi-phobia as a form of power and control by threatening to out bisexual survivors, if they were to report the abuse within their relationship or attempt to exit their relationship. Bisexual survivors experience biphobia within LGBTQH communities and non-LGBTQH communities and may need specific outreach and programs to allow bisexual survivors to feel safe accessing support from mainstream and LGBTQH anti-violence programs.

RACE/ETHNICITY

LGBTQH people of color were more likely to report experiencing physical violence and to report IPV to the police.

LGBTQH people of color were almost 2 times (1.77) as likely to report experiencing physical violence compared to non-people of color.[26] 82.9% of people of color experienced physical violence, while 73.4% of non-people of color experienced physical violence. This data likely indicates that LGBTQH people of color are more likely to report physical violence to LGBTQH anti-violence programs than other forms of violence, as opposed to the possibility that LGBTQH people of color experience higher rates of physical violence.

People of color were also almost 2 times (1.78) as likely to report IPV to the police compared to non-people of color.[27] 44.1% of people of color reported IPV to the police, while 30.8% of non-people of color reported IPV to the police. This finding seems connected to the previous data highlighting disproportionate reports of physical violence among these communities. Neighbors, friends, and witnesses are more likely to notice physical violence and call emergency services than with other forms of intimate partner violence. In many communities nationwide, when emergency services are called both paramedics and the police respond. Any community that experiences high degrees of physical violence and injuries is also likely to experience increased police reporting, including LGBTQH survivors of color. This data is more likely to increased interaction with law enforcement whether willing or unwilling.

People of color were more likely to report experiencing threats/intimidation within IPV and less likely to experience verbal harassment.

People of color were almost 1.5 times (1.34) as likely to experience threats/intimidation compared to non-people of color. 49.8% of people of color experienced threats/intimidation, while 42.6% of non-people of color experienced threats/intimidation.[28] However, people of color were 28% less likely to experience verbal harassment compared to non-people of color. 46.3% of people of color experienced verbal harassment, while 54.6% of non-people of color experienced verbal harassment.[29] These two seemingly contradictory statistics illustrate the complicated dynamics in serving LGBTQH survivors of color. The decreased reports of verbal harassment suggest that LGBTQH survivors of color are more likely to seek assistance or be connected to LGBTQH anti-violence programs for physical violence. However, threats, intimidation, and physical violence can often happen simultaneously. NCAVP will continue to examine this theme in future reports.

[25] (95%, Confidence Interval=1.20, 2.73)
[26] (95%, Confidence Interval=1.26, 2.48)
[27] (95%, Confidence Interval=1.26, 2.51)
[28] (95% Confidence Interval=1.03, 1.74)
[29] (95% Confidence Interval=0.55, 0.93)

AGE

Youth and young adults were more report experiencing injuries and physical violence, and less likely to report experiencing financial abuse.

People under 30 were almost 2 times (1.78) as likely to be injured as a result of IPV, compared to people 30 and over.[30] 67.3% of people under 30 were injured as a result of IPV, while 53.6% of people 30 and over were injured as a result of IPV. People under 30 were about 1.5 times (1.59) as likely to experience physical violence as compared to people 30 and over.[31] 88.8% of people under 30 experienced physical violence, while 83.4% of people 30 and over experienced physical violence. This suggests that either, youth and young adults experience more severe forms of IPV, or they are less likely to seek support from anti-violence programs unless they are experiencing physical injuries. The disproportionate rates of injuries and physical violence are likely connected because injuries are often a result of physical violence within relationships. People under 30 were half (0.51 times) as likely to experience financial abuse compared to those 30 and over. 7.5% of people under 30 experienced financial abuse, while 13.6% of people 30 and over experienced financial abuse.[32] NCAVP members often observe that a substantial amount of LGBTQH youth survivors are often disproportionately affected by poverty and homelessness, and this data shows that people over 30 may have a higher level of economic resources, as compared to those under 30, making them more vulnerable to abuse that targets their economic resources.

AGE & RACE

LGBTQH people of color under 30 were more likely to report experiencing injuries, physical violence, and threats and intimidation.

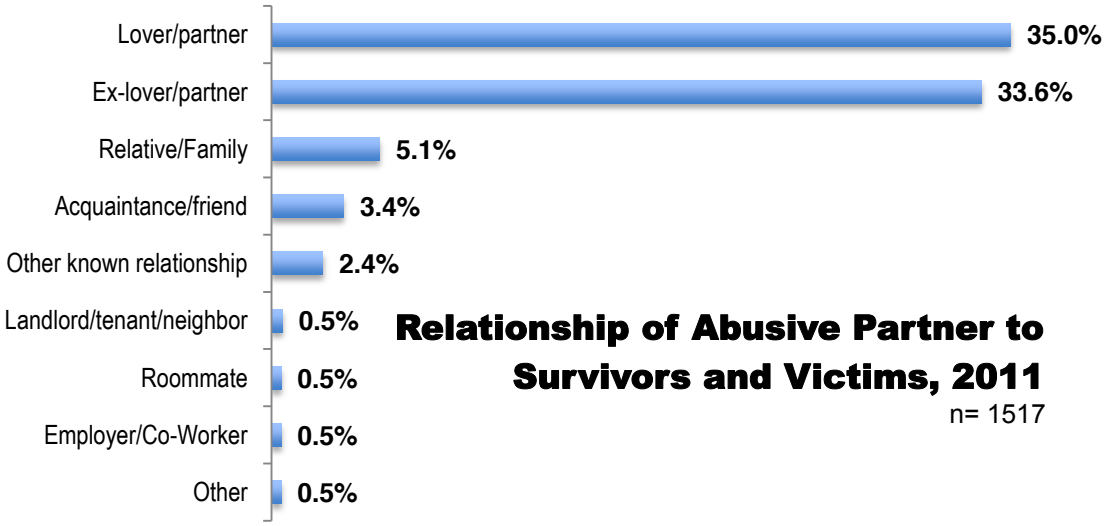
People of color under 30 reported some of the highest disproportionate rates of injury and physical violence. People of color under 30 were almost 2.5 times (2.49) as likely to be injured as a result of IPV, compared to those who were not people of color under 30.[33] 72.3% of people of color under 30 were injured as a result of IPV, while 51.1% of people who were not people of color under 30 were injured as a result of IPV. People of color under 30 were also almost 4 times as likely (3.98) to experience physical violence, compared to people who were not people of color under 30. 94.3% of people of color under 30 experienced physical violence, while 80.6% of people who were not people of color under 30 experienced physical violence.[34] Finally, people of color under 30 were 1.51 times as likely to experience threats or intimidation, compared to those who were not people of color under 30. 57.3% of people of color under 30 experienced threats or intimidation, while 47.1% of those who were not people of color under 30 experienced threats or intimidation.[35]

[30] (95%, Confidence Interval=1.10, 2.89)
[31] (95%, Confidence Interval=1.00, 2.581)
[32] (95%, Confidence Interval=0.30, 0.87)
[33] (95%, Confidence Interval=1.5, 4.15)
[34] (95%, Confidence Interval=2.26, 6.99)
[35] 95%, Confidence Interval=1.13, 2.02)

INCIDENT DETAILS

This section provides data and analysis on the dynamics of relationships between survivors and their abusive partners, as well as survivors' experiences with injury and efforts to access safety, services, and support.

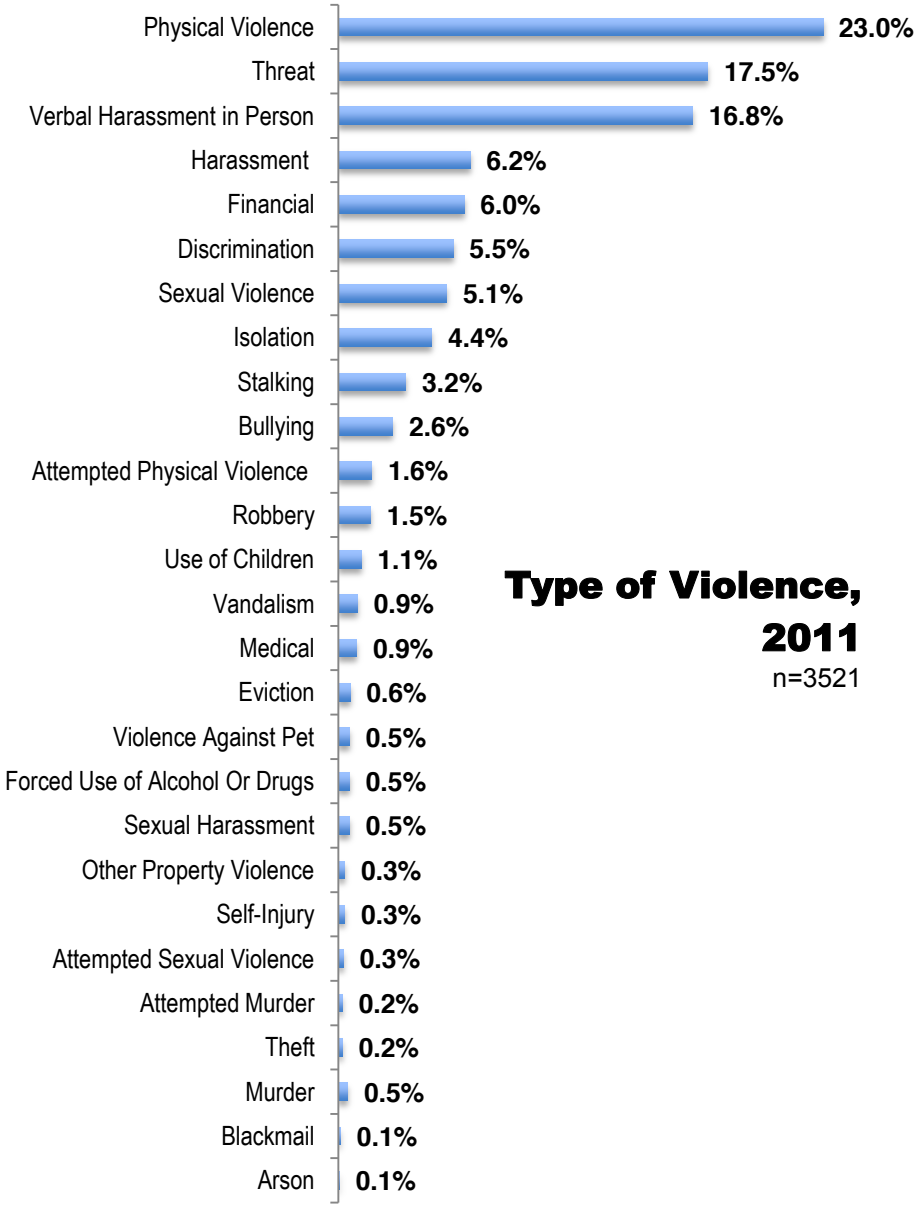
RELATIONSHIP BETWEEN ABUSIVE PARTNER AND SURVIVOR



Of survivors who disclosed this information to NCAVP, 34.9% of survivors experienced violence or abuse from current lovers or partners, while ex- lovers/partners made up 33.6% of abusers. Survivors who described their abusive partners as relatives/family represented 5.1% of total known categories. Acquaintances, friends, other relationships, landlords, tenants, neighbors, employers, coworkers, police, and service providers each represented fewer than 5% of the total IPV survivor's abusive partners.[36] In 2011, the amount of survivors experiencing IPV from current lovers and partners decreased from 50.6% in 2010. Ex-lovers and ex-partners increased from 29.2% in 2010 to 33.6% in 2011. The increase in the amount of abusive ex-lovers and ex-partners highlights that IPV does not end when relationships end. In fact when relationships end IPV may escalate or survivors may be more likely to report or seek support for this violence.

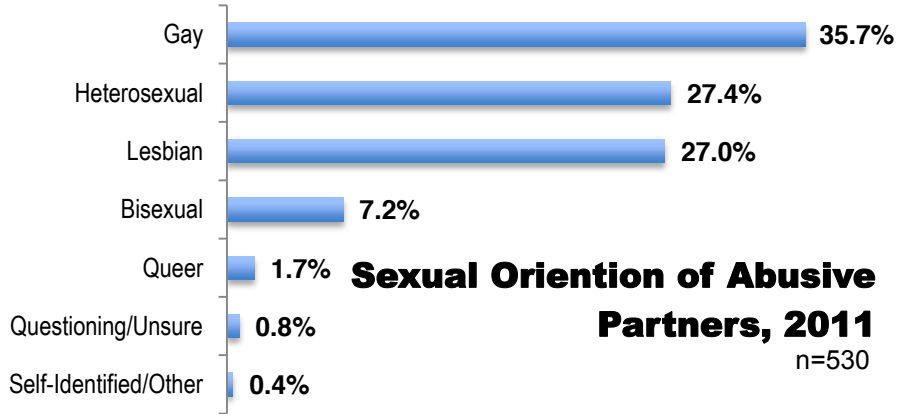
[36] NCAVP restructured these categories in 2011 therefore only some comparisons to 2010 are available.

TYPES OF IPV



LGBTQH abusive partners use a variety of tactics to assert power and control within intimate relationships, ranging from threats to homicide. For the survivors who reported this information, 23% of incidents involved physical violence, 17.5% of incidents involved threats of any kind, 5.1% of incidents involved sexual violence, 3.2% of incidents involved stalking. There was a substantial decrease in physical violence from 2011 (23%) to 2010 (55.4%). This decrease in reports of physical violence is a likely indication that LGBTQH survivors are reporting a broader range of abusive behaviors to NCAVP and is less likely to indicate a decrease in the severity of violence that LGBTQH IPV survivors experienced. 17.5% of survivors indicated that their abusive partner used threats as a tactic, a slight decrease from 2010 (20.7%). Reports of sexual violence showed a slight decrease from 9.2% in 2010 to 5.14% in 2011. Stalking also decreased from 2010 from 7.3% to 3.2%.

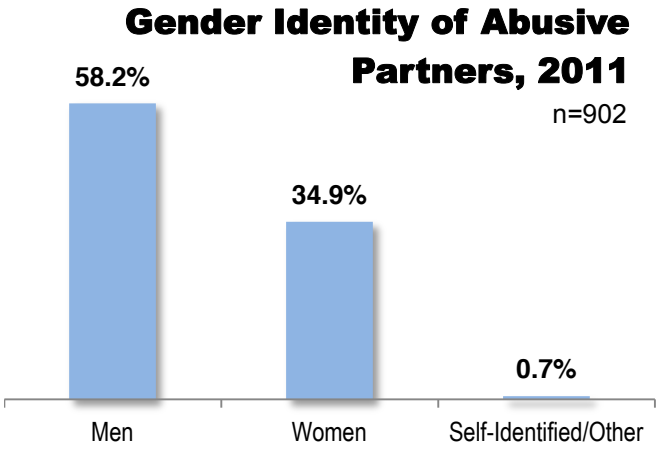
SEXUAL ORIENTATION OF ABUSIVE PARTNERS

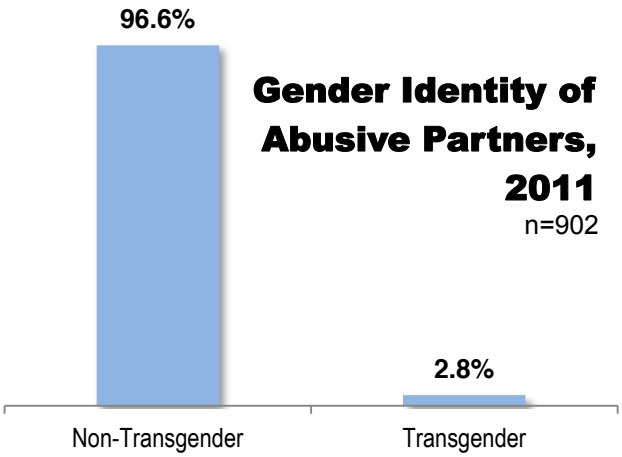


The largest proportion of survivors reported that their abusive partners identified as gay (35.5%).[37] The remainder of abusive partners in 2011 were reported to be heterosexual (27.2%), lesbian (26.8%), bisexual (7.1%), queer (1.7%), questioning/unsure (0.8%), and self-identified (0.4%). The sexual orientation of abusive partners mirrors survivor sexual orientation with survivors who identified as gay (38.7%) and lesbians (31.3%). The much higher amount of heterosexual abusive partners (27.4%) than heterosexual survivors (12.8%) indicates that a substantial amount of survivors are in relationships with someone who identifies as heterosexual. While some of these abusive partners may still identify as part of the LGBTQH community, others may not. LGBTQH IPV survivors in abusive relationships with partners who do not also identify as LGBTQH may face barriers seeking support and can feel that mainstream and LGBTQH-specific anti-violence programs may not fully understand their relationships.

[37] NCAVP did not track this data in 2010 so comparisons are not available.

GENDER IDENTITY OF ABUSIVE PARTNERS

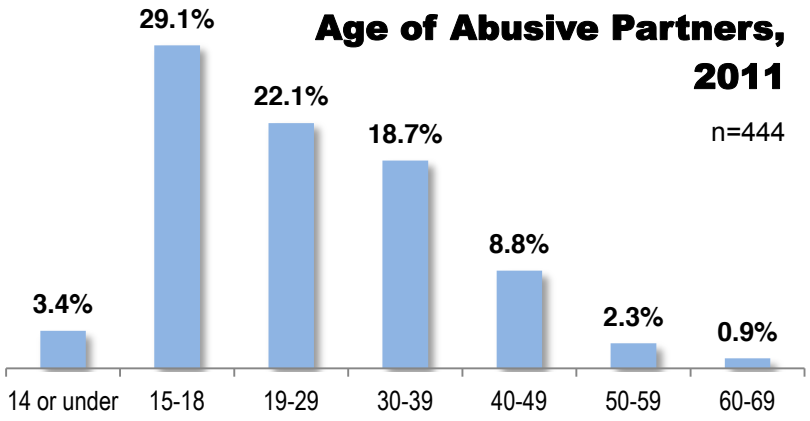




Survivors reported that the majority of their abusive partners were men (59.2%) while women represented more than a third (35.5%) of abusive partners, and self –identified and other abusive partners represent 0.7%.[38] The vast majority of abusive partners were reported to be non-transgender (98.2%). This is fairly consistent with the gender identity of survivors who 92.8% identified as non-transgender. While a majority of abusive partners (59.2%) were reported to be men in 2011, the highest proportion of IPV survivors (50.5%) identified as women. This difference could show that LGBTQH relationships are broader than same-gender relationships, and include a broad range of sexual orientations and gender identities. However the high amounts of non-disclosed gender identities for abusive partners also indicates that this data may not fully represent all the abusive partners of LGBTQH IPV survivors in 2011.

[38] NCAVP did not track this data in 2010 so comparisons are not available.

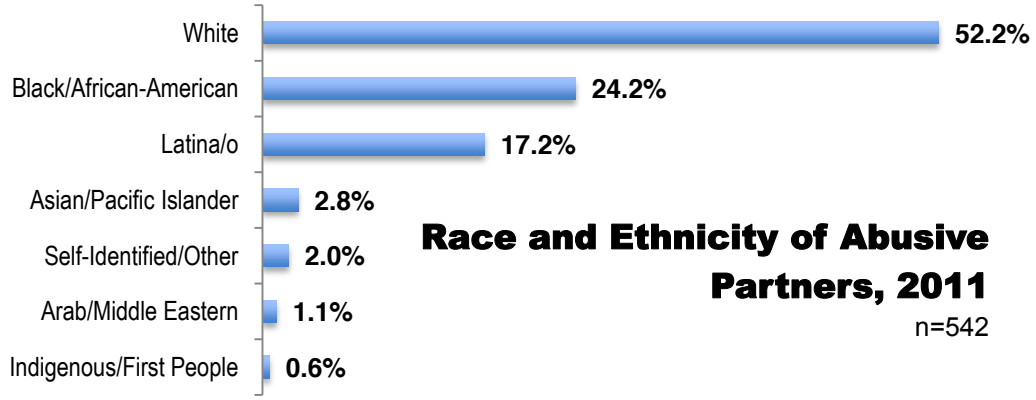
AGE OF ABUSIVE PARTNERS



The most common age of abusive partners reported to NCAVP was 19-29 (29.1%).[39] 22.1% of abusive partners were between 30-39 and 18.7% of abusive partners were between 40-49 years of age. Abusive partners ages 15-18 comprised of 3.4% of reported abusive partners, 40-49 were 18.7%, 50-59 were 8.8%, abusive partners 60 and over represented a combined 3.2% of the total sample. The most common age for survivors mirror age of abusive partners, 38.5% of survivors were 19-29 and 23.5% of survivors were between 30-39, suggesting that survivors and abusive partners date within their same age range.

[39] NCAVP did not track this data in 2010 so comparisons are not available.

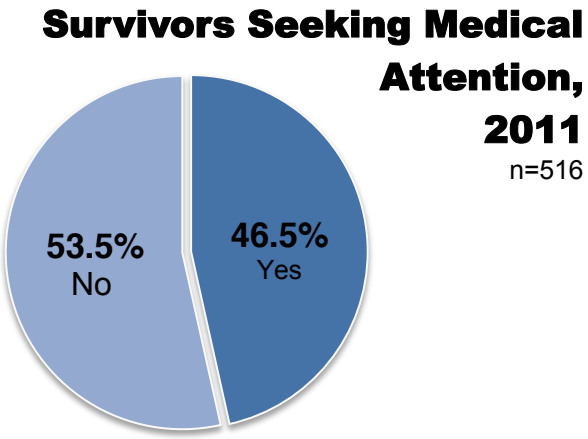
RACE/ETHNICITY OF ABUSIVE PARTNERS

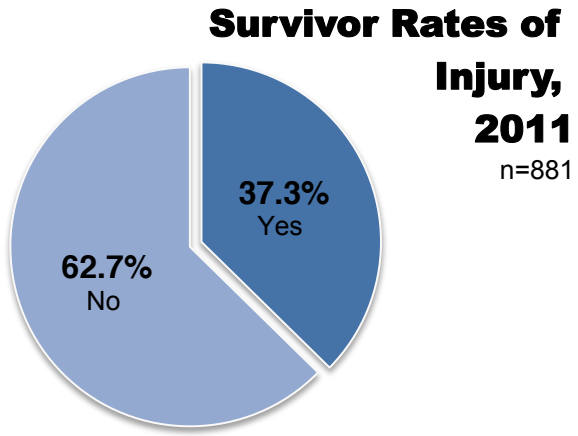


More than half of abusive partners were reported to be white (51.9%), which is higher than the proportion of survivors who identified as White (40.8%).[40] People of color account for less than half of all reported abusive partners (47.9%), yet people of color as a whole represented a majority of survivors (63.2%). Within people of color, Black/African American abusive partners made up 24.0% of abusive partners, yet, Black/African American survivors represented only 14.8% of survivors. This suggests that White and Black/African American abusive partners make up a larger proportion of abusive partners than survivors, which could mean that survivors are more likely to report the race of their abusive partner when the partner is White or Black/African American. 17.2% of abusive partners were Latina/o and less than 5.9% of abusive partners were identified as Asian/Pacific Islander, Self- Identified/Other, Arab/Middle Eastern or Indigenous/First Nation respectively. Latina/o survivors represent 36.6% of survivors when compared to Latina/o abusive partners (17.2) which suggest that while Latina/ o survivors make up a large portion of survivors they may be experiencing IPV in interracial relationships, or that survivors are less likely to identify their abusive partners race as Latina/o.

[40] NCAVP did not track this data in 2010 so comparisons are not available.

INJURY AND MEDICAL ATTENTION

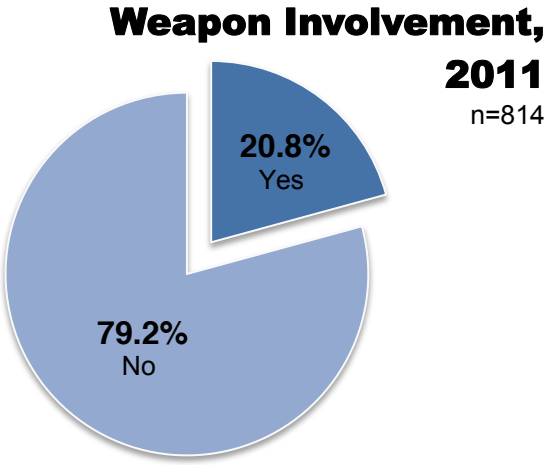




In 2011, 37.3% of survivors who disclosed this information to NCAVP experienced injury.[41] Injuries are an indicator of the severity of IPV. IPV can cause short term, life-long injuries, and even permanent disabilities. These injuries can escalate over time, even resulting in murder, and it is critical for LGBTQH IPV survivors to find support for injuries. In 2011 46.5% of LGBTQH survivors who reported on medical attention to NCAVP sought medical attention. This is nearly half of survivors who reported incidents of IPV. IPV survivors can seek medical attention for physical and emotional support. Medical providers can often assess IPV based on the types of injuries, the trauma that IPV survivors present, and the stages of healing for these injuries. For LGBTQH survivors, medical providers may not have the training and knowledge to recognize LGBTQH IPV.

[41] This information was not tracked in 2010 so no comparison is available.

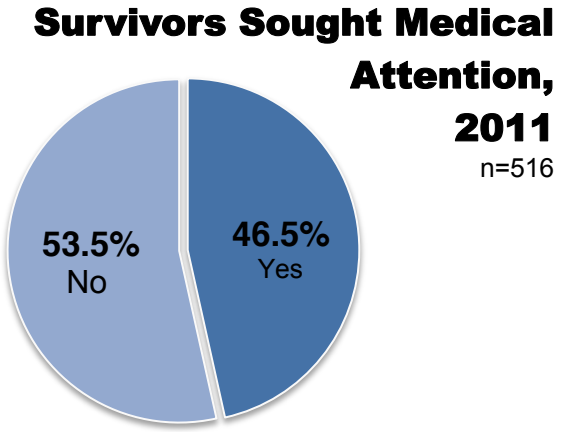
WEAPONS



In 2011 20.8% of survivors who reported this information to NCAVP experienced IPV involving a weapon, while 84.2% of homicides in 2011 involved a weapon.[42] Weapons represent a very important aspect of IPV, particularly IPV homicide. This data could indicate that weapons do not play a central role within the IPV that the majority of LGBTQH survivors reported to NCAVP. Survivors experiencing IPV that involves weapons may also be too fearful of their abusive partner to risk reporting IPV, or they may feel embarrassment reporting this, even while of seeking support for IPV. Survivors who are not ready or who do not want to exit their relationships, may be protective of their abusive partner and may not report weapons to avoid potential legal action against their partners. This is particularly likely if that partner is also LGBTQH, and may be subjected to bias, discrimination, and violence within the criminal legal system.

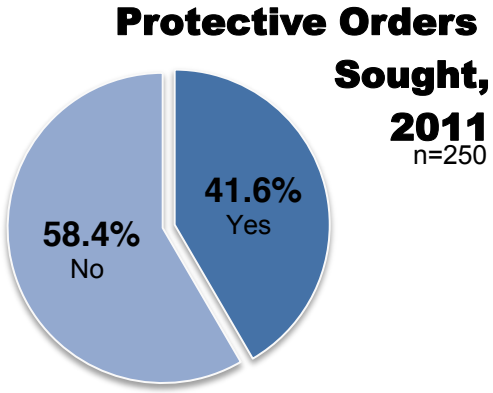
[42] This information was not tracked in 2010 comparison are not available.

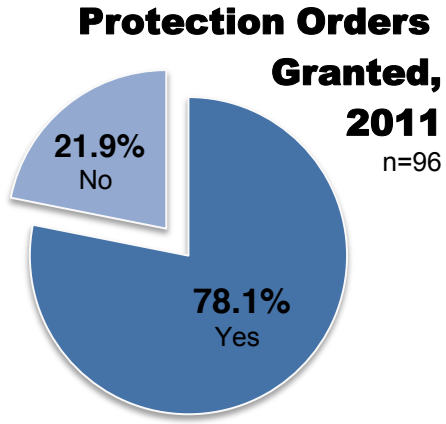
SURVIVOR EFFORTS TO ACCESS DOMESTIC VIOLENCE SHELTER



In 2011, 219 survivors reported to NCAVP that they sought access to domestic violence shelters. Of those seeking shelter 61.6% were turned away, while only 25.7% were admitted to a shelter. More survivors in 2011 (61.6%) were turned away from shelter than in 2010 (44.6%). Access to domestic violence shelters can be critical for the safety of LGBTQH IPV survivors, particularly those who depend on their abusive partner for housing and economic support, or when the abusive partner has threatened to stalk a survivor if they attempt to exit their relationship.

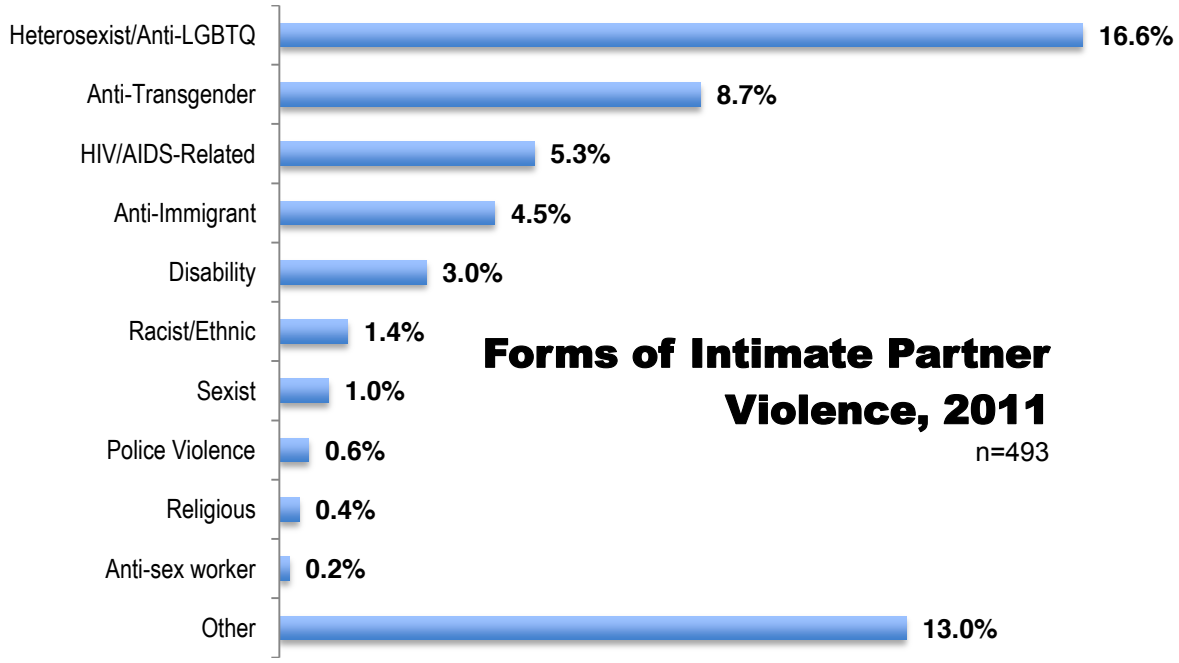
SURVIVOR EFFORTS TO ACCESS ORDERS OF PROTECTION





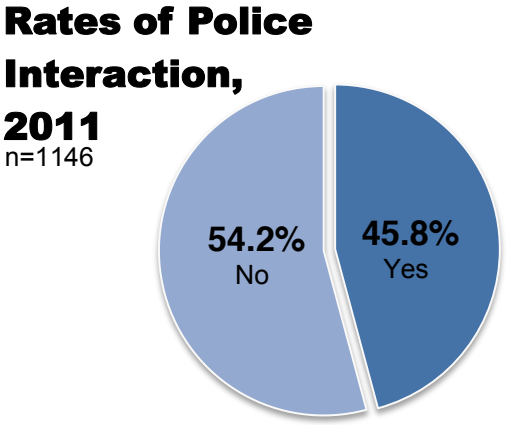
In 2011, 2.7% of total survivors reported to NCAVP that they applied for orders of protection, which is relatively consistent with 2010 (1.8%). The remaining survivors did not disclose their attempts to obtain orders of protection to NCAVP. In 2011, 78.1 % of survivors seeking an order of protection received one, a slight decrease from 2010 where 83.7% of LGBTQH IPV survivors seeking an order of protection received one.

FORMS OF INTIMATE PARNTER VIOLENCE

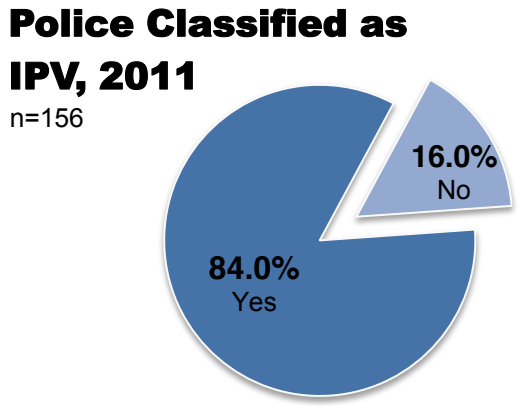


In 2011, 16.6% of abusive partners used heterosexist and anti-LGBTQ forms of IPV against their partners, while 8.7% of abusive partners used anti-transgender IPV. HIV/AIDS-related IPV and anti-immigrant IPV represented relatively similar proportions with 5.3% and 4.5% respectively. IPV related to disability status, sexism, police violence, anti-religious bias, and anti-sex worker bias each represented less than 4% of total reports from survivors individually. Abusive partners use a myriad of tactics that mirror and are reinforced by societal oppression and discrimination to exert power and control over survivors.

POLICE INTERACTIONS



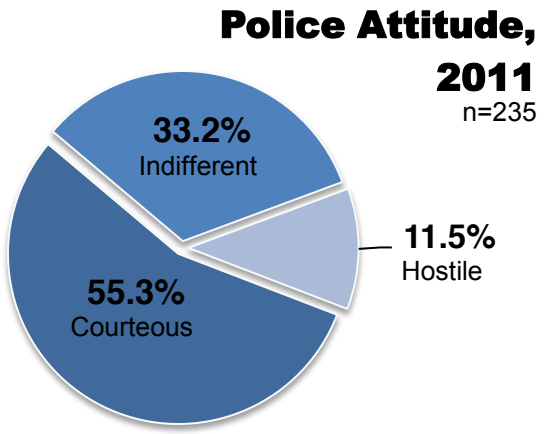
In 2011, 45.7% of survivors who reported to NCAVP also reported to the police. While still less than half of LGBTQH IPV survivors, this is an increase from 2010 where 29.7% of survivors called the police. This data may in part result from the historical distrust within LGBTQH communities towards the police. Many LGBTQH community members have experienced or witnessed discrimination and violence from the police.[43] Many LGBTQH IPV survivors do not reach out to the police for assistance for this very reason, leaving them with less support to create safety within or outside of their relationships.



For the survivors who reported their police interactions to NCAVP, 84.0%% of survivors who reported to the police experienced the police classifying their incident as IPV. This characterization of IPV is important because it allows survivors to be eligible for some resources that may rely on police reports or court orders to determine their eligibility for services such as housing, shelter, and orders of protection. Survivors also reported that that in 44.4% of incidents involving the police, the police arrested the abusive partner, which is a slight decrease from 47.1% in 2010. When the police arrest the abusive partner it can reduce immediate danger and increase a sense of safety for many LGBTQH survivors.[44]

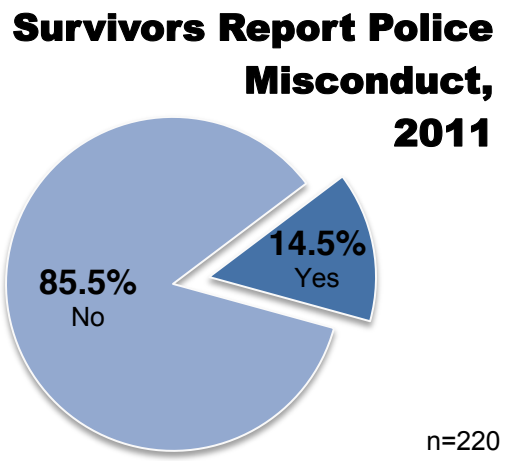
[43] Amnesty International USA – *Stonewalled: Police Abuse and Misconduct Against Lesbian, Gay, Bisexual and Transgender People in the US.* Retrieved on Sept 15, 2012, from http://www.amnesty.org/en/library/asset/AMR51/122/2005/en/17385cd5-d4bd-11dd-8a23-d58a49c0d652/amr511222005en.html.

[44] NCAVP did not track this data in 2010 so no comparisons are available.

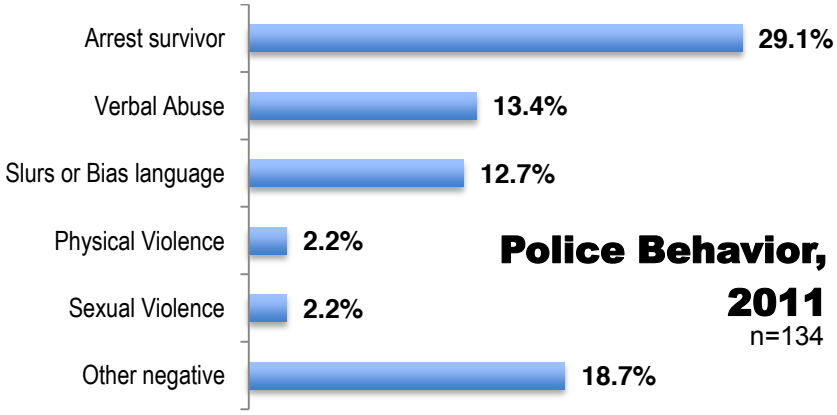


Of those who interacted with the police, 11.5% reported to NCAVP that police attitudes were hostile, 33.2% reported indifferent attitudes from the police, and 55.3% of survivors reported that police attitudes were courteous. Indifferent and hostile police attitudes can deter LGBTQH IPV survivors from reporting future experiences of violence to law enforcement and to anti-violence programs. Survivors who experience courteous responses are more likely to seek additional support for their experiences of IPV and encourage other survivors that they know to seek support.

POLICE BEHAVIOR



Survivors reported police misconduct in 14.6% of incidents involving the police, an increase from 2010 (6.1%).



Within police misconduct, in 28.4% of incidents in 2011 the police arrested the survivor a slight increase from 2010 (23.2%). LGBTQH IPV survivors also experienced other forms of police misconduct[45] including non-specific negative experiences (18.7%), verbal abuse (13.4%), slurs or bias language (12.7%), and physical violence (2.2%) and sexual violence (2.2%). As previously stated, police misconduct can deter LGBTQH survivors from reporting in the future and can increase the historical distrust that LGBTQH survivors have with law enforcement.

[45] NCAVP did not track these forms of police misconduct in 2010 so no comparisons are available.

DISCUSSION

DECREASE IN REPORTS

Between 2010 and 2011the total number of reported incidents decreased by 22.2%. NCAVP attributes this to a decrease in reporting as opposed to a decrease in LGBTQH IPV, resulting from NCAVP members having less capacity to collect reports from LGBTQH IPV survivors. Funding cuts caused some NCAVP member programs to reduce staff and infrastructure. Some member programs are working with fewer staff because they are still recovering from the U.S. economic downturn. For example, NCAVP member program the Los Angeles Gay and Lesbian Center (LAGLC) lost two outreach staff in the past year. This substantially reduced their capacity to conduct outreach to access survivors and reports of violence. These reduced reports may also be connected to the increase in reports of IPV homicides in 2011. For already under-resourced LGBTQH anti-violence programs, an increase in homicides forces programs to shift staff from other programmatic activities such as outreach and survey efforts that allow anti-violence programs to document reports of LGBTQH IPV in their local areas. This decrease demonstrates the need for funding for outreach, public education programs, and anti-violence prevention initiatives in order collect reports of LGBTQH IPV.

A decrease in reporting can also result from LGBTQH survivors reporting IPV. Survivors can be reluctant to report IPV for a variety of reasons, including fears of censure from close-knit LGBTQH communities, internalized and societal homophobia, biphobia, and transphobia, fearing that reporting will reduce their safety, and a lack of a consistent understanding of LGBTQH IPV.[46] Research indicates that transgender IPV survivors fear reporting incidents of IPV due to the high likelihood of re-victimization by direct service providers.[47] Studies also show that gay men fear experiencing discrimination when seeking support leading them to report IPV less as well.[48] LGBTQH anti-violence programs offer a unique resource to address these barriers for LGBTQH IPV survivors. These programs create safer ways for survivors to report IPV and seek assistance and also advocate for LGBTQH IPV survivors who have experienced discrimination when seeking support.

INCREASE IN HOMICIDES

IN 2011 NCAVP recorded the highest number of IPV homicides ever recorded by NCAVP, with 19 documented LGBTQH IPV homicides in 2011. NCAVP sees this increase in reported LGBTQH IPV homicides as a rise in the public understanding of LGBTQH IPV, which allows the media to publish these stories and for loved ones to report LGBTQH IPV homicides to NCAVP. Intimate partner violence homicide is often mischaracterized when law enforcement and the media do not understand or recognize LGBTQH relationships, due to homophobia and transphobia. Sometimes LGBTQH IPV homicide is mischaracterized as hate violence, since anti-LGBTQH hate violence has more public visibility than LGBTQH IPV within broader society. The large numbers of IPV homicides occurring near NCAVP member programs shows the impact that LGBTQH anti-violence programs can have on educating the community, local media, and local law enforcement on the dynamics of LGBTQH IPV. NCAVP member programs often create trainings to law enforcement and direct service providers LGBTQH IPV and create public education events on LGBTQH IPV. These activities can increase the likelihood

[46] Duke, Alysondra & Dividson, Meghan. (2009). *Same- Sex Intimate Partner Violence: Lesbian, Gay and Bisexual Affirmative Outreach and Advocacy*. Journal of Aggression, Maltreatment and Trauma, 18, 801.
[47] Stotzer, Rebecca.(2009) *Violence Against Transgender People: A Review of United States Data*. Aggression and Violent Behavior, 14, 171.
[48] Duke, Alysondra & Dividson, Meghan. (2009). *Same- Sex Intimate Partner Violence: Lesbian, Gay and Bisexual Affirmative Outreach and Advocacy*. Journal of Aggression, Maltreatment and Trauma, 18, 805.

that LGBTQH IPV homicides are reported, publicized, and investigated accurately. The degree of discrimination and bias that LGBTQH survivors face when seeking to access mainstream IPV services can also increase the likelihood of homicide for LGBTQH IPV survivors. Broader literature states that when IPV survivors are unable to access crisis services the consequences can be deadly.[49] NCAVP members frequently observe that the more contact that an IPV survivor has with an anti-violence program the less they are likely to experience homicide.

DISPROPORTIONATE IMPACT OF HOMICIDE AND SEVERE VIOLENCE ON GAY MEN

The majority of 2011 IPV homicide victims were men (63.2%) but men only represented 41.1% of total reports. Gay men also were more likely to report experiencing injuries. As previously stated, the public image that IPV survivors are non-transgender women within heterosexual relationships excludes the realities of LGBTQH survivors of IPV, and limits access to gay men IPV survivors. In "Domestic Violence Between Same-Gender Partners: Recent Findings and Future Research," Joan McClennen finds that lesbians were significantly more likely to seek help for IPV than gay men due to the fact that many lesbians were involved in and aware of the Battered Women's Movement and had more knowledge about and access to IPV services.[50] In particular, domestic violence shelters can be a life-saving resource for IPV survivors seeking to safely exit their relationships. However, NCAVP members frequently observe that gay men are among some of the least likely to access shelter among LGBTQH survivors, due to many shelter's refusals to accept men. NCAVP believes that this inability to gain access to domestic violence shelter is directly connected to the disproportionate rates of IPV homicide and injuries among gay men.

Societal and cultural bias can also make it less likely for LGBTQH men who are IPV survivors to acknowledge and understand that they are experiencing IPV within their relationships. These survivors may assume that IPV doesn't occur in gay relationships or among men. Anti-LGBTQH bias in society also makes gay men likely to remain silent about IPV in order to prevent further stigma and negative views about gay relationships in society.[51] When gay men do seek support they often seek support from their friends and rarely seek formal support.[52] Informal and community support can be extremely useful for IPV survivors. However many survivors need access to formal support from medical providers, law enforcement, counselors, advocates, shelter providers, and other direct service providers.[53] This data highlights the deadly consequences for the cultural and societal oppression against gay men IPV survivors and calls for urgent attention from policymakers, service providers, and anti-violence programs.

DISPROPORTIONATE SEVERE VIOLENCE AGAINST YOUTH AND YOUNG ADULTS

Youth, young adults, and youth and young adults of color were more likely to experience injuries, physical violence, and threats and intimidation than survivors who did not identify in these ways. The intersecting oppressions that these communities experience due to their age, race, and LGBTQH identities contributes to an increased likliehood of

[49] Iyengar, Radha & Sabik, Lindsay. (2009). *The Dangerous Shortage of Domestic Violence Services*. Health Affairs, Vol. 28. 1063.
[50] McClennen, Joan C.(2005). *Domestic Violence Between Same-Gender Partners: Recent Findings and Future Research*. Journal of Interpersonal Violence, Vol 18. 150.
[51] Turell, Susan C. & Cornell- Swanson, La Vonne. (2005). *Not All Alike: Within Group Differences In Seeking Help For Same Sex Relationship Abuses.* Journal of Gay and Lesbian Studies. Vol. 18. 74.
[52] Ibid
[53] McClennen, Joan C. (2005). *Domestic Violence Between Same-Gender Partners: Recent Findings and Furture Research*. Journal of Interpersonal Violence, Vol 18. 152.

experiencing poverty, lowered academic achievement, homelessness, and unemployment.[54] Employment barriers can begin early in life for LGBTQH youth, because they may face homophobic, biphobic, and transphobic, violence at school or home. Current research highlights that LGBTQH young people are more likely to experience sexual violence, feel unsafe at school, and experience physical violence than their non-LGBT peers.55 Scholars also estimate that 20-40% of homeless youth are LGBTQ.[56] Low-income LGBTQH youth and LGBTQH youth of color who face homophobia or transphobia at home are more likely to become homeless or become part of the foster care system because of limited economic resources within their families and communities. The specific context of school-based anti-LGBTQH violence also can increase the likelihood for poverty for LGBTQH young people.

To maximize resources, NCAVP members frequently see that these survivors may live within small interdependent communities that rely on each other for safety from multiple forms of violence and to ensure that they meet their basic needs, particularly for youth and young adults of color.[57] When IPV exists within their relationships, they may not choose to leave because it means leaving their communities and their means of supporting themselves, thereby increasing the severity of IPV within their relationships. The higher dropout rates for LGBTQH youth can create later employment barriers for LGBTQH youth, resulting in engagement either by choice or by coercion, in underground economies such as sex work and selling illegal drugs for survival. All of these types of employment can increase the risk of violence and can create barriers for LGBTQH youth to seek assistance and support from law enforcement for the violence they experienced. A 2006 study showed that almost 60 percent of transgender youth of color had traded sex for money or resources.[58] Criminal convictions bar access to many services such as Supplemental Nutrition Assistance Program (SNAP), public housing, employment and unemployment benefits, some IPV specific services, and Temporary Assistance for Needy Families (TANF). These barriers can also deter survivors from seeking additional resources even from LGBTQH anti-violence programs, because survivors may assume that they may not have access to these services, also increasing the severity of the IPV that these survivors experience. Among homeless LGBTQH youth and young adults of color, the barriers to accessing services are particularly high.[59]

PEOPLE OF COLOR MORE LIKELY TO EXPERIENCE PHYSICAL VIOLENCE, THREATS, AND INTIMIDATION

NCAVP's 2011 report highlights that LGBTQH people of color survivors experienced disproportionate rates for physical violence, threats, and intimidation. This dynamic shows that LGBTQH survivors of color are more likely to report physical violence to NCAVP member programs than other forms of violence. NCAVP also recognizes that this physical violence is often accompanied by threats and intimidation. Research shows that LGBTQH IPV survivors, African American and

[54] D'Agelli, Anthony R., Pilkington, Neil W. & Hershberger, Scott L. (2002). *Incidence and Mental Health Impact of Sexual Orientation Victimization of Lesbian, Gay, and Bisexual Youths in High School*. School Psychology Quarterly. Vol. 17. 163.

[55] Centers for Disease Control and Prevention *Sexual Identity, Sex of Sexual Contacts, and Health-Risk Behaviors Among Students in Grades 9–12 — Youth Risk Behavior Surveillance, Selected Sites, United States, 2001–2009*. 2011. Accessed from: http://www.cdc.gov/mmwr/pdf/ss/ss60e0606.pdf on Sept, 14, 2012

[56] National Gay and Lesbian Task Force, "*Lesbian, Gay, Bisexual and Transgender Youth: An Epidemic of Homelessness" (2006*). Accessed from: http://www.thetaskforce.org/reports_and_research/homeless_youth on Sept, 18, 2012.

[57] Turell, Susan C. & Cornell- Swanson, La Vonne. (2005). *Not All Alike: Within Group Differences In Seeking Help For Same Sex Relationship Abuses*. Journal of Gay and Lesbian Studies. Vol. 18. 75.

[58] Garofalo R et al. Overlooked, misunderstood, and at risk: exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. *Journal of Adolescent Health* 2006; 38(3): 230-6.

[59] Gipson, L. Michael.(2002, April/May). *Poverty and Race Research Action Council*. Retrieved on September, 25, 2012, from http://www.prrac.org/full_text.php?text_id=743&item_id=7785&newsletter_id=61&header=Race+%2F+Racism.

Latina/o LGBTQH survivors in particular are less likely to seek IPV resources.[60] Several LGBTQH anti-violence programs were founded by or have long term roots in communities of gay, white, men. LGBTQH survivors of color may not know about these LGBTQH anti-violence programs, respond to the same types of outreach as other survivors, may prefer services from someone of their same racial identity, or may not live in the same neighborhoods as white LGBTQH communities.[61] While LGBTQH anti-violence programs have developed many programs to increase diversity such as support groups, outreach, and organizing campaigns focusing on the needs and experiences of LGBTQH communities of color, these survivors can still face barriers in accessing services. Additionally, these survivors can experience homophobia, biphobia, transphobia, and racism when attempting to access non-LGBTQH specific IPV programs or IPV programs that are specific to communities of color. LGBTQH communities of color are shown to experience increased rates of homelessness, unemployment, poverty, and HIV.[62] This necessitates that anti-violence programs need to create support and prevention strategies to address the intersection of IPV, poverty, and HIV-status and to address the impact that power and control can have on survivors experiencing these multiple marginalized identities.

SEXUAL VIOLENCE WITHIN INTIMATE PARTNER VIOLENCE

Transgender IPV survivors and queer IPV survivors both reported disproportionate rates of sexual violence to NCAVP. Transgender survivors of IPV may experience disproportionate sexual violence due to experiences of transphobia within IPV, from non-transgender abusive partners, or from transgender partners who have internalized transphobia. Transphobic violence can often have a sexual nature, rooted in the hatred associated with those who do not conform to a traditional gender binary of men and women.[63] For example, NCAVP members observe that abusive partners can use transphobic tactics of power and control to violate transgender survivors' sexual boundaries. These abusive partners can justify these violations claiming that "real men or women" have sex in this way. Research also shows that some of the most documented types of violence against transgender people are sexual assault and rape.[64] Many studies on transgender people are funded or written by state and local Departments of Health.[65] These studies usually focus on sexual behavior (i.e. condom use, unprotected sex, and anal sex) in order to draw connections with HIV/AIDS status and transmission. Despite this research these studies often do not focus on the dynamics of sexual violence within IPV for transgender survivors.

For years LGBTQH anti-violence programs have conducted training to mainstream direct service providers and LGBTQH communities to increase the public understanding of queer sexual violence. The disproportionate rates of sexual violence within IPV for queer survivors may show that the idea persists that, "sexual violence does not exist within queer relationships." Sexual violence is a key component within many abusive and violent relationships and often accompanies other forms of intimate partner violence including physical violence, verbal harassment, threats, and intimidation. Since queer is a term and identity that originated in progressive and academic LGBTQH communities, this data may indicate an increased reporting to LGBTQH anti-violence programs for these survivors. Currently limited research on sexual violence and queer survivors exists. However, NCAVP will continue to examine this dynamic in future years. These

[60] Turell, Susan C. & Cornell- Swanson, La Vonne. (2005). *Not All Alike: Within Group Differences In Seeking Help For Same Sex Relationship Abuses*. Journal of Gay and Lesbian Studies. Vol. 18. 75.
[61] Turell, Susan C. & Cornell- Swanson, La Vonne. (2005). *Not All Alike: Within Group Differences In Seeking Help For Same Sex Relationship Abuses*. Journal of Gay and Lesbian Studies. Vol. 18. 75.
[62] Dunn, Melissa & Moodie-Mills, Aisha C. (2012, April 13). The *State of Gay and Transgender Communities of Color 2012*. Retrieved on September 25, 2012, from http://www.americanprogress.org..
[63] Ibid
[64] Stotzer, Rebecca. (2009). *Violence Against Transgender People: A Review of United States Data*. Aggression and Violent Behavior, Vol.14. 171.
[65] Ibid.

disproportionate rates of sexual violence for these communities show the need to design specific programs that prevent sexual violence within queer and transgender communities, and culturally competent services for these survivors.

HOMOPHOBIC, TRANSPHOBIC, AND BIPHOBIC BIAS AND OPPRESSION AS A METHOD OF POWER AND CONTROL

NCAVP's data highlights that bisexual survivors and transgender survivors face heightened risks for particular kinds of IPV, including threats and verbal harassment. While commonly seen as separate forms of violence, homophobic, transphobic, and biphobic bias violence can also be used by abusive partners as a method of power and control. Threats and verbal harassment can accompany biphobic and transphobic bias that bisexual and transgender survivors experience within IPV. Abusive partners often exploit survivors using whatever forms of power and privilege they have, in order to control survivors' emotions, movement, resources, and to reduce their safety. For example abusive partners will control transgender survivor's access to hormones, harass and ridicule transgender partner's bodies, use biphobic and transphobic statements such as "no one else could ever love you" against bisexual and transgender survivors. When bias is present within IPV, abusive partners can also use the threat of outside oppression against survivors, such as threatening to out bisexual and transgender survivors at their workplaces.[66] LGBTQH communities and transgender and bisexual survivors in particular can face social isolation.[67] Homophobic, biphobic, and transphobic power and control can capitalize on that isolation to control survivors. LGBTQH survivors and abusive partners both know that survivors may face poverty, homelessness, and unemployment when they attempt to exit their relationships. Homophobic, transphobic, and biphobic power and control tactics are particular forms of IPV that are uniquely experienced by LGBTQH survivors. In order to fully prevent LGBTQH IPV and support LGBTQH IPV survivors, providers must receive education on these issues and learn how to support survivors in a welcoming and bias-free environment that does not trigger LGBTQH IPV survivor's experiences of abuse.

LOW RATES OF POLICE REPORTING AND POLICE INTERACTION

In this year's report less than half of survivors reported to the police. While this is an increase from 2010, this continues to show that a substantial amount of LGBTQH IPV survivors are not seeking support from law enforcement. Violence in LGBTQH relationships remains underreported, similar to non-LGBTQH survivors, out of fear of retaliation from abusive partners. Until recently sodomy laws deterred many LGBTQH IPV survivors from reporting IPV for fear of being arrested for same-gender sexual activity.[68] Most states repealed anti-sodomy law in the 1970's and 1980's. The U.S. Supreme Court ruled the remaining anti-sodomy laws unconstitutional in 2003.[69] Research on LGBTQH survivors also shows that survivors are particularly reluctant to report out of fears associated with confronting homophobia, transphobia, and biphobia from law enforcement.[70] LGBTQH communities have historic negative police experiences that continue to the present day such as: police raids of LGBTQH bars and clubs, anti-LGBTQH police violence and profiling, false arrests, and homophobic, biphobic, and transphobic harassment when attempting to seek support from law enforcement.[71] One serious experience

[66] Kae Greenberg.(2009). *Still Hidden in the Closet: Trans Women and Domestic Violence*. Berkley Journal of Gender, Law and Justice.206.
[67] Kae Greenberg.(2009). *Still Hidden in the Closet: Trans Women and Domestic Violence*. Berkley Journal of Gender, Law and Justice. 215.
[68] Joan C. McClennen. (2005).*Domestic Violence Between Same-Gender Partners: Recent Findings and Furture Research*. Journal of Interpersonal Violence. Vol .18, 152.
[69] *Lawrence vs. Texas*. Retrieved on September 30, 2012, from http://en.wikipedia.org/wiki/Sodomy_laws_in_the_United_States
[70] Leslie K. Burke & Diane R. Follingstad.(1999). *Violence In Lesbian and Gay Relationships: Theory, Prevalence, and Correlational Factors*. Clinical Psychology Review, Vol. 19, 491.
[71] NCAVP – *Hate Violence Against Lesbian, Gay, Bisexual, Trnasgender, Queer, and HIV- affected Communities: In the United States in 2011*. Retrieved on September 30, 2012, from http://avp.org/documents/NCAVPHVReport2011Final6_8.pdf.

for LGBTQH IPV survivors is mis-arrest, when the survivor is arrested as opposed to the abuser. In 2011 a little less than one third of survivors reported experiencing mis-arrest. Mis-arrest can result from police officers not understanding how to identify an abuser within LGBTQH relationships and assuming who the abuser is based size, perceptions of strength, or stereotypes who the abuser is. Many NCAVP member programs train law enforcement on LGBTQH IPV to help reduce to possibility of negative police experiences, especially mis-arrest. These combined experiences of police violence, criminalization, and negative treatment by law enforcement when seeking support have contributed to cultural distrust within LGBTQH communities to report violence within LGBTQH relationships to the police.[72]

EX-PARTNERS AND INTIMATE PARTNER VIOLENCE

In this report survivors reported substantially more IPV from abusive ex-partners as compared to previous years. Breakups can increase tensions within abusive relationships and can increase the severity of the violence that LGBTQH survivors experience. Ex-partners may feel that they have lost control over their relationship, and therefore increase their abusive tactics, and/or stalk their ex-partners. Survivors are also shown to be more likely to seek help when violence within their relationships is severe and this can contribute to the high amount of reported abusive ex-partners. 2011's data highlights that safety planning on violence and abuse from ex-partners in addition to current partners is critical for LGBTQH survivors. Programs that seek to support survivors and prevent IPV should develop specific programs to address violence from ex-partners. Currently, there is limited research on this topic, and NCAVP will continue to monitor this dynamic in future reports to monitor increases or decreases over time.

DECREASE IN SURVIVORS ACCESSING DOMESTIC VIOLENCE SHELTERS AND ORDERS OF PROTECTION

The decrease of survivors accessing domestic violence shelters highlights a continuing issue that many mainstream shelters may not be equipped to house LGBTQH survivors.[73] NCAVP members frequently encounter many mainstream shelters that have policies that explicitly prohibit men and transgender survivors from their shelters. Policies that exclude LGBTQH survivors, particularly men and transgender survivors, compel LGBTQH survivors to seek support from homeless shelters, which may not be equipped to support LGBTQH IPV survivors' needs. Homeless shelters may not have IPV specific services such as counseling and support groups, staff who are familiar with LGBTQH terminology, access to gender neutral restrooms and accommodations, knowledge of LGBTQH IPV issues, and institutional policies to prevent discrimination and violence within the shelter for LGBTQH survivors.[74] This data demonstrates the need for increased advocacy to increase LGBTQH IPV survivors' access to domestic violence shelters and to increase LGBTQH inclusivity within mainstream domestic violence services.

The decrease in survivors receiving orders of protection suggests that LGBTQH survivors continue to face barriers in seeking support from law enforcement, as previously discussed. Orders of protection may be of great assistance to a survivor trying to increase their safety. Orders of protection can help the survivor distance themselves from their abusive partner, and provide law enforcement and legal support to prevent an abusive partner from returning to their home or the relationship. In some cases, orders of protection may not be the support a survivor needs, and can possibly put survivors at

[72] Amnesty International USA – *Stonewalled: Police Abuse and Misconduct Against Lesbian, Gay, Bisexual and Transgender People in the US*. Retrieved on Sept 15, 2012, from http://www.amnesty.org/en/library/asset/AMR51/122/2005/en/17385cd5-d4bd-11dd-8a23-d58a49c0d652/amr511222005en.html.
[73] Kae Greenberg.(2009). *Still Hidden in the Closet: Trans Women and Domestic Violence*. Berkley Journal of Gender, Law and Justice. 234.
[74] *Why It Matters: Rethinking Victim Assistance for LGBTQ Victims of Hate Violence & Intimate Partner Violence*. National Center for Victims of Crime and the National Coalition of Anti-Violence Programs, 2010. Retreived on September 5, 2012, from http://www.avp.org/documents/WhyItMatters.pdf.

additional risk. Some abusive partners may increase their abusive tactics in retaliation after an order of protection is filed against them.

UNDERREPORTED CATEGORIES

Many survivors did not report their HIV, disability, or immigration status to NCAVP. This indicates that survivors could need more support in safely and comfortably disclosing these identities to NCAVP. Advocacy and policy work needs to continue within these communities in order to ensure access to appropriate services. Given the high percentage of undisclosed answers in these particular categories, NCAVP found it important to look at the potential reasons as to why people were not disclosing in these categories.

HIV STATUS

Consistent with previous year's 60% of survivors did not disclose their HIV status in 2011. Stigma against HIV-affected communities, lack of access to appropriate services, and challenges in proving discrimination based on HIV status leads HIV-affected survivors to underreport experiences of violence and discrimination.[75] While these trends are commonly observed for reporting to law enforcement the high percentage of survivors who did not report their HIV status to NCAVP in 2011 may reflect these trends as well. Many states also have confidentiality laws related to collecting information on HIV status, which can reduce the amount of NCAVP programs collecting information on HIV-affected IPV survivors. HIV-positive survivors can experience specific forms of IPV that are critical to document and research. Abusive partners can use survivor's HIV-status as a tool to maintain power and control by withhold or threaten to withhold medication as a tactic of power and control, interfere with HIV-related medical appointments, increase physical violence when HIV-positive survivors are physically-ill, and inflict HIV-related emotional abuse such as threatening to out an HIV-positive survivor's status or trying to shame them because of having HIV. These abusive tactics can substantially reduce the physical and mental health for HIV-affected survivors. NCAVP will continue to document the experiences of HIV-affected survivors in order to increase their access to services and safety.

IMMIGRATION STATUS

Similar to HIV-status only 50% of all survivors reported their immigration status. Some NCAVP member programs do not collect immigration status information for fear that recording this information may inadvertently put survivors at risk of deportation. This can increase the amount of non-disclosed immigration responses. LGBTQH immigrant survivors could also not disclose their immigration status to anti-violence programs out of a fear of deportation. Federal immigration programs such as Secure Communities (S-Comm), a fingerprint-sharing program that shares fingerprints of suspected undocumented people with the FBI's database when they encounter law enforcement, results in expedited and increased deportations. Programs like S-Comm can deter LGBTQH IPV immigrant survivors from reporting to law enforcement and anti-violence programs. LGBTQH IPV immigrant survivors often need specific services and prevention programs to that address the intersections of the LGBTQH identity and immigration status. Abusive partners of LGBTQH immigrants can also use a survivor's immigration status as a tactic of power and control by threatening to call Immigration and Customs Enforcement (ICE). NCAVP will strive to safely increase the data on LGBTQH immigrant survivors to document and continue to advocate for these issues.

[75] Lambda Legal —*HIV Stigma and Discrimination in the US: An Evidence-Based Report// November 2010*. Retrieved on May 20th, 2012, from http://data.lambdalegal.org/publications/downloads/fs_hiv-stigma-and-discrimination-in-the-us.pdf.

BEST PRACTICES

INCREASE SURVIVOR LEADERSHIP

Community-based organizations should prioritize and support the leadership of LGBTQH IPV survivors by creating survivor-led programs.

LGBTQH anti-violence organizations, non-LGBTQH anti-violence organizations, and other community based organizations should support and prioritize the leadership of survivors of intimate partner violence to better serve the communities most impacted by severe IPV and homicide. This includes programs such as speaker's bureaus, participatory action research projects, community advisory boards, and organizing campaigns that focus on increasing survivor leadership, input, and participation in anti-violence advocacy. As 2011's data documents gay men, LGBTQH youth and young adults, LGBTQH survivors of color, and transgender survivors face disproportionate experiences with severe forms of violence. Leadership programs for these communities should include curriculum, dedicated outreach, and services that address the intersections of their oppressions in culturally specific ways to support increasing leadership and safety for these survivors. LGBTQH IPV survivor's direct experiences provide invaluable perspectives for IPV prevention programs and direct services. When IPV survivors speak with other survivors they can help break the isolation that survivors experience through IPV and can be a crucial support when survivors are safety planning. Research and data on the needs and priority issues of LGBTQH IPV survivors remains limited. Developing the skills of LGBTQH IPV survivors as direct service providers, advocates, organizers, managers, and administrators can help to ensure anti-violence organizations utilize the expertise and remain accountable to the communities most directly affected by violence.

INCREASE SURVIVOR SAFETY

Mainstream community-based organizations should increase access to services for LGBTQH survivors of IPV through institutional policies, procedures, hiring, training, and assessment tools that explicitly include the needs of LGBTQH survivors.

Most mainstream victim service providers do not have programming that comprehensively meets the needs of LGBTQH survivors.[76] LGBTQH-specific anti-violence organizations should support mainstream programs through training and technical assistance to increase their LGBTQH-specific expertise particularly within direct services, outreach, advocacy, and community organizing. The NCAVP National Training and Technical Assistance Center has a list serve, warmline, conducts training and webinars, and has tools to support these providers to increase the LGBTQH-inclusivity of their programs.

Mainstream and LGBTQH-specific anti-violence programs should implement Comprehensive Screening and Assessment Practices.

Many non-LGBTQH specific anti-violence organizations assume that all survivors are women and abusive partners are men which decreases LGBTQH survivors' access to life-saving services, especially for men and transgender survivors. These gendered assumptions do not accurately screen abusive partners for same gender relationships and often are ill-equipped to address the needs of transgender IPV survivors and their partners. Community-based anti-violence organizations, including

[76] *Why It Matters: Rethinking Victim Assistance for LGBTQ Victims of Hate Violence & Intimate Partner Violence*. National Center for Victims of Crime and the National Coalition of Anti-Violence Programs, 2010. Retreived on September 5, 2012, from http://www.avp.org/documents/WhyItMatters.pdf.

mainstream domestic violence organizations and LGBTQH-specific anti-violence programs, should implement comprehensive screening and assessment practices to determine who the survivor is and who the abusive partner within IPV is. Law enforcement, other first responders, and anti-violence organizations can mistakenly identify an abusive partner as being a surviving partner, and provide services according to that mistaken assessment. When first responders and service providers wrongly assess who are the survivor and abusive partner within an intimate partner violence relationship, it compromises a survivor's safety by denying them access to confidential services, safety planning, and other critical forms of support to address intimate partner violence. Further, when services intended for survivors are offered to abusive partners, it validates their abusive actions and releases them from attempts to hold them accountable for their behavior. Screening and assessment skills require thorough and in-depth training and practice, and community based organizations and anti-violence programs should ensure that all levels of their organization are trained in how to assess and screen when responding to intimate partner violence.

Mainstream anti-violence programs and LGBTQH anti-violence programs should create and support direct support models to serve LGBTQH IPV survivors not able or willing to engage with the criminal legal system.

As mentioned in this report, historically LGBTQH IPV survivors faced discrimination, violence, or criminal charges when engaging law enforcement and the legal system for support. In 2011 less than half of all LGBTQH IPV survivors reported sought support from law enforcement. This can be due to negative past experiences with law enforcement, having a criminal record, having regular engagement with illegal activities, being an undocumented immigrant, or having other immigration concerns. A small but growing number of organizations are developing skills and best practices on anti-violence work separate from the criminal legal system. These strategies are variably called community accountability or transformative justice. LGBTQH anti-violence programs and non-LGBTQH service providers should collaborate with community accountability or transformative justice anti-violence groups to receive training and technical assistance on these models for programming and support.

PREVENT VIOLENCE

LGBTQH-specific and mainstream community-based organizations should develop programs and campaigns to prevent and increase public awareness of LGBTQH IPV.

Mainstream and LGBTQH-specific organizations should raise awareness of IPV within LGBTQH communities to create a culture of intolerance for LGBTQH IPV. Community-based organizations can use outreach, public awareness campaigns, community organizing campaigns, and cultural events to educate community members on LGBTQH intimate partner violence, to teach people how to recognize the warning signs of abusive behavior, and how people can assist LGBTQH survivors of IPV to seek support for abusive relationships. Community organizers and service providers should conduct strategic outreach to LGBTQH communities to increase visibility of intimate partner violence prevention programs and services available to survivors of intimate partner violence. Without diverse and frequent outreach, LGBTQH survivors may not know where to go for support and safety. LGBTQH community centers, LGBTQH campus centers, and LGBTQH-specific policy organizations should train their staff and their constituencies about LGBTQH intimate partner violence and violence prevention strategies. Community organizations can also create organizing campaigns to confront mainstream IPV institutions that discriminate against LGBTQH IPV survivors and to demand that educational institutions

include an analysis of the impact of intimate partner violence in LGBTQH relationships within educational curricula regarding intimate partner violence.

Mainstream community-based organizations such as community centers, direct service organizations, religious institutions, political organizations, and civic organizations can play leadership roles in changing community attitudes regarding LGBTQH intimate partner violence. Mainstream anti-violence organizations should collaborate with LGBTQH organizations to ensure that their outreach initiatives are LGBTQH inclusive. Mainstream organizations can benefit from LGBTQH anti-violence organizations' expertise on LGBTQH violence prevention. These collaborations can allow both organizations to share violence prevention strategies and create future collaborations. These partnerships can maximize opportunities for funding and growth, increase the reach of anti-violence initiatives, create strategic alliances with diverse groups of policymakers and public figures, and increase resources for more successful campaigns and programs. These partnerships are particularly important in geographic areas of the country where LGBTQH-specific anti-violence services are scarce, such as the South and in rural areas.

Community-based organizations and educational institutions should prioritize early intervention and prevention strategies for youth to prevent and reduce IPV in LGBTQH communities.

Community based organizations and educational institutions should prioritize providing education on the dynamics and warning signs of IPV to youth to increase early intervention of IPV and prevent IPV from developing into long-term cycles of violence. The 19-29-year-old age group comprised the largest percentage of survivors reporting to NCAVP members in 2011, indicating that IPV in LGBTQH youth and young adults continues to be a serious and pervasive issue. Additionally LGBTQH youth and young adults experienced disproportionate amounts of injuries and physical violence as compared to overall LGBTQH survivors. Sexual education curricula often do not include information on LGBTQH relationships or information on IPV. Comprehensive sexual education must include information on LGBTQH identities and include LGBTQH people in discussions about IPV to allow LGBTQH youth to recognize early warning signs of abuse. These curricula should also educate youth and young adults on changing abusive behavior, provide examples and support towards creating healthy relationships, and assist these communities in understanding that violent and abusive behavior is unacceptable. NCAVP recognizes that diverse political climates prevent such sexual education curricula from being possible in many areas of the country, and encourage LGBTQH youth organizations to collaborate with NCAVP members and anti-violence programs in developing these prevention strategies at the community level.

Mainstream anti-violence programs and LGBTQH anti-violence programs should create and support LGBTQH Batterer Intervention Programs.

Currently there are very few LGBTQH-inclusive or specific batterer intervention programs in the United States. LGBTQH organizations should increase their knowledge and expand programs geared toward preventing, reducing, and ending violent behavior within LGBTQH relationships, focusing on programs that work with abusive partners. Recognizing the large role that ex-partners played in abuse these programs should focus on both current and former partners.

All anti-violence organizations should adopt and utilize an Anti-Oppression Framework.

IPV is a pattern of behaviors exerted by a partner to assert and maintain power and control over another partner. Cultural and institutional homophobia, biphobia, transphobia, sexism, ableism, racism, classism, and other oppressions throughout broader society are also abuses of power where one group of people maintains power and control over another group of people. Cultural and institutional oppression supports the existence of IPV by teaching people that it is desirable to have

power over someone else. Many NCAVP members and anti-violence organizations recognize that in order to end IPV, they must challenge and the broader culture of oppression and abuses of power. Community-based organizations and anti-violence programs should incorporate anti-oppression analyses, practices, and trainings into their ongoing work in order to challenge a culture that sanctions and condones oppression and abuses of power. Incorporating an anti-oppression framework can include developing an understanding of multiple forms of oppression and working to challenge oppressive behavior within anti-violence organizations and participating in social movements to end oppression throughout the broader society. Organizations can create an internal committee or working group to examine how the organization's policies, practices, and programmatic work can incorporate anti-oppression principles. Organizations can also devote organizational retreats to developing an anti-oppression framework, or invite outside speakers to provide education on various forms of oppression and strategies to work against oppressive behaviors, practices, and policies. Using an anti-oppression framework can also ensure that an organization is being accountable to the diversity of their communities by targeting outreach and service to traditionally marginalized and underserved communities including LGBTQH people of color, transgender and gender non-conforming communities, non-English speaking LGBTQH communities, LGBTQH youth, LGBTQH people with disabilities, and other communities.

LGBTQH anti-violence programs and mainstream anti-violence programs should increase outreach and programs to under-represented communities.

NCAVP's 2011 data lacks representation from LGBTQH elders, HIV-affected communities, LGBTQH immigrants, Asian Pacific-Islander communities, and Native communities. NCAVP members do not feel this is due to lower rates of IPV experienced by these communities. Instead NCAVP members believe that these communities experience barriers to report and access services, as well as a lack of specific in outreach and collaboration with these communities. Anti-violence organizations should prioritize outreach to reach under-represented LGBTQH survivors of IPV and collaborate with organizations within these communities to develop specific and targeted initiatives to best meet the needs of these underserved communities.

FULL RECOMMENDATIONS FOR POLICYMAKERS AND FUNDERS

PREVENT

- Policymakers and funders should fund LGBTQH anti-violence organizations to conduct intimate partner violence prevention initiatives.
- Policymakers and funders should ensure that all dating violence curricula includes information about LGBTQH dating violence, and that sexual education curricula includes information about dating violence inclusive of LGBTQH communities.
- Policymakers and funders should support early intervention and prevention programs for youth to prevent and reduce IPV in LGBTQH communities.
- Policymakers and funders should support programs and campaigns to prevent and increase public awareness of LGBTQH intimate partner violence.

RESPOND

- Policymakers, public, and private funders should increase local, state, and national funding to LGBTQH-specific anti-violence programs, particularly for survivor-led initiatives.
- Congress should pass an LGBTQ-inclusive Violence Against Women Act (VAWA) to improve access to services for LGBTQH survivors of intimate partner violence, dating violence, sexual assault and stalking.
- Policymakers should institute LGBTQH-specific non-discrimination provisions to increase support and safety for LGBTQH survivors of violence, while also eradicating affirmatively discriminatory laws and policies that increase barriers for LGBTQH IPV survivors when seeking support.
- Policymakers should support LGBTQH training and technical assistance programs to increase the cultural competency of all victim service providers to effectively work with LGBTQH survivors.

RESEARCH

- Policymakers and funders, including the Department of Justice's Bureau of Justice Statistics, should increase research and documentation of LGBTQH intimate partner violence.
- Policymakers should ensure that the federal government collects information on sexual orientation and gender identity, whenever demographic data is requested in studies, surveys, and research including IPV.

CONCLUSION

Violence within LGBTQH relationships has historically been an invisible within and outside LGBTQH communities. This invisibility isolated many LGBTQH survivors of IPV, prevented LGBTQH communities from taking action on IPV, and made it more difficult to challenge the re-victimization of LGBTQH survivors by mainstream IPV service providers. This report provides insight into IPV within LGBTQH communities and highlights some key barriers between survivors and safety. In 2011, NCAVP saw a substantial increase in IPV related homicides. This increase in homicide not only gives us a clearer picture of IPV within LGBTQH communities, but it also gives us the opportunity to learn about the deadly impacts of the barriers LGBTQH IPV survivors experience when accessing support systems. Lifesaving resources for IPV survivors, including healthcare, shelter, legal support, counseling, and advocacy have expanded over the past few decades, but are often not accessible to all LGBTQH survivors. These resources are essential to support survivors' plans to be safe within their relationships, or safe to leave them. LGBTQH survivors of IPV have been historically under-served by the mainstream support systems created to respond to this violence. The unique experiences of LGBTQH survivors, within the context of interpersonal and institutional homophobia, biphobia, transphobia, and heterosexism, create barriers that survivors may need assistance to navigate. NCAVP creates this report to highlight these barriers and provide concrete ways to overcome them. NCAVP aims to prevent and eventually eradicate IPV within LGBTQH communities by utilizing this research to inform direct services, public advocacy, public education, and community organizing.

Power and control dynamics continue to permeate the fabric of our society. Popular culture, media, family structures, and educational systems can create and reinforce societal norms that either condone abusive behavior or work to eradicate it. To u shift the conditions that create IPV within all relationships, communities must work collectively to challenge these cultural norms and support survivors of abuse. To end IPV all communities must understand and examine the ways that power, control, privilege, discrimination, and oppression intersect and manifest within relationships and survivor support systems.

NCAVP writes this report annually to ensure comprehensive and current information on the unique experiences of LGBTQH survivors is available to inform policy and programming. Policy makers and service providers should use the information provided in this report to inform their decisions and IPV programming. LGBTQH community members can use this report to spread awareness of IPV within LGBTQH communities, a topic rarely talked about within many LGBTQH organizations and social settings. No community, including LGBTQH communities, can afford to ignore IPV, when it can exact such a deadly price.

LOCAL SUMMARIES

BUCKEYE REGION ANTI-VIOLENCE ORGANIZATION (BRAVO)

OHIO STATEWIDE

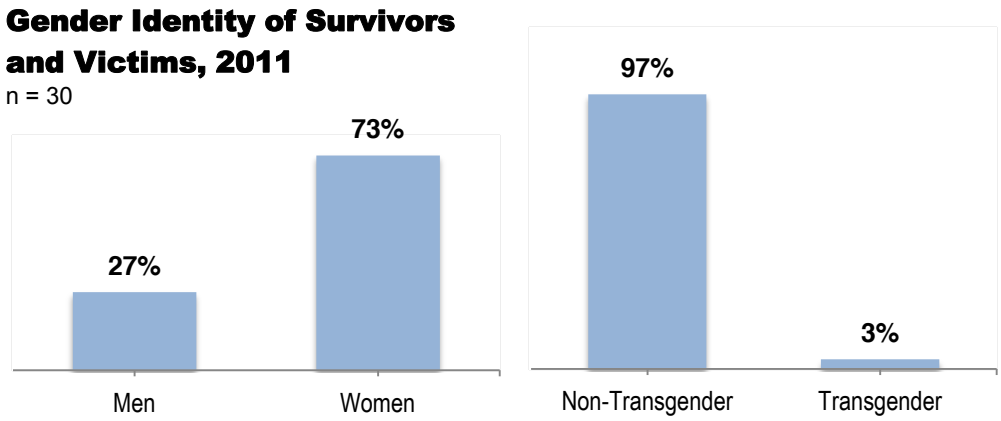
Buckeye Region Anti-Violence Organization (BRAVO) works to eliminate violence perpetrated on the basis of sexual orientation and/or gender identification, domestic violence, and sexual assault through prevention, education, advocacy, violence documentation, and survivor services, both within and on behalf of the lesbian, gay, bisexual, and transgender communities.

BRAVO's services include anonymous, confidential crisis support and information via a helpline with trained staff and volunteers, documentation of hate crimes and intimate partner violence, hospital and legal advocacy, public education to increase awareness of hate crimes and LGBTQ intimate partner violence and to increase knowledge about support services available, education of public safety workers, and service and health care providers to increase their competency to serve LGBTQ victims.

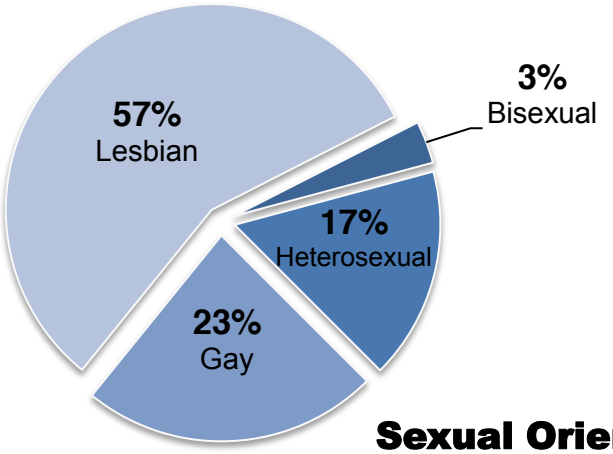
BRAVO is committed to our belief that the best way to reduce violence is to foster acceptance. Only by making people and institutions aware of these issues and "demystifying" LGBTQ people and the issues that LGBTQ people face can we assure quality services to victims and ultimately reduce the incidence of violence.

BRAVO received 30 reports of Intimate Partner Violence (IPV) in 2011, a 63% increase from the previous year. The increase in reports for 2011 could demonstrate increased reporting as reflected in previous years. Increased reporting may also be attributed to BRAVO subcontracting with the Legal Advocacy for Victims (LAV) grant from the Ohio Domestic Violence Network (ODVN). This grant allowed BRAVO to hire a dedicated IPV/SA part-time legal advocate, increase statewide outreach and services for LGBTQI survivors, and provide LGBTQI specific trainings for victim advocates and attorneys throughout the state.

27% of callers were non-transgender men (8 total callers) and 73% were non-transgender women (21 callers). One survivor identified as a transgender woman. The year 2011 saw a 27% decrease in men reporting (11 in 2010 to 8 in 2011) and a 175% increase by women (8 in 2010 to 22 in 2011). Previous years have shown a much more equitable reporting rate between men and women, with men reporting slightly higher rates of IPV the past three years.



In 2011, of those reporting, 23% identified as gay men (7) and 57% as lesbians (17). 17% of survivors were heterosexual women (17), with one bisexual male survivor reporting (3%).



n=30

Sexual Orientation of Survivors and Victims, 2011

47% of survivors interacted with the police (14 survivors). 50% of those reported courteous behavior (7 survivors), and 21% reported indifferent or hostile attitudes by the police (3 survivors). In 2011, BRAVO had no reports of law enforcement arresting the survivor. As BRAVO has continued to provide outreach, training, and incident response to law enforcement agencies statewide we are encouraged that these statistics show an increasing positive trend toward better response and improved attitudes by law enforcement working with LGBTQ survivors of IPV in Ohio.

BRAVO has seen continued success with the statewide LGBTQI Domestic Violence and Sexual Assault Task Force. The Task Force is a multidisciplinary group of direct service providers, community-based agencies, advocates, educators, policy makers, funders, and their allies who are working on behalf of Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex (LGBTQI) communities affected by domestic violence and sexual assault. The Task Force's mission is to raise awareness of and improve response to domestic violence and sexual assault impacting LGBTQI communities throughout the state. In addition, the Task Force seeks to support service providers, advocates, policy makers and others by providing education and advocacy, fostering collaboration, and identifying and working towards needed systems change for the LGBTQI communities.

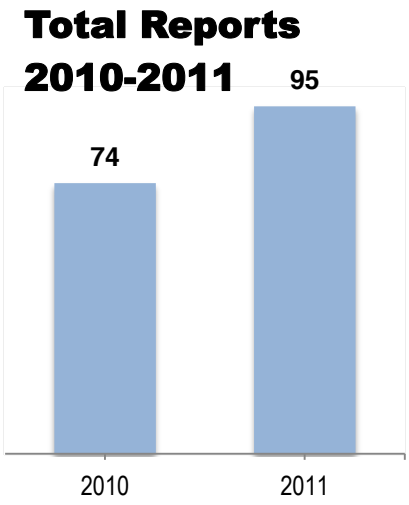
In 2011, the Task Force launched a statewide "Safe Zone" training for domestic and sexual violence programs. The "Safe Zone" training is an initiative to increase safety and resources for survivors of domestic violence, sexual assault, and stalking in the Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex communities. Participants in this project will learn about LGBTQI communities and how to integrate policies and procedures that will ensure safety to survivors. The project is supported by the Ohio Attorney General's Crime Victim Section, Ohio Office of Criminal Justice Services and the Ohio Department of Health.

CENTER ON HALSTED ANTI-VIOLENCE PROJECT (COH AVP)

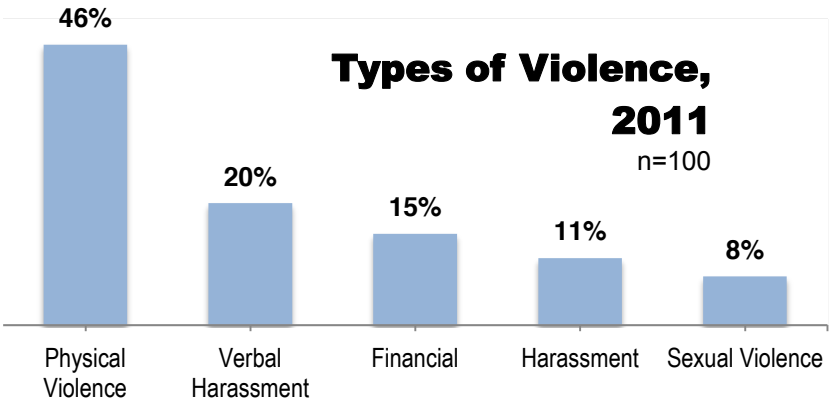
CHICAGO, IL

Center on Halsted advances community and secures the health and well-being of the LGBTQ people of Chicago. Center on Halsted envisions a thriving lesbian, gay, bisexual, transgender and queer community, living powerfully in supportive, inclusive environments.

Center on Halsted's Anti-Violence Project (COH AVP) responds to LGBTQ hate, domestic, sexual, police, and HIV-related violence across our region, providing direct support and services to survivors and witnesses, including crisis support, counseling, advocacy, safety planning, court accompaniment, and information and referrals. Our Training & Violence Prevention programs decrease the impact of bias in the lives of LGBTQ people, reducing both risk for harm and re-victimization by emergency responders and service providers.



In 2011, COH AVP provided support to 95 survivors of intimate partner violence. This is a 28% increase from 2010. During 2011, COH AVP was able to increase staffing from 1 to 2.5, enabling us to perform more outreach and provide more rapid response to survivors of violence. We believe our increased staffing accounts for the higher number of reports recorded because we are better able to respond with relevant and meaningful services in a timely manner, comprehensively, and with longer-term engagement. More outreach, more training, and more staff to perform intakes and develop services has meant that survivors identify COH AVP as a responsive, meaningful resource where "something will happen" as a result of reporting. This underscores a continuing need for relevant and meaningful capacity development and resources at local violence response programs.



46% of 2011's reports (46 reports) included physical violence (a 39% increase compared to 33 reports of physical violence in 2010), making it the most-reported type of violence. Compared to 2010 where the most-reported type of violence was verbal harassment. Also, in 2011, reports of sexual violence (sexual assault and sexual abuse) included as an aspect of a survivor's experience of IPV increased by 167% (from 3 reports in 2010 to 8 in 2011), representing 8% of the total IPV survivor reports this year. 15% (15 reports) of our 2011 IPV reports also included disclosure of financial or economic abuse, representing a 25% increase from 2010 reports (12 reports in 2010). Only 1 out of 5 people who reported incidents of IPV to COH AVP disclosed that they had also reported the incident to their local law enforcement. This information helps to illustrate LGBTQ IPV survivors' needs for safe spaces to disclose instances of violence and receive healing, supportive responses from communities and institutions to promote accountability and prevent re-victimization. In addition LGBTQ-specific prevention efforts reduce the number of people exposed to violence and abuse.

THE CENTER FOR WOMEN AND FAMILIES

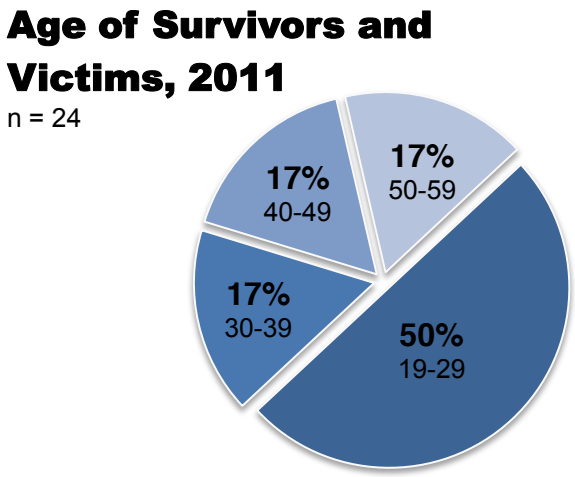
LOUISVILLE, KY

The Center for Women and Families helps victims of intimate partner abuse or sexual violence to become survivors through supportive services, community education, and cooperative partnerships that foster hope, promote self-sufficiency, and rebuild lives. Originally part of the YWCA, The Center for Women and Families has been serving our community since 1912. Today The Center is a private nonprofit organization with 5 regional locations serving 7 Kentuckiana counties: Bullitt, Henry, Jefferson, Oldham, Shelby, Spencer and Trimble counties in Kentucky, and Clark and Floyd counties in Indiana.

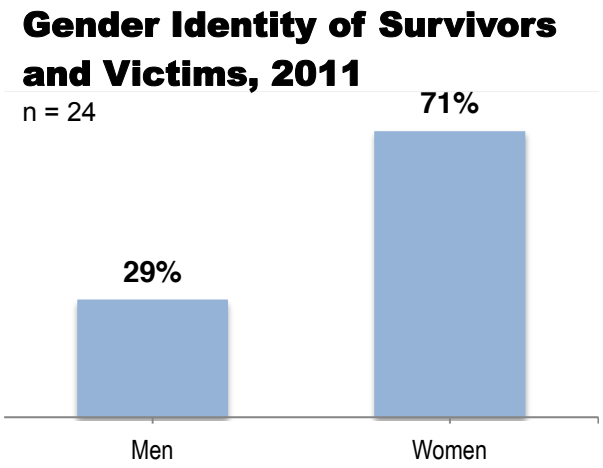
The Center for Women and Families offers services to all survivors of intimate partner abuse or sexual violence. Our clients include men and gay, lesbian, bisexual, and transgender people in addition to women and dependent children. We provide a variety of residential and nonresidential services including emergency shelter, transitional housing, counseling and advocacy. We staff a 24-hour crisis line, as well as have staff on call at all times to respond to sexual assault and domestic violence victims at area hospitals for advocacy and support. In 2011 The Center directly served over 7,000 clients who were affected by intimate partner and sexual violence, including primary victims of violence and the family and friends who are secondary victims, and reached over 30,000 community members through direct services, prevention trainings, and awareness efforts.

In recent years The Center formed an internal LGBTQ committee, which strives to create a safe and inclusive culture for LGBTQ individuals who have experienced intimate partner abuse or sexual violence by raising community awareness, fostering partnerships, educating staff and developing best practices. This committee's work includes internal training and resources to increase cultural competency related to LGBTQ populations, outreach efforts to the area's LGBTQ populations, and an effort to help create accessible and affirming space in our shelters and offices for all persons.

We recognize that our statistics do not accurately reflect the incidence of intimate partner violence and sexual assault in the local LGBTQ population, nor the number of LGBTQ persons served by The Center in 2011. Collecting sexual orientation and gender identity demographics is not currently required, and often has not been an inquiry of staff upon client intake or not disclosed by clients. Moving forward, The Center aims to improve data collection related to sexual orientation and gender identity so that we can better provide area statistics for LGBTQ populations and contribute to NCAVP research initiatives. Of the small collection of data we did receive specifying LGBTQ clients, all 24 cases were victims of intimate partner violence, many of whom reported multiple violent behaviors by their perpetrators, including physical violence, sexual assaults, threats and harassment. Two-thirds of these clients reported that the perpetrator was a current intimate partner, while the others reported the perpetrator was aformer partner or friend.



50% (12) of survivors were ages 19-29, which is consistent with the national data. Ages 30-39; 40-49; and 50-59 were the remainder of survivors who reported and received services. While our sample size is small, making it difficult to discern these breakdowns, younger survivors may be more comfortable disclosing their sexual orientation or gender identity, making them a larger percentage of reports.



Women represented a majority of survivor's with 71% (17 survivors) and men were the remainder with 29% (7 survivors). While 29% of men is larger than the overall percentage of men we serve who are not GBTQ-identified, due to the small sample size it is difficult to make a conclusion on why this may be the case. The Center is committed to increasing our data collection for the NCAVP reports to better understand LGBTQH intimate partner violence in our region.

COLORADO ANTI-VIOLENCE PROGRAM (CAVP)

DENVER, CO

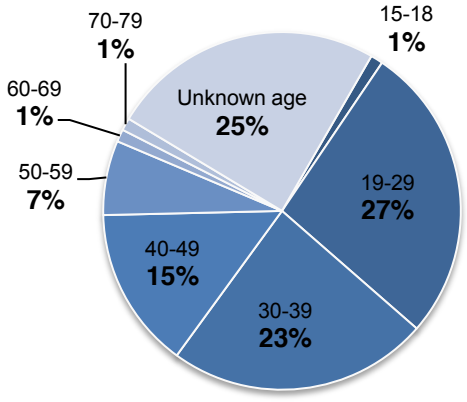
The Colorado Anti-Violence Program (CAVP) works to eliminate violence within and against the lesbian, gay, bisexual, transgender and queer (LGBTQ) communities in Colorado; in addition we seek to provide the highest quality services to survivors. CAVP provides direct services including a 24-hour state-wide hotline for crisis intervention, information and referrals as well as advocacy with other agencies, court accompaniment, and case management. CAVP also provides technical assistance and training and education for varied audiences including, but not limited to, service providers, homeless shelters, community organizations, law enforcement, and LGBTQ community members.

Branching Seedz of Resistance (BSEEDZ) is a youth-led project of CAVP that works to build community power to break cycles of violence affecting LGBTQ young people in Colorado. Using strategies of community organizing, arts and media, action research, and direct action, BSEEDZ sparks dialogue, educates, and empowers youth to take action. Led entirely by youth, BSEEDZ continues to build a base of youth leaders locally and nationally who are committed to fighting for safety and justice in their lives, families, and communities.

CAVP saw a small increase in the number of reports, from 86 in 2010 to 89 in 2011 (a 3% increase). This increase in reports may be due to increased outreach efforts and enhanced Spanish language support for our statewide hotline. Although the numbers are higher than the previous year, we do believe that as CAVP improves outreach across the state and shifts in the way that reports are collected and tracked, the number of reports annually will continue to increase in future years. For example, some other program or projects operating in the state give us anecdotal information about LGBTQ intimate partner violence incidents that are reported to their office, or survivors who were supported by them; these numbers are, however, not reported to CAVP. As part of outreach and collaborations, CAVP may look to collaborate with these organizations, so that we are able to further improve our data collection.

Age of Survivors and Victims

n=89



In 2011, CAVP saw that the highest number of survivors of intimate partner violence were from those aged between 19-29 with 27% of total reports (24), whereas the age group with the highest numbers in 2010 were between the ages of 30-39 (24%) with 21 reports. There were more reports from both men and women in 2011 as compared to 2010, with men at 63% (56 of total reports) and women at 39% (35) of the total in 2011. Reports from transgender individuals decreased,

from 6 in 2010 to 3 in 2011. CAVP saw an increase in numbers from those who had self-identified disabilities: in 2010, 6 persons reported having a disability. In 2011, 12 persons (13% of total survivors) reported the having a disability. Survivors who reported HIV+ status also went up. In 2010, we had 2 reporting that they were HIV+; in 2011, 7 survivors reported that they were HIV+, consisting of 8% of total reports.

Physical violence was the tactic most commonly experienced in intimate partner violence in 2011 (25% of cases, 22 reported incidents), followed by verbal harassment in person (9%, 8 reports), threats (8%, 7 reports) and sexual violence (6%, 5 reports). Financial/economic abuse went up from 2 cases in 2010 to 4 in 2011, making up 4% of total reports.

Current lovers or partners were the highest percentage of known offenders, and we tracked a 213% increase in numbers from 2010: in 2011, 47 survivors (as opposed to 15 in 2010) identified a current lover or partner as the offender. Ex-lovers or partners, however, were also a significant number (in both years) and were 19% of the total number (17 reports in both 2010 and 2011). Gay men were the highest number of survivors reported, as well as the highest number of offenders. In 2011, 48% (43 survivors) of the survivors were gay men and 18% (16 survivors) were lesbians. Reported offenders who were identified as gay men were 15% of the total number in 2011 (13), lesbians were 7% (6), and heterosexual men and women were 4% (4).

CAVP continued to note that many survivors prefer not to report to the police. High profile police brutality cases from the previous year which had not been resolved by the Denver Police Department in a way that was reassuring for community organizations and members likely contributed to a continuing distrust or fear of reporting to police. 13% (12 survivors) of survivors reported to the police: of these 25% (2) reported being treated courteously by the officers, while 50% reported that they encountered either "indifferent" attitudes, or "hostile" attitudes, including the use of slurs or bias language (4). CAVP is exploring strategies of working with the police, particularly in Denver, to more effectively support LGBTQ survivor safety and reporting.

7% of the survivors (6) pursued a Protection Order, and 83% of these were granted (5). The top needs of survivors that CAVP was able to support were the following: 20% of the survivors needed support in finding housing (18 survivors); 16% sought counseling help (14). Referrals for legal aid or advice were sought by 15% of the survivors (13), and shelter by 12% (11). 12% of the survivors were either already homeless or anticipating homelessness as a result of the intimate partner violence (11 survivors). CAVP hotline advocates and office staff supported 24% of the survivors with safety planning, (21 survivors) and 7% received some form of emergency funds (6 survivors).

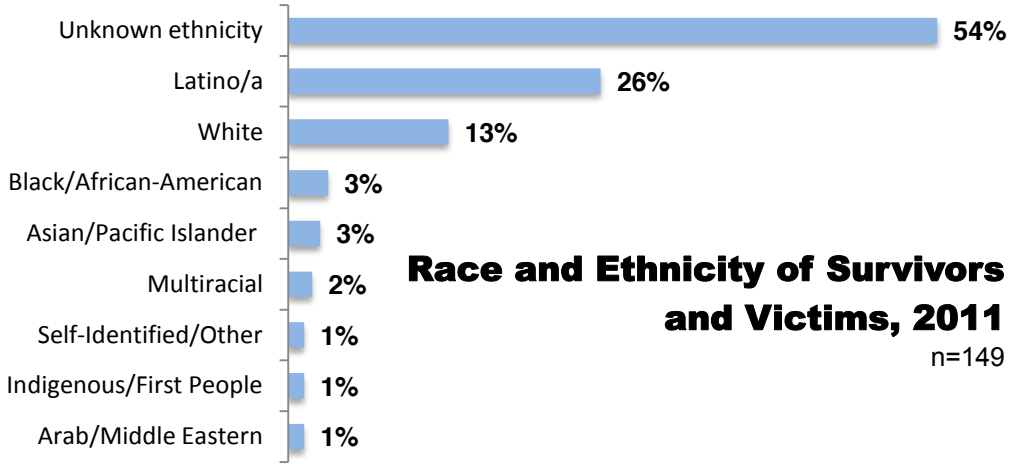
CAVP continues to increase its outreach, education, and training efforts in diverse communities. While CAVP has seen improvements from its work with shelter access, particularly for transgender persons, gay men, same-gender couples, and also gender non-conforming individuals, most of these are only within the Denver–metro area. Working within limitations of funding and capacity, CAVP is seeking to improve advocacy and support for survivors across the state, and also improve data collection to more accurately reflect the impact of intimate partner violence within the LGBTQ communities in Colorado.

COMMUNITY UNITED AGAINST VIOLENCE (CUAV)

SAN FRANCISCO, CA

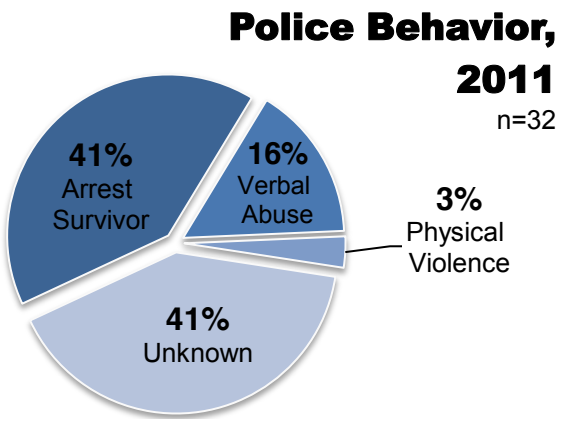
Since its inception in 1979, during a political climate of heavy policing in lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities and the assassination of San Francisco's first openly gay supervisor Harvey Milk, members of Community United Against Violence (CUAV) have worked to find innovative community-based solutions to create safety and build power. To this day, CUAV remains true to that vision, providing free, bilingual peer support for low- and no-income LGBTQ people of color facing hate violence, domestic violence, and police violence, while simultaneously organizing LGBTQ survivors to participate in local policy campaigns that address issues of inequity such as a lack of safe and affordable housing, the criminalization of immigrant LGBTQ communities, and issues of employment discrimination.

In 2011, CUAV saw a 28% decrease in reported incidents of domestic violence from 2010 (207 reports) to 2011 (149 reports) Latina/o's made up the largest percentage in 2011 with 50.6% of survivors who disclosed their race. Though not everyone disclosed their sexual orientation, the majority of individuals reporting self-identified as gay (53% of cases where the person disclosed their sexual orientation), a 10% increase from 2010.



The decreased number of people reporting to CUAV may be a result of programmatic transitions. After undergoing an extensive strategic planning process, the organization decided to phase out its 24-hour hotline and shift our focus from crisis response to supporting the on-going mental, emotional, and physical wellness of low- and no-income LGBTQ survivors of violence. At its core, this shift was about broadening our definition of anti-LGBTQ violence to include institutional and state violence, so as to better capture the impacts of chronic homelessness, unemployment, and/or incarceration on individual experiences of LGBTQ safety and wellness. Programmatically for CUAV, this approach looks like a variety of different activities, from working with LGBTQ survivors around finding resources to address a specific incident of violence to researching and taking action on long-term solutions to the cycles of violence many LGBTQ survivors face.

In 2011, CUAV worked with people whose experiences ranged from HIV positive survivors who became homeless after being kicked out by their abusive partners, abusive partners using their fluency in English to get survivors arrested after they called the police, to partners using the threat of deportation to keep people from leaving. In all of these cases, a lack of economic security, safe and independent housing, and societal homophobia and transphobia severely limited people's options for survival.



Though reports of LGBTQ domestic violence decreased in 2011, the data collected about police interaction from this report highlights an important contradiction many LGBTQ survivors of violence face. Only 21% of survivors reported interacting with the police. Of the survivors who interacted with the police, 16% of those individuals reported police attitudes as "hostile" and 13% of those individuals reported police attitudes as "indifferent". Police arrested the survivor in 41% of cases where people reported interacting with the police. Whereas police reports are generally required to legitimize experiences of violence and open doors to public victim assistance resources, when attempting to report violence to the police, many survivors face the risk of arrest themselves. This risk may make survivors more vulnerable to on-going violence and isolation, particularly LGBTQ immigrants who could be deported under local law enforcement collaborations with Immigration and Customs Enforcement (ICE) through programs such as "Secure Communities".

EQUALITY MICHIGAN

DETROIT, MI

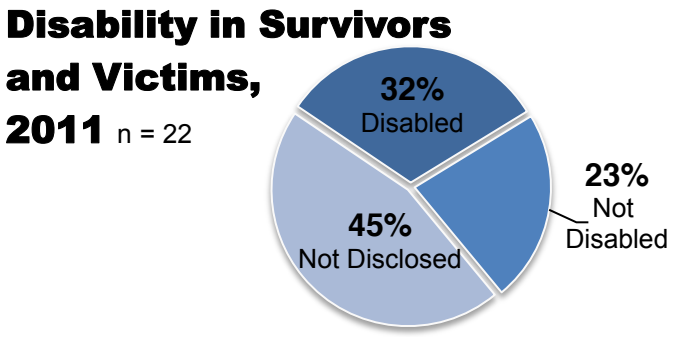
Equality Michigan works to achieve equality and respect for all persons, regardless of sexual orientation, gender identity, or gender expression. The Department of Victim Services at Equality Michigan strives to secure freedom from violence, intimidation, discrimination and harassment for LGBT and HIV-positive (HIV+) people.

Equality Michigan was formed in early 2010 from the merger of Michigan's two leading LGBT organizations: the Triangle Foundation and Michigan Equality. The leaders of the two organizations decided that unity was essential in order to effectively counter the heavily anti-equality political landscape in our state. Equality Michigan continues the work of the Triangle Foundation through its Department of Victim Services, and the organization is headquartered in Detroit in the former Triangle Foundation building. Additionally, Equality Michigan has an office located in Lansing. The Department of Victim Services provides free and confidential intervention, information, personal support and advocacy, criminal justice advocacy and referrals for attorneys, shelters, counseling, and other agencies to LGBT and HIV+ victims of violence, vandalism, intimidation, and harassment, as well as to LGBT and HIV+ victims of Intimate Partner Violence (IPV).

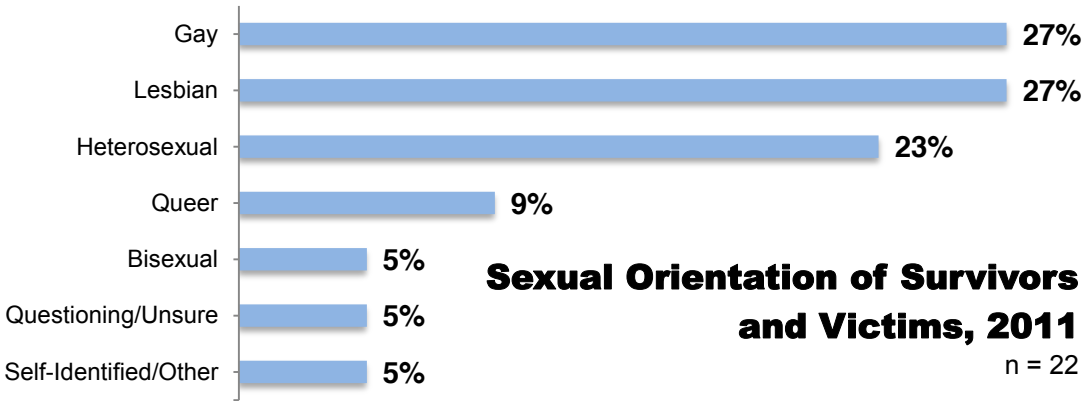
Equality Michigan is reporting incidents of intimate partner violence for the second time in its history. Though we have always provided assistance to survivors of intimate partner violence, these services are part of our larger anti-violence program and such services are provided in conjunction with local partners. The need for greater resource allocation to IPV services for LGBTQ and HIV positive individuals is glaringly evident in our report. There have been minor improvements in available services, with a third shelter in the state providing resources to transgender women in addition to the two confirmed shelters we reported in 2010. The Michigan Coalition Against Domestic and Sexual Violence's LGBT taskforce, in recognition of the limited services available to survivors of LGBT and HIV positive intimate partner violence hosted a regional training assisted by the Northwest Network in 2011. As was true last year, this year's report is a reflection more of the work needed to provide better services to LGBTQ and HIV survivors of intimate partner violence rather than a representation of actual IPV victimization.

Some element of bias was present in 8 of 22 cases (20%), including religious bias and anti-LGBTQ bias. The presence of bias in intimate partner violence may reflect an aspect of power and control dynamics of intimate partner violence.

A higher-than-expected number of survivors identified as having a disability in 2011 (7 reports; 32% of 2011 survivors), in line with other reports of persons with disabilities having higher risk of suffering intimate partner violence.[77]



[77] Protection and Advocacy, Inc. (2003) *Abuse and Neglect of Adults with Developmental Disabilities: A Public Health Priority for the State of California.*



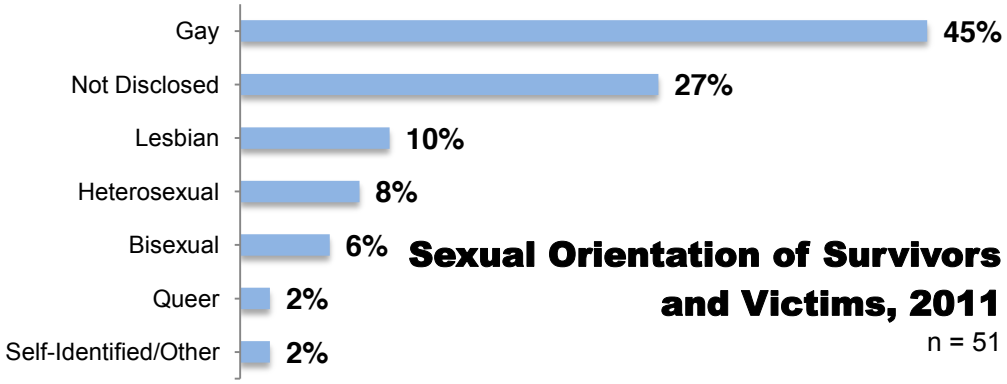
The IPV survivors represented were approximately evenly split between those who identified as gay (27%, 6 survivors), lesbian (27%, 6 survivors), and heterosexual (23%, 5 survivors). The high representation of heterosexual survivors of IPV demonstrates the availability of our services to all populations, and perhaps is a result of effective outreach to various mainstream shelters as part of our cultural competence education program.

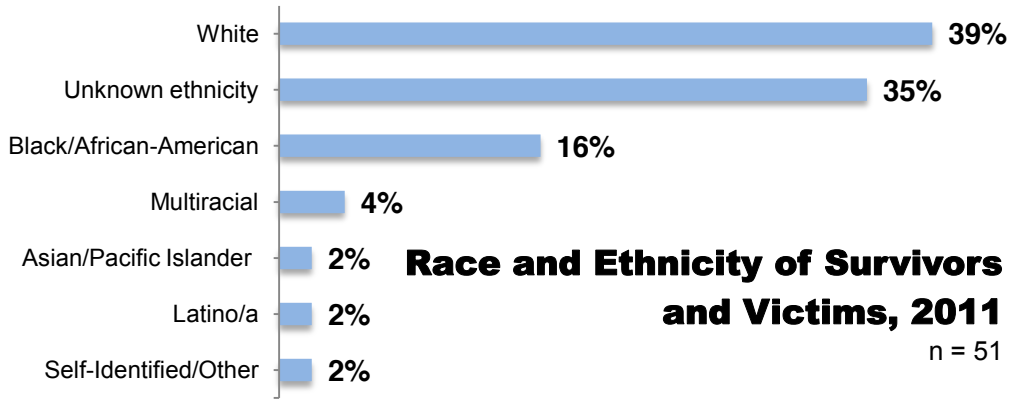
THE VIOLENCE RECOVERY PROGRAM AT FENWAY COMMUNITY HEALTH

BOSTON, MA

The Violence Recovery Program (VRP) at Fenway Community Health was founded in 1986 and provides counseling, support groups, advocacy, and referral services to lesbian, gay, bisexual, and transgender (LGBT) victims of bias crime, domestic violence, sexual assault, and police misconduct. The VRP mission is to provide services to LGBT victims who have experienced interpersonal violence as well as information and support to friends, family, and partners of survivors, raise awareness of how LGBT hate crime and domestic violence affects our communities through compiling statistics about these crimes, and ensure that LGBT victims of violence are treated with sensitivity and respect by providing trainings and consultations with service providers and community agencies across the state.

In 2011, the Violence Recovery Program documented 51 new cases of LGBT Intimate Partner Violence. This represents a 7% decrease from 2010. We believe this decrease represents not a genuine drop in incidents over the state but rather reflects the ongoing difficulty LGBT people have in accessing culturally competent support services. A 2010 survey commissioned by the Gay Men's Domestic Violence Project, a Massachusetts-based LGBT domestic violence organization, found that 82% of people surveyed felt domestic violence was a priority for the community, yet only 24% could name a resource to help them if they were victimized. Although the number of cases reported decreased slightly overall, the level of violence survivors reported to VRP increased with an additional 14% of survivors reporting injury. Of survivors who disclosed their sexual orientation 45% identified as gay. The next highest are were those who did not disclose at 27%. The press in Massachusetts also better documented LGBT intimate partner violence homicides in 2011, most likely as a result of efforts to raise awareness of LGBT intimate partner violence in Boston for several years. From March through August 2011, there were at least 4 confirmed or suspected gay male domestic violence homicides in Massachusetts reported in the media.



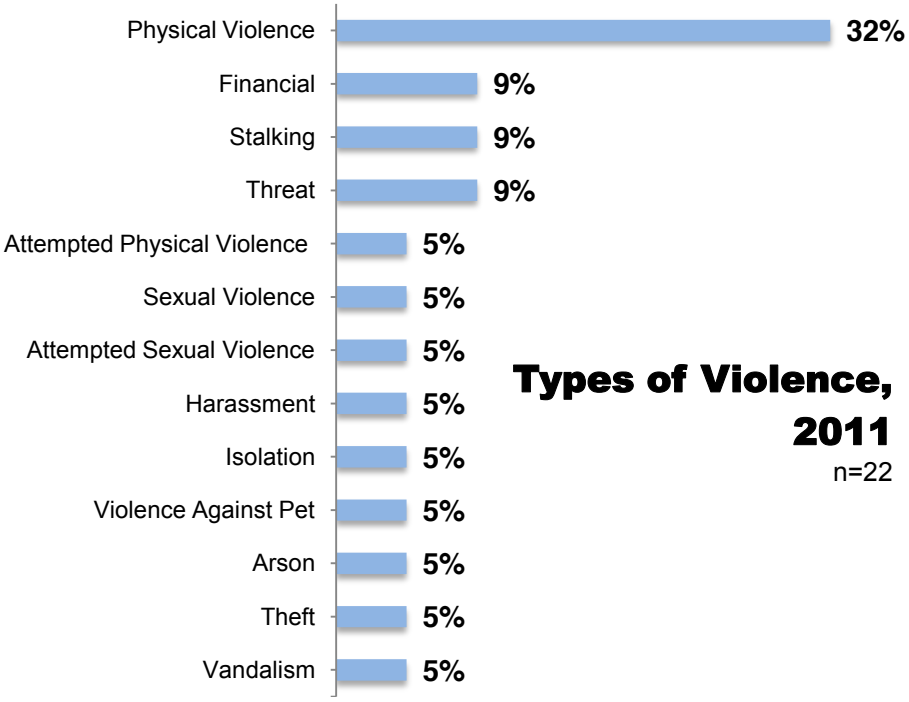


Historically the VRP has reported higher numbers of white survivors. However, this year we have seen a spike in LGBTQ people of color reporting IPV. Most notably, we saw a 60% increase in the number of Black/African American survivors. This increase may be due to an organizational collaborative that the VRP spearheaded in 2011. This collaborative, entitled TODAS (Transforming Ourselves through Dialogue Action and Services) was awarded a 2-year, $300,000 grant by the U.S. Department of Justice: Office of Violence against Women to address LGBT domestic violence in Boston-area African-American and Latina/o communities. Other partner organizations include the Hispanic Black Gay Coalition, The Network/La Red, and Renewal House. The VRP is aware that the expectation that LGBT people of color receive care in a white-dominated environment where services are created without community input can contribute to a feeling of alienation. It is possible that this new partnership and opportunity to work as a community has contributed to higher numbers of LGBTQ people of color to report hate violence to our agency.

GAY ALLIANCE OF GENESEE VALLEY

ROCHESTER, NY

The Gay Alliance of the Genesee Valley is dedicated to cultivating a healthy, inclusive environment where individuals of all sexual orientations and gender expressions are safe, thriving, and enjoy full civil rights. Unfortunately, like many other non-profit organizations across the country, it has been impacted by reduced state support and while private donations continue to be strong, they cannot keep pace to replace shrinking grant support.



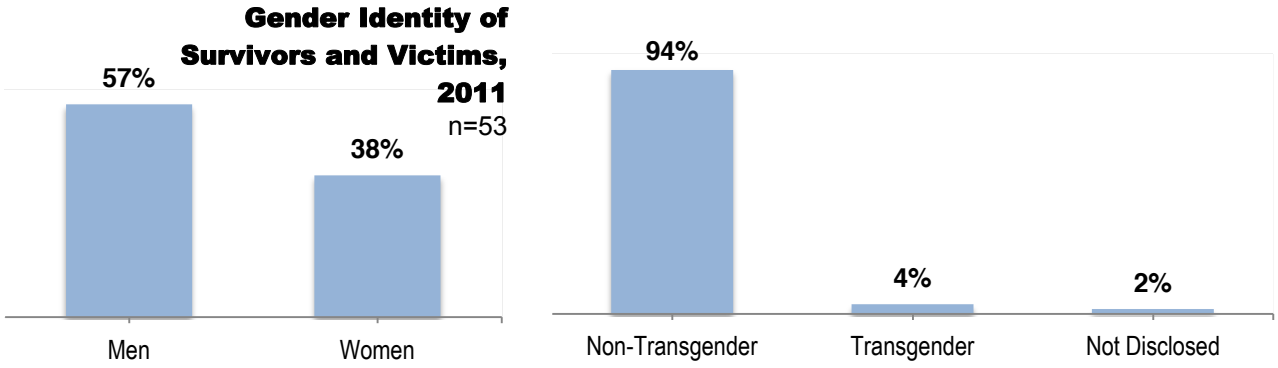
In 2011, the number of IPV victims served by the agency decreased by 31%, from 13 reports in 2010 to 9 reports in 2011. This is likely because of a decrease in outreach efforts due to funding and staff reductions as the agency lost the last of 3 grants that funded its Community Safety Programs. While the number of victims decreased, the range of violent behaviors reported by victims increased from 2010 and included physical violence (from 6 reports to 7 reports, 32% of total 2011 reports), attempted physical violence (from 0 reports to 1 report, 5% of total 2011 reports), sexual assault (from 0 reports to 1 report, 5% of total 2011 reports), attempted sexual assault (from 0 reports to 1 report, 5% of total 2011 reports), arson (from 0 reports to 1 report, 5% of total 2011 reports), theft (from 0 reports to 1 report, 5% of total 2011 reports) and vandalism (from 0 reports to 1 report, 5% of total 2011 reports). The number of injuries reported increased by 300% over 2010 (from 0 to 3) with 66% of victims making reports to local police (6 reports) compared to just 15% the previous year; (2 reports). At a time of shrinking resources for the program, the range of support needed by victims increased. We provided housing, legal, medical, public benefits, and shelter referral, as well as court accompaniment. For the first time we provided referral for emergency pet respite in not one but two cases in which pets were at risk.

KANSAS CITY ANTI-VIOLENCE PROJECT (KCAVP)

KANSAS CITY, MO

The Kansas City Anti-Violence Project provides information, support, referrals, advocacy and other services to lesbian, gay, bisexual, and transgender (LGBT) victims of violence including domestic violence, sexual assault, and hate crimes, focusing these services within the Kansas City metropolitan area. KCAVP also educates the community at large through training and outreach programs.

In 2011, there was a 20% decrease in survivors contacting KCAVP for services when compared to 2010 (66 to 53). This may be due to a decrease in incidents of IPV in the area, or a change in organizational focus from KCAVP outreach staff from outreach to prevention programming. KCAVP's outreach staff focused on a prevention initiative with youth in schools in 2011, decreasing their ability to conduct as much external outreach. 55% (29 survivors)of survivors did not seek protective orders against the offender (29 survivors), possibly because they did not want to navigate the court system or feel a protective order would provide safety. 75% (40 survivors) of survivors reported that the offender was their lover/partner.



In 2011, 57% of IPV survivor reports were made by those who identified themselves as non-transgender men. Women made up 38% of survivors and 4% idenitified themselves as transgender women. More survivors who identify as men, than survivors who identify as women, may have contacted KCAVP because they are less comfortable contacting mainstream programs primarily designed to work with women.

55% of IPV survivors reporting IPV incidents to KCAVP in 2011 identified themselves as gay, followed by 34% who identified as lesbian. An equal amount of survivors served by KCAVP identified themselves as bisexual (4%) and heterosexual (4%). Sexual orientation breakdowns reflect gender breakdowns, where a larger percentage of gay men may have contacted KCAVP in 2011 because few other services exist for gay men in the Kansas City metro area.

Of the IPV survivors served by KCAVP in 2011, 57% identified themselves as white, 21% identified themselves as black, 4% identified as multiracial, 2% identified at Latina/o and 2% identified as Asian/Pacific Islander. These numbers do not reflect the overall demographics of the Kansas City metropolitan area, but rather may be indicative of the limited capabilities of staff to provide outreach and direct services to non-English speaking communities in the area. KCAVP continues to work to increase language accessibility of KCAVP's programs.

VICTIM RESPONSE, INC./THE LODGE (VRI/THE LODGE)

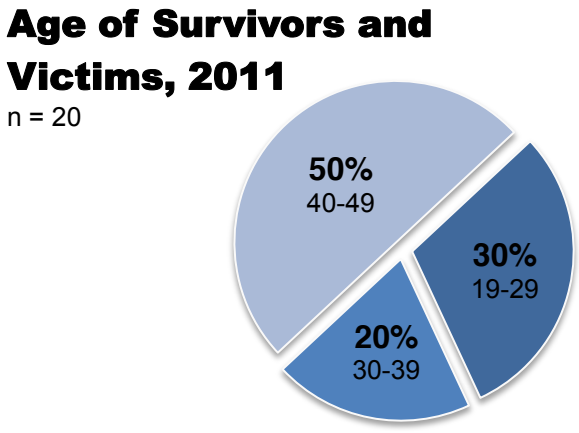
MIAMI, FL

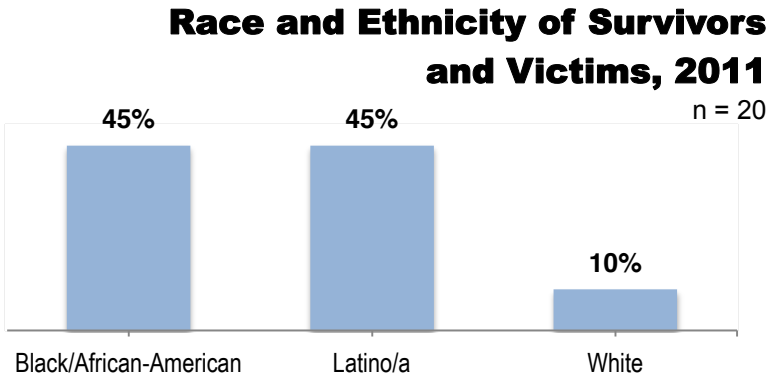
VRI/The Lodge is certified by the State of Florida Department of Children and Families and offers emergency shelter, 24-hour crisis hotline, information and referral, advocacy, case management, safety planning, counseling, and other services to survivors of gender violence and their dependents. VRI/The Lodge also provides technical assistance, training, and community education and advocacy with other agencies including, but not limited to, service providers, homeless shelters, community organizations, law enforcement and other community members Victim Response, Inc./The Lodge has been a place of renewal, reconnection and safety since 2004. Our mission is to serve as a catalyst of social change to transform our community and champion the human rights of survivors of gender violence and their dependents. This mission is accomplished by our continued efforts to create, develop, and support a comprehensive shelter system which promotes safety and independence. Through the efforts of advocacy, education, leadership, and prevention, we will promote healthy relationships. As we grow and transform, we strive to deliver premier services by embracing the following core values:

- Support and empower individuals, families and communities;
- Be progressive and innovative;
- Strive for self-sufficiency and independence;
- Be responsive to community needs and create awareness;
- Conduct ourselves in an ethical and transparent manner;
- Create community and foster inclusion;
- Be an architect of change;
- Promote safety, creativity and community collaboration;
- Create a safe haven; and,
- Be vigilant, brave, and a defender of human rights.

2010 was the first year for VRI/The Lodge to contribute to the NCAVP report and during that reporting period, VRI/The Lodge reported all participants served by our agency during that year. In 2011,VRI/The Lodge reported only LGBTQ survivors served by the agency during the 2011 calendar year.

In 2011, of the LGBTQ survivors served at VRI/The Lodge, 55% identified as women (11) , 25% identified men (5 reports) and 20% identified as intersex (1). VRI served 30% of survivors between ages 19-29 (6), 20% between the ages of 30-39 (4) and 50% between the ages of 40-49 (10).





45% of survivors/victims identified as African American (9), 45% of survivors/victims identified as Latina/o (9), and 10% identified as White (2). The high number of people of color could be a result of the Miami area having large populations of Latina/o and African American LGBTQ communities.

THE LOS ANGELES GAY & LESBIAN CENTER

LOS ANGELES, CA

The L.A. Gay & Lesbian Center's STOP Partner Abuse/Domestic Violence Program (STOP DV)
The L.A. Gay & Lesbian Center's Domestic Violence Legal Advocacy Project (DVLAP)

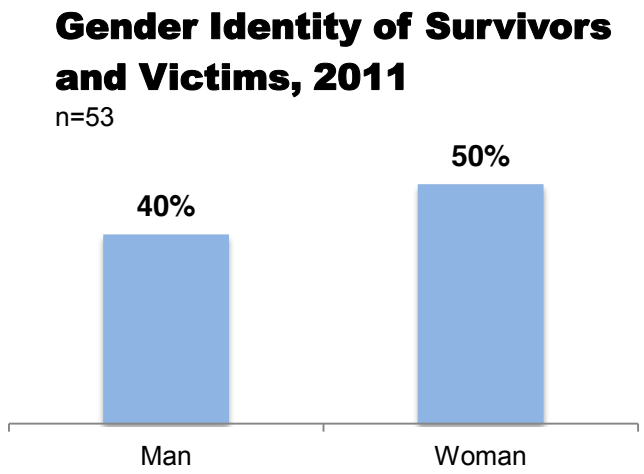
Since 1987, the L.A. Gay & Lesbian Center has been dedicated to reducing, preventing, and eliminating intimate partner abuse in the lesbian, gay, bisexual, and transgender communities in Southern California. The L.A. Center's intimate partner violence intervention and prevention services are comprised of those offered by its STOP Partner Abuse / Domestic Violence Program (STOP DV = Support, Treatment/Intervention, Outreach/Education, and Prevention) and its Domestic Violence Legal Advocacy Project (DVLAP). Together, both STOP DV and DVLAP provide a broad array of services including survivors' groups, a court-approved batterers' intervention program, crisis intervention services, brief and on-going counseling and mental health services, prevention groups and workshops, specialized assessment, referral to LGBT sensitive shelters, advocacy, assistance with restraining orders, court representation, immigration and U-visa preparation, and training and consultation.

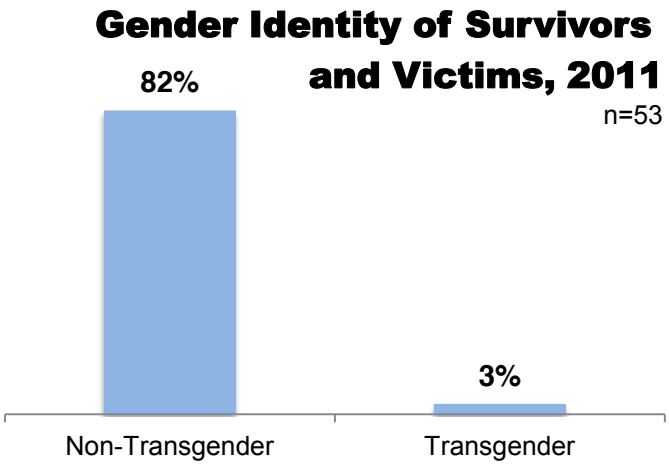
Reported cases of LGBT domestic violence in the greater (5-county) Los Angeles area reflected a 42.7% decrease from 3344 cases in 2010 to 1917 cases in 2011. These cases were either reported to, or assessed by STOP DV (404 unduplicated individuals assessed to be survivors of domestic violence), or DVLAP (113 unduplicated cases), or via STOP DV surveys distributed at LGBT pride festivals throughout L.A. County (1400 unduplicated cases).[78] While this decrease may be due to an actual reduction in cases in greater L.A., it is more likely due to the following factors: 1) a reduction of two full time staff positions in STOP DV for a portion of the year resulting from funding decreases to the Center's Mental Health Services Department (where STOP DV is strategically located); 2) a decrease in attendance at two large LGBT pride festivals; 3) programming changes within DVLAP. (During the reporting period, the Domestic Violence Legal Advocacy Project made a concerted effort to increase the provision of holistic legal services to LGBT immigrant survivors of domestic violence by expanding our services to include U-visa assistance. This shift led to a substantial increase in mono-lingual Spanish speaking survivors, many of whom were transgender woman, receiving survivor services. As a result of this expansion in services, the time investment given individually to each client increased leading to a slight reduction in the overall number of clients served.)

Of the 1917 reported cases in 2011, females accounted for 962 cases (50%) while males accounted for 760 of the total (40%). There were 52 documented transgender cases (3%) and 16 intersex cases (1%). The remainder of the total was comprised of individuals with undisclosed gender identities (3%). The majority of cases came from individuals who identified as gay (661, 34%), or lesbian (582, 30%), while 259 individuals identified as bisexual (14%). Twenty-one individuals identified as queer (1%), 24 identified as questioning (1%), and 144 identified as heterosexual (8%). The majority of individuals were between the ages of 19 – 49 (34%) and Latina/o (722, 38%) or White/Caucasian (545, 28%).

Based on our experiences working with LGBT survivors in greater Los Angeles, in 2011, as in previous years, LGBT survivors continued to face significant challenges. These challenges include insufficient response by law enforcement and mainstream social service providers to LGBT domestic violence including difficulties in providing accurate assessment of the involved parties including abuser/survivor differentiation; lack of understanding of the unique differences and complexities of LGBT domestic violence; and failure to utilize appropriate standards of care or protocols when responding to LGBT cases.

[78] *STOP DV offers services for both domestic violence survivors as well as abusers. Only survivors are included in STOP DV's total above.*


Gender Identity of Survivors and Victims, 2011
n=53
40%
50%
Man
Woman


Gender Identity of Survivors and Victims, 2011
n=53
82%
3%
Non-Transgender
Transgender

MONTROSE COUNSELING CENTER

HOUSTON, TX

Montrose Counseling Center empowers our community, primarily gay, lesbian, bisexual, and transgender individuals and their families to enjoy healthier and more fulfilling lives by providing culturally affirming and affordable behavioral health and preventative services.

Montrose Counseling Center works with survivors of intimate partner violence by providing counseling, case management, advocacy, hospital/police/court accompaniment, and housing to those fleeing same-sex domestic violence or those dealing with intimate partner violence issues in counseling. Montrose Counseling Center offers individual counseling as well as group therapy by specifically trained licensed therapists. We also offer education and training to other agencies in the area which include homeless shelters, law enforcement and other agencies and community support systems. We continue to work on building good relationships with law enforcement and are attending several of their trainings to ensure that law enforcement has a better understanding of working with the GLBT community.

The Montrose Counseling Center serves a targeted population of GLBT clients in the Houston area. In 2011, of the 27 survivors of intimate partner violence assisted, 14 (52%) were men, 12 (44%) were women and 1 (4%) identified as transgender. Montrose Counseling Center does see a larger population of men being served in part because there are so few services offered to men through other agencies. The Montrose Counseling Center fulfills a vital role in the community in dealing with intimate partner violence ensuring services to the GLBT community.

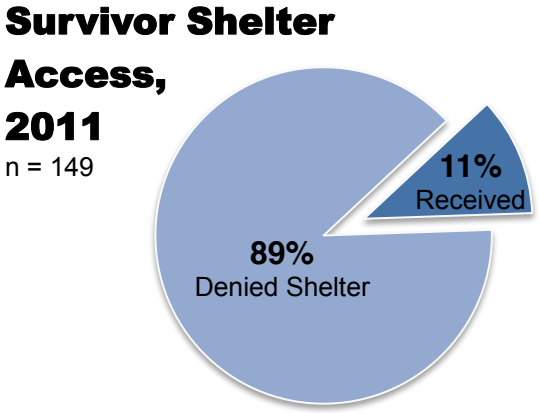
Of those survivors, 11(41%) were African American, 13 (48%) were Caucasian, 2 (7%) were Latina/o and 1 (4%) was Asian. 15 (56%) survivors identified as gay and 12 (44%) identified as lesbian. With regard to age, 9 (33%) survivors were ages 19 to 29, 9 (33%) survivors were ages 30-39, 7 (27%) survivors were ages 40-49, and 2 (7%) survivors were ages 50-59. These demographics fit the average demographics for the Houston area.

THE NETWORK/LA RED (TN/LR)

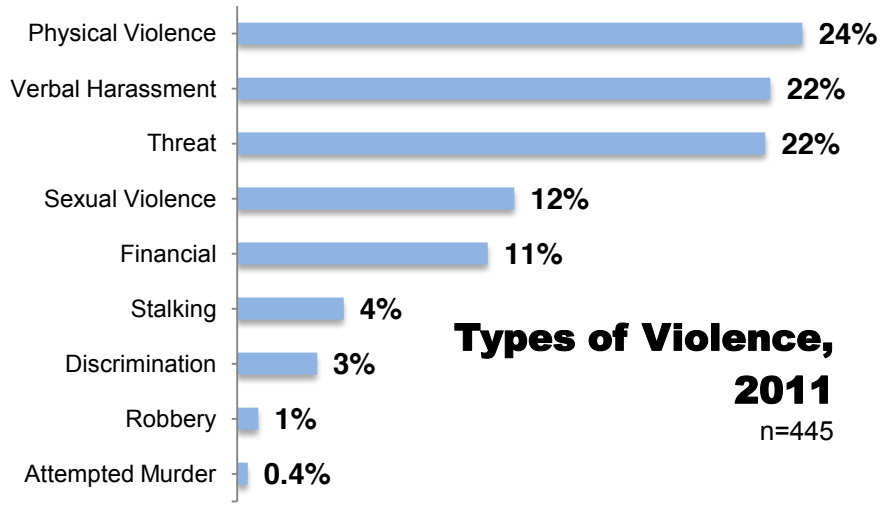
BOSTON, MA

The Network/La Red (TNLR) is a survivor-led, social justice organization that works to end partner abuse in lesbian, gay, bisexual, queer and /or transgender, BDSM, and polyamorous communities. Rooted in anti-oppression principles, our work aims to create a world where all people are free from oppression. We strengthen our communities through organizing, education, and the provision of support services. The Network/La Red's support services include a 90-hour per week hotline, short-term emergency safehome, in-person and phone-based support groups, advocacy, information, and referrals. TNLR also provides technical assistance, training and education, and advocacy with other agencies including, but not limited to, service providers, community organizations, legal agencies, law enforcement, and other community members.

Overall, the number of survivors calling TNLR's hotline for information or advocacy in 2011 decreased by 6% compared to 2010 (316-297). This is likely due to various transitions in direct service staff within TNLR and decreased capacity related to these transitions. We experienced a 55% increase in the number of survivors seeking shelter (96-149), a 41% decrease in the number of survivors receiving shelter (29-17), and a 97% increase in the number of survivors who were denied shelter (67-132). 89% of survivors who sought shelter were denied in 2011. Although The Department of Children and Families has mandated that domestic violence organizations be accepting and inclusive of LGBQ/T survivors in their services, the number of survivors being denied shelter may be due to the lack of shelter availability.



In Massachusetts, there were 3 confirmed LGBQ/T partner abuse related homicides reported in 2011. 2 survivors reported experiencing attempted murder in 2011, compared with no reports of attempted murder in 2010. There were substantial increases in the reported types of harm survivors were experiencing including an increase in threats (7-99, totaling 22% of 2011 reports), an increase in stalking (5-20, 4% of 2011 reports), an increase in financial abuse (32-47, 11% of 2011 reports), an increase in sexual violence (38-52), and an increase in physical violence (86-106, 12% of 2011 reports). There was an increase of survivors experiencing abuse from an ex-lover/partner (72-92, 31% of 2011 reports) and the number of survivors experiencing abuse from a current lover/partner remained consistent (40-41, 14% of total reports). These increases may not necessarily be attributed to an actual increase in the types of harm survivors are experiencing from their abusive partners, but more to an increase in the data collection of these types of tactics of abuse.



Of the survivors who called TNLR in 2011, there was an increase of gay identified individuals (27-30, 10% of 2011 reports) as well as queer identified individuals (9-10, 3% of total 2011 reports), a decrease of straight identified individuals (17-13, 10% of total 2011 reports), a decrease in lesbian identified individuals (41-32, 11% of total reports), and the number of bi-sexual identified individuals stayed the same (14, 5% of 2011 reports). The increase in the number of gay and queer identified individuals may be due to the increased familiarity with TNLR's mission statement, which was changed in 2010 to reflect the communities we work with. Additionally, TNLR is known to be one of very few organizations that will support and shelter GBQ/T men. There was a decrease in survivors who identify as a woman (129-80, 27% of total reports), a decrease in survivors who identify as a man (56-49, 16% of total reports), a decrease in survivors who identify as transgender (30-25, 8% of total reports), an increase in survivors who self-identified their gender (1-5, 2% of 2011 reports), and an increase in survivors who did not disclose their gender identity (127-152, 51% of total reports). The increase in the number of individual's self-identifying their gender can be attributed as well to the LGBQ/T communities' increased familiarity with TNLR's mission and knowledge of the organization to be inclusive of all gender identities and expression. There was a decrease in the number of survivors ages 15-18 (4-1, less than 1% of the total 2011 reports), a decrease in the number of survivors ages 19-29 (34-25, 8% of 2011 reports), a decrease in the number of survivors ages 30-39 (19-10, 3% of total 2011 reports), a decrease in the number of survivors ages 50-59 (12-8, 3% of total 2011 reports) and decrease in survivors ages 70-79 (1-0). There was an increase in the number of survivor ages 40-49 (9-10, 3% of 2011 reports), an increase in the number of survivors ages 60-69 (2-4, 1% of 2011 reports), and an increase in the number of survivors who did not disclose their age (235-239, 80% of total 2011 reports).

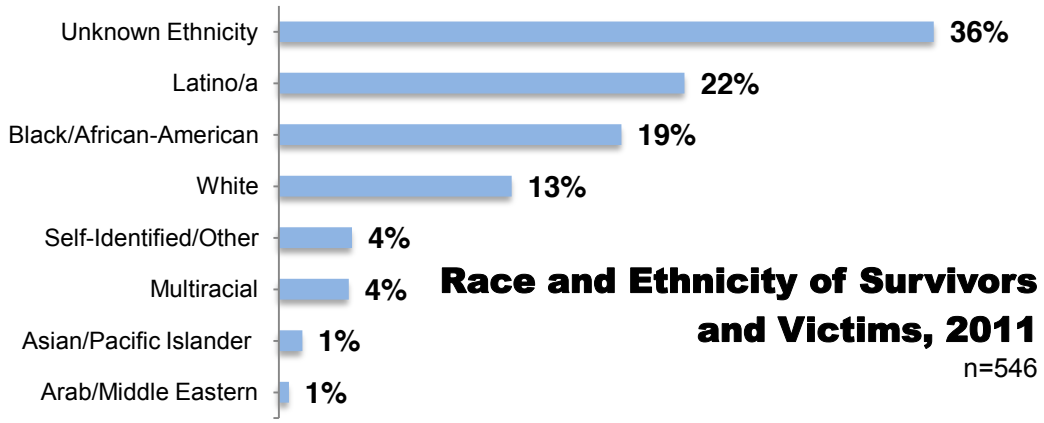
THE NEW YORK CITY ANTI-VIOLENCE PROJECT (AVP)

NEW YORK, NY

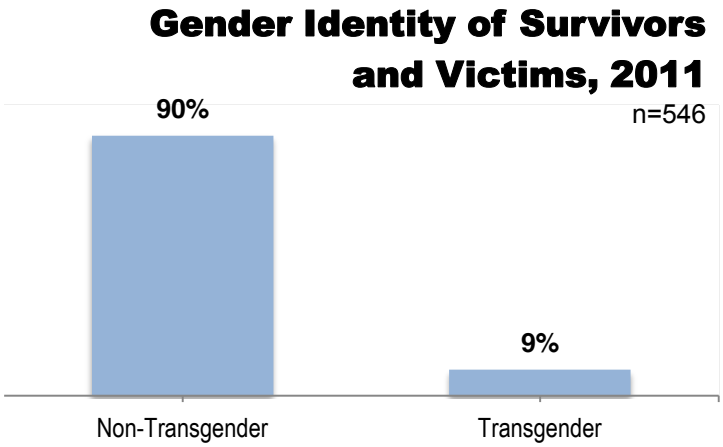
The New York City Anti-Violence Project (AVP) envisions a world in which all lesbian, gay, bisexual, transgender, queer, and HIV-affected (LGBTQH) people are safe, respected, and live free from violence. AVP's mission is to empower LGBTQH communities and allies to end all forms of violence through organizing and education, and support survivors through counseling and advocacy. AVP was founded in 1980, and today provides free and confidential assistance to thousands of LGBTQH people each year from all five boroughs of New York City through direct client services and community organizing and public advocacy. In 2010-2011, AVP was named a White House Champion of Change for our work on intimate partner violence (IPV) within LGBTQH communities.

To accomplish our mission, AVP has developed a range of community-based approaches that reach people at the intersections of communities defined by geography and by identity. AVP is currently conducting on-site intake in 8 locations across NYC, in addition to our central office in Manhattan. Sites include two of the NY Family Justice Centers, local pride centers, LGBTQH youth programs, community health clinics, multi-service and legal service organizations serving LGBTQH, and harm reduction organizations serving those who use substances. Part of this community-based programming focused specifically on reaching TGNC people of color, who are disproportionately impacted by violence, as demonstrated in this year's NCAVP report. In 2011 AVP has successfully engaged more LGBTQH survivors from across all five boroughs of New York City (NYC), and in engaged more marginalized LGBTQH communities, including survivors who identify as transgender and gender non-conforming (TGNC) people, people of color, and immigrants. AVP saw an increase of 24% in the numbers of survivors of IPV reporting to and seeking services from AVP in 2011 as compared to 2010 (from 439 to 546), continuing the increase (14%) we saw from 2009 to 2010. AVP reported two murders related to IPV in 2011, Camila Guzman, a transgender Latina woman murdered by her boyfriend in her apartment, and Carlos Castro, a gay rights activist in Portugal, who was killed by his boyfriend on a trip to NYC. These murders bring home the tragic and deadly consequences IPV has for LGBTQH communities.

In response to the increase in reports of LGBTQH intimate partner violence and its deadly consequences, AVP continued to increase the awareness and build the power of our community members to address this violence, through survivor leadership and community education programs. In August, we organized a vigil in memory of Camila Guzman, with the coordination and support of Guzman's close friends and family. We also debuted our Real Talks discussion series, a series of IPV survivor-led community events created to build survivor-led LGBTQH IPV community organizing campaigns. Moving forward, we continue to track local incidents of LGBTQH intimate partner violence, responding through outreach and trainings in affected communities, as well as citywide communications. These events have been well attended and help to increase the numbers of people who know about AVP's direct services and community organizing programs.



2011's data indicates that AVP's targeted services to marginalized LGBTQH IPV survivors has seen success. Of the survivors who reported their racial and/or ethnic identity to AVP, the proportion who identified as people of color increased by nearly a third from 2010 to 2011 (32%, from 222 to 292), including a 39% increase in survivors who identified as African American (74 in 2010 to 103 in 2011), and a 7% increase in survivors who identified as transgender (from 46 in 2010 to 49 in 2011).



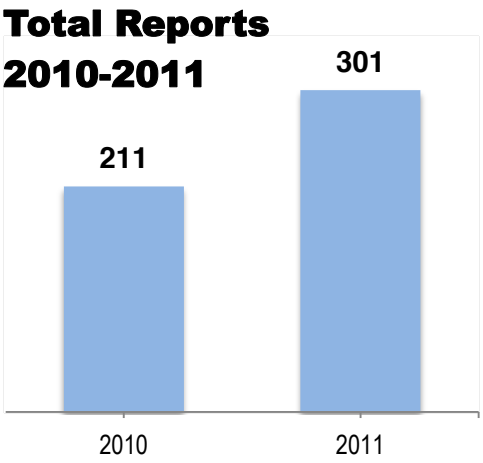
Improvements in AVP's data collection and tracking mechanisms allowed us to get additional information about survivors' identities and experience. In 2011, 19% (63) of those who reported their immigration status identified as non-citizens, including 7% (39) who identified as being immigrants currently out of status. In 2011, 38% (208) of LGBTQH IPV survivors reported their experiences of IPV to the police. Nearly 40% (47) of those reporting on police attitude (122) shared that police were hostile or indifferent to survivors. Highlighting the intersections between hate violence and IPV, survivors reported that abusive partners incorporated bias into tactics of abuse, including anti-LGBTQ/ heterosexist (8%, 62), anti-transgender (4%, 33), anti-immigrant (3%, 22), HIV/AIDS related (3%, 23), and other forms of bias (6%, 51).

OUTFRONT MINNESOTA

MINNEAPOLIS, MN

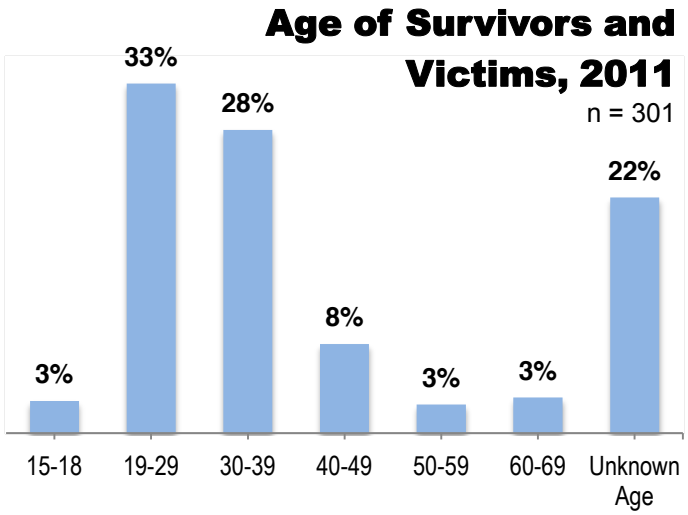
OutFront Minnesota is the state's leading advocacy organization working with lesbian, gay, bisexual, transgender, queer and allied people. Our mission is to make Minnesota a place where LGBTQA individuals have the freedom, power, and confidence to make the best choices for their own lives.

Our Anti-Violence Program is committed to honoring the unique needs of LGBTQ crime victims and their friends and families throughout Minnesota. We work to build the safety and power of survivors and community members and to create opportunities for support and healing through the provision of crisis intervention, advocacy, counseling, community education, and outreach. To attain equity for LGBTQ survivors, we approach this through an intersectional lens that locates and honors our many layered identities at the heart of our work. At OutFront Minnesota, we work to create social change at every level, from the individual to the community, to the state. We believe that social change occurs when we work to prevent violence from occurring within and against our communities through education and increased visibility; help survivors of violence find their own paths to healing and empowerment through the provision of safe and effective advocacy support services, and, work with other organizations to create a strong network of well-trained and supportive service providers throughout Minnesota

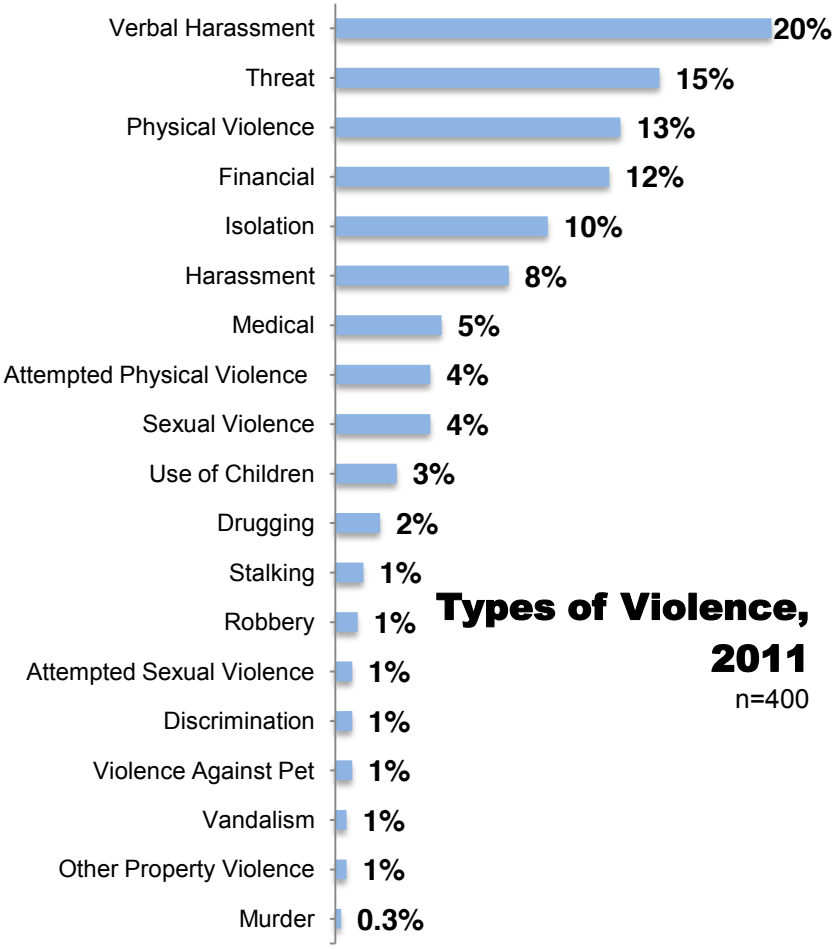


Overall, the numbers of survivors accessing services through our Anti-Violence Program increased by 43% in 2011. We believe that this increase is a reflection of targeted outreach and the visibility of the anti-violence, including the murder of Krissy Bates, a transgender woman murdered by her boyfriend, and several community education initiatives specifically highlighting intimate partner violence.

Ages 19-29 represented the highest number of reports with 33% of total reports, ages 30-39 represented the next highest with 28%. Both are consistent with national data. 22% of reports age was unknown and the remaining 17% of reports was made up of ages 15-18 (3%), 40-49 (8%), 50-59 (3%) and 60-69 (3%). The information suggests that ages 19-39 are areas with the highest reports of IPV and outreach efforts should continue to focus on those age groups.



The Anti-Violence Program received high numbers of reports of verbal harassment (78 reports), threats (58 reports), physical violence (51 reports), and financial abuse (49 reports) . We believe that this reflects the complexity of incidents that comprise the spectrum of intimate partner violence. We also believe that moving forward, educating our own communities about all of the different ways (beyond physical assault) that IPV occurs is crucial to creating safer communities.



28% of our total our total clients reported to law enforcement, which represents an 11% increase (76 to 84) over 2010. Of those clients who reported to law enforcement, 42% reported a courteous or indifferent response. We believe that this increase in positive response stems in part from our increased dedication to relationship-building and targeted education efforts with local law enforcement agencies. Unfortunately, in 5% of our cases, survivors also reported mis-arrest of the survivor. We recognize the continued need for deeper education with law enforcement agencies to strengthen knowledge about how to identify primary aggressors and recognize that this area is one of tremendous growth potential for our anti-violence work to create better access to safer systems for LGBTQ survivors.

SAFESPACE ANTI-VIOLENCE AT R U 1 2? COMMUNITY CENTER

WINOOSKI, VT

RU12? Community Center's SafeSpace Program is a social change and social service program working to end physical, sexual, and emotional violence in the lives of lesbian, gay, bisexual, transgender, and queer (LGBTQ) people, and the only LGBTQ anti-violence program in the state.

SafeSpace provided services to 17 new IPV survivors in 2011, compared to 14 new IPV survivors in 2010. Three primary factors most likely contributed to this 21% increase. SafeSpace conducted a statewide conference in November of 2010 specifically targeting health care providers for the first time. Since this conference, service providers and mental health professionals have been referring clients to SafeSpace. The rise in reported IPV cases may also be attributed to an increase in direct service staff hours which has allowed SafeSpace to have dedicated staff for education and outreach. Lastly, in October of 2011, keeping with the agency's mission, SafeSpace began to strategically expand education and outreach efforts from a county level to a statewide level. Of the new cases in 2011, SafeSpace served 7 gay male survivors in 2011 (41%) compared to 2 gay male survivors in 2010. This increase in gay men reporting IPV to SafeSpace may not indicate a rise in IPV within the community but rather may be the result of SafeSpace's increased outreach efforts to gay men through advertising support groups for male identified survivors of IPV.

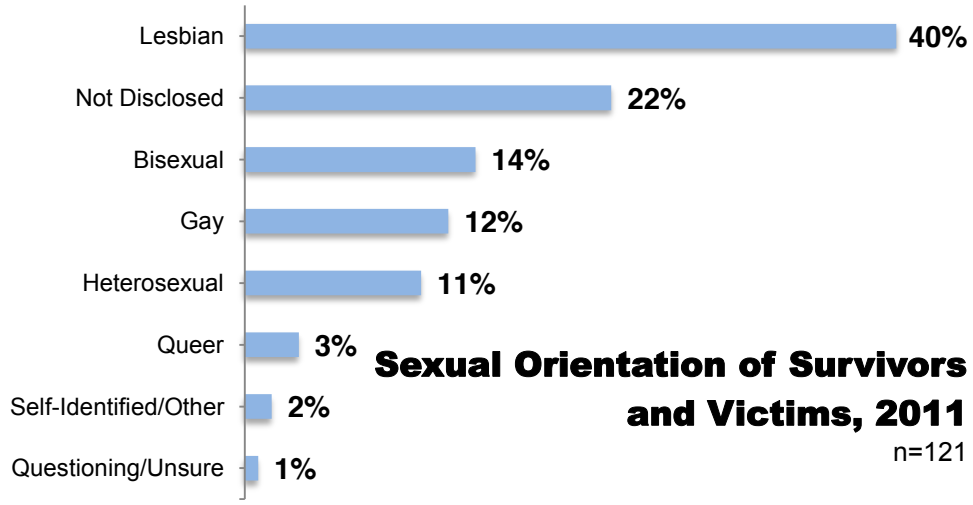
The number of IPV survivors/victims who reported to police increased from 14% in 2010 (2 total reports) to 29% (5 total reports) in 2011. Survivors/victims may be experiencing more confidence with law enforcement's ability to provide culturally competent services and they may be experiencing an overall heightened sense of confidence in various victim assistance systems related to the cumulative effects of legal protections that the LGBTQA communities have fought for and won. Starting in 1992 with the passage of the LGB anti-discrimination law and the passage of civil unions in 2000, to the 2007 addition of gender identity to the anti-discrimination law and the 2009 passage of marriage, as well as a host of additional protections, LGBTQ Vermonters live in a remarkably LGBTQ friendly state. In advocating for legislative protection, the LGBTQ activists and advocates have done significant, long-term education within victim assistance systems, including outreach to police department victim advocates as well as victim advocates working within the prosecutor's office, and within the LGBTQ communities. Lastly, Patrick Leahy Vermont's U.S. Senator, is a champion of VAWA that is being held up for reauthorization by bipartisan politics, which at least for Vermonters, sends a strong message that at the highest levels of state government, there is a very clear voice of support.

SEAN'S LAST WISH

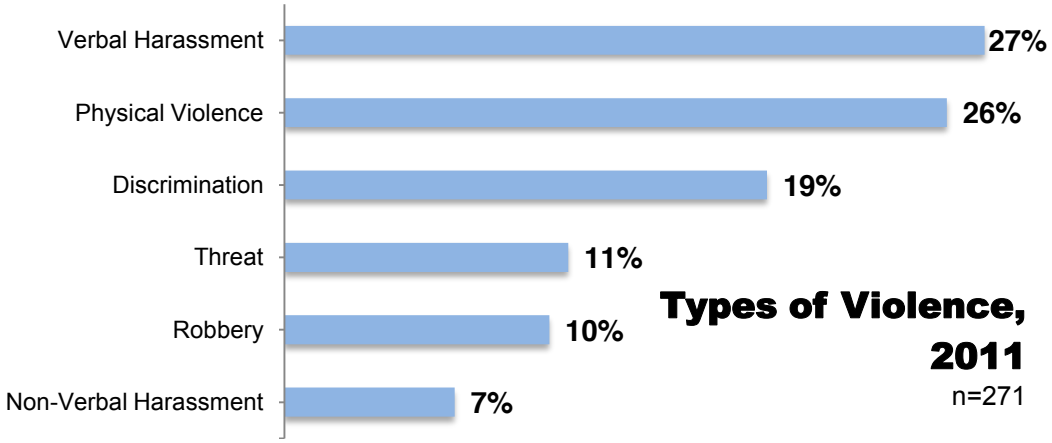
GREENVILLE, SC

Founded by Elke Kennedy in 2007 after the anti-gay murder of her son Sean Kennedy, Sean's Last Wish aims to change hearts and minds through educating people about how bullying, hatred, violence, prejudice, and religious beliefs leads to senseless crimes. Sean's Last Wish was established to support and educate the public. The mission of Sean's Last Wish is to empower the community through educational diversity programs, nonviolent conflict resolution, and community involvement.

In 2011 Sean's Last Wish attended 45 community events and visited six colleges and universities in Georgia, North Carolina, and South Carolina. During these events Sean's Last Wish educated community members about the impact of anti-LGBTQ bullying, LGBTQ domestic violence, and anti-LGBTQ hate violence. Sean's Last Wish also administered a survey at these events asking LGBTQ youth and young adults (primarily ages 13-29) to report their experiences of bullying, hate violence, domestic violence, violence at school, and suicidal ideation. Some respondents also filled out the survey online.



A total of 549 people took the survey with 121 reported cases of intimate partner violence in Georgia, North Carolina, and South Carolina in 2011. Regarding gender identity, 63% of respondents identified as women, 23% identified as men, 5% identified as transgender, and 8% of survivors did not disclose their gender identity. Regarding sexual orientation, 14% of survey respondents identified as bisexual, 12% identified as gay, 11% identified as heterosexual, 40% identified as lesbian, 22% did not disclose, 1% were questioning/ and 2% had a self-identified sexual orientation.



The majority of intimate partner violence cases reported to Sean's Last Wish were verbal harassment (74 total reports), followed by physical violence (70 total reports), discrimination (51 total reports), threats (30 total reports), robbery (28 total reports), and non-verbal harassment including phone, cyber, and e-mail harassment (18 total reports).

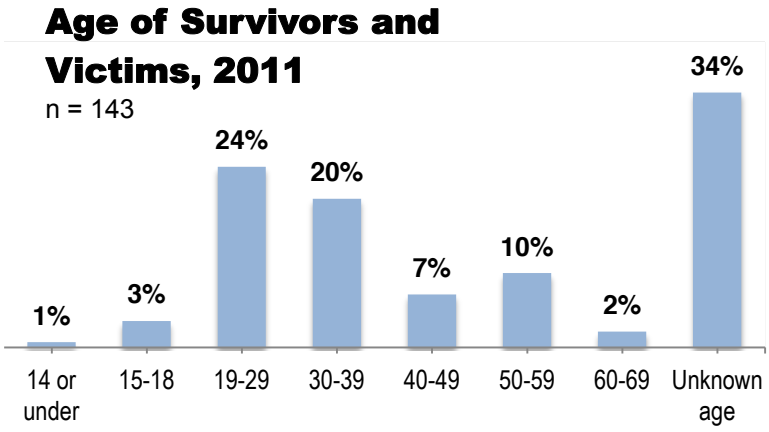
In speaking to community members, Sean's Last Wish found that many people were eager to report their experiences to raise awareness about LGBTQ Intimate Partner Violence. Many of the people that Sean's Last Wish spoke with expressed that they did not tell anyone about their experience or seek help because they believed that no support was available for LGBTQ people in the South. Many of the support services available in the Southern states are faith-based, which are not always safe places for LGBTQ survivors to turn to due to religious intolerance of LGBTQ identities.

Given these reports of LGBTQ intimate partner violence in Georgia, North Carolina, and South Carolina, Sean's Last Wish continues to educate community members about the root causes and impacts of violence, share the story of losing Sean Kennedy to anti-gay hate violence, and advocate for systemic policy change to address domestic violence, anti-LGBTQ violence and bullying.

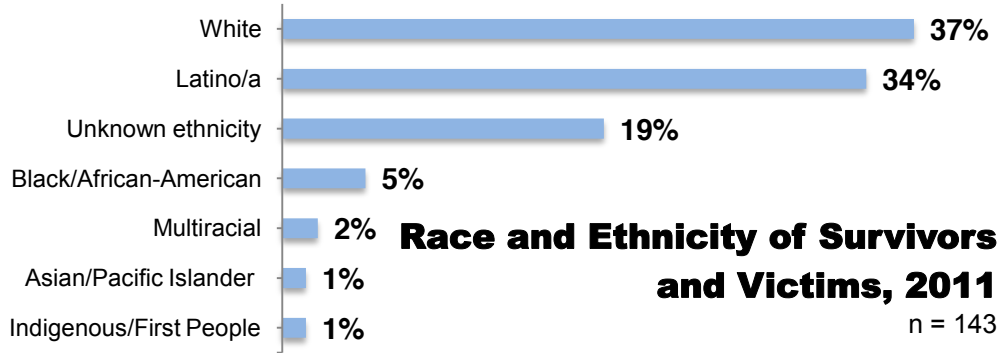
WINGSPAN ANTI-VIOLENCE PROGRAMS

TUSCON, AZ

The Wingspan Anti-Violence Programs (AVP) is a social change and social service program that works to address and end violence in the lives of lesbian, gay, bisexual, and transgender (LGBT) people. We provide free and confidential 24-hour crisis intervention, information, support, referrals, emergency shelter, and advocacy to LGBT victim/survivors of violence. Additionally, we offer extensive outreach and education programs. Wingspan is Southern Arizona's lesbian, gay, bisexual and transgender (LGBT) community center. Wingspan is a non-profit, charitable organization that serves Tucson and Southern Arizona.



Wingspan served 143 survivors of Intimate Partner Violence (IPV) in 2011. The ages of 2011's IPV survivors are of particular interested to us at the Wingspan AVP. Our services are widely known amongst the LGBT and Allied community in Southern Arizona, but we have often noticed that less people between the ages of 29-49 were reaching out for support. We responded to messages from this demographic that Wingspan services seem to only be for young LGBTQ communities, transgender folks, or the senior population. As a result, we assessed the effectiveness of our outreach and made significant changes in our approaches to outreach. According to the data collected from IPV survivors in 2011, our efforts may have proven to be effective as a majority of survivors served by Wingspan were ages 19-39 in 2011. Although it is never encouraging to notice spikes in people utilizing our crisis line and or walk in hours, it is encouraging to know that these survivors are having access to life saving and changing advocacy and resources. We will continue to reach out to all of the LGBT community here in Tucson and all of Southern Arizona to continue creating networks of safety and support.



Because of the racial demographics of our service area, we have access to working with a very diverse population. Many of our community members live in rural Arizona, on the border of Mexico and within Indigenous Lands. In 2011 we were

able to work with 49 Latina/o identified survivors. We accredit much of this connection to that community because of projects like Puertas Abiertas or Open Doors. Puertas Abiertas is Wingspan's social and outreach project for LGBT Latina/o's. The group holds regular meetings, and hosts events, forums, and educational and social events. Since its inception, Puertas Abiertas has been bringing Latina/o's together to celebrate their heritage and LGBT pride, creating a sense of community. This project developed a result of community need, and although not all of the participants are survivors of IPV, many get their first connection with Wingspan AVP through this type of programming.

UNITED 4 SAFETY (U4S)

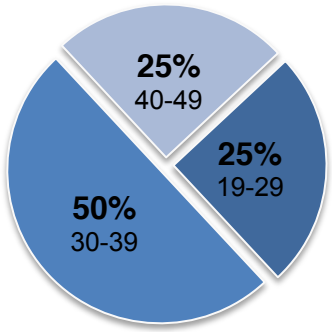
GEORGIA STATEWIDE

United 4 Safety (U4S) is the first 501c3 organization solely committed to reducing the incidence of domestic violence (DV) within the Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) community in Georgia. United 4 Safety's mission is to end the crime of intimate partner violence within the LGBTQ community.

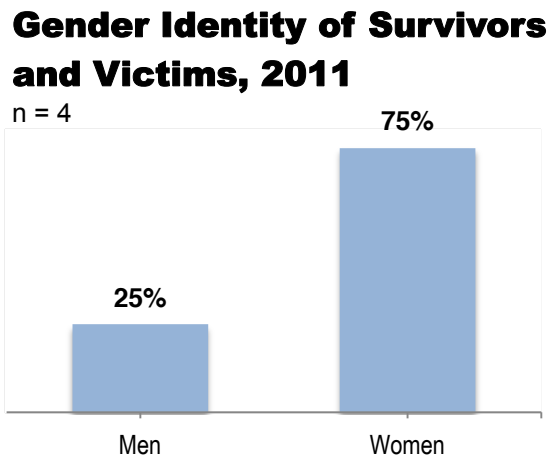
Since 2008, U4S has reached a total of 14,675 individuals through its helpline, training and outreach efforts, assisted 41 survivors who called the helpline and received in person and on the phone support for crisis intervention, housing and referral to group and individual counseling, trained 4,059 individuals including DV & SA advocates, reached 10,448 individuals through community events, and facilitated 108 individuals in a 9 month roundtable discussions on ending homophobia in the faith community. Through trainings supported by the Allstate Foundation from 2009-2011, U4S conducted 5 trainings for DV and SA advocates: 3 trainings in Georgia (Macon and Atlanta) and 2 in North Carolina (Asheville). In the Fall of 2011, U4S began a support group for LGBTQ survivors of DV, the first of its kind to be offered in Georgia. This valuable service is supported by U4S's annual fundraisers, individual donations, and LGBTQ community yoga classes. United 4 Safety remains a 100% volunteer run organization until larger grant sources can be secured.

Age of Survivors and Victims, 2011

n = 4



In 2011 U4S served 4 survivors of Intimate Partner Violence through our direct service efforts. 75% of these survivors identified as women and their orientation as lesbian. 1 survivor identified as HIV positive. 1 survivor identified themselves as having a mental disability. All 4 stated that they had suffered physical injuries yet only 1 had received medical attention. 2 individuals sought a protection order against their partner and were granted those orders. All survivors were given safety planning information and 3 received emergency financial assistance.



United 4 Safety served 30 individuals through our hotline by providing resources and referrals, including housing, legal, and shelter referrals.

STORIES OF LOSS:

2011 IPV-RELATED HOMICIDES

This report was written by the
NATIONAL COALITION OF ANTI-VIOLENCE PROGRAMS
A program of the **NEW YORK CITY ANTI-VIOLENCE PROJECT**
240 West 35th St., Suite 200
New York, NY 10001
www.ncavp.org



DATA COLLECTION, ANALYSIS, AND WRITING:

Tasha Amezcua, New York City Anti-Violence Project
Shelby Chestnut, New York City Anti-Violence Project
Ejeris Dixon, New York City Anti-Violence Project
Adam Payne, New York City Anti-Violence Project

DATA & REPORT DESIGN

Joyce Choi Li, New York City Anti-Violence Project
Kate Florence Traub, New York City Anti-Violence Project

Copyright © 2012 New York City Gay & Lesbian Anti-Violence Project, Inc. All Rights Reserved.
This report was produced in part with the generous support of the Arcus Foundation.

INTRODUCTION

The National Coalition of Anti-Violence Programs (NCAVP) presents this collection of stories of lesbian, gay, bisexual, transgender, queer, and HIV-affected (LGBTQH) intimate partner violence (IPV) homicide victims in 2011 as a supplement to the annual intimate partner violence report. This document provides a snapshot of IPV victims' experiences, and seeks to honor their memory.

In 2011, the National Coalition of Anti-Violence Programs (NCAVP) saw the highest ever reported number of IPV homicides since NCAVP began documenting this violence. NCAVP documented 19 homicides in 2011 greater than three times the amount of homicides documented in 2010. While homicides rose, NCAVP also documented a 22% decrease in overall hate violence incidents from 5,052 in 2011 to 3, 930 in 2010. NCAVP member programs report that this homicide increase highlights the need to increase funding for LGBTQH-specific anti-violence programs. 2011's IPV homicides have a disproportionate impact on men and gay men in particular with 63.6% of the homicide victims identifying as men and 57.9% of homicide victims identifying as gay. These findings continue to shed light on the importance of prevention, strategic response, research, and accurate reporting of hate violence as it affects LGBTQH communities.

This supplemental report brings to light the severity of IPV within LGBTQH communities, in the hopes of allowing the reader to examine themes in LGBTQH IPV homicide and to see the diversity of 2011's homicide victims. The report highlights the narratives of nineteen known LGBTQH IPV homicides in 2011. Some of these incidents have not been classified by law enforcement as domestic violence. However, NCAVP member programs have carefully selected these stories because they include information that actually or indicates a strong likliehood that IPV either motivated or was related to the homicide. NCAVP wrote these narratives using information from media outlets, family/friends, and local NCAVP members. NCAVP is not responsible for the complete accuracy of these narratives and the specific details pertinent to allegations, police investigations, and criminal trials.

These narratives illustrate the need for the existence and expansion of LGBTQH anti-violence programs. If you are interested in starting an anti-violence program, becoming a member of the National Coalition of Anti-Violence Programs, or if you would like more information, contact NCAVP at info@ncavp.org or 212.714.1184.

2011 IPV HOMICIDE NARRATIVES

ALPHABETICAL BY STATE

JACK BAKER: 67, White, gay, non-transgender man

San Francisco, CA, February 11, 2011

On February 11th, 2011 police found Jack Baker (67) stabbed to death in his Nob Hill apartment in San Franciso, CA. According to news reports, police found Baker's body brutally beaten, strangled and stabbed. His roommate, 24-year-old Waheed Kesmatyer, was arrested and charged with murder. The roommate plead not guilty to the murder and no motive has been released.

FREDDY CANUL-ARGUELLO: 23, Latino, gay, non-transgender man

San Francisco, CA, June 9, 2011

On June 9th, 2011 Freddy Canul-Arguello (23) an immigrant from Mexico met David Diaz in a bar in the Castro area of San Francisco. Canul-Arguello worked at Pi bar in the San Francisco, Mission District and often performed in their drag shows. According to news reports Canul-Arguello and Diaz visited Buena Vista Park, potentially to have sex after meeting at an area bar. Family members say that although the park is known as a gay cruising area and that Canul-Arguello was gay, he would never have gone to the park of his own volition. Canul-Arguello died as a result of erotic asphyxiation. Following Canul-Arguello's asphyxiation, Diaz allegedly shoved Canul-Arguello's body in a blue recycling bin and set fire to it. By the time the fire department responded to a small brush fire in Buena Vista Park, Canul-Arguello was already dead. Media sources state that David Diaz is charged with murder, robbery, mutilating/maiming/disfiguring a body, and destruction of evidence.

CHRISTOPHER ALAN TRUEHEART: 44, African American, gay, non-transgender man

Washington, DC, February 13, 2011

On February 13th, 2011 police in Prince Georges County, MD responded to Temple Hills, MD for a call of intimate partner violence. Police found the body of Christopher Alan Trueheart (44) fatally stabbed. Police charged Trueheart's partner Eldridge Slaughter (42) of the murder. When Slaughter was apprehended a few days later he pled guilty to murder . In news reports friends stated that Trueheart was a "such a gentle soul who loved everyone" and that he was active in the DC chapter of ADODI, a Black gay community group.

MONAI BUCHANAN: 23, African American lesbian non-transgender woman

New Orleans, LA, April 3, 2011

Shortly after noon on Sunday, April 3, 2011, Monai Buchanan (23), mother of two, was found shot dead in her Algiers home. Her children were not home at the time of the shooting. According to media reports, she was killed by her girlfriend, Daviane Shelling (21), as a result of a domestic dispute. Buchanan's family reported a history of violence in the couple's relationship.

CHARITY ANN PILLARS: 32, White lesbian non-transgender woman, and
CHELSEA PATRICK: 21, White non-transgender woman

Richland Parish, LA, September 28, 2011

On September 9, 2011, Charity Ann Pillars (32) and Chelsea Patrick (21 – bystander) were killed by Charity's former partner, Tina McIntyre (44). Investigators believe MyIntyre requested that Pillars visit her home. News sources state a confrontation ensued between the three women upon Pillars and Patrick's arrival at McIntyre's, which ended in the fatal shooting of both Pillars and Patrick in McIntyre's doorway.

BRIAN BERGERON: 55, White gay, non-transgender man

Malden, MA, March 16, 2011

On March 9, 2011 media sources state that the body of Brian Bergeron (55) was found stabbed, dead and wrapped in a blue tarp in the dining room of a Malden, MA apartment shared by Mr. Bergeron and his husband Micheal Losee (41). It is alleged that after the homicide Losee called a friend in Florida to confess to the crime and that friend called the police. Media sources document that Losee surrendered to the police from his lawyer's office and has consistently maintained his innocence. The Middlesex, MA, District Attorney stated that, "This appears to be a tragic incident of domestic violence, committed by the spouse of the victim."

CASEY TAYLOR: 36, ethnicity unknown, gay non-transgender man

Winthrop, MA, August 9, 2011

Casey Taylor (36) was reportedly stabbed in the heart by John Lacoy (47), of Winthrop, MA, during an argument. According to news reports, Taylor, who was previously homeless and Lacoy hadbeen romantically involved, and their relationship had a history of violence. Taylor's body was found by Winthrop, MA police on August 9th, 2011, underneath Lacoy's porch. According to news reports, Taylor was killed in Lacoy's second-floor apartment at the Winthrop home and his body was subsequently moved underneath the porch. Shortly after the homicide Lacoy sent out a text message saying Taylor "won't be able to leech off me anymore." Lacoy pleaded not guilty during his murder arraignment.

IRVING BURKIN: 65, ethnicity unknown, non-transgender man

Malden, MA, March 2011

In Malden, MA two residents, Irving Burkin (65) and Burton Berenson(65) died in what is believed by the police to be a murder-suicide. News reports state that police determined that Berenson shot Burkin several times and then shot himself. In an article about Burkin and Berenson's deaths, a person who stated they were a friend from Seattle, WA commented, "I can only submit that they each had lost ALL that was important to them and they both wanted the final escape."

KRISSY BATES: 45, White transgender woman

Minneapolis, MN, January 6, 2011

On the evening of January 6, 2011, after an argument in Bates' Minneapolis apartment, news reports state that Arnold Waukazo initially strangled Bates to the point of unconsciousness. Media sources document that within Waukauzo's taped confession, when she showed signs of life, he reached for a switchblade and stabbed her multiple times causing fatal injuries. After the stabbing, Waukazo left the apartment, leaving Bates to be found five days later by apartment staff. Arnold Waukazo was convicted of Second Degree Murder in the death of Krissy Bates. Waukazo waived his right to a jury trial. According to trial testimony, Bates had recently begun dating Waukazo and told friends that he was "the one."

ONGE'LE MARIE BARNETT: 30, African American lesbian non-transgender woman

Kansas City, MO, December 25, 2011

Media sources state that prosecutors charged Kansas City, MO, woman, Lacresha A.V. Barnett, in the death of her longtime partner, Onge'le Marie Barnett, who was found fatally stabbed by Barnett in their apartment on December 25, 2011. Lacresha A.V. Barnett, 36, was charged with second-degree murder and armed criminal action in the death of 30-year-old Onge'le Marie Barnett. The couple wed in a civil ceremony out of state a few years prior. News reports state that Onge'le Barnett's relatives told police that they went to her apartment to check on her and talked to Lacresha. Family members said Lacresha told them that Onge'le Barnett had gone to the store. The family left and returned a short time later to a locked house. A relative pried open a window, entered the apartment and found Onge'le Barnett's body in the living room. Police soon after arrested Lacresha Barnett. According to news reports, Lacresha Barnett told police that Onge'le Barnett had

become angry with her and displayed a knife, then began choking her. She said she picked up the knife and stabbed Onge'le Barnett multiple times. Barnett told the police she did not call for help after the stabbing or after Onge'le Barnett's relatives stopped by the apartment. Court documents say, Lacresha Barnett left and watched for police to arrive.

FRANCISCO R. GONZALEZ FUENTES: 46, Latino gay non-transgender man

Cliffside Park, NJ, January 13, 2011

Pedro Garcia (33), the boyfriend of Francisco R. Gonzalez, and Wilfredo Sanchez (34), were charged with the murder and dismemberment of Francisco R. Gonzalez Fuentes (46) in January 2011. According to news reports, Mr. Fuentes' body parts were found in three garbage bags left in two locations in suburban Cliffside Park, NJ. The homicide occured after a house party in Mr. Fuentes' home. It was the result of a domestic argument that took place between Pedro and Francisco.

CARLOS CASTRO: 65, White, gay, non-transgender man

New York, NY, January 10, 2011

Carlos Castro (65) was a journalist, a TV personality, and a noted LGBTQ activist from Cantanhede, Portugal. News reports state that Mr. Castro was visiting New York City as a tourist with his lover Renato Seabra (21). They were staying on the 34th floor of the Intercontinental Hotel in the Times Square area of Manhattan. According to a news source, Mr. Castro was killed as the result of an argument possibly over money. He was bludgeoned in the head with a heavy object and then castrated with a corkscrew. His alleged killer, Renato Seabra, showered and put on a new suit while Mr. Castro bled to death in their shared hotel room. Seabra then took a cab to Roosevelt Hospital for treatment of cuts and scrapes received during the fight. Mr. Castro's body was found by hotel staff at the urging of a friend who became worried after seeing and talking with Seabra in the hotel lobby. Seabra confessed to the murder.

CAMILA GUZMAN: 38, Latina transgender woman

New York, NY, August 1, 2011

On August 1, police found Camila Guzman of East Harlem, NY dead and lying face down on her bed at her home. She had been stabbed several times in the back. Guzman moved to New York City from Chile in 2002 to live openly as a transgender woman. Equan Southall, 25, had been dating Guzman for four months when he killed her. Motive is unknown, but according to a friend of Ms. Guzman, "We know in our hearts this crime was based on discrimination against transgender women." Equan was arrested and has confessed to Guzman's murder.

DAVID WALTON: 41, White gay non-transgender man

Provincetown, MA, April 2, 2011

David Walton, (41) was camping with his boyfriend James Costello (45) in Provincetown, MA over the weekend of April 2-3, 2011. There was a history of violence in the relationship. In 2006 Costello was convicted of assaulting his lover, Mr. David Walton. He was issued a restraining order. After the order expired media sources state that Costello and Walton got back together. According to news sources, Costello admitted to killing Mr. Walton by stomping on him around 6 AM on the morning of April 2. David Walton was pronounced dead by police at 6:22 AM April 2. An autopsy revealed that Walton's actual cause of death was strangulation.

RALPH BELL: 54, White gay non-transgender man

Winooski, VT, July, 2011

According to news sources, sometime during the evening of July 18 or early morning of July 19, Ralph Bell (54) was stabbed several times in the neck and face by his lover and neighbor, Daniel Whalen (25), and subsequently fell 50 feet from the bridge whereon the stabbing occurred.. According to the same source, friends of Bell's said their relationship was violent at times.

RENE MINARD: 39, White Lesbian non-transgender woman

Okanogan, WA, August 25, 2011

On Thursday, August 25, 2011 news reports state that Shelly Payton, shot her ex-girlfriend, Rene Minard, mother of one, and wounded co-worker and family friend, Catrina Fling. The shooting took place at the home that Payton shared with Minard in suburban northeastern Washington, while Minard's son was at football practice. News sources state that the Okanogan sherrif's office was notified of three shots fired. The first shot presumably killed Minard, the second shot wounded Fling, and then Payton turned the gun on herself. Minard and Payton were found dead by sherrifs upon arrival. News sources state that Payton had some military training.

ERIC COOPER: 29, Asian American gay non-transgender man, and
COOPER CHEN: 2, surrogate child

Seattle, WA, August 11, 2011

On August 11th, 2011 Dr. Louis Chen (39) didn't show for his first day of work at a hospital in Seattle, WA. A nurse from the hospital stopped by his home to make sure he was ok. According to news reports, Chen answered the door naked and covered in blood. Chen had supposedly argued with and then stabbed his boyfriend Eric Cooper (29) and the couple's two year-old son Cooper Chen. News sources state that Chen allegedly confessed to the murders, and waived his right to trial. He has been charged with two counts of aggravated first-degree murder, and faces life in prison if convicted. His trial has been postponed.

NCAVP MEMBER AND AFFILIATE LIST

(ALPHABETICAL BY STATE OR PROVINCE)

The following NCAVP member and affiliate list is current as of February, 2012. If you have corrections, want to learn more about our work, or know of an organization that may be interested in joining NCAVP, please contact the NCAVP Coordinator, at extension 50, or info@ncavp.org.

PROGRAM INFORMATION BELOW IS LISTED AS FOLLOWS:

STATE
CITY
ORGANIZATION NAME
FOCUS AREAS:

- **HV (HATE VIOLENCE)**
- **IPV (INTIMATE PARTNER VIOLENCE)**
- **PM (POLICE MISCONDUCT)**
- **SV (SEXUAL VIOLENCE)**

PHONE NUMBERS
WEB

ARIZONA

TUCSON

WINGSPAN ANTI-VIOLENCE PROGRAMS
HV, IPV, PM, SV
CLIENT: (800) 553-9387
OFFICE: (800) 624-0348
WEB: WWW.WINGSPAN.ORG

CALIFORNIA

LOS ANGELES

LA GAY & LESBIAN CENTER (LAGLC) ANTI-VIOLENCE PROJECT
HV, PM, SV
CLIENT (ENGLISH): (800) 373-2227
CLIENT (SPANISH): (877) 963-4666
WEB: WWW.LAGAYCENTER.ORG

LAGLC DOMESTIC VIOLENCE LEGAL ADVOCACY PROJECT
IPV, SV
OFFICE: (323) 993-7649
TOLL-FREE: (888) 928-7233
WEB: WWW.LAGAYCENTER.ORG

LAGLC STOP DOMESTIC VIOLENCE PROGRAM
IPV, SV
OFFICE: (323) 860-5806
WEB: WWW.LAGAYCENTER.ORG

SAN DIEGO

SAN DIEGO LGBT CENTER
HV, IPV, PM, SV
CLIENT: (619) 692-2077 X208
WEB: WWW.THECENTERSD.ORG

SAN FRANCISCO

COMMUNITY UNITED AGAINST VIOLENCE
HV, IPV, PM, SV
24 HOUR HOTLINE: (415) 333-HELP
WEB: WWW.CUAV.ORG

COLORADO

DENVER

COLORADO ANTI-VIOLENCE PROGRAM
HV, IPV, PM, SV
CLIENT: (888) 557-4441
OFFICE: (303) 839-5204
WEB: WWW.COAVP.ORG

FLORIDA

BROWARD COUNTY

BROWARD LGBT DOMESTIC VIOLENCE COALITION (NCAVP AFFILIATE)
IPV, SV
OFFICE: (954)7645150 X.111

MIAMI

THE LODGE/VICTIM RESPONSE, INC.
IPV, SV
CRISIS LINE: (305) 693-0232
WEB: WWW.THELODGEMIAMI.ORG

TALLAHASSEE

INCLUSIVE LGBTQA TASK FORCE
HV, IPV
E-MAIL: YFAIRELL@HOTMAIL.COM

WILTON MANORS

SUNSERVE SUNSHINE SOCIAL SERVICES
IPV
OFFICE: (954) 764-5150
WEB: WWW.SUNSERVE.ORG

GEORGIA

ATLANTA

SPEAKOUT GEORGIA
HV, IPV, SV
HOTLINE: (678) 861-7867
WEB: WWW.SPEAKOUTGEORGIA.ORG

UNITED4SAFETY
IPV, SV
HELPLINE: (404) 200-5957
WEB: WWW.UNITED4SAFETY.ORG

ILLINOIS

CHICAGO

CENTER ON HALSTED ANTI-VIOLENCE PROJECT
HV, IPV, PM, SV
24 HR CRISIS LINE: (773) 871-CARE
WEB: WWW.CENTERONHALSTED.ORG

KENTUCKY

LOUISVILLE

CENTER FOR WOMEN AND FAMILIES
IPV, SV
24 HR CRISIS LINE: (877) 803-7577
WEB: WWW.THECENTERONLINE.ORG

LOUISIANA

NEW ORLEANS

BREAKOUT!
HV, PM
OFFICE: (504) 522-5435
WEB: WWW.YOUTHBREAKOUT.ORG

HIV/AIDS PROGRAM, LOUISIANA OFFICE OF PUBLIC HEALTH (NCAVP AFFILIATE)
HV, IPV, SV
OFFICE: (504) 568-7474

LGBT COMMUNITY CENTER OF NEW ORLEANS
HV, IPV, PM, SV
OFFICE: (504) 945-1103

MASSACHUSETTS

BOSTON

FENWAY COMMUNITY HEALTH VIOLENCE RECOVERY PROGRAM
HV, IPV, PM, SV
INTAKE: (800) 834-3242
OFFICE: (617) 927-6250
WEB: WWW.FENWAYHEALTH.ORG

THE NETWORK/LA RED
IPV, SV
ENGLISH/SPANISH HOTLINE: (617) 423-7233
WEB: WWW.TNLR.ORG

MICHIGAN

DETROIT

EQUALITY MICHIGAN
HV, IPV, PM
CLIENT: (866) 926-1147
WEB: WWW.EQUALITYMI.ORG

MINNESOTA

MINNEAPOLIS

OUTFRONT MINNESOTA
HV, IPV, PM, SV
HOTLINE: (612) 824-8434
WEB: WWW.OUTFRONT.ORG

MISSOURI

KANSAS CITY

KANSAS CITY ANTI-VIOLENCE PROJECT
HV, IPV, PM, SV
CLIENT: (816) 561-0550
WEB: WWW.KCAVP.ORG

ST. LOUIS

ANTI-VIOLENCE ADVOCACY PROJECT OF ALIVE
HV, IPV, SV
24 HR CRISIS LINE: (314) 993-2777
WEB: WWW.ALIVESTL.ORG

ST. LOUIS VIOLENCE RESPONSE INITIATIVE
HV, IPV, SV, PM
OFFICE: (314) 329-7660
HOTLINE: (314) 329-7668
WEB: WWW.EJUSTMO.ORG

NEW YORK

ALBANY

IN OUR OWN VOICES
HV, IPV, SV
HOTLINE: (518) 432-4341
OFFICE: (518) 432-4341
WEB: WWW.INOUROWNVOICES.ORG

BAYSHORE

LONG ISLAND GLBT SERVICES NETWORK
HV, IPV, SV
OFFICE: (631) 665-2300
LONG ISLAND GAY AND LESBIAN YOUTH, INC.
WEB: WWW.LIGALY.ORG
LONG ISLAND GLBT COMMUNITY CENTER
WEB: WWW.LIGLBTCENTER.ORG

NEW YORK
NEW YORK CITY ANTI-VIOLENCE PROJECT
HV, IPV, PM, SV
24 HR ENGLISH/SPANISH HOTLINE: (212) 714-1141
OFFICE: (212) 714-1184
WEB: WWW.AVP.ORG

ROCHESTER
GAY ALLIANCE OF THE GENESEE VALLEY
HV, IPV, PM, SV
OFFICE: (585) 244-8640
WEB: WWW.GAYALLIANCE.ORG

NORTH CAROLINA

CARY
RAINBOW COMMUNITY CARES, INC.
HV, IPV, PM, SV
OFFICE: (919)342-0897
WEB: WWW.RCCARES.ORG

OHIO

STATEWIDE, COLUMBUS OFFICE
BRAVO (BUCKEYE REGION ANTI-VIOLENCE ORGANIZATION)
HV, IPV, PM, SV
CLIENT: (866) 86 BRAVO
WWW.BRAVO-OHIO.ORG

BLACKLICK
NATIONAL LEATHER ASSOCIATION
IPV (NCAVP AFFILIATE ONLY)
WEB: WWW.NLAIDVPROJECT.US/WEB

ONTARIO

TORONTO
THE 519 ANTI-VIOLENCE PROGRAMME
HV, IPV, PM, SV
CLIENT: (416) 392-6877
WEB: WWW.THE519.ORG

RHODE ISLAND

PROVIDENCE
SOJOURNER HOUSE
HV, IPV, PM, SV
CLIENT: (401) 658-4334
WEB: WWW.SOJOURNERRI.ORG

SOUTH CAROLINA

GREENVILLE
SEAN'S LAST WISH
HV, IPV, PM, SV
OFFICE: (864) 884-5003
WEB: WWW.SEANSLASTWISH.ORG

TENNESSEE

MEMPHIS
TABERNACLE OF LOVE MINISTRIES – MEMPHIS
HV, IPV, PM, SV
OFFICE: (901) 730-6082
WEB: WWW.TABERNACLEOFLOVEMINISTRIES.ORG

TEXAS

DALLAS
RESOURCE CENTER DALLAS
IPV
OFFICE: (214) 540-4455
WEB: WWW.RCDALLAS.ORG

HOUSTON
MONTROSE COUNSELING CENTER
HV, IPV, SV
OFFICE: (713) 529-0037
WWW.MONTROSECOUNSELINGCENTER.ORG

VERMONT

WINOOSKI
SAFESPACE AT THE R U 1 2? COMMUNITY CENTER
HV, IPV, PM, SV
CLIENT: (866) 869-7341
WEB: WWW.RU12.ORG

VIRGINIA

ALEXANDRIA
ALEXANDRIA SEXUAL AND DOMESTIC VIOLENCE PROGRAMS
IPV, SV
IPV HOTLINE: (703) 746-4911
SV HOTLINE: (703) 683-7273
OFFICE:(703) 746-5030

RICHMOND
VIRGINIA ANTI-VIOLENCE PROJECT
HV, IPV, PM, SV
OFFICE: (804) 925-8287
WEB: WWW.VIRGINIAAVP.ORG

QUEBEC

MONTREAL
CENTRE DE SOLIDARITÉ LESBIENNE
IPV, SV
CLIENT: (514) 526-2452
WEB: WWW.SOLDARITELESBIENNE.QC.CA

WASHINGTON, D.C

DC TRANS COALITION
HV, IPV, PM, SV
OFFICE: (202) 681-DCTC
WEB: WWW.DCTRANSCOALITION.ORG

GLOV (GAYS AND LESBIANS OPPOSING VIOLENCE)
HV, PM
OFFICE: (202) 682-2245
WEB: WWW.GLOVDC.ORG

RAINBOW RESPONSE COALITION
IPV, SV
OFFICE: (202) 299-1181
WEB: WWW.RAINBOWRESPONSE.ORG

WISCONSIN

APPLETON
FOX VALLEY/OSHKOSH LGBTQ ANTI-VIOLENCE PROJECT
HV, IPV, PM, SV
E-MAIL: FOXOAVP@GMAIL.COM

MILWAUKEE
MILWAUKEE LGBT CENTER ANTI-VIOLENCE PROJECT
HV, IPV, SV
OFFICE: (414) 271-2656
WEB: WWW.MKELGBT.ORG

FORGE SEXUAL VIOLENCE PROJECT
SV
OFFICE: (414) 559-2123
WEB: WWW.FORGE-FORWARD.ORG



NATIONAL OFFICE
NEW YORK CITY ANTI-VIOLENCE PROJECT
240 WEST 35TH STREET, SUITE 200
NEW YORK, NY 10001
PHONE: 212-714-1184
FAX: 212-714-2627

TRAINING BULLETIN

DOMESTIC VIOLENCE IN THE GAY, LESBIAN, BISEXUAL & TRANSGENDER COMMUNITY

SAME SEX DOMESTIC VIOLENCE

How is lesbian and gay battering <u>similar</u> to battering in heterosexual relationships?

- No one deserves to be abused
- Abuse can be physical, sexual and verbal behavior to coerce or humiliate, emotional or psychological.
- Abuse often occurs in a cyclic fashion
- Abuse can be lethal
- The purpose of the abuse is to maintain control and power over one's partner. Routine intimidation is used to gain that power.
- The abused person feels isolated, afraid and usually convinced that they are at fault.
- The incidence rate in relationships for gay/lesbian battering and heterosexual battering is approximately the same – 25-30% of relationships are abusive.

How is lesbian and gay battering <u>different</u> from heterosexual battering?

- Lesbians and gay men who are abused have much more difficulty finding appropriate support than heterosexual women do.
- The myth that lesbian/gay domestic violence is "mutual" prevails. No one would assume that heterosexual battering is mutual and therefore less important.
- Utilizing existing services such as in the legal system or battered women's movement is tantamount to "coming out" and a major life decision.
- Support services often minimize lesbian/gay domestic violence because gay bashing is OK in this society, because it is easy to fall into the trap that size has anything to do with battering and because to acknowledge this abuse destroys the myth of a "lesbian utopia" and the gay male "enlightenment."
- Lesbian and gay survivors may know few or no other gays: leaving the abuser could mean total isolation from every community.
- The gay/lesbian community is small and it is likely everyone the survivor knows will soon know of his/her abuse.
- The batterer can use blackmail to hold the victim in the relationship. Being "outed" at work or to parents is sometimes more threatening than the abuse.
- If there are children in the relationship seeking help will mean the survivor will never again see the abuser's children since gays and lesbians have no parental rights and if children are the survivors seeking help may mean the county will want to step in and take the child from the "violent, homosexual deviant" relationship.
- Often for gays/lesbians sympathetic friends are hard to find since the gay/lesbian community is not eager to acknowledge weakness which the heterosexual world will use to support its homophobia stereotypes. No one would claim that all heterosexual relationships are mentally unstable because there is sometimes abuse.

Common Myths About Same-Sex Partner Abuse[1]

- Myths about same-sex partner abuse impede social and legal awareness and action to address the problem and prevent further abuse.
- Essentially, these myths further the silence that already surrounds these issues.
- Listed below are several myths that have been perpetuated about same-sex partner abuse

Myth: Battering and abuse do not exist in the lesbian community as only men abuse women
Fact: Domestic violence does exist in the lesbian community. This is not a problem limited to heterosexual relationships

Myth: Domestic violence only affects certain groups of lesbians.
Fact: Violence and abuse are found in all parts of the lesbian community.

Myth: The problem in lesbian relationships is really fighting or mutual battering and not domestic violence.
Fact: The issue in domestic violence is control.

Myth: Domestic violence is not a problem for gay men.
Fact: Because men traditionally have been encouraged to use violence and power to control others, it is difficult for gay men to identify violence in their lives.

Myth: Domestic violence affects only certain groups of gay men.
Fact: Violence and abuse are found in all parts of the gay community.

Myth: same-sex partner abuse is really 'mutual combat' or a 'fair fight.'
Fact: same-sex partner abuse is not usually 'fair' or 'mutual,' despite the shared gender of the abuser and the victim.

Myth: true victims do not fight back or do not fight back effectively; victims who do fight back will further support the myth of fair fight/mutual abuse
Fact: true victims- even heterosexual victims- often do fight back, but they need to be treated as victims.

Myth: batterers will always be bigger and stronger than obviously weaker victims
Fact: It is not true that batterers have to be stronger than their victims. This myth ignores the power of psychological abuse, property destruction or tactics of intimidation used to control abused partners.

Myth: same-sex partner abuse is merely a form of sadomasochistic sexual behavior; he myth furthers society's belief that gays and lesbians are aberrant, immoral, and abnormal people.
Fact: not all gays and lesbians engage in S-M behavior. They are just as capable of caring, loving, and tender relationships as heterosexuals.

---

[1] New York City Gay and Lesbian Anti-Violence Project, "Behind Closed Doors: Battering and Abuse in Lesbian Relationships" and "Behind Closed Doors: Battering and Abuse in Relationships for Gay Men"; Da Luz, supra note , at 283.

Client Screening and Assessment

Screening asks about a client's perceived risk of violence. It is important that screening happen during every new client intake, even if you believe that a client may receive services at another agency.

Some screening questions:

- Do you feel safe at home?
- Has anyone (partner, family member, roommate, care provider) ever threatened to harm you or physically harmed you?
- Tell me how you and your partner handle anger.

Assessment determines if a client is the victim or perpetrator of violence.

Every assessment should pay attention to:

- PATTERNS and HISTORY over the span of the whole relationship
- CONTEXT in which the behavior occurred
- INTENT of its use
- EFFECT of the behavior on both people

Some assessment questions:

- How would your best friend describe your relationship with your partner?
- What is your support network like outside of your relationship with your partner?
- If your relationship has been violent, what percentage of the time do you feel you were responsible for abuse?
- Which times/behaviors did you do in self-defense?

According to the entire assessment, whose life appears to be "getting smaller" (who has access to the fewest resources, support people, least money, etc.)?

Screening and Assessment of Victims/Perpetrators of Lesbian, Gay, Transgender and Bisexual (LGTB) Domestic Violence

© 2000 D. R. Dolan-Soto, CSW

Note: This tool is only a guide and cannot definitively tell you whether you are working with a victim or a perpetrator of domestic violence. Supervisory or team review is strongly recommended to achieve the most accurate assessment.

Because abuse occurs in about one in four relationships regardless of sexual orientation or gender identity, there is a good likelihood that you will encounter clients experiencing domestic violence. In work with LGTB domestic violence no presumptions can be made about a client as either a victim or an abuser based on a client's sex. Similarly presumptions cannot be made about a client's sexual orientation based solely on the client's perceived presentation.

To make the most accurate assessment and to provide the most appropriate service, assessment should include the possibility that the presenting client may be *either* victim *or* perpetrator. Assessment must be conducted for *both* possibilities.

LGTB Domestic Violence Defined

The New York City Gay and Lesbian Anti-Violence Project defines domestic violence as any pattern of behavior within an intimate relationship which coerces, dominates or isolates. It is the exertion of any form of power, which maintains control. Additionally Fenway Community Health of Boston adds to this that the above induces fear in the victim. If all of these aspects are present, it is likely you are working with domestic violence. If, however, there is no pattern, no distinguishable power and control, no consequences to one partner for not complying with the other and no fear, the situation may not be domestic violence.

Distinguishing Victims from Perpetrators

- What prompted the client to come to your agency? Who referred the client?
- What is the client seeking?
- Have the client describe the most recent event which caused her or him to seek services.
- The client should be able to help you to clearly understand what prompted the incident, how it progressed, what happened and the outcome.
- Are there children in the home? How many, ages? Who is the birth or custodial parent? How are they affected?

- Who handles the finances?
- Who works?
- What is the arrangement for housing? Is the apartment, home, etc. in both names?
- What kind of difficulties has the client experienced in their relationship?
- How are disagreements handled?

- During the assessment ask the client *both* of the following questions:
  - Have you ever felt afraid of being hurt by your partner or have you ever been hurt by your partner?

    and
  - Have you ever hurt your partner, or been afraid or concerned that you might hurt your partner?
- Ultimately it is necessary to determine which partner's life experience has narrowed during the course of the relationship, and who has experienced consequences. (Consequences refer to losses experienced by the victim over time, usually during violent episodes. For example, an abuser breaks a victim's irreplaceable family heirloom in the course of an argument. Or an argument over phone contact results in a victim having to choose between contact with a trusted friend/family member and the abusive partner—the consequence of maintaining peace in the intimate relationship results in consequences to the victim which effectively dissuade the victim from asserting their own opinions, concerns or needs.)
- If neither partner's life has narrowed or been impacted by consequences, see Rule Outs below.

Rule Outs

Note: In instances where 'mutual' violence is presented, a practitioner needs to assess for domestic violence. If *domestic violence* is present, the violence ***cannot be*** mutual. Mutual violence implies an equal capacity among the partners. Domestic violence by definition must include the dynamic of power and control of one partner over another *and* a pattern of abuse, so within a domestic violence context *abuse* cannot be mutual.

- Assessment should determine the presence of substance abuse, mental illness, physical violence or other complicating factors.
- Determination should be made as to whether these issues are the cause of the violence or are factors which complicate, and create additional aspects to, the domestic violence.

Involvement of Legal and Other Agencies

- Determine the nature and history of police involvement and who (the client, partner, neighbors, etc.) initiated that contact.
- Who has police or other social service involvement benefited?
- Has there ever been an Order of Protection?
  - Against whom? What prompted this? Who called the police?

Assessment for Victimization

Does your client indicate

- that the relationship either seems terrific, tense or awful, but rarely just okay?
- they are often walking on eggshells?
- their partner's (use client's term) behavior has changed?
- that *their* life has narrowed over the course of the relationship?

Has the partner

- told them who they could or couldn't see?
- told them what to wear, criticized their dress or appearance?
- falsely accused them of flirtations or affairs?
- been jealous or accusative about time or effort related to family, friends, work, etc.?
- insulted them based on their sexual orientation or gender identity?
- threatened or intimidated them?
- neglected them?
- pushed or hit them? physically attacked surgically or hormonally altered body parts?
- restrained them?
- controlled what they do with their money?
- threatened to out their sexual orientation or gender identity to neighbors, co-workers, employers, city, state and federal employees?
- destroyed any of their belongings?
- stopped them from getting needed medical services?
- forced them to have unwanted, or unsafe sex? threatened to go outside the relationship for sex? criticized sexual performance based on role expectations or impact of hormones or surgery?

If the answer to these questions is generally yes *and* the client expresses that they have in the past been afraid of or currently fear that their partner may hurt them, it is likely you are dealing with a victim of domestic violence. If a client denies fear, assess the client's ability to refuse to cooperate with partner or to assert their own needs *without* consequences. If consequences generally influence the client to cooperate with the partner, you are likely working with a victim.

It is important to do a risk assessment and safety planning as indicated by the assessment.

- Does the client's partner know they came today?
- Do they live together?
- Are there children in the home? How many? What ages? Who is the birth or custodial parent? How are the children affected? Determine need to report.
- How does the client think the partner will act when he or she gets home?
- Is the client concerned that the partner might hurt him or her today? This week?
- What is the client's plan to deal with the partner's reaction? (See Safety Planning)
- History: (To assess for risks other than imminent danger e.g. child abuse/neglect, depression for the client, etc.)
  - Police or other social service involvement? Has the intervention been beneficial or problematic? In what ways?
  - Has the patient ever avoided or been unable to have social, familial, medical or social service contact, been out of work or been unable to fulfill other roles (parental, etc.) because of the relationship?
  - Assess impact and need for protective intervention and assistance.
- Is emergency housing needed?

  Information about LGTB sensitive and appropriate shelter resources should be determined by interviewer *prior* to assessment, or plans should be made for emergency housing through a hotel, safe home or other local resource.

Assessment for Perpetration

- Is the client vague about the details of the violence?
- Does the client express being upset with the partner for not responding the way the client would like despite their efforts?
- Does the client pursue contact with the partner despite the other partner's distancing behaviors?
- Does the client seem comfortable with anger, aggression, jealousy or assertion of their needs within the relationship?
- Does the client express the violence as the responsibility of the partner?
- Does the client appear focussed on meeting their own needs?
- Does the client appear to 'assert' their role as the victim in the relationship?

If the answer to the majority of these questions is yes *and* the client expresses concern about previously hurting their partner or the fear that she or he may hurt the partner in the future, it is likely you are dealing with the perpetrator of domestic violence. Also ask what happens if the client does not go along with the partner. Absence of consequences to the client for asserting his or her needs, also indicates that you are likely dealing with the perpetrator.

It is important to do a risk assessment and safety planning as indicated by the assessment.

Risk Assessment with Perpetrators

- Victim's name, address, telephone number available for reporting if needed?
- Do they live together?
- Accessibility of client to victim?
- History of use of weapons (knife, gun—permit?, other household objects)?
- Are there children in the home? How many? What ages? Who is the birth or custodial parent? How are the children affected? Determine need to report.
- Assess for imminent risk. Is there intent, a plan, and the means available to carry out the plan? Determine need to report.
- If a client indicates ideation or intent to harm their partner or other party, appropriate disclosure and reporting avenues ***must occur immediately***. Try to detain client and involve local emergency services.
- If no immediate risk is apparent, still determine level of risk and appropriate interventions, including referral to an appropriate LGTB batterer's program.

Safety Planning/Risk Assessment

Safety planning and risk assessment should be done *as indicated* by the assessment.

Use standard domestic violence safety planning tools **with clients identified as victims.** Assessment of client's risk based on sexual orientation and gender identity as well as level of comfort or risk in outing this information to police, social service and others ***must*** be considered for its potential benefit and/or harm to the client. These considerations should also be extended to the impact on any children who may be affected. ***Advocacy or assisted linkages may be necessary to assure safe and appropriate interventions are obtainable for LGTB victims of domestic violence.***

If the client is a perpetrator assessment for imminent risk of lethality must be done. Appropriate interventions and disclosures must be made if imminent risk is presented. **If risk is not imminent,** temporary safety planning should include exploration of safe outlets for anger e.g. leaving the residence, not going home when angry, etc. A referral should be made to an appropriate batterer's program if available, or if no program is available, to social service providers who work with anger management. If a perpetrator is forthright about their actions or demonstrates remorse or accountability, validate and encourage the client's efforts at disclosure and seeking assistance. (Questions about the client's concern for the victim and for concern about possible involvement with the legal system may help clarify a perpetrator's capacity for remorse and accountability.) It is important to clearly express that violence and abuse are unacceptable and to encourage the importance of the client getting the appropriate supports to prevent further violence.

For consultation, or for questions related to the Screening and Assessment of Victims/Perpetrators of LGTB Domestic Violence call the NYC Gay and Lesbian Anti-Violence Project's (AVP) 24 hour bi-lingual (English/Spanish) hotline at (212) 714-1141.

AVP is a member of the National Coalition of Anti-Violence Projects (NCAVP).
Call the hotline number above for a listing of an NCAVP member organizations and locations.



Safety Planning:
A Guide for Transgender and Gender Non-Conforming Individuals who are experiencing intimate partner violence

About This Document

There are many sections to this safety planning document in order to provide a more comprehensive tool. It may feel long and overwhelming. Consider reading only a few sections at a time. Remember also that *any* step you take to improve your safety is important; you do not need to take them all.

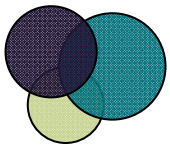
Ideally, people using this Safety Planning tool should write out their answers and notes, to help solidify their thinking and so they can access help remembering their plans if they are under stress, such as during an episode of violence. HOWEVER, it is EXTREMELY important that these notes – whether they be on paper or electronic – NOT be left anywhere where an abuser could find them. Possible places where it **may** be safe to make and leave notes include: your computer at work; on a thumb drive you always carry with you or hide at a friend's house, a public (i.e., library) computer where you can store the answers "in the cloud"[1] under a password your abuser doesn't know; a friend's computer; or at a helping agency or professional's office, such as your therapist's office or your local domestic violence program. It is also advised that any lists of friends' contacts, bank accounts, service options, etc. that you generate be kept separately, to minimize the risks should one fall into your abuser's hands.

The Purpose of Safety Planning

There are some very common, but mistaken, beliefs about intimate partner violence (IPV). Some of the primary myths include:

- The victim[2] believes it is their/zir/his/her behavior that causes the abuser[3] to "lose control." This belief is often fostered by the abuser, who usually blames the victim for "provoking"

[1] GoogleDrive, Dropbox, SugarSync and other cloud-based providers offer small amounts of free storage.
[2] "Victim" may be a word that doesn't resonate with you. This document uses victim to include anyone who is currently or previously experiencing abuse or violence by their partner (from dating partners or long term relationships).
[3] "Abuser" may also not be a word that feels comfortable or relatable. Throughout this document, the use of "abuser" is a date or partner who is exhibiting abusive behavior, power, control, or violence against you.



the victim. That means the abuser doesn't have to take responsibility for their abusive actions. It also, perversely, helps the victim imagine they[4]/ze/he/she has some control over the situation.

- The victim and/or abuser may believe that relationship violence is normal and to be expected.

- The victim and/or abuser may believe that the violence was a one-time occurrence that will not be repeated.

- The victim and/or abuser may believe that it's only domestic violence if it's a man abusing a woman.

Through safety planning, friends, family, advocates, and concerned professionals can help victims understand that these beliefs are dangerous myths and help the victim focus on where they/ze/he/she actually does have power and control: planning for and taking concrete actions that can enhance their/zir//his/her safety.

What is Intimate Partner Violence (IPV)?

IPV is known by many names, including domestic violence, family violence, abuse, and battering. While most people think IPV involves physical violence, it can also include forced sexual activity, financial exploitation, stalking, blackmail, coercion, isolation, harassment, and emotional abuse. The line between normal disagreements or tension between within a relationship and IPV may be subtle. Many people say that it is IPV when one person routinely tries to control the other through violence, threats, and manipulation. If you feel afraid at home or when you are with your partner, there's a good chance you are experiencing IPV. Another sign of IPV is realizing that your partner has slowly managed to isolate you, separating you from your normal supports, activities, and friendships. Abusers tend to do this to make their victims more dependent on them, and to lower the chances that the victim will decide to leave. A third possible sign of IPV is realizing that your partner has made you feel chronically ashamed of yourself or worthless.

Some abusive relationships will only contain one or two of these components, while other relationships will have many, complicated, forms of abuse woven throughout multiple aspects of their relationship dynamic. Any amount of abusive behavior is abuse. You deserve to access support that will help you live without abuse. Everyone deserves relationships that are free from abuse of all kinds.

[4] To be inclusive of all genders of victims and abusers, this document will list multiple pronouns or use "they" as a singular pronoun.

How Often Does IPV Occur?

IPV is very common. A lot of research indicates that roughly 1 in every 4 intimate relationships – be they heterosexual or lesbian, gay, or bisexual; people who are transgender, gender non-conforming, or non-transgender; people of any race, age, level of disability, income level, religion – experiences IPV. Despite how common it is, it is not something you have to live with. Many people grew up in abusive households and never learned that living together peacefully is normal and something they should have. Transgender[5] people, often having grown up subject to others' hurtful name-calling and/or abuse because they are gender non-conforming, seem particularly likely to believe that they are lucky to ever find love, even if that love turns violent. No person should have to be in a relationship that is abusive. Transgender people can and should have loving partnerships that are free from violence or coercion.

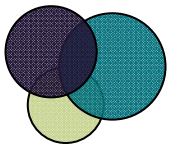
Can Abusers Change?

Some abusers do eventually learn how to have an intimate relationship without hurting or trying to control their partner. However, this is not an easy process and almost never happens after an abuser simply promises they will never be violent again. Instead, violent or coercive partners have to unlearn habits of thought and behavior that lead them to try to control their partners' behavior rather than their own behavior and emotions. Oftentimes, they have to work through and heal their own experiences of having been abused. Then they have to learn and practice new interpersonal skills to a point where even under substantial stress, they are able to control their emotions and behavior, which result in making choices that are healthy for both partners. Making these changes takes a lot of time and effort, and usually requires therapy or other professional assistance.

Some domestic violence advocates urge partners who are being harmed to ***not*** attend couples counseling with their abuser. Their fears include:

- the therapist may agree with the abuser that the victim needs to make all the changes;
- the victim may say something in therapy the abuser may use against him or her later; and
- the abuser may use therapy as just another setting in which to make the victim feel bad.

[5] FORGE uses "trans," "transgender" and "gender non-conforming" as very large umbrella terms that are fully inclusive of hundreds of gender identities, histories, experiences, and expressions. Although this document will primarily use the terms "trans" and "transgender," FORGE includes and presumes that many individuals will more closely align with terms such as genderqueer, gender fluid, bi-gender, omni-gender, two-spirit, androgynous, femme, butch, transsexual, crossdresser, woman of transsexual experience, man of transsexual history, trans man, trans woman, boi, T-girl, stud, aggressor, and many other terms.



However, you know your abuser better than anyone else, and only you can decide if couples counseling will be safe for you and might be helpful to both you and your partner.

For a variety of reasons, many people who experience IPV choose to stay with their partner, either temporarily or permanently. (Individuals who experience harm from their partners also frequently leave and then return, sometimes more than once before they are able to permanently stay away.) If this is true for you, you can and should think about how you can lower the chances of you and/or your children and pets being harmed by your abusive partner. Safety planning can help you do this.

What Is a Safety Plan?[6]

A Safety Plan is a set of actions you can take if you stay with the abuser, while preparing to leave the abuser, and/or after you have left. This document will help you identify ways of being more prepared to keep yourself (and your children and pets, if you have them) safe. Work through the sections in this safety planning tool that are relevant to you – by yourself, or ideally with a friend, advocate or provider.

Remember that a Safety Plan can't prevent abuse, because that's under the control of the abusive partner (no matter how much they claim you provoked it). But if you:

- Plan what to do ahead of time;
- Prepare to carry out your plan; and
- Rehearse the steps you need to take…

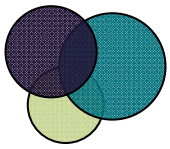
you are far more likely to be successful at avoiding the worst.

Note that the suggestions in this Safety Plan are written for a wide range of situations. You know your situation best, so make sure you think through what is best *for you* and make whatever changes or additions feel right to you.

Laying the Groundwork

You can't always predict an incidence of violence, and many victims find that they are either gradually or suddenly being subjected to much worse violence than they were at first. For both

[6] FORGE is grateful for other LGBTQ organizations who have constructed safety plans. Some content in this document has been adopted from the online Safety Planning guide of the Gay Men's Domestic Violence Project (http://gmdvp.org/domestic-violence/safety-planning) and the "Intimate Partner Violence Safety Plan" developed by Outfront Minnesota (http://www.outfront.org/programs/avp).



these reasons, seriously consider laying important groundwork that may later prove lifesaving, even if you think your current situation doesn't warrant such measures.

Identify service and support options. Find out what domestic violence services are offered in your area, and what their phone numbers are. There are over 40 LGBTQ[7] anti-violence programs (AVPs) across the country. AVPs exist to support people who have or are experiencing abuse or assault. They work hard to identify local, state and regional resources for LGBTQ people who have experienced violence and need help. You can find a list of the AVPs at http://www.avp.org/storage/documents/NCAVP_member_and_affiliate_list_October_2012.pdf). If one is near you (in your state or region), include them first on your resource list.

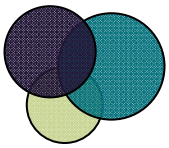
Identify other local domestic violence services. One place to start looking for referrals is The National Domestic Violence Hotline at 1-800-799-SAFE (7233). (Their TTY number is 1-800-787-3224).

When you are ready to call an AVP, the National Domestic Violence Hotline, or any other DV program, call them from a safe place (see "Become aware of your electronic trail," below) and find out what their policies are about serving transgender people and what services, if any, they may be able to offer you while you remain with your abuser and/or if you choose to leave.

Start a dated journal of your abuse. Include threats, stalking, and destruction of property. Add photos if you can. This information will be useful in securing a restraining order or any other legal action you may need to take later on. Obviously, it is critical that this journal be kept somewhere where your abuser will never find it. Consider renting a safety deposit box to keep hard copies of journal entries or photos. A second relatively secure option is to use a password protected cloud-based electronic file service, so no electronic file is on your computer's hard drive, and no photos are on your phone or hard drive.

Begin recruiting supporters and develop code words. Transgender people may need to think very carefully about who they know who they can trust to keep confidential information from the abuser. Such individuals may be friends (particularly if they are not also friends with the abuser), neighbors, co-workers, or other people you know. When you identify such individuals, begin sharing your situation and ask them specifically if they would be willing to help you if the situation got worse. Set up a code word or phrase that will tell them you are in danger and need them to call for help (make sure you are

[7] LGBTQ = Lesbian, Gay, Bisexual, Transgender, Queer/Questioning



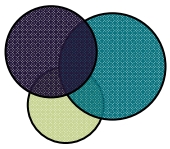
explicit about what kind of help you want them to call). Find out if they would be able to offer other concrete help such as housing you in an emergency, storing duplicate copies of important papers, or keeping your safety bag of packed clothes/supplies.

Stock your wallet and its backup. Keep your wallet with important identification, credit cards, and other material with you at all times. Make copies of critical documents and account numbers and keep them someplace safe, such as a friend's house, at work, or in a password protected computer file stored outside of the house. A following list includes most of the documents you might need if you leave for a lengthy period of time:

- Driver's license/state identification card, car registration, and proof of insurance
- Work ID/work permit
- Health care insurance or Medicaid/Medicare ID cards
- Social Security card
- Birth certificate
- Passport
- Green card, visa, or other immigration papers
- Carry letter if your identification has not been completely updated
- Surgeon's letter if your identification has not been completely updated
- Court order for name/gender change
- Copies of any restraining order, if you have obtained one
- Welfare identification
- Lease or home deed, house or renters insurance information
- Children's identification/adoption records
- Paternity or custody records
- School and vaccination records (self and children)
- Marriage license or divorce papers
- Medical records
- Other court documents
- List of possible service organizations (see Laying the Groundwork)
- List of friends' and therapist's addresses and phone numbers

It is common for abusers to become angry and increase the level of violence when their partner leaves, even if they intend to come back. Leaving is therefore a very dangerous time for victims. Begin planning for this eventuality by developing **two useful habits**.

1. **Become aware of your electronic trail.** With many people carrying cell phones that can be tracked by GPS and using computers that keep traces of users' searches and communications, it is becoming increasingly easy for knowledgeable individuals who wish to control or stalk their partners to track down where their victims have gone.



Your travels may be traceable through credit card bills, debit card statements, your cell phone, and, of course, your social media updates. If you search for shelters on your home computer or a tablet you leave behind, your abuser may be able to learn where you might be. Don't trust your cell phone to keep all of your friends' and resources' phone numbers (it might be left behind or broken), but don't leave a paper or computerized directory around where your abuser can find it, either. Make sure you have multiple ways of accessing important numbers, and that they are kept in places your abuser doesn't have access to, like at friends' houses, work, or electronic storage not accessed by computers/phones at home. Whenever possible, do your resource scouting at public computers and/or public phones, or borrow a friend's. Hide critical computerized information behind passwords your abuser would never guess, not your usual ones.

2. **Develop habits that regularly take you out of the home.** Develop a regular habit that takes you out of the house, such as daily taking out the garbage, going for a walk, or getting a newspaper. This activity can be used as an excuse to leave if you have warning that abuse is about to occur. Or if you are planning to leave, the activity can be a safe way to get out of the home.

Staying Safe at Home

Scout out your home. Sometimes when it's not possible to avoid a peak violent episode, a victim can still maneuver that outburst to a safer spot.

You want to avoid:

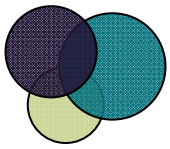
- Being cornered in closets, small spaces, or bathrooms;
- Rooms where weapons (guns) or potential weapons (knives, fireplace tools, or fire extinguishers) are stored; and
- Stairways, unless you are using them to flee the home.

You do want:

- Rooms with a phone and/or a door or window you can escape out of.

Try not to have your abuser standing between you and an exit. Think ahead. Before an incident, practice how to get out. Teach the escape plan to your children, if you have any. If you live in a tall building, consider what elevators, stairwells, or fire escapes you can use.

Recruit your neighbors. While some trans and gender non-conforming people do not feel like calling the police is helpful, others do. If you do want the police called when you are in



danger, consider talking to trustworthy neighbors and asking them to call the police if they hear suspicious noises coming from your house. You may also want to develop a code phrase or visible sign (like a towel hung in a window) that will signal them that you are in trouble and want them to call the police.

Emergency Safety Bag

Abuse can get worse over time or quite suddenly. If you have ever felt in danger from your abuser, consider preparing an "emergency safety bag" that can save you precious time if you suddenly need to leave your home. This bag should be stored in a safe and easily accessible place, such as a friend's or family member's home, at work, in a car trunk, or any place to which the abuser will not have access.

Possible contents include:

Finances

- Cash
- Credit cards and ATM cards[8]
- Checks[9]

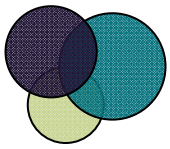
Essential resources

- Keys to car, house, work, safety deposit/post office boxes
- List of possible service organizations (see Laying the Groundwork)
- List of friends' and therapist's addresses and phone numbers
- Spare glasses or contact lenses
- Medications, prescriptions, contact information for doctor(s) and pharmacy
- Cell phone and charger[10]
- Any assistive devices you need
- Photos of the abuser
- Your journal of abuse, if you do not already store it elsewhere, and/or photos of injuries your partner has inflicted on you
- Public transportation schedule

[8] If your credit card and bank charges statements go to an address you share with the abuser, they can be used by the abuser to trace where you are. Ideally, change the address where these statements go so they do not fall into your abuser's hands. If the accounts are in both names, the abusive partner can still request access to the account information from the bank. It is safest to consider using only cash and/or opening new accounts if you leave.

[9] See above.

[10] Your cell phone may have a GPS that your abuser can use to track you. You definitely do not want to leave your cell phone where your abuser has access to it – it will contain too much information about your friends and contacts – but it may be safer for you to stash it someplace after you leave and purchase a new, limited-use phone. You can also ask a domestic violence program to assist you in obtaining a free cell phone that can only dial 911 in emergencies.



Identification and paperwork

- Driver's license/state identification card, car registration, and proof of insurance
- Work ID/work permit
- Carry letter if your identification has not been completely updated
- Surgeon's letter if your identification has not been completely updated
- Health care insurance or Medicaid/Medicare ID cards
- Social Security card
- Birth certificate
- Passport
- Green card, visa, or other immigration papers
- Court order for name/change change
- Copies of any restraining order, if you have obtained one
- Welfare identification
- Lease or home deed, house or renters insurance information
- Children's identification/adoption records
- Paternity or custody records
- School and vaccination records (self and children)
- Marriage license or divorce papers
- Medical records
- Other court documents

Hormones and prosthetics

- Hormones, prescriptions, contact information for doctor and pharmacy
- Binders
- Stand to urinate devices
- Packies or penile prosthetics
- Wigs
- Gaffing materials
- Shaving/plucking tools
- Breast/hip forms or other feminizing prosthetics
- Makeup

Clothing

- Change of clothes and shoes
- Note: if you have difficulty finding clothes and/or shoes in your size, consider buying extra items when you find them and asking friends or colleagues to keep them for you. Also add your favorite clothing sources to the list of addresses and phone numbers you take with you.

Other things to consider taking

- Jewelry, personal photographs, and other valuables
- Personal items that bring you comfort or peace
- Small saleable items
- Items of special sentimental value

If you do leave and you have the time, clear the browser history on any computer left where the abuser can access it.

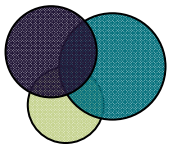
Note that if you want to leave, you do not have to wait for the violence to escalate or something terrible to happen. It's ok for you to go whenever you want to or can.

Financial Planning

Many transgender people are living paycheck (or benefits check) to paycheck and find it extremely difficult to put aside money that can be used in an emergency. Whatever you can put aside, however, even if it is just the change from your pocket every day, will increase your options should the abuse you have experienced gets worse.

Just as important, you can take some steps now to make you safer in the future. Remember that account information now typically includes all uses of your debit card as well as checks, and can be accessed online as well as by mail and in person; if your abuser shares your account(s) or even simply knows your passwords, they/ze/he/she may be able to access information that might help track down where you are if you leave. Therefore, if possible, open a new account that does not have your abuser's name on it, and have the statements sent to an address you do not share with the abuser (such as a post office box). (Alternatively, find an online bank that doesn't send statements at all. Make sure, however, that you use a password your abuser doesn't know and wouldn't guess.) Use only this account if you leave your abuser.

Also pay attention to what happens to paperwork concerning any large asset you both own, such as a house or other property. Abusers may work to put assets in their names only, often offering very convincing reasons why this is a good idea (tax benefits, avoiding potential problems with antagonistic family members, avoiding the confusion that might result if you are planning to change your name, etc.). Given how few transgender people are protected by marriage and/or community property laws, allowing any asset to be held only in your abuser's name may mean you will lose whatever equity you put into the asset. Make sure you consult a trans-knowledgeable lawyer so that assets are held in a way that protects you and your interests.



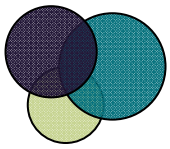
If you hold any joint credit cards with your abuser, find out which ones you are liable for and make sure you monitor how much your abuser charges to them. You can request one free credit report every 12 months by contacting Central Source at www.annualcreditreport.com or calling them at 877-FACT-ACT (322-8228). You may then need to call each credit card issuer to determine how the card is held and what your liability is. If you need to start disentangling yourself from debts your abuser should be responsible for, contact your local credit counseling agency, domestic violence program, or United Way for a referral in your area that can help you begin the process. If you do leave and end up responsible for credit card debt, be sure to contact the issuing company or companies to discuss the situation and see if they will suspend late fees or interest, let you negotiate lower payments, or otherwise accommodate your situation. Any proactive effort you make to address debt problems will result in a better outcome than simply abandoning those accounts and financial responsibilities.

Safe Havens

Transgender people who experience domestic abuse have fewer options for finding safety than most non-transgender (female) victims. Most domestic violence shelters do not house men (non-transgender or transgender), and many will not accept transgender women, either. Some will provide hotel vouchers, but these are typically only for a very few nights. If you live in an area with an LGBTQ anti-violence program (a list is available at http://www.avp.org/storage/documents/NCAVP_member_and_affiliate_list_October_2012.pdf), contact them first, as they may know who might serve you and will advise and advocate for you no matter what other services you may be able to access. If there is no local AVP, you can call the National Domestic Violence Hotline at 1-800-799-SAFE (7233) for a list of local referrals. (Their TTY number is 1-800-787-3224).

Every shelter has a different policy about who they house and what specific requirements need to be met. For example, there is no consensus among shelters as to whether transwomen who live in a female gender role, have identification in their current name and female gender will be allowed access into a women-only shelter. There are also pros and cons about if a transgender person should disclose their trans status to shelter staff (prior to or after being accepted into shelter). Some individuals have found it safer to have disclosed, others have noted it has increased their risk of discrimination or even ability to access shelter services. You will need to make the decision about whether or not you disclose your transgender status/history based on your own values, safety considerations, and what other options, if any, you have.

Options beyond public shelters may be limited, as well. Family members may be estranged, and friends may feel divided loyalties if they are also friends with the abuser. If you need to get out but can't find a place to stay, hospitals, airports, bus terminals, convenience stores, and



some restaurants are often open 24 hours. If you choose to go to an emergency room, you do not need to go into detail with the staff about your situation, but alerting a triage nurse that you are in flight from your abuser will allow you access to some assistance. Most emergency rooms have social workers on call who are available to help secure shelter, work with police, and contact family or friends. You will also be safe, while you are at the emergency room, which may buy you some time to consider your next steps. If you wish to remain anonymous and/or not contact the police or try to enter an emergency shelter (which are often unprepared to shelter transgender people and/or keep trans people safe), simply ask the triage nurse if you can stay in the waiting room because you are not safe on the street.

Obviously, LGBTQ community centers, transgender support groups, service organizations, and social groups may be unsafe if you leave your abuser and your abuser frequents these settings, as well, or knows that you do. Consider calling ahead and discussing the situation with staff members to problem-solve and/or make emergency plans in case your abuser should seek you out at these sites.

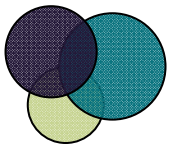
Safety in Your New Place

Abusers tend to be very emotionally tied to their victims, and frequently attempt to find them to "bring them back" if or when they leave. Here are some ways to increase your safety after you have relocated. (If you relocate to a domestic violence shelter, the staff can also help you think about how to stay safe.)

Consider getting a restraining order. If you have not previously done so, now would be a very good time to think about getting a restraining order. See the "Restraining Order" section for more information.

Recruit allies. Give neighbors, any security guards, workplace security or colleagues, landlord or rental property manager and friends a picture of your abuser, tell them that the abuser does not live with you, and ask them to call the police if they see them/zir/him/her near your home. If you have a restraining order against your abuser, by all means share copies of that with others, as it may make them realize the seriousness of your situation and encourage them to help you. Make sure that friends and family members know to never give your new address to the abuser.

Revisit your safety plan and repack your emergency safety bag. Now that you have new surroundings, develop and rehearse a safety plan in the event the abuser shows up at your new home, including an escape route and where you would go in an emergency. Repack an emergency safety bag in case you need to leave suddenly.



Install home security measures. Add a peephole to outside doors and increase outside lighting if appropriate. Consider an alarm system, security cameras, as well as a smoke alarm and fire extinguishers. Make sure all windows have locks or window bars to prevent them from opening from the outside. If your outside doors are wood, consider replacing them with metal doors. Purchase home rope ladders to be used for escape from a second floor window.

Stop your electronic trails. Change all passwords and PIN numbers, such as on telephones, ATMs, computers, etc. If you have any kind of credit card, bank, or cell phone statements going to the abuser's home, change those immediately by closing the accounts and reopening new ones. If your abuser may be able to track you using the GPS on your cell phone, discontinue using that phone and obtain a new phone and cell phone plan, which might be a limited-use one. Change to an unlisted number. If you cannot afford another phone and cannot borrow one from someone, consider asking police or a domestic violence program if they can give you a free 911 phone that will at least allow you to call police in an emergency. If you are on government assistance programs, you may qualify for a free cell phone with 240 minutes per month through SafeLink (http://www.safelinkwireless.com). An additional benefit of this program is that they don't have billing statements or require a credit check.

If you change your address with the department of motor vehicles, be sure to ask them to use a number other than your Social Security number to identify you, and ask them to code your address to keep it confidential. (You may have to explain that you have a pursuing abuser who you need to shield your new address from.) If your abuser seems to know where you go, there is a possibility that they/ze/he/she may have placed a GPS device on your car or somewhere in your possessions. Carefully go through all your belongings and have your car inspected to see if you can find and then destroy or disable any such device.

Screen incoming and outgoing calls. Use caller ID and voice mail or answering machines to avoid accidentally answering a call from your abuser. If you want to try to block calls coming from telephone numbers you know your abuser might use, read a how-to guide at http://electronics.howstuffworks.com/blocking-incoming-call.htm. To limit how many people know your new number (and can therefore accidentally share it with your abuser), start all calls by dialing *67 before the number, so that the caller's phone will display only "Blocked Number."

Keep records of abuser attempts to contact you. Keep copies of all emails and phone messages and logs of all of your abuser's attempts to contact you. These may be useful if further legal efforts are necessary.

Safety on the Job and In Public

Recruit allies. Abusers commonly come to the workplaces of victims who have left them. If your company or building has security personnel, give them a photograph and name of the abuser and tell them you are not interested in speaking with them/zir/him/her. If you have a restraining order, give security a copy and tell them to call police if the abuser shows up. You may want to do the same with your Human Resources department and/or supervisor. If your abuser has visited your workplace on a friendly basis in the past, you may need to inform your co-workers about your situation and ask them to help. If possible, have someone screen your calls at work, especially if your workplace does not have caller ID.

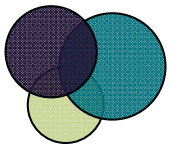
Create a workplace safety plan. As you did with your home, scout out your workplace to identify where you will go and how you will get help if your abuser shows up. You may need to recruit help from co-workers. Check if your workplace has policies regarding domestic violence and/or workplace violence and remind receptionists not to give out your home address or telephone number to anyone other than authorized individuals. If you encounter resistance from your supervisor or co-workers, consult with a domestic violence program or attorney to see what laws protect you.

Vary your route to and from work. Use a variety of routes and times to arrive and depart work, if you can. Travel with others when possible. Rehearse a safety plan in the event that something were to happen on the way to or from work. If you will be leaving after dark or working late, try to move your car closer to the entrance during lunch or a break, and if possible, leave the building with a co-worker. If you commute by bus, consider getting off at a different stop than your abuser might expect, or only get off when other people are exiting as well.

Vary your other routines. Consider switching your usual grocery store, bank branch, etc. Go at times that are different from what you habitually did when you were partnered with the abuser. Arrange for direct deposit, or ask someone to make deposits for you.

Orders of Protection

All states permit some people to obtain a legal order of protection (also called restraining order, a “stay away” order, and other names) against someone who threatens them. However, state laws differ and some do not cover same-sex couples and/or people with varying household and legal arrangements. You can do an initial check of whether your state’s



domestic violence order of protection law may cover your situation by checking the chart at http://www.americanbar.org/content/dam/aba/migrated/domviol/pdfs/dv_cpo_chart.authcheckdam.pdf

Although procedures for obtaining an order of protection vary from state to state, they all involve contact with the court and, possibly, law enforcement, and some trans people therefore do not wish to try to obtain one. It is also true that the court may not grant you the order, and that the abuser may not obey the order even if it is granted. However, having an order of protection may help get you faster and more cooperative help from law enforcement and other security personnel if your abuser does show up at your home or workplace.

A general description of orders of protection and state-specific information is available at http://www.womenslaw.org/laws_state_type.php?statelaw_name=Restraining%20Orders&state_code=GE (note that some descriptions only describe abusers as "he" which may not correspond with your situation).

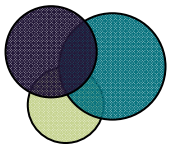
Most LGBTQ anti-violence programs (a list is available at http://www.avp.org/storage/documents/NCAVP_member_and_affiliate_list_October_2012.pdf), and most domestic violence programs (The National Domestic Violence Hotline at 1-800-799-SAFE (7233) can give you local referrals; their TTY number is 1-800-787-3224) can provide advocates and/or advice on how to file for a protective order in your jurisdiction.

If you obtain an order, make sure it is listed in the registries of counties where you live, work, and travel by calling the Clerk of the Court and/or the sheriff's office for each county. Make copies of your order and keep them at work, in your car, and on your person. Give copies to security personnel at home and work.

Protecting Children and Pets

If you have children living with you, they are almost invariably already aware of your partner's anger and/or abuse. They will most likely be less afraid, not more, if you teach them what they can do when you are abused and/or they are afraid.

Therefore, teach them not to get in the middle of a fight between you and your abuser. Develop a signal you can use if you want them to summon help or call 911. Make sure they know their own names, addresses, and phone numbers, and teach them how to call 911 and what to say. If you do not want them calling the police, teach them who else to call. Teach them about where to go to be safer during an incident, based on whether your abuser is likely to go after them as well, or will concentrate on you. You may want to teach them to run to a neighbor's house or nearby public place. Tell them how to call you (including making a collect



call) if your abuser takes them somewhere without your knowledge or consent. If your children are very young or liable to get confused in an emergency, prepare a laminated card for them to carry with important information on it. Make sure your children know what other adults you trust and what information you do not want shared with others.

Make sure that the people who care for your children – teachers and school administrators, day care staff, babysitters, Sunday school teachers, and others -- know who has permission to pick up your children, and give them a copy of any restraining order. Make sure the school or daycare knows not to give your address and phone number to anyone, and set up a password so they can be sure it is you on the phone when you call for information. Make sure your children know who to tell at school if they see the abuser.

If you have pets, you will need to make plans for them in case you need to or decide to leave. Some shelters will temporarily board the pets of people who are fleeing domestic violence, so call your local shelter ahead of time to find out if this is a possibility for you. Perhaps a friend or relative who cannot shelter you would be willing to shelter your pet(s). Your vet may even be willing to donate some boarding time if you let them know the reason and how soon you think you can make alternative arrangements.

Emotional Support

A common hallmark of domestic violence is that the victim has become isolated from other people. This may have happened slowly and subtly, without your conscious awareness, or it may be clear that your abuser is trying to control who you see. Either way, it is important to recognize that everyone needs other people, and that if you are isolated, you need to take steps to bring more people into your life. This may be by attending support groups, volunteering in places where you work with other people, or by reaching out to people who are already around you, like coworkers. Remember that while some people prefer to pretend domestic violence doesn't exist, 1 in 4 people have been in a situation similar to what you are experiencing. You are not alone, and you need others' input to help you stay safe and sane if you are living with an abusive partner or have just left one.

Domestic violence programs and LGBTQ anti-violence programs often have emotional support services at no cost. Ask about support groups that are open to any gender, therapists, social workers, or other supports that can connect you with others.

This project was supported by Grant No. 2011-TA-AX-K121 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication / program / exhibition are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.



Deaf Advocacy



Greetings,

I wanted to thank your organization for your interest in our Technical Assistance packet to increase knowledge in working with Deaf/Deaf-Blind/Hard of Hearing survivors.

This Deaf packet has information such as what is the difference between a "signer" and an "interpreter" or understanding Deaf culture (ex. Myths & Facts).

Before reading this packet, here are some questions to ask yourself:

1. What would you do if a Deaf client walked in the door today needing services?
2. Do you know who to call to schedule an interpreter and how to work with interpreters?
3. Are you prepared to provide culturally sensitive and completely accessible services to Deaf victims?
4. What unique safety issues and barriers do Deaf victims face; How do you safety plan around those issues and remove those barriers?
5. Did you know that there is a Transitional Housing Program in Seattle for victims of abuse and their children and it is the first in the nation that is fully accessible for Deaf, Deaf-Blind and Hard of Hearing victims?

If you don't know the answers, that's okay! We are here for you and can help answer those questions.

Who We Are:
The National Domestic Violence Hotline and Abused Deaf Women's Advocacy Services have partnered together to provide accessible National Hotline services for Deaf victims, as well as technical assistance and outreach to Deaf and Hearing service providers, Coalitions, and agencies throughout the nation to increase education and access for Deaf victims of abuse.

ADWAS has trained and experienced Deaf advocates available who understand the unique ways that Deaf victims experience abuse and who can communicate effectively to meet all communication needs.

What We Believe:
We believe that no caller should face communication barriers in reaching the Hotline. We believe every caller deserves to be treated with dignity and respect. We believe that every family deserves to live in a world free from violence. We believe that safe homes and safe families are the foundation of a safe society. Until the violence stops, the hotline will continue to answer…One Call at a Time.

Who We Serve:
We serve all callers including Deaf, Hard of Hearing, Deaf-Blind and Hearing who are victims, friends and family, service providers, as well as the general public assistance for all callers.

How to Reach the Hotline:
Deaf advocates are on duty Monday – Friday, 9 am to 5 pm (PST) and can be reached in a variety of ways giving callers unique options that best fit their communication needs.

National Hotline Videophone: 1-855-812-1001
Local Hotline Videophone: 206-812-1001
Instant Messenger: DeafHotline
Email: DeafHelp@thehotline.org

What We Do:
We are trained to handle crisis calls, requests for information and referral, DV education, and technical assistance for all callers.

How We Can Support You:
You can contact us!
We are here to provide support, technical assistance, outreach and education for hearing and Deaf Domestic Violence and Sexual Assault service providers, agencies, coalitions, and shelters.

You can receive our E-newsletter!
We send electronic newsletters 2-3 times a year as a way to address emerging issues, provide safety tips, share news and stay in touch. Go to www.adwas.org and look for the box to fill out your contact information and you will be signed up to receive their e-newsletters!

Sincerely,

Frannie

Deaf Hotline Advocate
ADWAS/NDVH
www.adwas.org
Email: DeafHelp@thehotline.org

Materials Included in this Technical Assistance Packet

Deaf Resources in Your Area
Domestic Violence/Sexual Assault and Deafness at a Glance
Deaf DV and SA Programs and Contact Information
Deaf Power and Control Wheel/Triangle
Deaf, Deaf-Blind Victims/Survivors
Technology Safety
Domestic Violence Video and Book Resources
ADWAS Order Form
ADA Requirements For Domestic Violence Programs and Shelters
Checklist for Acquiring an Interpreter
Tips for Using a Sign Language Interpreter
Code of Professional Conduct for Interpreters
Interpreters vs. Signers
Understanding Deaf Culture
Myths and Facts of Deaf Culture
Nine Guidelines of Deaf Culture for Hearing Allies
TTY Cheat Sheet
Relay Tips for Hearing People
Video Relay Service Providers List

ADWAS National Hotline Resources
Contact a Deaf Domestic Violence Advocate
Monday through Friday, 9 am to 5 pm (PST)
AIM: DeafHotline
National Hotline VP: 1-855-812-1001
Local Hotline VP: 206-812-1001
EMAIL: DeafHelp@thehotline.org

Domestic Violence/Sexual Assault and Deafness at a Glance

- Deaf women are not abused more than hearing women. Half of all women have been abused (domestic violence and/or sexual assault) at least once in their lives. What is unique about Deaf and Deaf-Blind women is that abuse for these women can be experienced differently; for example they may have communication barriers when attempting to access or deal with the police, court and health care systems. They may also experience difficulty finding accessible safe places to live. Deaf victims also may have to deal with seeing their abuser at Deaf community events or become increasing isolated from their community to avoid seeing their abuser after she has left.

- A Deaf woman may experience target abuse directed at her differences, or designed to compound the isolation she experiences; for example, her abuser refusing to allow the use of sign language in her house, taking away her TTY, pager, hearing aid, guide dog, videophone, or computer, or criticizing her English language skills or lack thereof.

- In the Deaf community it is common for news to travel across the country to other Deaf people very quickly. The Deaf community has a very strong "grape vine" through which information travels at great speed making it harder for the women to keep her plans a secret, finding a confidential place to live, and making it harder to move away or hide from the abuser.

- Due to lack of outreach by domestic violence and sexual assault agencies, Deaf people may not be educated about domestic/sexual violence. This may result in Deaf survivors not receiving support from their own community.

- Deaf women have been struggling for a long time for their rights as a Deaf person and may not have had time or the chance to learn about their rights as women.

- Their abuser might misinterpret or lie to the victim about access issues. For example, the abuser may tell them that the police will not provide an interpreter.

- Deaf women sometimes feel uncomfortable using hearing domestic violence shelters or services because often there are no staff who use American Sign Language or have any knowledge of Deaf culture, furthering their sense of isolation and rejection. Deaf women living in hearing shelters often return to their abusers because of the isolation she experiences at the shelter where no one use her language. At least at home, she knows what to expect and she can communicate with her abuser.

ADWAS National Hotline Resources
Contact a Deaf Domestic Violence Advocate
Monday through Friday, 9 am to 5 pm (PST)
AIM: DeafHotline
National Hotline VP: 1-855-812-1001
Local Hotline VP: 206-812-1001
EMAIL: DeafHelp@thehotline.org

Deaf DV Program Contact Information

1. California – San Francisco
Deaf Hope
470 27th St.
Oakland, CA 94612
Office: 510-267-8800 (V/TTY) – **NOTE: Family Justice Center will take your message for you and pass on to Deaf Hope staff**
Fax: 1-510-740-0946
Business email: DeafHope@deaf-hope.org
Website: www.deaf-hope.org

2. California- Los Angeles
Peace Over Violence
Deaf, Disabled & Elder Services
d213.955.9090 voice
866-947-8684 VP
866-824-9907 VP
213.955.9093 fax
email: peggie@peaceoverviolence.org
Website: http://peaceoverviolence.org

3. California- San Diego
National Center for Deaf Advocacy
10765 Woodside Avenue Suite B
Santee, CA 92071
www.NCDA-USA.org
858-997-2285 (VP)
619 456 9609 (Voice)
858 568 7147 (Message)
877 276 1922 (Fax)
FrontDesk.NCDA@gmail.com

4. California- Sacramento
Deaf Survivor Advocacy for Empowerment (DeafSAFE) program (under NorCal Services for Deaf/HH)
4708 Roseville Road, Suite 111
North Highlands, CA 95660
916-993-3393 direct/VP –
916-993-3048
E: deafsafe@norcalcenter.org
W: www.norcalcenter.org/deafsafe

5. Colorado
DOVE-Advocacy Services for Abused Deaf Women and Children (Deaf men & teenagers too)
PO Box 181118
Denver, CO 80218
24 hour Crisis Line: 1-303-831-7874 (Videophone/Voice) or Hotline@deafdove.org
Office: 303-831-7932 (Videophone/Voice)
Fax: 303-831-4092
Email: info@deafdove.org
Website: www.deafdove.org

6. Iowa
DIAA-Deaf Iowans Against Abuse
4403 1st Ave SE STE 302
Cedar Rapids, IA 52402
Videophone: 319.432.7675
Crisis Text Line Only: 515-867-8177
Email: jupah@c-s-d.org
Fax: 319-294-4183
TTY: 319-294-4181
Website: www.c-s-d.org

7. Illinois
Chicago Hearing Society-Domestic Violence Program
2001 N Clybourn Ave
Chicago, IL 60614
Office: 1-773-248-9174 (TTY)
Office: 1-773-248-9121 (Voice)
Videophone: 773-904-0156
Fax: 1-773-248-9176
Email: AskCHS@anixter.org
Website: www.chicagohearingsociety.org

8. New York- NYC
Barrier Free Living's Non-Residential Domestic Violence Program
P.O Box 20799
New York, New York 10009
Videophone: 866-641-4604; 646-350-2662
Fax: 212-673-5167
Nicolyn Plummer
E-mail: Nicolynp@bflnyc.org
Hotline: 212-533-4358 V; After 5 P.M: 866-689-4357
Website: www.bflnyc.org

9. New York- Rochester
ASADV-Advocacy Services for Abused Deaf Victims
Mailing address: PO Box 20023
Rochester, NY 14602-0023
VP: 585-286-2713
Email: ASADVhope@gmail.com
Website: www.asadv.org

10. New York- Syracuse
Vera House, Inc.
6181 Thompson Road, Suite 100
Syracuse, NY 13206
Phone: 315-425-0818
24-hour Crisis and Support Lines:
315-468-3260 Domestic Violence
315-422-7273 Rape & Sexual Assault
TTY: 315-484-7263 (business hours)
Lindsay Ryan (Volunteer Advocate)
Email: lryan@ariseinc.org
Text- 315-224-9490
VP 315 679 4165

11. Minnesota
CSD of Minnesota-DV Program
2800 Rice Street
Saint Paul, Minnesota 55113
Office Videophone: 651-964-2051
Videophone to reach Advocate: 651-964-2052
Text Hotline: 651-403-9431
Email: jfrank@c-s-d.org
Fax: 651-256-1053
Website: www.c-s-d.org

12. Ohio
DWAVE-Deaf World Against Violence Everywhere
PO Box 1286
Worthington, OH 43085
Office Videophone: 614-678-5476
Videophone to reach Advocate: 614-678-7822
Prevention and Education 614-388-9858 (VP)
Office Email: info@dwaveohio.org
Website: www.dwaveohio.org

13. Texas
Safe Place
PO Box 19454
Austin, TX 78760
Email: Info@SafePlace.org (general); Deafservices@SafePlace.org (staff)
24-hour hotline: 512-267-SAFE (7233)
TTY: 512-927-9616
Website: www.SafePlace.org

14. Utah
SLCAD: Sego Lily Center for the Abused Deaf
452 east 3900 south
Salt Lake City, Utah. 84107
Office hours Mon-Thurs 9-4pm, Fridays by appt only
(24/7 hotline services available for after hours)
801-590-4920 (general)
Info@slcad.org for general inquiries

15. Vermont
DVAS-Deaf Vermonters Advocacy Services
PO Box 61
South Barre, VT 05670
Office Videophone/Voice: 802-661-4091
Fax: 1-802-479-9446
Email: kdarling@dvas.org
Website: www.dvas.org

16. Washington, D.C.
DAWN-Deaf Abused Women's Network
5321 First Pl NE
Washington, DC 20011
24/7 Hotline Pager Email: Hotline@deafdawn.org
Voice/Videophone: 202-559-5366
Fax: 1-202-742-1730
Email: info@deafdawn.org
Website: www.deafdawn.org

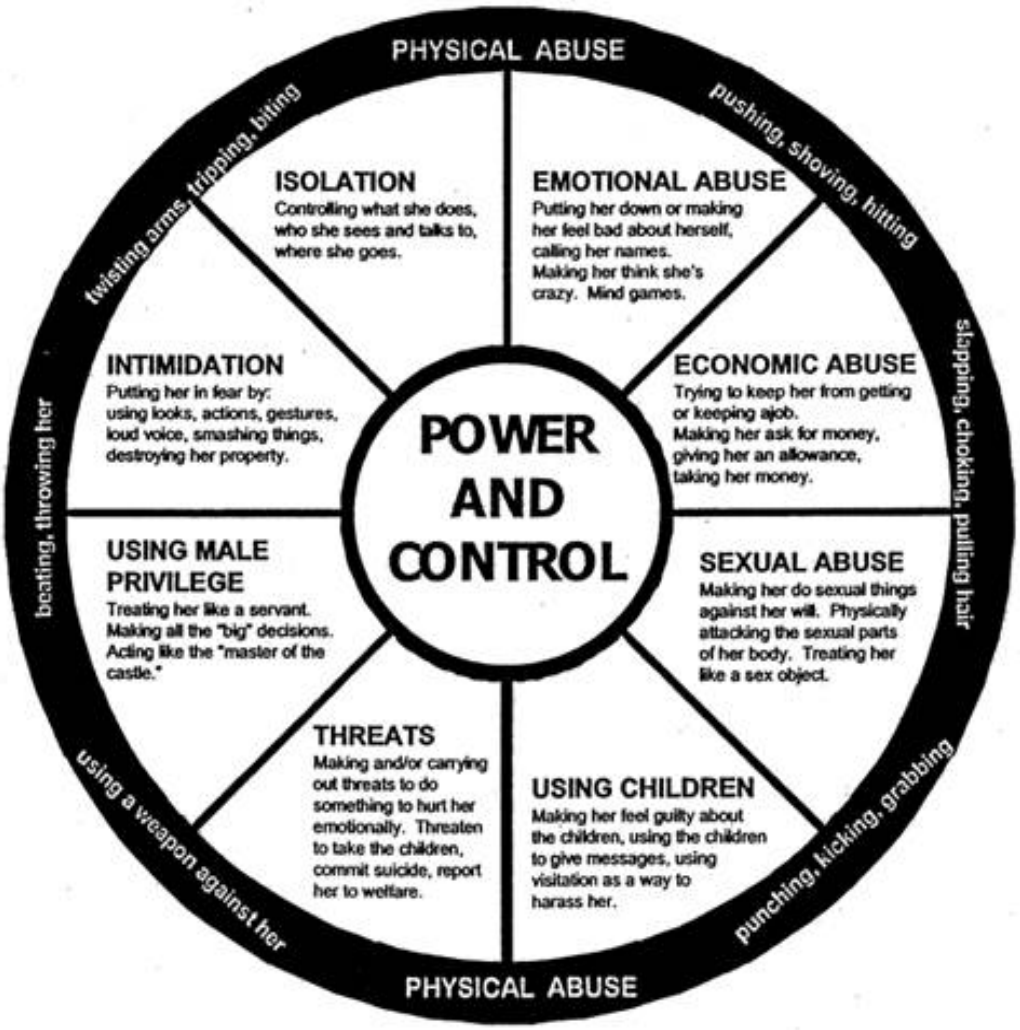
17. Washington
ADWAS-Abused Deaf Women's Advocacy Services
8623 Roosevelt Way NE
Seattle, WA 98115
24 Hour Crisis Line: 206-257-7035 (VP)
Office: 206-922-7088 (VP)
Fax: 1-206-726-0017
Email: adwas@adwas.org
Website: www.adwas.org

18. Wisconsin
Deaf Unity
PO Box 8713
Madison, WI 53708
Hotline Email: help@deafunitywi.org
Local Hotline: Monday to Friday 9am to 5pm & 6pm to 10pm (Central Time)
Website: www.deafunitywi.org

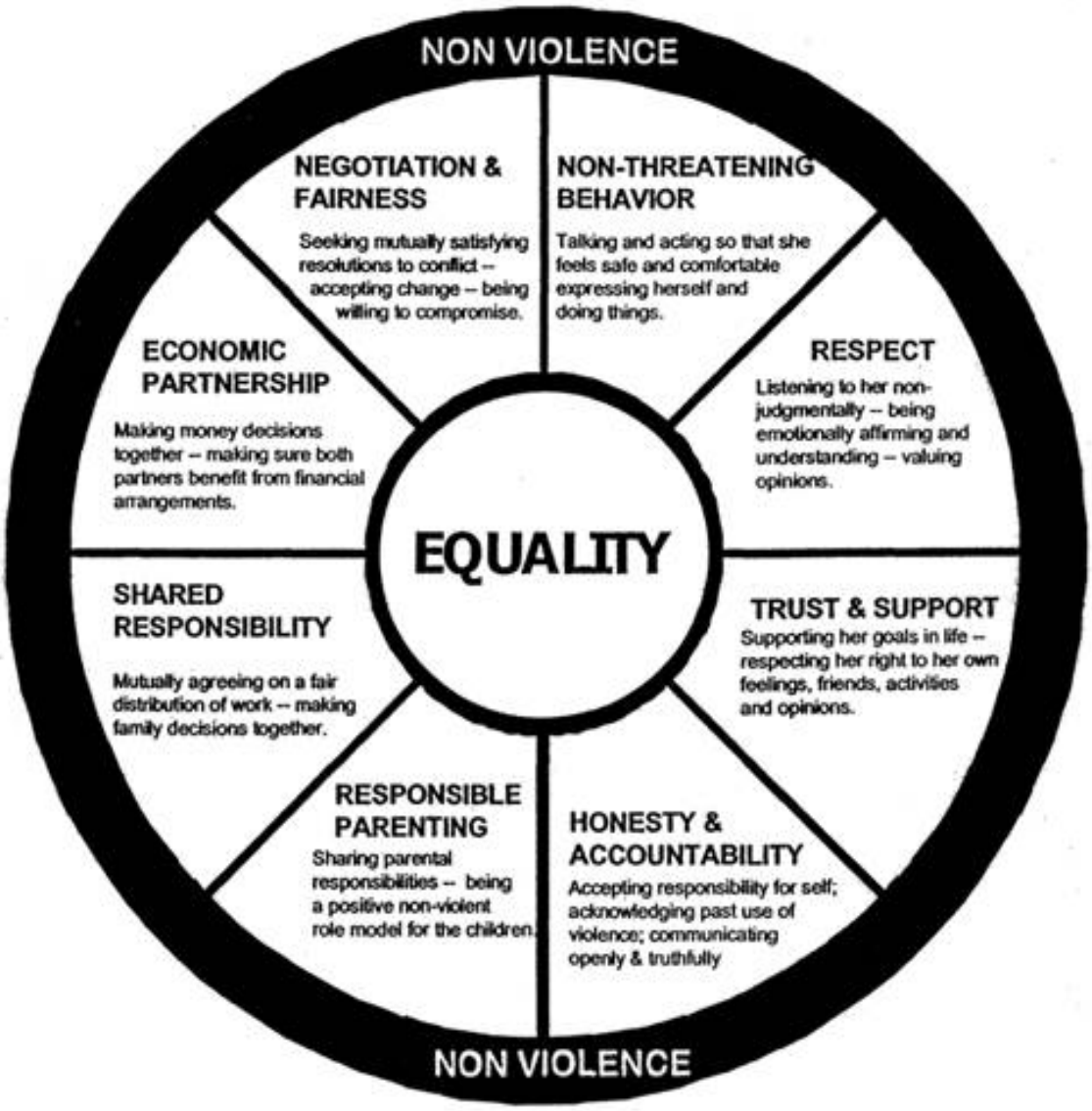
INTENT OF THE VIOLENCE:
Power and Control

The following chart is called the Power and Control Wheel developed by the Domestic Violence Intervention Project in Duluth, Minnesota.

At the hub of the wheel is the intention of all the tactics - to establish power and control. Each spoke of the wheel represents a particular tactic, and the rim of the wheel indicates physical abuse which reinforces the pattern of control.



A Healthy Relationship Model…



Deaf and Deaf-Blind Victims/Survivors

Things to Keep in Mind When Working with Deaf Victims

- The Deaf community is very diverse. Not all Deaf individuals use American Sign language; some use gesturing, some have no language, some use other signing forms such as Signed Exact English (not a true language). Whatever communication modality the person uses, you must find an interpreter with skills in the Deaf person's "language." This becomes a critical safety issue working with the hospital, police and the legal system if miscommunication occurs due to using an interpreter that does not meet the victim's communication needs, and it can be very dangerous. Always ask the victims who her preferred interpreters are or what her preferred mode of communication is and use them whenever possible.

- Nationally, the Deaf community is a tightly knit community and it is not uncommon for one person's crisis to be common knowledge across the country in one day. The Deaf community has many shared social events, services and the use of instant messaging and videophones is quite extensive, which makes it harder for a Deaf victim to relocate or flee their abuser without the Deaf community and or the abuser knowing where the victim is. Safety planning must be done around this.

- Because the Deaf community is a very small community with a global network, it is always best to check with the victim first before using any specific services for the Deaf to avoid having wrong information getting in the wrong hands that could be dangerous for the victim.

- Your domestic violence or sexual assault program should have emergency interpreters' phone numbers readily available. Be sure to ask the interpreter service if they work with or for the abuser to avoid a conflict of interest. If they do, find another interpreter that does not.

- Advocates should be aware that the TTY relay service at 711 will transmit all phone numbers to any caller ID, *regardless of whether your phone number is blocked or not*. Do not use the TTY relay to place a call from a confidential phone number such as a shelter or safe home. This applies to both hearing and Deaf 711 relay users. Many Deaf individuals have discontinued their landline phone services and TTY machine that use landline phones. This makes calling 911 difficult in case of emergencies. Brainstorm with the victim how she can call 911 and explore possible and creative options.

ADWAS National Hotline Resources
Contact a Deaf Domestic Violence Advocate
Monday through Friday, 9 am to 5 pm (PST)
AIM: DeafHotline
National Hotline VP: 1-855-812-1001
Local Hotline VP: 206-812-1001
EMAIL: DeafHelp@thehotline.org

- Erase memory on the TTY machine and Videophone after a confidential conversation. The TTY has a computer chip that retains previous phone calls in its memory. If a caller is leaving the TTY behind, the abuser can find out where the victim went by reading your crisis phone conversation on the TTY memory. Most videophones store recent incoming and outgoing call information with ability to "dial back". Encourage the victims that use videophone to erase their call history after placing and receiving calls.

- You cannot tell the identity, gender or attitude of a person talking on the TTY, instant messenger or Relay. Some abusers have pretended to be victims using these methods to try and gain information. Set up a code word between you and the victim in order to verify with whom you are speaking.

- Suggest that the victim save an outgoing message to 911 typed into her TTY memory so that she can quickly ask for emergency police response. The message should include her address and any court order numbers she may obtain.

- Abusers often damage TTYs, pagers, and Videophone machines to prevent the victim from communicating with others. If the victim is without a TTY, contact the State Office for the Deaf and Hard of Hearing, to see if they provide TTYs to Deaf residents on a reduced fee basis depending on income.

- Flashing lights and vibrating pagers can be connected to a motion detector, alarm system, doorbell or other device to improve a victim's safety. All these devises make a light flash in different light flashing sequences when it hears a sound such as a baby crying or an alarm going on.

- If the victim has a speech disability or does not talk and does not use a TTY or a specialized phone, have someone record a message (giving name, address, and other pertinent information) into a tape recorder for the victim to use if she needs to call the police.

- If a victim does not have access to TTY, brainstorm ways with the victims on how they can call someone in case of an emergency such as police and shelter.

Source: Model Protocol on Safety Planning for Domestic Violence Victims with Disabilities Washington State Coalition Against Domestic Violence

ADWAS National Hotline Resources
Contact a Deaf Domestic Violence Advocate
Monday through Friday, 9 am to 5 pm (PST)
AIM: DeafHotline
National Hotline VP: 1-855-812-1001
Local Hotline VP: 206-812-1001
EMAIL: DeafHelp@thehotline.org

Smartphones/Pagers

What Advocates need to know	What Advocates can do
• Most cell phone companies now have the ability to archive text messages. Sometimes these text messages can be subpoenaed (just like emails) by the courts. • Newer cell phones have Global Positioning System (GPS) built in. (note: It is enhanced 911 or better known as e-911, a GPS locator on a cell phone can find callers in immediate need of assistance). • Smartphone/Personal Digital Assistance (PDA) have multiple features such as email, instant messaging, web browsing, etc. (note: Some pagers can download relay software.	• Do not send confidential information through text messaging or email. • Encourage the victims to call the company to turn GPS off on their cell phone/pager and limit it to 911 only. • Encourage the victims to leave pagers at home if fleeing. (note: There is pre-paid cell phone options with text messaging available they can purchase). • Talk to the victims about potential impersonation by the abuser by using VP, VRS & IP services. • Encourage victims to use their local library computer if they need to place a relay call. (note: some relay call conversations, placed over internet, can be viewed by others).
For Victims • Inform the victim that their pager or cell phone can be viewed online by anyone with access to a computer and their pager/cell phone telephone number and their password/pin number. They should never give out their information to anyone.	**For Victims** • More cell phone companies are providing "paperless bills," which means that the victim/survivor will not get their bills through the mail, but rather they can view their bills online.

ADWAS National Hotline Resources
Contact a Deaf Domestic Violence Advocate
Monday through Friday, 9 am to 5 pm (PST)
AIM: DeafHotline
VP: 1-855-812-1001
EMAIL: DeafHelp@thehotline.org

TTY/Telephone Calls

What the Advocate needs to know	What the Advocate can do
• When using the TTY relay system (phone number 711), your caller ID will transmit even if you have it blocked on your phone system. • Because you do not hear a voice on the TTY, do not assume the gender of the caller. (note: Abusers have tried to pretend they are the victims on the TTY when calling a domestic violence organization looking for the victim). • Most TTYs have a memory. Your crisis call with the victim will be preserved in the machine for anyone to replay, including the abuser. Be sure to erase the call from the TTY machine. (Some TTYs have a print feature, which you may want to use to keep a record of the call before you erase it on the machine.) • Not all Deaf people are comfortable using English based conversations. If they are not skilled in written English they are likely to type in ASL grammatical order, which may be difficult for the Advocate to understand. Therefore, respect the caller's wish to meet in person for better communication using an interpreter. • Most TTY's have a printer that records conversations. Do not leave a printed record of your confidential calls attached to the machine for the next caller to see. (note: A TTY display is visible and can be read from several feet away. Make sure no one is able to read your TTY display. Ask the victim if she is in a private place without onlookers before you begin private conversations).	• Domestic Violence programs who call a victim through a relay service will have their phone numbers revealed. (note: Have your own TTY and avoid using the relay service). • You can set up a code name or word with the victim who calls regularly to ensure identification before any confidential information is transmitted. • Ask the victim to erase her TTY memory at the end of the crisis call. (note: If the victim is seeking shelter, she can bring her TTY machine unless the shelter already has one). • In a crisis, if you need to know a person's emotions on the TTY and don't know their "typing style" then make sure to ask specific questions in text. The best practice is to meet face to face with the victim and an interpreter. • At this time, 911 is not able to accept calls from the internet/wireless technology. Modern technology has expanded options for telecommunications for Deaf people, including using their computer/DSL line as their "phone" link. Urge victims to maintain a land phone line if possible, or make other arrangements for them to call 911 in an emergency.

ADWAS National Hotline Resources
Contact a Deaf Domestic Violence Advocate
Monday through Friday, 9 am to 5 pm (PST)
AIM: DeafHotline
National Hotline VP: 1-855-812-1001
Local Hotline VP: 206-812-1001
EMAIL: DeafHelp@thehotline.org

Computers

Tech savvy abusers can get into other people's computers. Here are some safety tips to prevent the abuser from accessing information on your and the victim's computer.

What Advocates need to know	What Advocates can do
• Electronic communication is often risky because a computer is not always secure or confidential. • Spyware can be installed on any computer without the user's knowledge. • Sending email over the internet can be intercepted. • Keystrokes logging hardware can retrieve information from stored keystrokes (note: it can check the website you visit, the password/pin# you use, etc). **Note:** To prevent adware or spyware from being installed on your computer, go to Microsoft.com and install Windows Defender. This dramatically cuts down on adware and spyware. Other sites you can use are: • www.freezonealarm.com • www.gaintcompany.com • www.webroot.com • www.bitdefender.com • www.xblock.com. **Remember**, the websites listed are not 100% guaranteed.	• Do not email back and forth with the victim/survivor. If possible, when replying, do not include the original message in reply email (note: you can set your email software to exclude the original message from the reply message.) • Never send victim/survivor's name or confidential information by email. • Ask the victim if the abuser is tech savvy and ask if they feel that their computer is being monitored. • Encourage the victim to use computers at local library or friend's. • Never open unfamiliar attachments from unknown sources. Spyware can be imbedded in attachments.

(The information was complied based on materials of National Network to End Domestic Violence's project of National Safe and Strategic Technology)

ADWAS National Hotline Resources
Contact a Deaf Domestic Violence Advocate
Monday through Friday, 9 am to 5 pm (PST)
AIM: DeafHotline
National Hotline VP: 1-855-812-1001
Local Hotline VP: 206-812-1001
EMAIL: DeafHelp@thehotline.org

Technology Safety Tips: What Advocates Need To Know and What You Can Do

(There is no 100% guarantee that technology is safe.
When in doubt, follow your instincts).

Among Deaf and Deaf-Blind people, technology is highly utilized for communication. Below is a list of different technology and ways to help make it safer to use for the victim/survivor.

Videophone (VP), Video Relay Services (VRS) & Internet Protocol Relay (IP)

What Advocates need to know	What Advocates can do
• VP phone numbers can be created by anyone, the number is not assigned and sometimes it cannot be traced. IP addresses however can be traced to users. • VRS is the preferred face-to-face telephone communication for Deaf people when they make a call to a hearing person because they are then able to use American Sign Language. • Any calls made through a relay service are confidential and they do not keep recordings of calls. (note: I.P. calls can be traced to an IP address).	• Use only Internet Protocol (i.p.) addresses when using VP. (note: For computer users, www.ip-address.com and www.whatismyipaddress.com shows the computer's i.p. address with features such as lookup i.p., hide i.p., trace i.p., etc). • Ask the victim where she is calling you from. (note: If they are at home, warn them of possibility that the abuser is monitoring their calls). • Talk to victims about potential relay call impersonations and develop a system for identifying victims such as a code word she can give you so you know its her and not the abuser. • Screen the call by asking general questions (note: never disclose information about victims).
For Victims • Like cell phones, VP conversation can be recorded without the caller's knowledge. • Ask that the victim checks her VCR/DVD to make sure the recording feature is off.	**For Victims** • Whenever possible, ask the victim if she can use safer VP access at local library or friend's. • Create a safety plan for using 3rd party/services (Relay services).

ADWAS National Hotline Resources
Contact a Deaf Domestic Violence Advocate
Monday through Friday, 9 am to 5 pm (PST)
AIM: DeafHotline
National Hotline VP: 1-855-812-1001
Local Hotline VP: 206-812-1001
EMAIL: DeafHelp@thehotline.org

American Disabilities Act Requirements For Domestic Violence Programs and Shelters

All public facilities, including domestic violence shelters, are required by federal law to provide reasonable and appropriate services to Deaf persons. Ask the Deaf person what her accommodation needs are.

Public Accommodation – Title 3

- Public facilities such as restaurants, hotels and retail stores may not discriminate against individuals with disabilities, effective January 26, 1992.
- Auxiliary aids and services must be provided to individuals with vision or hearing impairments or other individuals with disabilities, unless a unique burden would result and can be proved.
- Physical barriers in existing facilities must be removed, if removal is readily achievable. If not, alternative methods for providing the services must be offered if they are readily achievable.
- All new construction and alterations of facilities must be made ADA accessible.

State and Local government – Title 2

- State and local governments may not discriminate against qualified individuals with disabilities.
- All government facilities, services, and communications must be accessible consistent with the requirements of Section 504 of the Rehabilitation Act of 1973.

Telecommunications – Title 5

Companies offering telephone services to the general public must offer telephone relay services to individuals who use telecommunications devices for the Deaf (TTY/TDD) or similar devices.

For more information about ADA:
US Department of Justice, Civil Rights Division
Coordination and Review Section – ADA information line
PO Box 66118
Washington DC 20035-6118
202-514-0301 (Voice)
202-514-0381 (TTY)
202-514-0383 (TTY)
www.ada.gov

ADWAS National Hotline Resources
Contact a Deaf Domestic Violence Advocate
Monday through Friday, 9 am to 5 pm (PST)
AIM: DeafHotline
National Hotline VP: 1-855-812-1001
Local Hotline VP: 206-812-1001
EMAIL: DeafHelp@thehotline.org

Checklist for Acquiring an Interpreter

The best practice before hiring an ASL interpreter is to consult first with the Deaf or Deaf-Blind victim and ask them if they have a preference of interpreters. If they do, try to hire these interpreters first. If they are not available ask the victim if she has other interpreter preferences.

- In all circumstances only certified interpreters should be hired and preferably interpreters that have training in domestic violence and/or sexual assault.
- Ask the Deaf person if they prefer a female interpreter.

To contact an interpreter or interpreter referral services, please have the following information available prior to making the call (check the yellow pages of your local telephone book or use Google to find sign language referral services in your area or call the local Deaf community center or the state Office of the Deaf for a list):

- Date, time, duration, nature and location of the assignment
- Communication mode of the consumer (ASL, Tactile, Close Vision, PSE, SEE, Cued Speech, etc)
- On-site contact person and telephone number
- Names of consumers, case number
- Special considerations, such as badges, security passes, parking, printed materials and logistical needs
- Who and where to bill their invoice to
- Make sure the interpreter is not allied with the Abuser

Payment procedure:

- The fee
- Cancellation policy
- Travel time charge
- Parking and mileage reimbursement
- Interpreting agencies may have a fixed rate. Fees will vary somewhat depending on the type and duration of the assignment, regional price differences, and the interpreter's certification and experience. Fees will generally range from $45 to $65 an hour.

ADWAS National Hotline Resources
Contact a Deaf Domestic Violence Advocate
Monday through Friday, 9 am to 5 pm (PST)
AIM: DeafHotline
National Hotline VP: 1-855-812-1001
Local Hotline VP: 206-812-1001
EMAIL: DeafHelp@thehotline.org

Tips for Using a Sign Language Interpreter

- An interpreter's role is to bridge the communication gap between Deaf and hearing people. Interpreters sign everything that is spoken (not necessarily every English word used) and voice everything that is signed.

- Interpreters have different levels of skill and experience. It is important to hire an interpreter who has the right skills and experience for the situation. It is important for the interpreter to have certification from the National Registry of Interpreters for the Deaf (RID- www.rid.org).

- Some Deaf people may need a certified Deaf interpreter in addition to a hearing certified interpreter because the Deaf person has limited formal education or uses a native language other than ASL or is developmentally delayed or has very little communication skills. In addition, Deaf people who use a foreign sign language sometimes may require the use of a foreign sign language interpreter as well.

- Ask the Deaf person if she knows interpreters who she feels comfortable with, then hire those interpreters, if available. Always make sure that any interpreter used is not aligned with the abuser.

- When you use an interpreter, speak directly to the Deaf person and maintain eye contact with her. (Be sure not to say to the interpret "tell her (the deaf person)….") Speak to Deaf people like you would to a hearing person.

- The interpreter is there only to facilitate communication between the two of you. Interpreters must hold all information acquired while interpreting confidential, are not allowed to voice their own opinion or "take over" for the Deaf person. (RIT Code of Professional Conduct.) Do not ask the interpreter any questions pertaining to the situation or victim. Make sure that the interpreter hired does not have any professional or social relationship with the abuser.

- Direct eye contact on the part of the Deaf person may not be possible since the Deaf person will need to watch the interpreter. Most Deaf people will look directly at you while signing (talking) to you.

- Visibility is crucial; therefore the interpreter should sit next to or a bit behind the hearing person so that the Deaf person can see both the hearing person and the interpreter. The hearing speaker and the interpreter should not sit in front of a window because the glare could be distracting to the Deaf person. Interpreters should wear solid color garments, which contrast with their skin color. This helps aid the understanding of sign language. Sufficient lighting is also important. Talk at a normal rate of speed. Interpreters will let you know if you need to slow down.

- ASL is a true language with its own grammar, syntax, and structure; it is not English. Remember, you are dealing with two different languages. The Deaf person may nod yes and yet the interpreter might answer "no" in English!

- It is normal for the interpreter to lag behind the speaker for a sentence or two, so the interpreter might still be signing after the speaker has stopped talking, or still talking after the Deaf person has stopped signing.

- Interpreting is taxing, mentally and physically, and requires total concentration. For assignments lasting 1.5 hours or longer, it is best to hire two interpreters who can relieve each other approximately every 20 minutes. For assignments 1.5 hours or less, an interpreter is likely to need breaks once in while. The interpreter will let you know when she/he needs a break.

Code of Professional Conduct for Interpreters

- Interpreters adhere to standards of confidential communication.
- Interpreters possess the professional skills and knowledge required for the specific interpreting situation.
- Interpreters conduct themselves in a manner appropriate to the specific interpreting situation.
- Interpreters demonstrate respect for consumers.
- Interpreters demonstrate respect for colleagues, interns, and students of the profession.
- Interpreters maintain ethical business practices.
- Interpreters engage in professional development.

(This Code of Professional Conduct was created by the National Association for the Deaf (NAD) and the Registry of Interpreters for the Deaf (RID).

Please see RID's website for full access to the Code of Professional Conduct.)

RID's Website: http://www.rid.org/ethics/code/index.cfm

ADWAS National Hotline Resources
Contact a Deaf Domestic Violence Advocate
Monday through Friday, 9 am to 5 pm (PST)
AIM: DeafHotline
VP: 1-855-812-1001
EMAIL: DeafHelp@thehotline.org

Interpreters vs. Signers

Interpreter

- A certified or pre-certified professional
- Bound by a Code of Professional Conduct
- Trained to facilitate communication
- Stays within his/her role as expected of any interpreter
- Interprets everything that is said or signed
- Skilled with interpreting; transliterating, sign to voice, and voice to sign
- Knowledge of deafness/cultures
- Fluent in signing

Signer

- Not certified, often is a friend or family member
- Not bound by Code of Professional Conduct
- Not trained
- Little or no knowledge of the interpreter's role
- May be unable to say or sign everything
- Some skills in this area or none
- May or may not have some knowledge
- Limited or basic signing only

ADWAS National Hotline Resources
Contact a Deaf Domestic Violence Advocate
Monday through Friday, 9 am to 5 pm (PST)
AIM: DeafHotline
National Hotline VP: 1-855-812-1001
Local Hotline VP: 206-812-1001
EMAIL: DeafHelp@thehotline.org

Understanding Deaf Culture

- Deaf culture is based on the vibrant language (ASL), heritage, customs, history, and traditions of the Deaf community.

- Deaf culture includes ASL story-telling, performance, and art, social, political, business and sports organizations. The Deaf community has its own unique cultural norms, rules and traditions. Deaf culture meets the definition of a "true culture." Subgroups within the Deaf community are based on communication modes used: Users of American Sign Language (ASL), Oral Deaf, tactile ASL, Signed English users and cued sign.

- The community is unified based on a shared language, values, traditions and rich history in addition to common experiences of being Deaf in a hearing society, such as: limited accessibility to services, being part of an oppressed group, experiencing isolation, and facing communication barriers.

- American Sign Language (ASL) is a mix of manual gestures called signs, with its own grammatical structure and syntax. It is a recognized language and the language shared by most Deaf people.

- There are many successful Deaf individuals. Deaf people can work, drive, raise families and contribute to society just like hearing people. Deaf people take pride in their Deaf identity and do not consider themselves disabled and rather view themselves as part of linguistic minority.

- Deaf people are very visually oriented. Eyes are not only used to communicate, but also to take in environmental and situation stimuli.

ADWAS National Hotline Resources
Contact a Deaf Domestic Violence Advocate
Monday through Friday, 9 am to 5 pm (PST)
AIM: DeafHotline
National Hotline VP: 1-855-812-1001
Local Hotline VP: 206-812-1001
EMAIL: DeafHelp@thehotline.org

Myths and Facts about Deaf Culture

MYTH: All Deaf people use sign language.

FACT: Deaf people are not born with the ability to sign. Where the Deaf person received her education, her family influences, exposure to other Deaf people while growing up, and personal preference determines whether a Deaf person uses American Sign Language as her preferred mode of communication.

MYTH: Deaf people are expert lip-readers

FACT: No! Lip-reading is about 80 percent guesswork. Only 20% of speech is visible on the lips. Even the best lip-readers can only catch up to 26 percent of what is said. Lip-readers rely on cheeks, teeth, tongue, neck and facial expressions of the speaker as well as context of the conversation to lip read. Many words sound different when spoken, but appear the same on the lips; for example "mom, pop, bob, bomb, bad, bat." Or combinations of the words such as, "Do you like this with an island view?" and "Do you like this with olive juice?" Or, "I love fried eggs" and "I love Fridays." There are other lip-reading barriers such as moustaches, speaking too slowly, exaggerated pronunciation, or speaking too fast.

MYTH: If Deaf people wear hearing aids it means they can understand everything you say.

FACT: Hearing aids are not the solution to perfect hearing. Hearing aids amplify certain sounds. How well they work varies from individual to individual, depending on the severity and type of hearing loss.

MYTH: It is acceptable to use the term "deaf and dumb" or "deaf-mute"

FACT: No. Many Deaf people are offended by these terms. "Dumb" and "mute" were used in the early 1900's when the words meant "silent," but the meaning has evolved from that to "stupid."

MYTH: "Hearing-Impaired" is the most appropriate term to use when talking about Deaf people.

FACT: No. "Hearing-Impaired" is an euphemism; the term implies that hearing loss is a medical problem that can be fixed. Most Deaf people would not choose to have their hearing "fixed." The term "Deaf" is the most common and widely accepted term used in this country and Deaf with a capital D connotes Deaf culture.

MYTH: Domestic violence is more prevalent in relationships where one or both partners are Deaf than it is when both people are hearing.

FACT: Statistically the numbers are no different. The percentage of Deaf women who are abused by their intimate partners is equal to that of hearing women. However, Deaf women may be less likely to report abuse because of lack of information and lack of accessible resources and services, including a historically inaccessible legal system.

ADWAS National Hotline Resources
Contact a Deaf Domestic Violence Advocate
Monday through Friday, 9 am to 5 pm (PST)
AIM: DeafHotline
National Hotline VP: 1-855-812-1001
Local Hotline VP: 206-812-1001
EMAIL: DeafHelp@thehotline.org

Nine Guidelines of Deaf Culture for Hearing Allies

- Think of hearing culture and Deaf culture as equals.
- Always maintain eye contact with the Deaf person when communicating.
- Communication should always be in American Sign Language.
- If you know American Sign Language, that's great, but do not become the Deaf person's sign language instructor.
- It is not your role to teach the Deaf person English or correct their grammar.
- It is not your role to be the Deaf person's speech therapist by correcting their pronunciation.
- Offensive Deaf jokes and puns are not appreciated.
- Understand and support that Deaf people are a linguistic minority, not handi-capped or disabled needing to be "fixed."
- Believe Deaf people can do all things.

ADWAS National Hotline Resources
Contact a Deaf Domestic Violence Advocate
Monday through Friday, 9 am to 5 pm (PST)
AIM: DeafHotline
National Hotline VP: 1-855-812-1001
Local Hotline VP: 206-812-1001
EMAIL: DeafHelp@thehotline.org

TTY CHEAT SHEET

- Bear in mind Deaf people are individuals and they vary in language orientation
- Give yourself a few minutes to size up their level of communication and match their language:
  - Very English oriented
  - Fairly good English skills
  - Minimal language skills
- Type short sentences; use one brief question at one time and get the response before going on to the next question. Keep it as brief and to the point as possible
- Sometimes no articles are used (a, the) when communicating through TTY
- Be patient however they express themselves, some Deaf callers will be very clear, some may be confusing, some will go off on tangent
- Gender identity may not be clearly identifiable so go ahead an ask if you're not sure
- Many Deaf people are often afraid to reveal anything because they live in a close-knit community and/or need to build trust and find out who they are talking to first. Build rapport as needed. Give the caller the option to contact a Deaf NDVH TTY Hotline Advocate if they feel more comfortable with that
- Do safety planning around the Deaf "Grape Vine" where information can travel across the country in seconds through technology, making relocating, or fleeing more difficult
- Do safety planning around technology. Many abusers work for pager companies and Video Relay Service providers and may have increased access to victim's pager and VP conversations. Ask victim if their abuser is tech savvy and where abuser works. Encourage use of a safe VP, or leave their pager behind when fleeing. If abuser works for Sprint, T-moblie, Sorenson, Hamilton, Hawk Relay, CSD, HOVRS this is an immediate red flag if caller is using pagers (sidekick, blackberry etc) or a Videophone.
- Validate the caller's experience if they are not getting support in the Deaf community which often is not supportive of DV or SA victims (does not believe them, blames the victim, etc) This can be a very isolating experience for Deaf victims. Work with them on ways to connect with other Deaf survivors or Hearing survivors to get support and understanding.
- Inform Deaf callers that NDVH can send a Deaf Packet to hearing DV/SA agencies that explains how to work with Deaf victims
- Refer Deaf callers to a Deaf DV/SA agency whenever possible, and when you can't ask Deaf NDVH TTY Hotline Advocate to work with hearing agencies and shelters for technical assistance
- The caller may hang up on you for some reason - someone may be looking over their shoulder - or someone else cut off the conversation
- Deaf callers sometimes appear blunt, do not take it personally
- Some may get angry because they are frustrated already with various systems
- Many Deaf callers are comfortable with various technology such as computers, pagers, videophones, so they may prefer to communicate with you through AIM or email if not VP. If so, refer to NDVH TTY Hotline staff
- TTY Etiquette requires the use of GA at the end of your typing as a way to let the other person know it is their turn to talk. Wait for them to type GA so you know when to begin typing. SK is used as a signal to end a conversation "Bye SK"
- Often TTY callers will use abbreviations similar to Instant Message: LOL. BRB. TTUL. IDK. ROTFL.
- Encourage caller to erase TTY memory before you say goodbye as part of their safety plan as most TTY can retain records of conversation.

ADWAS National Hotline Resources
Contact a Deaf Domestic Violence Advocate
Monday through Friday, 9 am to 5 pm (PST)
AIM: DeafHotline
National Hotline VP: 1-855-812-1001
Local Hotline VP: 206-812-1001
EMAIL: DeafHelp@thehotline.org

Relay Tips for Hearing People

WHEN MAKING RELAY CALLS

If you do not have a TTY, dial 711. When the operator answers let them know what number you would like to call. The operator will RELAY the live conversation between the 2 callers. Try it, it's easy!

WHEN ANSWERING RELAY CALLS

When answering the phone, you may receive a call placed through the relay. You will hear a relay operator say "Hello, a person is calling you through XXXX Relay. This is Relay Operator (RO) number XXXX. Have you received a relay call before?"

If you are not familiar with relay say "NO" and the RO will explain how relay works. If you have any questions, you will need to ask them at this time.

If you are familiar with relay say "YES" and the call will begin.

MORE TIPS

When Relay calls, don't hang up.
The person calling is deaf, hard of hearing or speech disabled and is using the Relay to contact you. This is not a telemarketing call and it is very important that you do not hang up on the caller.

Say "Go Ahead" or "GA" each time you have finished speaking.
The term "Go Ahead" or "GA" is important for relay calls for turn taking purposes. "GA" insures that you (the standard phone user) and the relay user do not respond at the same time and miss each other's communication. Say "Go Ahead" or "GA" each time you have finished speaking and are ready for a response. When you hear the RO say "GA" it is your turn to speak again.

Speak directly to the person calling, not the CA.
Talk in the first person and pretend the Relay Operator is not on the call. The RO is not part of the conversation and will not acknowledge you if you speak to him/her.

Asking the relay user questions.
If you need to ask the relay user a series of questions, please ask them one at a time, wait for a response, and then ask the next question. This will give the relay user a chance to respond to each question and will reduce misunderstandings.

Be patient, and speak slowly.
Relay calls take longer than regular telephone calls. Because the RO must type everything you say verbatim, please speak slowly. If you are speaking too fast, the RO may ask you to slow down or repeat yourself. There may be a pause before the RO begins relaying the response back to you.

ADWAS National Hotline Resources
Contact a Deaf Domestic Violence Advocate
Monday through Friday, 9 am to 5 pm (PST)
AIM: DeafHotline
National Hotline VP: 1-855-812-1001
Local Hotline VP: 206-812-1001
EMAIL: DeafHelp@thehotline.org

Video Relay Service (VRS) Providers List

CONVO
Web: www.convorelay.com
Videophone: 510-629-5622

HAMILTON
Hamilton Relay
Web: www.hipvrs.com
Videophone: HAMILTONVRS.TV

i711 VRS
i711
Web: www.i711.com
Videophone: PREVIEW.i711.COM

LIFELINKS VRS
LifeLinks
Web: www.lifelinks.com
Voice: 212-714-2900

NexTalk VRS
Web: www.nextalk.net
Voice: 801-274-6001

PURPLE
Web: www.purple.us
Videophone: 877-885-3172

SORENSONVRS
Sorenson Communications
Web: www.sorensonvrs.com
Voice: 801-287-9400

SNAP!VRS
Web: www.snapvrs.com
Videophone: 866-949-7627

ZVRS
Web: www.zvrs.com
Voice: 727-254-5600

(FYI, this is just a list of many VRS/ Videophone Providers. There may be more companies than what this list has.)

ADWAS National Hotline Resources
Contact a Deaf Domestic Violence Advocate
Monday through Friday, 9 am to 5 pm (PST)
AIM: DeafHotline
National Hotline VP: 1-855-812-1001
Local Hotline VP: 206-812-1001
EMAIL: DeafHelp@thehotline.org



Latinas/Hispanic & Sexual Assault

GLOSSARIES

Sexual Assault Glossary

RELATED RESOURCE

Spanish Pronunciation Guide, American Heritage Spanish Dictionary

English-to-Spanish Terms: Sexual Assault

24-hour free and confidential services for victims	servicios gratuitos y confidenciales para víctimas las 24 horas del día
24-hour hotline	línea de ayuda disponible las 24 horas del día
Accompaniment	acompañamiento
Acquaintance rape	violación por una persona conocida
Against his or her will	en contra de su voluntad
Age of consent	la edad de consentimiento
Anal trauma	trauma o herida anal
Bail	fianza
Bi-curious	bicurioso/a
Bisexual	bisexual
Blaming the victim	culpar a la víctima
Caller ID	identificador de llamadas telefónicas
Child prostitution	prostitución de niñas/niños o prostitución infantil
Child sexual abuse	abuso sexual de niñas/niños
Child sexual exploitation	explotación sexual de niñas/niños o explotación sexual infantil
Civil case	caso civil
Coercion	coerción
Commercial sexual exploitation	explotación sexual comercial
Counseling	terapia o consejería
Court	tribunal o corte
Courtroom	sala del tribunal o sala de audiencias
Crime	delito o crimen
Crime Victims Compensation Program	Programa de Compensación para Víctimas del Crimen
Criminal case	caso criminal
Criminal sexual conduct	conducta sexual criminal
Crisis counseling	asesoría o consejería para personas en crisis
Crisis intervention	intervención en situaciones o casos de crisis
Date rape	violación durante una cita de pareja
Deportation	deportación
Detective	detective
Disassociation	disociación cuerpo-mente
District attorney	fiscal del distrito
Drug-facilitated sexual assault	abuso sexual facilitado por el uso de drogas
Economic abuse	abuso económico o financiero
EEOC (Equal Employment Opportunity Commission)	La Comisión para la Igualdad de Oportunidades en el Empleo
Elder sexual abuse	abuso sexual de personas mayores o de edad avanzada

E-mail	correo electrónico
E-mail account	cuenta de correo electrónico o de Internet
Emergency contraception	anticonceptivo de emergencia o 'Plan B'
Emergency room	sala de emergencia
Emotional abuse	abuso emocional
Evidence	evidencia
Felony	delito grave o delito mayor
Flashback	recuerdo retrospectivo o recuerdo retrospectivo traumático
Flirting	coquetear
Fondling	manoseo, toques sexuales
Forced prostitution	prostitución forzada
Forced sodomy	Sexo oral o anal forzado o a la fuerza
Gender	género o sexo
Genital trauma	trauma genital
Genitals	órganos genitales
GLBT or LGBT	LGBT: lesbiana, gay, bisexual, transgénero
Grooming (explanation of concept)	estrategia utilizada por abusadores sexuales para manipular a niños, niñas, adolescentes y a los adultos encargados de su cuidado; para así facilitar el abuso sexual
Group counseling	terapia en grupo; consejería para grupos
Homophobia	homofobia
Hostile work environment	ambiente laboral hostil u ofensivo
Human trafficking	trata de personas
Immigrant survivor	sobreviviente inmigrante
Incest	incesto
Intimate contact	contacto íntimo
Intimate partner rape	violación entre pareja
Intimate partner sexual assault	agresión sexual conyugal
Intimate partner sexual violence	violencia sexual por la pareja
Jail	cárcel
Judge	juez(a)
Jury	jurado
Lawyer/attorney	abogado(a) defensor(a)
Legal advocacy	asesoramiento legal
Lesbian	lesbiana
Male privilege	privilegio masculino
Male rape	violación masculina o de hombres
Marital rape	violación dentro del matrimo
Medical exam	examen médico o chequeo médico
Medical expenses	gastos médicos
Misdemeanor	delito menor
Misogyny	misoginia
Parole/probation	libertad vigilada o provisional
Pedophile	pedófilo
Penetration	penetración
Perpetrator	perpetrador o agresor
Physical abuse	abuso físico
Physical isolation	aislamiento físico
Pimp	proxeneta o padrote (Mex)
Police	policía
Pornography	pornografía
Press charges	poner cargos o denunciar

Protection order	una orden de protección
Psychological abuse	abuso psicológico
Rape	violación
Rape by an intimate partner	violación entre pareja
Rape crisis center	centro de ayuda a víctimas de violencia sexual
Rape exam	examen forense por violación
Rape kit	paquete de herramientas para recoger evidencia de violación
Rape shield laws	leyes que protegen la privacidad de las sobrevivientes de violación
Rape trauma syndrome (RTS)	síndrome de trauma por violación (STV)[1]
Rapist	violador
Restraining order	orden de restricción
Re-victimization	revictimización
Re-victimize	revictimizar
Servitude	servidumbre
Sex crimes	delitos sexuales
Sex offender	ofensor o delincuente sexual
Sexual abuse	abuso sexual
Sexual abuse by a sibling	abuso sexual por parte de un hermano/a
Sexual assault	violencia sexual or agresión sexual [the Spanish word *asalto* has different connotations among various groups]
Sexual assault nurse examiners	enfermeras examinadoras de agresión sexual [2]
Sexual assault response team (SART)	equipo multidisciplinario que responde a las víctimas de violencia sexual
Sexual assault victim advocate	asesora de víctimas de agresión sexual
Sexual harassment	acoso sexual o hostigamiento sexual
Sexual intercourse/relations	relaciones sexuales
Sexual orientation	orientación sexual
Sexual predator	depredador sexual
Sexual violence	violencia sexual
Sexually transmitted diseases	enfermedades transmitidas sexualmente o enfermedades venéreas
Short-term counseling for groups	terapia/consejería a corto plazo para grupos
Short-term counseling for individuals	terapia/consejería a corto plazo para individuos
Stalk	acechar
Stalking	acecho
Statute of limitations	estatuto de limitaciones
Statutory sexual assault	estupro o violación técnica
Support groups	grupos de apoyo
Survivor	sobreviviente
Survivor with a disability	sobreviviente con una discapacidad
Threat(s)	amenaza(s)
Trafficking in human beings	trata de personas
Transgender	transgénero
Transexual	transexual
Triggers	detonantes
Undocumented	indocumentado/a
Vaginal trauma	trauma vaginal
VAWA (Violence Against Women Act)	Ley de Violencia Contra las Mujeres [3]
Victim	víctima
Victim advocate	asesora de víctimas
Victimize	victimizar
Without consent	sin consentimiento o sin dar permiso
Witness	testigo

[1] See term used at Planned Parenthood Federation of America's Planned Parenthood en Español: Glosario Web page (accessed March 1, 2011).

[2] See term used at the Office of the Attorney General of Texas' Web page Prevención de agresión sexual y servicios de crisis (accessed March 1, 2011).

[3] See term used at WomensLaw .org's Web page Leyes de VAWA para Víctimas del Abuso (accessed March 1, 2011).

Web Site Links Disclaimer

OVC Home | OVCRC | OVC TTAC | FAQs | Contact Us | Site Map | Library & Multimedia | Link to Us
DOJ Home | OJP Home | GMS | Grants.gov | Privacy Policy | Language Access | Legal Policies and Disclaimers | FOIA | USA.gov | Recovery.gov

Office for Victims of Crime
810 Seventh Street NW., Eighth Floor, Washington, DC 20531
The Office for Victims of Crime is a component of the Office of Justice Programs, U.S. Department of Justice.

Existe Ayuda

National Community Outreach Project

Latinas and Sexual Violence

Part 1



Population Overview and Projections

- By 2050, nearly one in three U.S. residents will be Hispanic (U.S. Census Bureau, 2008).
- According to a 2004 survey, one in six females age 13 and older will suffer some form of sexual violence (Bureau of Justice Statistics, 2004).
- The number of Hispanic females who have experienced some form of sexual violence could reach 10.8 million by 2050.

Diversity

A snapshot of Hispanics in the United States in 2008 (U.S. Census Bureau, 2010):

- 66% were of Mexican background.
- 9% were of Puerto Rican background.
- 3.4% were of Cuban background.
- 3.4% were of Salvadoran background.
- 2.8% were of Dominican background.
- 15.4% were of some other Central American, South American, or other Hispanic or Latin American origin.

Alternative Terms

"Hispanic" and "Latino" are not identical terms.

- Hispanic: Used most often in government publications.
- Latino: Generally used by grassroots organizations and community-based initiatives.

Alternative Terms (cont.)

Existe Ayuda materials use "Latina/o."

Immigrant References

- The phrases "illegal immigrant" and "illegal alien" both include politically charged words that many victim advocates see as dehumanizing labels.
- The phrase "undocumented immigrant" is often preferred.

Immigrant Assumptions

- It is important that victim advocates do not make assumptions about the immigration status of those they assist.
- Most Latina/o youth are not immigrants; two-thirds were born in the United States (Pew Hispanic Center, 2009).

Challenges

Challenge 1. Lack of bilingual and bicultural direct service staff and volunteers.

Challenges (cont.)

Challenge 2. Lack of bilingual and bicultural trainers.

Challenges (cont.)

Challenge 3. Lack of bilingual and bicultural materials.

Latinas and Sexual Violence

- Latina girls reported that they were more likely to avoid further harassment than to seek help and or report (American Association of University Women, 2000).
- Married Latinas were less likely to immediately define their experiences of forced sex as "rape" and terminate their relationships; some viewed sex as a marital obligation (Bergen, 1996).

Latinas and Sexual Violence (cont.)

- Female farmworkers (or "Campesinas") are 10 times more vulnerable than others to sexual assault and harassment at work (Lopez-Treviño, 1995).
- According to a 2009 report, 77 percent of Latinas said that sexual harassment was a major problem in the workplace (Southern Poverty Law Center, 2009).

Cultural Considerations

- Addressing cultural considerations is necessary for the development of protocols that eliminate access barriers and enhance outreach.
- Generalizations should also be avoided, especially when working with Latinas/os who are third-generation and longer residents of the United States.

Cultural Considerations (cont.)

When developing outreach strategies and materials, consider—

- Language.
- Gender.
- Level of acculturation.
- Education.

Gender Expectations

- Ongoing struggle between Latinos (who are encouraged to be sexually active) and Latinas (who are socialized to avoid the advances of males).
- "Amarra tu perra porque mis perros andan sueltos." (Tie your female dog because my male dogs are loose.)

Good Girls and "el Respeto"

- Good girls are expected to know how to make oneself be respected ("hacerse respetar") to avoid being raped.
- In some Latina/o communities "le faltó el respeto" ("he disrespected her") is another way of referring to a sexual assault.
- "Tengo suerte que me ha durado." (I am lucky that she has lasted.)

Emphasis on Virginity

- "Me siento sucia y dañada." (I feel damaged and dirty.)
- "He avergonzado a mi familia." (I have shamed my family.)
- "Ningún hombre querrá casarse conmigo." (No man will ever want to marry me.)

Emphasis on Virginity (cont.)

- The loss of control over a precious rite of passage does not need to define a survivor.
- Being raped as a virgin does not automatically imply the loss of virginity to rape.

Understanding "Culpa" (Blame)

"Por algo me pasó." (This happened to me for a reason.)

Language and "Confianza" (Trust)

- Trust may improve the survivor's comfort level when addressing very difficult and often taboo issues.
- An advocate can build trust by—
  - Speaking the same language.
  - Having a similar cultural heritage.
  - Demonstrating awareness of pertinent cultural issues.

Impact Through a Cultural Lens

Survivors often fear how the assault may affect their—

- Standing in the community.
- Feelings of self-worth.
- Reproductive options.
- Future marriage prospects.
- Future intimate partners/relationships.

Addressing Shame

- Latina/o victims can benefit from shame-releasing exercises that allow them to assign responsibility for sexual violence to the offender(s) (Fontes, 2007).
- For example, a "Testimonio" is a written or oral recounting of the victim's story that may allow others to bear witness to the trauma suffered by the survivor (Aron, 1992).

Diversity of the Spanish Language

The United States—

- Has the third largest Spanish-speaking population after Spain and Mexico.
- Is home to residents with Spanish dialects from South America, Central America, the Caribbean, North America, and other Spanish-speaking regions of the world.

Language Considerations

The most frequently reported barrier keeping Latinas from needed services was language—either not being able to speak English or not having an interpreter (Murdaugh et al., 2004).

Language Terms

- Limited English Proficiency or Proficient (LEP).
- English Language Learner (ELL).

Language Access Laws and LEP.gov

- Executive Order 13166 requires federal agencies and state and local agencies receiving federal assistance to develop guidelines guaranteeing accessibility to their programs by persons with LEP.
- U.S. Department of Justice LEP Guidance: www.ojp.usdoj.gov/about/ocr/lep.htm
- LEP Web site from the Federal Interagency Working Group on Limited English Proficiency: www.LEP.gov

Victim Service Access

English Language Learners require service access to—

- A crisis line at the moment of need.
- Information regarding the rape exam.
- The various levels of supportive services and legal advocacy that an agency may offer.

Victim Service Access (cont.)

Bilingual personnel are crucial for eliminating access barriers at every stage of the help-seeking process (ALAS, 2004).

Use of Interpreters

- All staff must know how to use an interpreter properly, whether the interpreter is a professional (such as an agency employee) or a non-professional (such as a friend of the survivor).
- Being a fluent Spanish speaker is not enough. Interpreters should also be familiar with and respectful of Spanish language regional differences.

Professional Interpreters

When working with professional interpreters—

- Verify the interpreter's experience with, or knowledge of, different Latin American dialects.
- Meet with the interpreter 15 to 30 minutes before the appointment.
- When meeting with the client, pause every three sentences or less.
- Look at and talk directly to the Spanish-speaking client, not the interpreter.

Non-Professional Interpreters

When working with non-professional or acquaintance interpreters, consider—

- Competence.
- Confidentiality.
- Appropriateness.
- Possible conflicts of interest.

Non-Professional Interpreters: Risks

- Confidentiality may be compromised.
- Feelings of embarrassment or shame may be made worse.
- The survivor may be less willing to share details when discussing his/her assault.

Non-Professional Interpreters: Ethical Issues

- Never use children as interpreters.
- Using family, friends, or other survivors can cause secondary victimization. This can create additional problems for the agency and victim.

Downside of Using Interpreters

- Communicating the trauma of sexual violence through an interpreter can make the help-seeking process even more difficult.
- Interpretation disrupts the smooth communication of events and sentiments.
- Outside professional interpreter services can be costly.

Specialized Lay Interpreters

- Band with other victim service agencies to train lay interpreters.
- Recruit Spanish-speaking college students as volunteers who are fluent or at least familiar with your target area's dialects.

Translations

To reach an audience that is more comfortable reading Spanish—

- Translate English language materials.
- Adapt materials already available in Spanish.
- Develop original materials in Spanish.

Downside of Translations

Myth: If the English language version works, then you can simply translate it into Spanish.

Facts:

- The ideas and concepts of the original version may not translate culturally.
- The translation may be too formal or at a reading level too advanced for the target population.
- If the material was not originally written with translation in mind, it requires careful editing and revision to be useful for the target audiences.

Machine Translation

- It may be tempting to rely on Web sites that translate text into various languages because it's quick and often free.
- This can be problematic when dealing with the specialized terminology of sexual assault and domestic violence advocacy.

Machine Translation: Risks

- Not accurately translating —There are some idioms, culture-specific phrases, and grammatical forms that only a native speaker can understand.
- Not adjusting for the English-to-Spanish translation expansion rate (16% increase in word count).
- Not using special Spanish characters that are often required in a translated document (such as the accent mark).

Machine Translation: Errors

- "Sexual Assault Awareness Month" was translated to "meses conciencia asalto sexual" (or "months awareness sexual assault").
- The specific sexual assault context of the term "grooming" was absent in the literal hygiene reference translation "aseo."
- "Acquaintance rape" was literally translated to "conocido violación" (or "known rape").

Machine Translation: Possible Consequences

- Agencies that use machine translation services often cannot understand the output and therefore cannot verify that it is correct.
- Agencies may suffer credibility issues because of incorrect or incoherent text.

Original Materials

Original Spanish-language and bilingual materials—

- Convey information in a manner that is culturally relevant and fluid.
- Ensure that agencies transmit the intended messages and information effectively.
- Convey respect for cultural diversity and ethnic identity, even to bilingual speakers who may be proficient in English.

Original Materials (cont.)

Considerations for developing original materials in Spanish include—

- Economic and education level.
- Gender.
- Immigration status.
- Country of origin/dialect.
- Acculturation level.
- Attitude/awareness differences.

Visibility

All agency materials and online content should describe in Spanish the bilingual services offered.

- Services offered in Spanish – "servicios que se ofrecen en español."
- 24-hour hotline – "línea de ayuda disponible las 24 horas del día."
- Crisis counseling – "asesoría o consejería para personas en crisis."
- Support groups – "grupos de apoyo."
- Hospital accompaniment – "acompañamiento al hospital."
- Legal advocacy – "asesoramiento legal."

A Glossary Resource

Existe Ayuda's Sexual Assault Glossary:

www.ovc.gov/pubs/existeayuda/glossaries/sexualassault

Existe Ayuda

National Community Outreach Project

Latinas and Sexual Violence

Part 2

Immigrant Victimization

- Refugee and immigrant women are often beyond the reach of those who could help them.
- Rape has become so prevalent that many unauthorized immigrant women take birth-control measures before crossing the Mexico-United States border.

Latina Immigrant Vulnerability

Many immigrant Latina domestic workers (Vellos, 1997)—

- Have language barriers.
- Live in constant fear of being deported.
- Suffer social isolation.
- Depend on their employers for their livelihood and are vulnerable to their demands.

Latina Immigrant Vulnerability (cont.)

I was only 16 when I came to work in this country as a live-in maid. I was isolated from everyone I knew and felt very alone.

The woman who hired me took my personal documents and she had a temper. But I was more afraid of her husband and his friends when they got drunk. They made me very nervous when they would try to flirt and joke about me dancing for them like a stripper. They offered to pay me for it. I felt trapped and very afraid, especially when she was away.

—Translated survivor testimonial

Immigrant Survivors' Rights

Most survivors are eligible for—

- Police response and protection.
- Services from sexual assault and domestic violence programs.
- Civil protection orders from the courts.
- Criminal prosecution of assailants.
- Custody and support for children.
- Emergency medical care.

Immigrant Survivors' Legal Rights

- Violence Against Women Act.
- The Trafficking Victims Protection Act of 2000.
  - T-Visa (for victims of severe forms of human trafficking).
  - U-Visa (for victims of other types of crimes).

Online Visa Resources

- WomensLaw.org
  www.womenslaw.org
- U.S. Citizenship and Immigration Services
  www.uscis.gov/portal/site/uscis

Needs of Immigrant Victims: Services

- Interpretation by trained persons.
- Clear explanations of rights, options, services, and the criminal justice process.
- Legal advocacy from immigration specialists (bilingual staff or interpreters are crucial).
- Police protection without fear of deportation.

Needs of Immigrant Victims: Establishing Trust

- Ensure the victim is accompanied by companions "de confianza" (trustworthy) or victim advocates.
- Avoid referrals to several different advocates during the initial stage.
- Provide emotional support and spiritual support as the help-seeking process continues.

Needs of Immigrant Victims: Accountability

- Providing updates and keeping the survivor informed requires ongoing followup with the various agency contacts throughout the process.
- Promoting interagency accountability empowers survivors to regain some sense of control and not lose faith. It also helps keep a case alive.

Building Community Partnerships

- Rape crisis centers should focus on outreach and prevention as well as responding to trauma.
- By developing or upgrading relationships with agencies already providing education to the Latina/o community, an individual center can—
  - Promote awareness of the services it offers.
  - Enhance community member access to their center and services.
  - Promote cross-training and collaboration opportunities.

Building Community Partnerships (cont.)

- Established Latina/o organizations with existing bilingual/bicultural staff, programs, and community trust can be valuable allies and agents of change:
  - Local "centros" (Latina/o community centers).
  - "Promotoras" (community health workers).

Promotora/Community Health Worker

Promotora, Animadora, Community Health Advisor, Community Health Worker (CHW): Workers who are indigenous to the community and who serve and train through a community-based organization or health service agency.

Promotora/CHW Programs

- At least 600 promotora/CHW programs were using approximately 12,500 community health advisors in 1998 (University of Arizona and Annie E. Casey Foundation, 1998).
- The 2004 Centers for Disease Control and Prevention's community health advisor database listed profiles of over 200 programs representing more than 10,000 CHWs (Lujan, 2009).

Promotora/CHW Programs (cont.)

According to a 2007 study (Health Resources and Services Administration, 2007)—

- Approximately 86,000 CHWs assisted communities throughout the United States in 2000.
- The states with the largest CHW populations were California, New York, Texas, Florida, and Pennsylvania.

Promotoras as Allies

- They are part of social networks through which community members offer and receive social support among themselves.
- They may already be concerned about the sexual violence that affects their communities and know where survivors and perpetrators reside.

Promotoras as Allies (cont.)

- They can bridge the formal service delivery system of the survivor service agency and the community's informal social support system by directly reaching the survivors and referring them to advocacy and support.
- Their host agencies may already have established training programs that can easily integrate sexual assault issues (Zárate, 2003).

Educational Tools and Activities

- Spanish-language media.
- Popular education.
- Popular culture: songs and "telenovelas" (soap operas).
- Workshops, "pláticas" (informal talks), and psycho-education sessions conducted in Spanish.
- Community fairs/festivals.
- Faith-based groups.
- Beauty parlors.
- Schools.
- Health clinics.
- Resettlement organizations.

Educational Tools and Activities (cont.)

- In the past 20 years, Spanish radio in the United States has grown into a major multimillion-dollar industry (New America Media, 2009).
- During the first three quarters of 2009, $4.03 billion was invested in Spanish-language media (JakeAdams Editorial Services and Research Consultancy, 2010).

Educational Tools and Activities (cont.)

Outreach efforts can include the following Spanish-language media:

- Public service announcements on local radio stations.
- Articles in local newspapers and community newsletters, especially during Sexual Assault Awareness Month.
- Analysis of "telenovela" content for sexual assault themes for use in group discussions.
- Analysis of song lyrics for group discussion on male entitlement, victim blaming, sex with underage girls, and other rape culture themes.

Popular Education/Educación Popular

Popular education—

- Empowers people to be the subjects of their own development.
- Incorporates the whole person through movement, song, and theater.
- Often draws on popular culture, using drama, song, dance, poetry, puppetry, mime, art, storytelling, and other forms.

Popular Culture: A Tool for Sexual Assault Awareness

Popular culture can—

- Enhance communication among audiences with an oral tradition.
- Demonstrate respect for community cultural values and enhance group spirit.
- Demystify the information conveyed and make it accessible and relevant.
- Encourage participation and learning (Bates, 1996; Proulx, 1993).

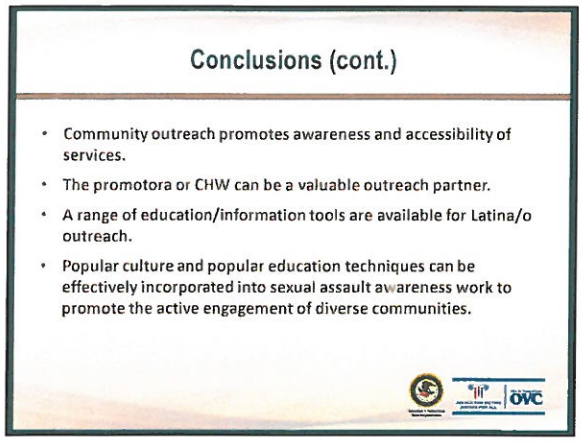
(Kerka, 1997)

Conclusions

- Latina/o communities are diverse and rapidly growing.
- Various barriers to services exist for monolingual Spanish-speaking survivors.
- Culture and social assumptions may hinder a survivor's ability to define and report sexual assault.

Conclusions (cont.)

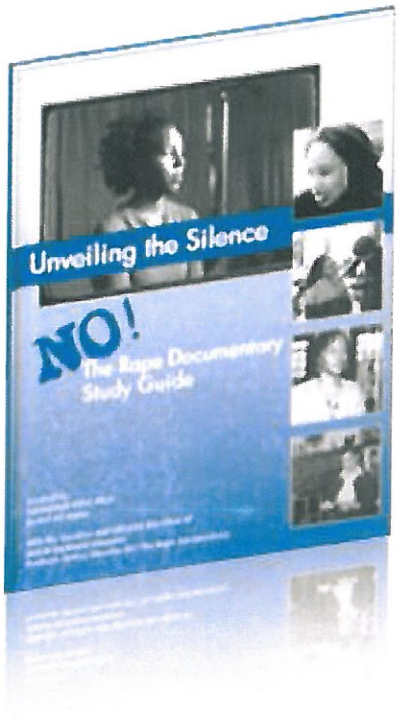
- Language plays a key role in intervention and prevention.
- Victim advocates should be knowledgeable of the cultural origins of their clients.
- The use of interpreters requires skill and training.
- Human translations are superior to non-human translations.


Conclusions (cont.)
• Community outreach promotes awareness and accessibility of services.
• The promotora or CHW can be a valuable outreach partner.
• A range of education/information tools are available for Latina/o outreach.
• Popular culture and popular education techniques can be effectively incorporated into sexual assault awareness work to promote the active engagement of diverse communities.
OVC

Sexual Assault Education | Download NO! The Rape Documentary Study Guide

Posted By admin On March 12, 2008 @ 21:05 In Uncategorized | 2 Comments

Download Unveiling the Silence: NO! The Rape Documentary Study Guide



The entire content of this guide is protected under copyright law. Please feel free to use any part of this guide as long as proper credit is attributed to the source of your information.

Click here [1], if you want to purchase a copy of NO! The Rape Documentary Study Guide.

To download your free copy of Unveiling the Silence: NO! The Rape Documentary Study Guide [2], you will need Acrobat Reader, which you can download free from Adobe if you don't have it. Click here for more information [3].

To download a PDF of the NO! The Rape Documentary Study Guide in its entirety, please click here.

To download PDFs of the NO! The Rape Documentary Study Guide in four sections, please click each section (Section I, [4] Section II [5], Section III [6], Section IV [7]).

Questions or concerns? Please click here [8].

Section I [4]
Study Guide Front Cover
Copyright page
Dedication page
Purpose of guide

Table of contents
Producer/Director's Statement – Aishah Shahidah Simmons
Synopsis of NO!
Creating a Safe Space for Discussion
Glossary of Terms
Key Myths and Facts

Section II [5]
(DVD) Chapter Guides
1. Introduction and Devastation of Date Rape
Salamishah Tillet's Testimony
Acquaintance Rape and Consent
2. Weapon of History
Slavery
Lynching
Great Migration
3. Survivors Silenced
Reanae McNeal's Testimony
Campus Safety
Racial Solidarity
4. Civil Rights and Wrongs
Gwendolyn Zoharah Simmons's Testimony
Sexual Harassment and Assault in the Civil Rights and Black Power Movements
Black Power and Sexual Assault
Black Lesbians and Activism Against Sexual Assault (*Queen's Testimony*)
Black Women Writers and Sexual Assault

Section III [6]
(DVD) Chapter Guides
5. Raping the Next Generation
Rosetta Williams' Testimony
Date Rape and Prevention
Adolescent Sexual Abuse and Prevention
Incest
6. Holding Men Accountable — Campus, Clergy, and Community
Intraracial Betrayal and Sexual Violence (*Janelle White's Testimony*)
Black Feminist Men and the Anti-Rape Violence Movement
Black Leaders and Sexual Violence (*Aaronette M. White's Testimony*)
The Mike Tyson Trial
Sexual Assault and Religion
Media, Stereotypes, and a Rape Culture
7. Unequal Justice Under Law
Audree Iron's Testimony
Sexual Assault and the Criminal Justice System
Disparities in the American Judicial System
8. Healing, Faith, and Hope
Loretta Ross's Testimony
Activism and Recovery
Arts as Recovery
Accountability and Recovery

Section IV [7]
Epilogue
The Role of Religion in Violence Against Women – Gwendolyn Zoharah Simmons, Ph.D.
Meditations of Resistance: A Triptych of Total Regeneration – Tamara L. Xavier, M.Ed.
Appendix
Because we….: – A Statement on NO! by the UBUNTU Education Working Group [9]
Taking Action
Media and Sexual Violence
Group Activities
National Rape and Sexual Assault Resources
Rape and Sexual Assault Organizations by State
Recommended Reading
Learn More about the Individuals in the Film
Film Credits

Biographies of Contributors to the Study Guide
Acknowledgements
Notes
Study Guide Back Cover

Article printed from NO! The Rape Documentary: **http://notherapedocumentary.org**

URL to article: **http://notherapedocumentary.org/download-sexual-assault-awareness-study-guide**

URLs in this post:

[1] Click here: **http://notherapedocumentary.org/purchase-sexual-assault-prevention-films**
[2] Unveiling the Silence: NO! The Rape Documentary Study Guide: **http://notherapedocumentary.org/sexual-assault-documentary-study-guide**
[3] Click here for more information: **http://www.adobe.com/products/acrobat/readstep2.html**
[4] Section I,: **http://www.notherapedocumentary.org/images/NO!_StudyGuide_Sec1.pdf**
[5] Section II: **http://www.notherapedocumentary.org/images/NO!_StudyGuide_Sec2.pdf**
[6] Section III: **http://www.notherapedocumentary.org/images/NO!_StudyGuide_Sec3.pdf**
[7] Section IV: **http://www.notherapedocumentary.org/images/NO!_StudyGuide_Sec4.pdf**
[8] Please click here: **http://notherapedocumentary.org/no-the-rape-documentary-contact-form**
[9] UBUNTU Education Working Group: **http://iambecauseweare.wordpress.com/**

Copyright © 2008 NO! The Rape Documentary. All rights reserved.



Male Survivors

BRAVO
BUCKEYE REGION ANTI-VIOLENCE ORGANIZATION

Male Sexual Victimization Myths & Facts

Myth #1 - Boys and men can't be victims
This myth, instilled through masculine gender socialization and sometimes referred to as the "macho image," declares that males, even young boys, are not supposed to be victims or even vulnerable. We learn very early that males should be able to protect themselves. In truth, boys are children - weaker and more vulnerable than their perpetrators - who cannot really fight back. Why? The perpetrator has greater size, strength, and knowledge. This power is exercised from a position of authority, using resources such as money or other bribes, or outright threats - whatever advantage can be taken to use a child for sexual purposes.

Myth #2 - Most sexual abuse of boys is perpetrated by homosexual males
Pedophiles who molest boys are not expressing a homosexual orientation any more than pedophiles who molest girls are practicing heterosexual behaviors. While many child molesters have gender and/or age preferences, of those who seek out boys, the vast majority are not homosexual. They are pedophiles.

Myth #3 - If a boy experiences sexual arousal or orgasm from abuse, this means he was a willing participant or enjoyed it
In reality, males can respond physically to stimulation (get an erection) even in traumatic or painful sexual situations. Therapists who work with sexual offenders know that one way a perpetrator can maintain secrecy is to label the child's sexual response as an indication of his willingness to participate. "You liked it, you wanted it," they'll say. Many survivors feel guilt and shame because they experienced physical arousal while being abused. Physical (and visual or auditory) stimulation is likely to happen in a sexual situation. It does not mean that the child wanted the experience or understood what it meant at the time.

Myth #4 - Boys are less traumatized by the abuse experience than girls
While some studies have found males to be less negatively affected, more studies show that long term effects are quite damaging for either sex. Males may be more damaged by society's refusal or reluctance to accept their victimization, and by their resultant belief that they must "tough it out" in silence.

Myth #5 - Boys abused by males are or will become homosexual
While there are different theories about how the sexual orientation develops, experts in the human sexuality field do not believe that premature sexual experiences play a significant role in late adolescent or adult sexual orientation. It is unlikely that someone can make another person a homosexual or heterosexual. Sexual orientation is a complex issue and there is no single answer or theory that explains why someone identifies himself as homosexual, heterosexual or bi-sexual. Whether perpetrated by older males or females, boys' or girls' premature sexual experiences are damaging in many ways, including confusion about one's sexual identity and orientation.
Many boys who have been abused by males erroneously believe that something about them sexually attracts males, and that this may mean they are homosexual or effeminate. Again, not true. Pedophiles who are attracted to boys will admit that the lack of body hair and adult sexual features turns them on. The pedophile's inability to develop and maintain a healthy adult sexual relationship is the problem - not the physical features of a sexually immature boy.

Myth #6 - The "Vampire Syndrome" that is, boys who are sexually abused, like the victims of Count Dracula, go on to "bite" or sexually abuse others
This myth is especially dangerous because it can create a terrible stigma for the child, that he is destined to become an offender. Boys might be treated as potential perpetrators rather than victims who need help. While it is true that most perpetrators have histories of sexual abuse, it is NOT true that most victims go on to become perpetrators. Research by Jane Gilgun, Judith Becker and John Hunter found a primary difference between perpetrators who were sexually abused and sexually abused males who never perpetrated: non-perpetrators told about the abuse, and were believed and supported by significant people in their lives. Again, the majority of victims do not go on to become adolescent or adult

perpetrators; and those who do perpetrate in adolescence usually don't perpetrate as adults if they get help when they are young.

Myth #7 - If the perpetrator is female, the boy or adolescent should consider himself fortunate to have been initiated into heterosexual activity

In reality, premature or coerced sex, whether by a mother, aunt, older sister, baby-sitter or other female in a position of power over a boy, causes confusion at best, and rage, depression or other problems in more negative circumstances. To be used as a sexual object by a more powerful person, male or female, is always abusive and often damaging.

Believing these myths is dangerous and damaging.

- So long as society believes these myths, and teaches them to children from their earliest years, sexually abused males will be unlikely to get the recognition and help they need.
- So long as society believes these myths, sexually abused males will be more likely join the minority of survivors who perpetuate this suffering by abusing others.
- So long as boys or men who have been sexually abused believe these myths, they will feel ashamed and angry.
- And so long as sexually abused males believe these myths they reinforce the power of another devastating myth that all abused children struggle with: that it was their fault. It is never the fault of the child in a sexual situation - though perpetrators can be quite skilled at getting their victims to believe these myths and take on responsibility that is always and only their own.

For any male who has been sexually abused, becoming free of these myths is an essential part of the recovery process.

male survivors

WHAT YOU SHOULD KNOW...

about men who have been sexually assaulted

Rape is a men's issue for many reasons. One we don't often talk about is the fact that men are sexually assaulted. We need to start recognizing the presence of male survivors and acknowledging their unique experience. The following questions and answers can help us all learn about male survivors so that we stop treating them as invisible and start helping them heal:

How often are men sexually assaulted?

While the numbers vary from study to study, most research suggests that 10-20 percent of all males will be sexually violated at some point in their lifetimes. That translates into tens of thousands of boys and men assaulted each year alongside hundreds of thousands of girls and women.

If there are so many male survivors, why don't I know any?

Like female survivors, most male survivors never report being assaulted, even to people they know and trust. They fear being ignored, laughed at, disbelieved, shamed, accused of weakness, or questioned about being gay. Perhaps worst of all, men fear being blamed for the assault because they were not "man enough" to protect themselves in the face of an attack. For all these reasons, many male survivors remain silent and alone rather than risk further violation by those around them.

Can a woman sexually assault a man?

Yes, but it's not nearly as common as male-on-male assault. A recent study shows that more than 86% of male survivors are sexually abused by another male. That is not to say, however, that we should overlook boys or men who are victimized by females. It may be tempting to dismiss such experiences as wanted sexual initiation (especially in the case of an older female assaulting a younger male), but the reality is that the impact of female-on-male assault can be just as damaging.

Don't only men in prison get raped?

While prison rape is a serious problem and a serious crime, many male survivors are assaulted in everyday environments (at parties, at home, at church, at school, on the playground), often by people they know -- friends, teammates, relatives, teachers, clergy, bosses, partners. As with female survivors, men are also sometimes raped by strangers. These situations tend to be more violent and more often involve a group of attackers rather than a single offender.

How does rape affect men differently from women?

Rape affects men in many ways similar to women. Anxiety, anger, sadness, confusion, fear, numbness, self-blame, helplessness, hopelessness, suicidal feelings and shame are common reactions of both male and female survivors. In some ways, though, men react uniquely to being sexually assaulted. Immediately after an assault, men may show more hostility and aggression rather than tearfulness and fear. Over time, they may also question their sexual identity, act out in a sexually aggressive manner, and even downplay the impact of the assault.

Don't men who get raped become rapists?

NO! This is a destructive myth that often adds to the anxiety a male survivor feels after being assaulted. Because of this misinformation, it is common for a male survivor to fear that he is now destined to do to others what was done to him. While many convicted sex offenders have a history of being sexually abused, most male survivors do not become offenders. The truth is that the great majority of male survivors have never and will never sexually assault anyone.

If a man is raped by another man, does it mean he's gay?

NO, again! While gay men can be raped (often by straight men), a man getting raped by another man says nothing about his sexual orientation before the assault, nor does it change his sexual orientation afterwards. Rape is primarily prompted by anger or a desire to harm, intimidate or dominate, rather than by sexual attraction or a rapist's assumption about his intended victim's sexual preference. Because of society's confusion about the role that attraction plays in sexual assault and about whether victims are responsible for provoking an assault, even heterosexual male survivors may worry that they somehow gave off "gay vibes" that the rapist picked up and acted upon. For a gay man, especially one who is not yet out of the closet, the possibility that he is broadcasting his "secret sexual identity" to others without even knowing it can be particularly upsetting.

How should I respond if a man I know tells me he has been assaulted?

While there may be some differences in how rape impacts a male versus a female survivor of sexual assault, the basics of supporting survivors are the same for men as for women. Believe him. Know what your community's resources are and help him explore his options. Don't push and don't blame. Ask him what he wants and listen. Be cautious about physical contact until he's ready. Get help for yourself.

Where can male survivors go for help?

Every community has its own services for survivors of sexual violence, including local or campus-based rape crisis centers. Most of these places have on-site counselors trained in working with male survivors or can refer men who have been assaulted to professionals in the area who can help. Know



P.O. BOX 57144•WASHINGTON, DC•20037
(202) 265-6530
info@mencanstoprape.org
www.mencanstoprape.org
© 1998, 2001 Men Can Stop Rape

Ohio Alliance to End Sexual Violence
Phone: 216-658-1381 / 888-886-8388 Email: info@oaesv.org

Male Survivor Resources

The Facts

- It is estimated that 1 in 6 men have experienced abusive sexual experiences before age 18.[1]
- 2.78 million men in the U.S. have been victims of sexual assault or rape.[2]
- The year in a male's life when he is most likely to be a victim of sexual assault is the age of four.[3]

Definition of Sexual Assault

Sexual assault is any forced or coerced sexual activity such as unwanted contact, committed against a person's will or without consent. Rape is a sexual assault that includes but is not limited to forced vaginal, anal, and oral penetration. Rape and sexual assault are crimes of violence with sex used as a weapon that can he committed by strangers, friends, relatives, dates, partners, lovers, and spouses. While females do commit sexual assault and other forms of sexual violence against men, the majority of perpetrators of sexual violence against men and boys are other males.

Common Reactions to Sexual Violence

Flashbacks ■ Guilt/Shame ■ Depression ■ Anger ■ Self-Blame ■ Anxiety ■ Concern about sexuality/sexual orientation ■ Disturbed sleep ■ Low self-esteem ■ Denial ■ Mood Changes ■ Retaliation fantasies ■ Compulsive behaviors ■ Powerlessness

Reactions Unique to Male Survivors

It is common for male survivors to question their masculinity in response to sexual violence and to question whether they are a "real man." Sexual violence may involve being sexually used/dominated, vulnerable, overwhelmed, and/or flooded by intense emotions—the opposite of what our society defines as masculine.[4] Adding to the confusion, it is common for the male body to respond to sexual violence with physical arousal and even ejaculation. Many survivors feel as though their body has betrayed them and it may cause some to question their sexual orientation. In reality, the survivor had no control over what happened and his body's response in no way indicates that he "enjoyed" it. Sexual abuse is *not* the result of a man's sexual orientation nor does it cause a change in one's sexual orientation.

Supporting a Survivor of Sexual Violence

- **Believe him.**
- **Listen to him.** Be there. Don't be judgmental.
- **Encourage him to contact one of the hotlines, but realize that only your loved one can make the decision to get help.**
- **Supporting a child:** If you are the non-abusing parent in a case of incest, it is important to support your son and help him through this situation without blaming him. In addition, some adult professionals have an obligation to report suspected abuse/incest to authorities. For more information, see OAESV's fact sheet entitled "Mandatory Reporting of Sexual Violence: A Guide for Advocates".
- **Help to empower your loved one.** Crimes of sexual violence take away an individual's power. It is important not to compound this experience by putting pressure on your loved one to do things that he is not ready to do yet.
- **If your loved one is considering suicide, maintain frequent contact with them and provide resources for help.** One resource is the National Suicide Prevention Lifeline, 1-800-273-TALK (8255); www.suicidepreventionlifeline.org.

[1] *See* 1IN6.ORG, *The 1 in 6 Statistic*, at 1in6.org/the-1-in-6-statistic (last visited Oct. 10, 2012).
[2] *See* National Institute of Justice & Centers for Disease Control & Prevention. *Prevalence, Incidence and Consequences of Violence Against Women Survey*. 1998.
[3] *See* Howard Snyder, *Sexual Assault of Young Children as Reported to Law Enforcement: Victim, Incident, and Offender Characteristics*, U.S. DEPARTMENT OF JUSTICE, BUREAU OF JUSTICE STATISTICS, at 4 (2000).
[4] See 1IN6.ORG, *How it Can be Different for Men*, at http://1in6.org/men/get-information/online-readings/masculinity-self-esteem-and-identity/how-it-can-be-different-for-men/ (last visited Oct. 10, 2012).

Ohio and National Resources	
Ohio Alliance to End Sexual Violence	➲ **www.oaesv.org/support-by-county.html** (Find services by Ohio county) ➲ **Call (216) 658-1381** or toll-free (888) 886-8388
National Sexual Assault Hotline	➲ **1-800-656-HOPE.** Over 1,100 trained volunteers are on duty and available to help victims at RAINN-affiliated crisis centers across the country.
www.malesurvivor.org	Includes therapist's directory, discussion forums, chat rooms, information and resources for survivors.
1in6.org	The mission of 1in6 is to help men who have had unwanted or abusive sexual experiences in childhood live healthier, happier lives. Features an online support line, peer support, and other resources.
Department of Defense (DoD) Safe Helpline	Crisis support services for members of the DoD community affected by sexual assault. The service is confidential, anonymous, secure, and available worldwide 24/7. ➲ **www.safehelpline.org:** Live, confidential help through a secure instant-messaging format ➲ **Call 877-995-5247:** available 24/7, worldwide ➲ **Text for Info:** Text your zip code, installation or base name to 55-247 (inside the U.S.) or 202-470-5546 (outside the U.S.), to receive referrals by text.

This publication was supported by grant number 2013VASAVE915 awarded by the Office for Victims of Crime, Office of Justice Programs, through the Ohio Attorney General's Office.



Child & Adolescent

From the Sexual Assault Response Network of Central Ohio, OhioHealth's Survivor Advocacy Manual January, 2013

Child and Adolescent Sexual Assault Overview

Definition:
Child and adolescent sexual assault or abuse is any manual, oral, or genital manipulation or contact between an adult and child/adolescent where the child/adolescent is unable to change or understand the adult behavior because of a lack of power or psychological development. The last phrase, "a lack of power or psychological development" is a key to understanding the sexual assault of children and adolescents, and the short and long-term consequences of the abuse.

Sexual assault/abuse disrupts the development of a child emotionally, psychologically, physically, intellectually, socially, and morally, by interfering with the mastery of developmental tasks. The abusive environment is simply beyond the capacity of the child to encompass and assimilate. The child is in a new role with the parent figure and that role relationship prevents the "normal" development of self.

Children are victimized because of their age, naiveté, and/or trust in adults or authority figures. Rarely is a child victimized in an aggressive manner. Sexual victimization is the abuse of power or trust, by an adult. The abuse of trust is the ultimate violation.

Issues at the Time of Disclosure:
Disclosure of sexual assault/abuse needs to be viewed not only as the disclosure of a crime but as a crisis for the entire family, regardless of who the perpetrator is. If the perpetrator is a member of the family, the crisis is more severe. This means that the situation is one in which a number of people have a lot of different needs. These needs crop up throughout interviews by police or child protective service workers and, also, in therapy.

First, children need to be told - many times – "it is not your fault"; "you didn't do anything wrong" and the adult to whom they are disclosing, believes them. Children may say directly "I don't think you're going to believe me." Even if they don't say it, most children feel like they are not going to be believed. In most situations, it's their word against an adult's and the adult is more powerful and believable. Even if children are told directly that they didn't do anything wrong, they may still feel at fault. They need both the reassurance that they did the right thing in telling, and that the adult they tell believes them.

Second, children need to be told that they are not the only ones this has happened to and that the adult to whom they disclosed, has talked to other kids about it. Children are often horrified and disgusted by what has happened to them - especially older children. They may fear that adults are going to be horrified and disgusted. They need to be reassured that the trusted adult has heard this before and that it's not going to disgust or cause discomfort to the adult. Adults may sometimes feel discomfort or disgust with disclosures, but need to not show these emotions to a child who came to them for help.

Third, they need reassurance that they will be protected and helped. They don't need unrealistic reassurances that can't be maintained, such as, "don't worry; it will never happen to you again."

That's not an assurance anyone can make. An assurance helpful to children might be, "we're going to do our best to keep you safe." This is a realistic but reassuring statement.

A fourth need children have at disclosure is to know what is going to happen next. They need realistic information that is appropriate to their age level. They especially need to be told the truth about telling their story. If they do have to talk to three more people after they talk to an adult, they need to be told, "you're going to have to tell your story again," rather than spare them or try to trick them into talking. It's not helpful to say, "don't worry, if you tell me, you won't have to tell anyone else." Lies to make children talk are not helpful to them because they feel tricked. Children who have been sexually assaulted have already been tricked and feel betrayed.

Adult Survivors of Child Sexual Assault have special considerations surrounding the legal parameters of disclosure. The state of Ohio has 20 years after the felony of rape is committed in which to press charges. The 20 year limitation for survivors under 18 years old begins either 1) once the child turns 18 or 2) when the child reports to a "responsible" adult. "Responsible" adult is considered a teacher, nurse, police officer, counselor, or parent. There are exceptions to "responsible" adults such as if a parent was told that her partner was perpetrating on the child yet does don't protect or report it to authorities, that parent is not considered a "responsible" adult. Therefore the 20- year limitation hasn't begun yet, and won't until a true responsible adult is told or the child turns 18.

Common Feelings of Children Who Have Been Sexually Assaulted:
Children's responses to sexual assault can depend on a number of factors. Those factors include their age and developmental level, who assaulted them, when the assault occurred, how many times it occurred, whether or not there was violence involved, what else was happening in the family at the time (or happening to them at the time), as well as personality factors. How the adults around them respond also affects children's responses to sexual assault. We cannot make generalizations about the impact of particular events, that is, if "X" happens, it's more traumatic than if "Y" happens. It varies so much with different children. However, there are some feelings and issues that are fairly common among children who have been sexually assaulted. Even children who appear to be coping well probably experience most of these feelings at some time.

Some of the Common Fears Children Have Include:

- Getting in trouble
- Causing trouble
- Being punished (for telling the secret that they were not supposed to tell)
- Losing the adults that are important to them
- Being taken away from their home

Fear is the major reason that children don't tell about sexual assault. Children are very dependent on the adults in their lives and losing them can be devastating.

Anger is another common feeling that children often have. The anger can be directed at a number of people. There are children who feel anger toward the perpetrator, and some that feel anger toward their mother or the other adults around them who didn't protect them. There are some children who feel anger at themselves because, again, they feel they are causing trouble in their family. If somebody else has told the secret, they may feel anger at that person for disclosing the abuse.

Children often feel guilty or ashamed of the abuse. They may feel that they caused it to happen because they were bad and did something wrong; they fear that the abuse is punishment they "deserve." Or they may feel that they caused it to happen because they wanted to be close to the perpetrator. They got the closeness, but they also got something they did not want - being molested or touched in some sort of way that made them feel funny. Even if they don't feel that they are to blame for starting the abuse, they may feel guilty for not stopping it, especially if the abuse has gone on for some time. Adolescents may feel guilty because they were doing something else at the time - something they shouldn't have been doing, such as drinking. Most children feel some shame about just being part of the kind of experience. For many children, talking about sexuality in general can cause guilt or shameful discomfort. Another reason children may feel guilty is it may have felt good physically to them. Consequently, they feel very confused about enjoying it and not wanting it at the same time.

Other common feelings are isolation or different ness - that "something is wrong with me." They may feel that what goes on in their family (in terms of the abuse) has never happened to anyone else, and they are consequently "weird." They are often relieved to learn that this has happened to other children.

The potential consequences of childhood/adolescent victimization are:

- Confused role identify
- Poor self image
- Pseudo-maturity
- Poor social skills
- Social isolation
- Poor peer relationships
- Hostility and/or aggressive behaviors
- Depression
- Lack of trust
- Lack of confidence
- Low self-esteem
- Self-destructive acting out
- Withdrawal
- Feelings of shame and guilt

Helping Parents of Children who have been assaulted:

When a child has been sexually assaulted, a parent or another family member will often contact a hotline. In speaking to parents, the helper should keep in mind the following objectives. It is almost impossible to talk a parent out of feeling guilty or assigning undeserved blame; but an advocate can reflect back to them a more realistic perception of the situation. Advocates can also remind parents that children's relative powerlessness, trustfulness, and confusion about what is appropriate sexual behavior, and ignorance of self-defense techniques can contribute to victimization.

Advocates should receive the parents' spontaneous reactions with empathy and understanding. They should also be accepting of whatever feelings the parents communicate and encourage expression of both "good" and "bad" feelings.

Common Reactions to Disclosure Include:

- **Shock:** "How could such a thing have happened?"
- **Helplessness:** Thinking there is nothing they can do to protect their child or make things better
- **Blame:** Parents may assign responsibility to the following persons:
    - Self: "How could I have let this happen?" Remorse at having ignored warning signs, having trusted the perpetrator, not having been sufficiently vigilant, etc.
    - Spouse or other family member: "You should have been stricter." "You should have known what would happen." "You should have known that she could not be trusted." This latter is most common when the perpetrator is a blood relative of the person receiving the blame.
    - Victim: for disobedience, for not taking safety precautions, for not refusing or resisting, for being naive or trusting, etc.
    - Perpetrator
- **Anger:** not only at the perpetrator, but also at the representatives of the many outside agencies that become involved with the family following the disclosure, e.g., children services, police, legal system, mental health system.
- **Grief:** over what has been done to the child; over the irreparable changes within each family member and within the family system; over the loss of trust and security.
- **Fear:** that the child will be irreparably damaged, that parents will not be able to protect the victim or other siblings from future assault, that the perpetrator will retaliate against the family, that the child and the family will be stigmatized by neighbors and friends.

In situations where the perpetrator is a parent, a stepparent, or other individual upon whom the family is dependent, there are additional fears concerning the consequences of disclosure. A mother may fear the loss of physical, economic, and emotional support. She may fear that her children will be removed from the home because of her failure to protect them.

Advocates Can:

- Help the parents accept the reality of what has happened. Because of guilt, fear, shame, etc., the parents may attempt to resist further disclosure by denying the occurrence of sexual assault or by attempting to pretend that what has happened was inconsequential. Such denial will prevent them from assisting in their child's recovery.
- Support the parents in believing the child.
- Support the parents in not blaming the child and in alleviating the child's sense of guilt. Pick up on comments that blame the child (I told him not to go into the park alone; I never trusted those kids that she hangs out with; they were right in the next room and he didn't even scream) or that negatively stereotype the child.
- Explain to parents why their child may not have been able to tell them about the assault.
- Assist the parent in doing what is necessary to provide for the child's physical safety. In cases where a perpetrator has present access to the child, immediate children's services intervention is usually required.
- Assist the parent in seeing that the child's health needs are attended to. In the case of such physical symptoms as vaginal or anal bleeding, discharge, rash, or sores, a referral to a pediatrician or hospital is indicated. Any competent pediatrician or hospital clinic equipped to diagnose and treat sexually transmitted disease, to conduct pregnancy tests, and to collect

evidence of sexual assault can also treat a child. It is common for children to be fearful of the medical procedures. Feelings of shame about self-exposure and guilt regarding the sexual assault may intensify their fear. Explanations about the purpose of the procedures, descriptions of what will be done to them and what they will feel can be reassuring. Advocates can help parents prepare their children for medical procedures and can accompany children to the hospital or clinic.

- Facilitate the beginning of parent-child communication regarding the assault. Children need honest and accurate information in order to understand what has happened to them. They need to be reassured that they were in no way to blame for what took place. They may be relieved to know that they are not the only ones who have been sexually assaulted; that it happens to other children. They need to ventilate the feelings they had during the assault - they may have felt hurt, scared, confused, and alone. They may also have had some pleasurable physical sensations and felt loved and cherished. Parents should let their children know that it is okay to feel as they do; they should react calmly and non-judgmentally. Children also need to share their current concerns. Often they fear that they will be punished for disclosing, that the perpetrator may retaliate or continue to harm them, or that their bodies will be permanently damaged as a result of the sexual assault. Repeated assurances by parents are essential.
- Encourage the parents to bring the child to the center for counseling. Parents report that they worry about whether certain behavioral manifestations are normal or whether they represent unhealthy modes of dealing with the experience of the assault. Sometimes they tend to magnify symptoms (such as age-appropriate interest in male-female differences) and sometimes they overlook signs of disturbance. Both for the welfare of the child and for the parents' peace of mind, it is advisable to have the child evaluated by a counselor.
- Alert the parent to the possibility that siblings or children outside of their family may also be the victims of the same perpetrator. Encourage them to seek help for these other children as well.

Common Reasons that Children Do Not Disclose to Family Members:

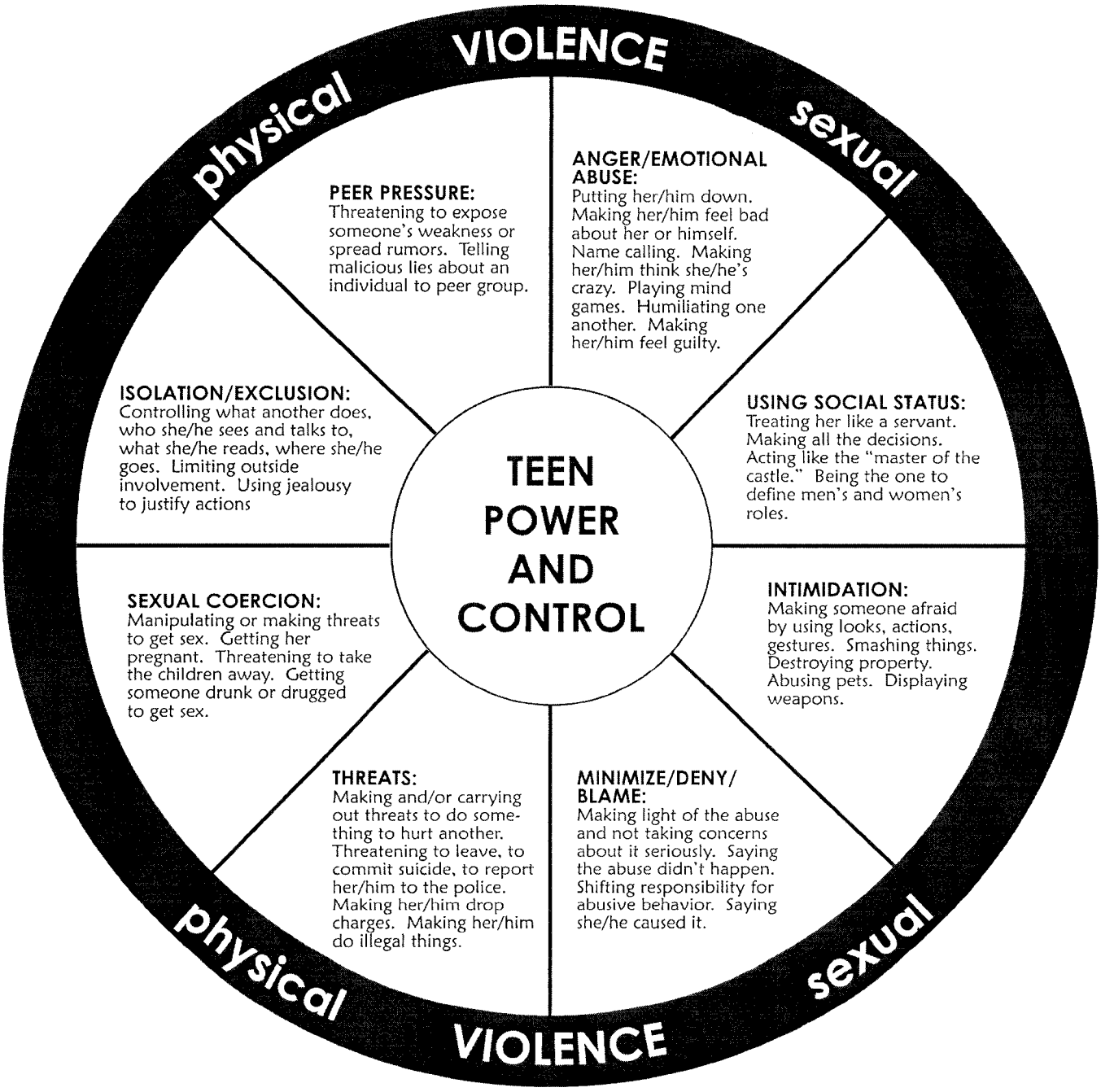
- Sex is a taboo subject in many families
- Children may not have the words to describe the experience
- Children are often confused about what kinds of touching are appropriate
- They fear parents' anger or blame
- They feel responsible or stupid for having let it happen
- Older children fear that parents will cease to trust them and will curtail their privileges
- They feel guilty for having derived some pleasure from the sexual stimulation
- They feel the explicit or implicit threats of the perpetrator

Suggestions for Helping Survivors of Childhood Sexual Assault

- Examine your own attitudes and experiences
- Do not say "It's all in the past" - our experiences affect the way we are today
- Believe the survivor - she may not have been believed in the past when she attempted to reach out for help
- Validate the damage done, her feelings, and needs
- Remember that abuse is never the child's fault
- Don't sympathize with the abuser - never rationalize or minimize the perpetrator's behavior
- Express genuine compassion

- Encourage the survivor to give herself time to heal - once beginning the recovery process, most survivors are impatient and want it to be "all better **now**"
- Encourage the survivor to get support - individual counseling, support groups, surrounding herself with friends/family who are supportive of her life as an adult
- Validate what the survivor did to cope with the experience
- Believe healing is possible
- Be willing to witness great pain
- Give the survivor the power and control – she is the expert regarding her own situation
- Respect gender requests and respect personal space
- Don't encourage the survivor to confront and/or forgive her abuser - this is an individual choice to be made by the survivor when she is ready
- Check for drug/alcohol problems, eating disorders, etc. - dysfunctional coping mechanisms are no longer necessary after the abuse has stopped
- Take care of yourself (so you can be an effective support person)!

TEEN POWER AND CONTROL WHEEL



Produced and distributed by:

Developed from:
Domestic Abuse Intervention Project
202 East Superior Street
Duluth, MN 55802
218.722.4134

NATIONAL CENTER
on Domestic and Sexual Violence
training · consulting · advocacy
4612 Shoal Creek Blvd. · Austin, Texas 78756
512.407.9020 (phone and fax) · www.ncdsv.org

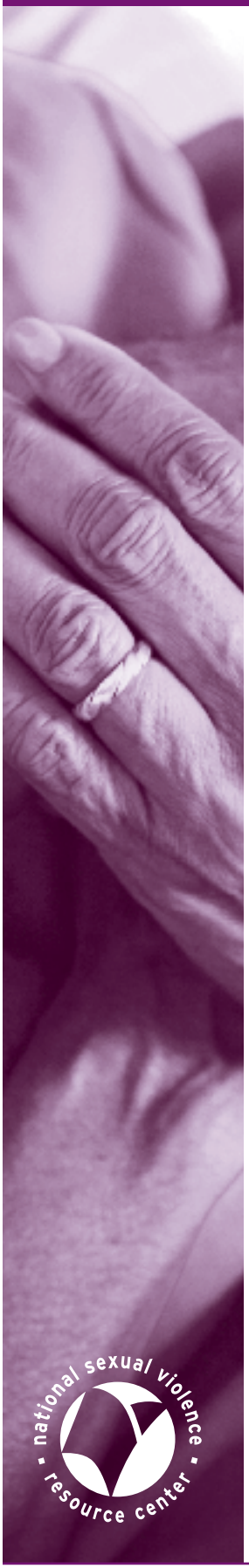


Elder Population

6. Page 324 *

SEXUAL VIOLENCE IN LATER LIFE

Fact Sheet



Sexual violence can affect individuals across the lifespan, including people in later life. Many older victims have survived multiple victimizations over the course of their lives. Recognition of sexual violence against people in later life is hindered by misconceptions that older adults are not sexual beings or sexually desirable and that rape is a crime of passion.

A high percentage of victims experience significant health problems and disabilities that increase vulnerability and reduce help seeking (Eckert & Sugar, 2008; Teaster & Roberto, 2004). Advanced age does not protect one from sexual assault, but rather increases risk in many ways.

The National Center on Elder Abuse (2007) defines sexual abuse as "non-consenting sexual contact of any kind" including unwanted touching; sexual assault or battery, such as rape, sodomy, and coerced nudity; sexually explicit photographing; and sexual contact with any person incapable of giving consent. Jurisdictions and agencies define "elder" differently but typically as commencing at age 60 or 65.[1]

Injuries

Due to age-related physiological changes, older victims tend to sustain more serious physical and psychosocial injuries during an assault than younger victims. Some of the signs and symptoms of sexual violence against people in later life include:

- Genital injuries, human bite marks, imprint injuries, and bruising on thighs, buttocks, breasts, face, neck, and other areas
- Fear, anxiety, mistrust, and dramatic changes in victims' behavior
- Eyewitness reports and disclosures by victims
- Observed suspicious behavior of perpetrators by others

Barriers to response and prevention

It is likely that sexual violence against people in later life is highly underreported. Many barriers impede the effective response and prevention of sexual abuse against older victims including:

- Social stigma and barriers preventing individuals from discussing sexual activities or sexual violence openly
- Disabling conditions that interfere with making reports
- Victim's fear of further harm
- Victim's reluctance to report, especially if perpetrator is a family member
- Misinterpretation of disclosure as part of dementia and of physical evidence as "normal" markings on an older body (Burgess & Clements, 2006)
- Delayed medical and police assistance and contamination of physical evidence

[1] Various jurisdictions and agencies define the "elder" portion of life differently, but typically as commencing at age 60 or 65. In contrast, the National Clearinghouse on Abuse in Later Life (NCALL) considers older victims to be those over age 50.

Victims

- Most identified older victims are female; however male victims have been reported in almost every study (Burgess, Ramsey-Klawsnik, & Gregorian, 2008; Ramsey-Klawsnik, Teaster, Mendiondo, Marcum, & Abner, 2008).
- In addition, genital injuries occur with more frequency and severity in post-menopausal women than younger rape victims (Poulos & Sheridan, 2008).
- Older victims are also more likely to be admitted to a hospital following assault (Eckert & Sugar, 2008).
- Victims, ranging from age 60 to 100, experienced psychosocial trauma whether or not they could discuss the sexual assault. There was no significant difference between those with and without dementia in post-abuse distress symptoms (Burgess et al., 2008).

Perpetrators

- Perpetrators of sexual violence against people in later life span a wide range in age and can be juveniles as well as other older adults (Burgess et al., 2008).
- Most perpetrators of sexual abuse against people in later life have special access to victims as family members, intimate partners, fellow residents, or care providers.
- Most identified offenders are male, however, female offenders have also been identified (Burgess et al., 2008; Ramsey-Klawsnik et al., 2008).
- Persons who sexually offend older adults within their families exhibit characteristics of mental illness, substance abuse, domineering or sadistic personalities, sexual deviancy, and sexist views of wives as property (Ramsey-Klawsnik, 2003).
- Sexual offenders who are older adults are typically not held accountable. National Institute for Justice Research demonstrated that the older a victim, the less likely the offender was found guilty. (Schofield, 2006).

For more information on how you can work to address and prevent sexual violence against people in later life, please contact your state, territory, or tribal coalition against sexual assault and/or the National Sexual Violence Resource Center (resources@nsvrc.org, 877-739-3895, http://www.nsvrc.org).

This fact sheet was developed by Holly Ramsey-Klawsnik, Ph.D., and is part of a Sexual Violence in Later Life Information Packet.

Resources

Burgess, A., & Clements, P. (2006). Information processing of sexual abuse in elders. *Journal of Forensic Nursing*, 2, 113 – 120.

Burgess, A., Ramsey-Klawsnik, H., & Gregorian, S. (2008). Comparing routes of reporting in elder sexual abuse cases. *Journal of Elder Abuse & Neglect*, 20, 336 – 352. doi:10.1080/08946560802359250

Eckert, L., & Sugar, N. (2008). Older victims of sexual assault: An under-recognized population. *American Journal of Obstetrics & Gynecology*, 198, 688.e1 – 688.e7. doi:10.1016/j.ajog.2008.03.021

National Center on Elder Abuse. (2007). *Major types of elder abuse*. Retrieved from: http://www.ncea.aoa.gov/NCEAroot/Main_Site/FAQ/Basics/Types_Of_Abuse.aspx

Poulos, C., & Sheridan, D. (2008). Genital injuries in post-menopausal women after sexual assault. *Journal of Elder Abuse & Neglect*, 20, 323 – 335. doi:10.1080/08946560802359243

Ramsey-Klawsnik, H. (2003). Elder sexual abuse within the family. *Journal of Elder Abuse & Neglect*, 15, 43 – 58. doi:10.1300/J084v15n01_04

Ramsey-Klawsnik, H., Teaster, P., Mendiondo, M., Marcum, J., & Abner, E. (2008). Sexual predators who target elders: Findings from the first national study of sexual abuse in care facilities. *Journal of Elder Abuse & Neglect*, 20, 353 – 376. doi:10.1080/08946560802359375

Schofield, R. (2006). Office of Justice Programs focuses on studying and preventing elder abuse. *Journal of Forensic Nursing*, 2, 150 – 153.

Teaster, P.B., & Roberto, K.A. (2004). The sexual abuse of older adults: APS cases and outcomes. *The Gerontologist*, 44, 788-796. doi:10.1093/geront/44.6.788

This document was supported by Cooperative Agreement #1VF1CE001751-01 from the Centers for Disease Control and Prevention.

© 2010 National Sexual Violence Resource Center. All rights reserved.



Stalking

Stalking resource center

stalking fact sheet

THE NATIONAL CENTER FOR Victims of Crime

WHAT IS STALKING?

While legal definitions of stalking vary from one jurisdiction to another, a good working definition of stalking is *a course of conduct directed at a specific person that would cause a reasonable person to feel fear*.

STALKING VICTIMIZATION

- 6.6 million people are stalked in one year in the United States.
- 1 in 6 women and 1 in 19 men have experienced stalking victimization at some point during their lifetime in which they felt very fearful or believed that they or someone close to them would be harmed or killed.

  Using a less conservative definition of stalking, which considers any amount of fear (i.e., a little fearful, somewhat fearful, or very fearful), 1 in 4 women and 1 in 13 men reported being a victim of stalking in their lifetime.
- The majority of stalking victims are stalked by someone they know. 66% of female victims and 41% of male victims of stalking are stalked by a current or former intimate partner.
- More than half of female victims and more than 1/3 of male victims of stalking indicated that they were stalked before the age of 25.
- About 1 in 5 female victims and 1 in 14 male victims experienced stalking between the ages of 11 and 17.

  [Michele C. Black et al., "The National Intimate Partner and Sexual Violence Survey: 2010 Summary Report," (Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2011).]
- 46% of stalking victims experience at least one unwanted contact per week.
- 11% of stalking victims have been stalked for 5 years or more.

  [Katrina Baum et al., "Stalking Victimization in the United States," (Washington, DC: Bureau of Justice Statistics, 2009).]

STALKING AND INTIMATE PARTNER FEMICIDE

- 76% of intimate partner femicide victims have been stalked by their intimate partner.
- 67% had been physically abused by their intimate partner.
- 89% of femicide victims who had been physically assaulted had also been stalked in the 12 months before their murder.
- 79% of abused femicide victims reported being stalked during the same period that they were abused.
- 54% of femicide victims reported stalking to police before they were killed by their stalkers.

  [Judith McFarlane et al., "Stalking and Intimate Partner Femicide," *Homicide Studies* 3, no. 4 (1999).]

RECON STUDY OF STALKERS

- 2/3 of stalkers pursue their victims at least once per week, many daily, using more than one method.
- 78% of stalkers use more than one means of approach.
- Weapons are used to harm or threaten victims in 1 out of 5 cases.
- Almost 1/3 of stalkers have stalked before.
- Intimate partner stalkers frequently approach their targets, and their behaviors escalate quickly.

  [Kris Mohandie et al.,"The RECON Typology of Stalking: Reliability and Validity Based upon a Large Sample of North American Stalkers," *Journal of Forensic Sciences,* 51, no. 1 (2006).]

IMPACT OF STALKING ON VICTIMS

- 46% of stalking victims fear not knowing what will happen next.
- 29% of stalking victims fear the stalking will never stop.
- 1 in 8 employed stalking victims lose time from work as a result of their victimization and more than half lose 5 days of work or more.
- 1 in 7 stalking victims move as a result of their victimization.

  [Baum et al.]
- The prevalence of anxiety, insomnia, social dysfunction, and severe depression is much higher among stalking victims than the general population, especially if the stalking involves being followed or having one's property destroyed.

  [Eric Blauuw et al., "The Toll of Stalking," *Journal of Interpersonal Violence,* 17, no. 1 (2002):50-63.]

STALKING LAWS

- Stalking is a crime under the laws of 50 states, the District of Columbia, the U.S. Territories, and the Federal government.
- Less than 1/3 of states classify stalking as a felony upon first offense.
- More than 1/2 of states classify stalking as a felony upon second or subsequent offense or when the crime involves aggravating factors.
- Aggravating factors may include: possession of a deadly weapon, violation of a court order or condition of probation/parole, victim under 16 years, or same victim as prior occasions.

  For a compilation of state, tribal, and federal laws visit www.victimsofcrime.org/src.

Last updated August 2012

THE STALKING RESOURCE CENTER

The mission of the Stalking Resource Center is to enhance the ability of professionals, organizations, and systems to effectively respond to stalking. The Stalking Resource Center envisions a future in which the criminal justice system and its many allied community partners will effectively collaborate and respond to stalking, improve victim safety and well-being, and hold offenders accountable. Visit us online at *www.victimsofcrime.org/src*. Contact us at 202-467-8700 or *src@ncvc.org*.

This document may be reproduced only in its entirety. Any alterations must be approved by the Stalking Resource Center.

This document was developed under grant number 2008-TA-AX-K017 from the Office on Violence Against Women (OVW) of the U.S. Department of Justice. The opinions and views expressed in this document are those of the author(s) and do not necessarily represent the official position of the Office on Violence Against Women of the U.S. Department of Justice. For more information on the U.S. Department of Justice Office on Violence Against Women visit http://www.ovw.usdoj.gov.

STALKING: KNOW IT. NAME IT. STOP IT.

Stalking Response Tips

for Victim Advocates

Did You Know?

Stalking is a dangerous crime that affects an estimated 6.6 million women and men each year. Stalking—generally defined as a course of conduct directed at a specific person that would cause a reasonable person to feel fear—is a crime under the laws of all 50 states, the District of Columbia, the U.S. territories, and the federal government. Stalking can have devastating and long-lasting physical, emotional, and psychological effects on victims. The prevalence of anxiety, insomnia, social dysfunction, and severe depression is much higher among stalking victims than in the general population. Victim advocates can help victims devise a safety plan, navigate the criminal justice system, assert their rights as crime victims, and obtain the services and support they need and to which they are entitled.

How Victim Advocates Can Help

1. Recognize that stalking is a pattern of conduct, and a stalking victim's level of fear and need may vary and change based on the stalker's behaviors.
2. Realize that stalking victims may maintain contact with their offenders to keep themselves (or loved ones) safe. Work with victims to establish safety plans.
3. Collaborate with others in your community, such as law enforcement, prosecutors, and community corrections, to help protect victims of stalking. Health care providers and members of faith communities also can be vital resources.
4. Work with law enforcement, prosecutors, and others to educate victims about the ongoing dynamics of stalking cases and what evidence and documentation may be required if they choose to report to the police.
5. Receive as much training as possible on this issue so you can be a leader and resource on stalking in your agency and community.

For More Information

National Stalking Awareness Month
http://stalkingawarenessmonth.org/

THE NATIONAL CENTER FOR Victims of Crime

Stalking Resource Center
www.victimsofcrime.org/src

Stalking resource center

This project was supported by Grant No. 2008-TA-AX-K017 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication/program/exhibition are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.



Drug Facilitated

From the Sexual Assault Response Network of Central Ohio, OhioHealth's Survivor Advocacy Manual January, 2013

Drug Facilitated Sexual Assault [ii]

Definition:
Sexual assault facilitated by the offender's use of an "anesthesia-type" drug which when administered to the victim (stealthily or not) rendered the victim "physically incapacitated or helpless," and thus incapable of giving or not giving consent. These victims are usually unconscious during their sexual assault and have anterograde amnesia upon gaining consciousness, similar to the effects of a surgery patient coming out of anesthesia.

Law enforcement, healthcare providers, and rape crisis personnel should look for various clues. Depending on the type of drug administered, i.e., GHB, Rohypnol, or some other legal or illegal sedative, barbiturate etc., the victim of a drug-facilitated sexual assault may exhibit signs of confusion, memory loss, dizziness, drowsiness, impaired motor skills, impaired judgment, reduced inhibition, slurred speech, or a variety of other symptoms.

The following is an overview of some of the drugs used by perpetrators to assist them in committing sexual assaults. At the present time, Rohypnol and GHB are the "drugs of choice" and the most widely publicized. There are numerous other drugs, however, which produce similar anesthetic effects that are also being used to facilitate sexual assaults. Many of these other drugs are legally available in the United States and should not be overlooked. The most common of these "other" substances is alcohol.

The Prevalence of Sexual Assault and Alcohol-Involved Sexual Assault [iii]
The prevalence of sexual assault, both involving and not involving alcohol use cannot be accurately determined, because it is usually unreported. Although alcohol consumption and sexual assault frequently co-occur, this phenomenon does not prove that alcohol use causes sexual assault. Thus, in some cases, the desire to commit a sexual assault may actually cause alcohol consumption (e.g., when a man drinks alcohol before committing a sexual assault in order to justify his behavior). Moreover, certain factors may lead to both alcohol consumption and sexual assault. For example, some fraternities encourage both heavy drinking and sexual exploitation of women (Abbey et al. 1996*b*). In fact, many pathways can prompt a man to commit sexual assault, and not all perpetrators are motivated by the same factors (Seto and Barbaree 1997). Heavy drinkers may routinely use intoxication as an excuse for engaging in socially unacceptable behavior, including sexual assault (Abbey et al. 1996*b*). Also, certain personality characteristics (e.g., impulsivity and antisocial behavior) may increase men's propensity both to drink heavily and to commit sexual assault (Seto and Barbaree 1997).

Certain alcohol expectancies have also been linked to sexual assault. For example, alcohol is commonly viewed as an aphrodisiac that increases sexual desire and capacity (Crowe and George 1989). Many men expect to feel more powerful, disinhibited, and aggressive after drinking alcohol. In turn, drinking in potential sexual situations increases women's risk of being sexually assaulted, both because sexually assaultive men may view them as easy targets and because the women may be less able to resist effectively. In fact, some studies indicate that completed rapes (as opposed to attempted rapes) are more common among intoxicated victims than among sober victims, suggesting that intoxicated women are less able than sober women to resist an assault effectively (Abbey et al. 1996*b*; Harrington and Leitenberg 1994).

Rohypnol: Rohypnol is the trade name for flunitrazepam, a central nervous system depressant and a member of the benzodiazepine family of drugs. It is related to Valium, another benzodiazepine, but is ten times more potent than Valium. Hoffman-LaRoche, Inc., a Swiss pharmaceutical company, manufactures Rohypnol. It is illegal to manufacture, import, and sell Rohypnol in the United States. It is currently a Schedule IV drug under the Federal Controlled Substances Act of 1970 with Schedule I penalties for illegal possession, importation, or distribution in the United States. Rohypnol is legally available in more than 70 countries worldwide, including several in Asia, Europe, and Latin America, where it is used as a sleeping pill and a pre-anesthetic. The drug is usually smuggled into the U.S. from a large number of countries, especially Mexico and Columbia, through mail and delivery services and by individuals who bring it across the border.

Street Names for Rohypnol:

- Ruffies or Roofies
- Roche or LaRoche
- Roachies
- The Forget Pill
- Rib
- Mexican Valium
- R-2
- Rope, Ropies or Roopies

The effects of Rohypnol can occur within 15-30 minutes after ingestion and last up to eight hours or more depending on the dosage. The typical dose often used in drug-facilitated rapes is a one to two milligram tablet. The tablet is usually white, round, and smaller than an aspirin tablet. The drug's effects are increased when combined with alcohol and can be fatal.

Hoffman-LaRoche has reformulated Rohypnol so that when it is placed in a drink, the drink will turn blue. The reformulated tablets are approved in twenty countries and have been marketed in Mexico since February 1999. However, the old non-colored tablets and non-colored counterfeit tablets are still being used. Therefore, some tablets may still be odorless, tasteless, and colorless when it is dissolves in

liquid. Rohypnol can be purchased for approximately 50 cents to $2.00 per tablet.

The Effects of Rohypnol and Other Benzodiazepines Include:

- Sedation
- Dizziness
- Motor in-coordination
- Muscle relaxation
- Slurred speech
- Memory impairment
- Impaired judgment
- Loss of inhibitions
- Loss of consciousness
- Visual disturbances
- Nausea
- Excitability or aggressive behavior in some cases

GHB: Gamma hydroxy butyrate (GHB) is a central nervous system depressant that, while not a controlled substance, is not approved for medical use in the United States. The FDA has issued advisories in 1990 and 1997 declaring GHB unsafe and illicit, except for use under FDA-approved physician supervised protocols. In other countries, GHB is used legally as an adjunct to anesthesia. It is used illegally in the U.S. and elsewhere for its ability to produce intoxication and euphoric effects.

GHB is usually a street manufactured drug, commonly found at nightclubs, underground RAVE parties, and used by body builders for its purported anabolic effects. However, the use of GHB and Rohypnol in sexual assaults has not been limited to adolescents and college students; men and women of all ages use it. Because GHB is not commercially available in the U.S., most GHB is homemade. Information on the ingredients for GHB, how to obtain the ingredients and "recipes" are available on the Internet. Its users, therefore, may not be aware of the homemade mixture's full potency or the toxicity of its ingredients.

Street Names for GHB:

- Gamma-OH
- Grievous Bodily Harm
- Georgia Home Boy
- Goop
- Liquid Ecstasy or Liquid X

GHB is often mixed with alcohol or fruit drinks to mask its salty taste. When combined with alcohol or taken in large doses, GHB can result in coma and even death. The typical dose is one to five grams. The effects occur within 15-30 minutes and last three to six hours, depending on the dosage. GHB is most commonly found in liquid form in small bottles or vials. Plastic sports bottles or spring water bottles and small Visine eye-drop containers are most often associated with its use. GHB is sold at bars and RAVE parties for about $10.00 per capful or "swig."

The Effects of GHB Include:

- Loss of consciousness
- Memory impairment
- Confusion
- Loss of inhibitions
- Seizures
- Dizziness
- Extreme drowsiness
- Stupor
- Agitation
- Nausea
- Visual disturbances
- Severe respiratory depression
- Reduced heart rate and blood pressure
- Coma
- Death

GBL: Gamma Butyrolactone (GBL) is a central nervous system depressant and acts on the same parts of the brain as alcohol and Valium. Products containing GBL are labeled as dietary supplements and sold in liquid and powder forms. The products are sold via the Internet and in some health food stores, gyms and fitness centers. The products are promoted with claims to build muscle, improve physical performance, enhance sex, reduce stress and induce sleep. Various brand names of these products include: Renewtrient, Revivarant, Revivarant G, Blue Nitro, Blue Nitro Vitality, GH Revitalizer, Gamma G, and Remforce. GBL is also used as an ingredient in paint remover and industrial solvents.

Effects of GBL Include:

- Seizures
- Vomiting
- Slow breathing and slow heart rate
- Amnesia
- Sweating
- Muscle spasms
- Bedwetting
- Diarrhea
- Confusion
- Coma
- Death

Reducing the Risk of Drug Facilitated Sexual Assault iv

Drug Facilitated sexual assault has been occurring more frequently in recent years. Although the often tasteless drugs are hard to detect, there are precautionary steps one can take to reduce the risk of becoming prey to this criminal conduct.

- Do not leave beverages unattended.
- Do not take any beverages, including alcohol, from someone you do not know well and trust.
- At a bar or club, accept drinks only from the bartender or server.
- Pay attention to the bartender who makes your drink; try to watch them make the drink.
- At parties, do not accept open-container drinks from anyone.
- Be alert to the behavior of friends and ask them to watch out for you. Anyone appearing to be extremely intoxicated after consuming only a small amount of alcohol may be in danger.
- Share this information with friends and talk about ways to look out for each other when you are at parties and social events.
- Anyone who appears they have consumed a sedative-like substance should be taken to a hospital emergency room or should call 911 for an ambulance. Try to keep a sample of the beverage for analysis.

Signs and Recommended Actions to Take if You Think You Have Been Drugged and Sexually Assaulted

Signs That You May Have Been Drugged:

- If you remember taking a drink, but cannot recall what happened for a period of time after you consumed the drink.
- If you feel as though someone had sex with you, but you can't remember any/all of the incident.
- If you feel a lot more intoxicated than your usual response to the amount of alcohol you consumed.
- If you wake up very hung over, feeling "fuzzy," experiencing memory lapse, and can't account for a period of time.

Actions to Take:

- Get to a safe place and call a family member, friend, the police, a doctor or 911 for help in getting to a hospital.
- Determine whether or not to report the incident to the police.
- Go to an emergency department for evidence collection (if desired) and treatment of injuries, prophylactic treatment for STDs, and pregnancy prevention, as well as support services.
- Request a urine test as quickly as possible to detect the presence of sedating substances. Every hour matters. Chances of getting proof are best when the sample is obtained soon after the substance has been ingested, but depending on the substance used, the test can be reliable even on a sample obtained 72 hours later. This test will identify multiple substances, including alcohol, amphetamines, barbiturates, benzodiazepines, cocaine, Rohypnol, GHB, marijuana, opiates, etc.

Issues to Be Considered For Survivors of Drug Facilitated Sexual Assaults [v]

A sexual assault survivor who was assaulted under the influence of a sedating substance will have additional issues that are likely to affect her recovery – issues often times involving her inability to recall the incident. Because the survivor may have been heavily sedated, she may not have complete recall of the assault. It is likely that she will be uncertain about exactly what happened and who was involved. It is extremely common for survivors of sexual assault to feel guilt or shame (however unwarranted) about a sexual assault. Survivors of substance-related rape are likely to struggle with these emotions to an even greater extent. The unknowns may create tremendous anxiety as survivors are left to fill in the gaps with their imagination. This dynamic exacerbates the loss of control that most survivors must overcome in their healing process.

These and other factors not only affect the recovery process for survivors, but also affect the ways in which survivors seek help immediately after an assault.

Barriers to Getting Survivors Tested in a Timely Manner:

- So few survivors present at emergency departments
- Survivors need time to process and identify what has happened to them
- Survivors may have a loss of memory or fragmented memories
- Survivors may be groggy; they may be experiencing post-anesthesia type effects
- Survivors may feel responsible for what happened because of their alcohol and/or drug use; they may question if they will be believed
- Drugs may be out of the survivor's system by the time they present to an emergency department
- Emergency department/medical staff may miss the "red flags" and drug testing may not be offered

Reasons Why a Survivor May Not Want to be Tested:

- Survivor's recreational drug use or concern about disclosing a medical condition (for which they take medication) that they were keeping private
- Cost of drug testing (if not covered in evidence collection)
- Results of tests will become part of the survivor's medical record and/or police record, which could potentially be used against them if their case goes to court
- If the survivor is a minor: parental notification and/or underage drinking could be possible concerns

Reasons Why Test Results May be Negative:

- The amount of time that elapsed from the ingestion of the drug until the survivor was tested
- The rate of survivor's metabolism
- The survivor may have urinated or vomited thus eliminating some of the evidence
- The amount of drug used

Remember, if the test results are negative, it does not necessarily mean that the survivor was not drugged. Survivor's symptoms are important to document as well as taking physical evidence. This information can be used in a potential court case.

Issues That Can Complicate Survivor Reactions:

- Not only is the survivor dealing with their sexual assault, but also with the lack of memory of what happened to them
- Fear of the unknown; survivor may never know what really happened to them (e.g., knowledge of perpetrator's condom use, perpetrator's STD and HIV/AIDS status, gender of perpetrator, number of perpetrators, identity of perpetrator, where and how they were violated, etc.)
- Were videos or photographs taken
- Were survivor's personal items taken
- Having to contact friends/family and asking humiliating questions to try to piece together what happened to them
- Will the survivor be able to effectively testify if the case makes it to trial
- The feeling of "loss of control" may be intensified
- Undirected anger if the survivor does not know who the perpetrator is
- Feelings that because of all of the "unknowns" the survivor can never truly deal with the assault and consequently will never recover from it

ii Adapted from "The Prosecution of Rohypnol and GHB Related Sexual Assaults," by the American Prosecutors Research Institute – Violence Against Women Program, 1999

iii "Alcohol and Sexual Assault", Antonia Abbey, Ph.D. et al, *Alcohol Research and Health*, Vol. 25 No.1, 2001.

iv Adapted from materials by the DC Rape Crisis Center

v Information taken from conference materials, "A Seminar on Drug-Facilitated Rape," presented by The Forensic Science Institute of Ohio and The Ohio State University Medical Center, November 12, 1999



Human Trafficking

From the Sexual Assault Response Network of Central Ohio, OhioHealth's Survivor Advocacy Manual January, 2013

Identifying and Interacting With Victim/Survivors of Human Trafficking [xxi]

The following provides a brief background on the trafficking problem, as well as tips for identifying and assisting trafficking victims:

- Human trafficking is a form of modern-day slavery, widespread throughout the United States. While trafficking is largely a hidden social problem, many trafficking victims are in plain sight if you know what to look for.
- Trafficking is not just forced prostitution. Victims of human trafficking may also be in forced labor situations as domestic servants (nannies or maids); sweatshop workers; janitors; restaurant workers; migrant farm workers; fishery workers; hotel or tourist industry workers; and as beggars.
- As a social service organization, you can help victims of human trafficking get the safety, protection and resources they need. You may be the only outsider with the opportunity to speak with a victim. There are housing, health, immigration, food, income, employment and legal services available to victims, but first they must be found.

Victim Identification

A victim of trafficking may look like many of the people you help every day. You can help victims of trafficking get the assistance they need by looking beneath the surface for the following clues:

- Evidence of being controlled
- Evidence of an inability to move or leave job
- Bruises or other signs of battering
- Fear or depression
- Non-English speaking
- Recently brought to this country from Eastern Europe, Asia, Latin America, Canada, Africa or India
- Lack of passport, immigration or identification documentation

Traffickers use various techniques to keep victims enslaved. Some traffickers keep their victims under lock and key. However, the more frequent practice is to use less obvious techniques including:

- Debt bondage – financial obligations, honor-bound to satisfy debt
- Isolation from the public – limiting contact with outsiders and making sure that any contact is monitored or superficial in nature
- Isolation from family members and members of their ethnic and religious community
- Confiscation of passports, visas and/or identification documents
- Use or threat of violence toward victims and/or families of victims
- The threat of shaming victims by exposing circumstances to family

- Telling victims they will be imprisoned or deported for immigration violations if they contact authorities
- Control of the victims' money, e.g., holding their money for "safe-keeping"

The result of such techniques is to instill fear in victims. The victims' isolation is further exacerbated because many do not speak English and are from countries where law enforcement is corrupt and feared.

Victim Interaction

- Asking the right questions may help you determine if someone is a victim of human trafficking. It is important to talk to a potential victim in a safe and confidential environment. If the victim is accompanied by someone who seems controlling, you should try to separate the victim from that person. The accompanying person could very well be the trafficker.
- You should also enlist the help of a staff member who speaks the potential victim's language and understands his or her culture. Although not ideal, you can enlist interpreter services such as those provided by the ATT Language Line.
- If the victim is a child, it is important to enlist the help of a social services specialist who is skilled in interviewing minor trafficking or abuse victims. Screen interpreters to ensure they do not know the victim or the traffickers and do not otherwise have conflict of interest.

Victim Assistance

- If you think you have come in contact with a victim of human trafficking, call the Trafficking Information and Referral Hotline at 1.888.3737.888. This hotline will help you determine if you have encountered victims of human trafficking, it will identify local resources available in your community to help victims, and will help you coordinate with local social service organizations to help protect and serve victims so they can begin the process of restoring their lives. For more information on human trafficking visit www.acf.hhs.gov/trafficking.
- If you think you have encountered a victim of human trafficking, it is important to collaborate among key service providers, including the Department of Health and Human Services, law enforcement and others at the local, state and Federal levels, to help the victim get the protection and services they need. Calling the Trafficking Information and Referral Hotline will provide important guidance on enlisting these support services.
- Under the Trafficking Victims Protection Act of 2000, victims of human trafficking in the U.S. who are non-citizens may be eligible for a special visa and comprehensive benefits and services. Victims who are U.S. citizens are already eligible to receive many of these benefits.

Screening Tool for Victims of Human Trafficking

The following are sample questions social service organizations can ask in screening an individual to determine if she is a potential victim of human trafficking. As with domestic violence victims, if you think a person is a victim of trafficking, you do not want to begin by asking directly if the person has been beaten or held against her will. Instead, you want to start at the edges of her experience. And if possible, you should enlist the help of a staff member who speaks the person's language and understands the person's culture, keeping in mind that any questioning should be done confidentially. You should screen interpreters to ensure they do not know the victim or the

traffickers and do not otherwise have a conflict of interest.

Before you ask the person any sensitive questions, try to get the person alone if they came to you accompanied by someone who could be a trafficker posing as a spouse, other family member or employer. However, when requesting time alone, you should do so in a manner that does not raise suspicions.

Suggested Screening Questions

- Can you leave your job or situation if you want?
- Can you come and go as you please?
- Have you been threatened if you try to leave?
- Have you been physically harmed in any way?
- What are your working or living conditions like?
- Where do you sleep and eat?
- Do you sleep in a bed, on a cot or on the floor?
- Have you ever been deprived of food, water, sleep or medical care?
- Do you have to ask permission to eat, sleep or go to the bathroom?
- Are there locks on your doors and windows so you cannot get out?
- Has anyone threatened your family?
- Has your identification or documentation been taken from you?
- Is anyone forcing you to do anything that you do not want to do?

The Mindset of a Human Trafficking Victim

When interacting with and providing assistance to potential trafficking victims, it is important to understand their mindset so you can provide them the best service and help them begin the process of restoring their lives.

- Many trafficking victims do not speak English and do not understand American culture. Preying upon the poor and destitute from countries in Eastern Europe, Asia, Latin America and Africa, traffickers lure their victims into the United States with promises of marriage, or a good job so they can provide for their families back home, and a better life.
- These promises and dreams quickly turn to nightmares as victims find themselves trapped in the sex industry, the service industry, in sweatshops or in agricultural fields – living daily with inhumane treatment, physical and mental abuse, and threats to themselves or their families back home. Sometimes victims do not even know what city or country they are in because they are moved frequently to escape detection.
- Victims of trafficking have a fear or distrust of the government and police because they are afraid of being deported or because they come from countries where law enforcement is corrupt and feared. Sometimes they feel that it is their fault that they are in this situation. As a coping or survival skill, they may even develop loyalties and positive feelings toward their trafficker or try to protect them from authorities.
- Confidentiality is vital for victims of trafficking. Their lives and the lives of their families are often at great risk if they try to escape their servitude or initiate criminal investigations against their captors. Therefore, it is imperative that you minimize the number of staff members who

come in contact with the victim. Ensure that all staff members who have contact with the victim, including interpreters and advocates; understand the importance of confidentiality for the safety of the person.

- Many victims do not self-identify as victims. They also do not see themselves as people who are homeless or drug addicts who rely on shelters or assistance. Victims may not appear to need social services because they have a place to live, food to eat, medical care and what they think is a paying job.

Messages for Communicating With Victims of Human Trafficking

Most victims of trafficking experience intense fear – of their traffickers and of being deported. Therefore, when interacting with potential trafficking victims, it is important to reassure them that they are safe so you can begin the process of helping them get the protection and assistance they need to rebuild their lives safely in the United States. Gaining the trust of human trafficking victims is an important first step in providing assistance.

Sample messages you can use to help gain this trust include:

- We are here to help you.
- Our first priority is your safety.
- Under the Trafficking Victims Protection Act of 2000, victims of trafficking can apply for special visas or could receive other forms of immigration relief.
- We will give you the medical care that you need.
- We can find you a safe place to stay.
- You have a right to live without being abused.
- You deserve the chance to become self-sufficient and independent.
- We can help get you what you need.
- We can help to protect your family.
- You can trust me.
- We want to make sure what happened to you doesn't happen to anyone else.
- You have rights.
- You are entitled to assistance. We can help you get assistance.

To Report Tips or Transfer a Caller: Central Ohio Rescue and Restore Coalition Human Trafficking Hotline **614.285.4357(HELP)**

xxi Adapted from The U/S Department of Health and Human Services

Ohio Alliance to End Sexual Violence
Phone: 216-658-1381 / 888-886-8388 Email: info@oaesv.org

U Visa and T Visa Fact Sheet

What are U and T visas?

U and T visas are visas for non-citizen victims of certain crimes (including sexual assault and human trafficking crimes) that allow the victim to remain legally in the U.S. for up to four years, and in some cases, to obtain permanent residence. Both visas are designed to strengthen the ability of law enforcement agencies to investigate and prosecute perpetrators of these crimes, while at the same time protecting victims.

The U and T visas were created as part of the Victims of Trafficking and Violence Protection Act (included in the Battered Immigrant Women's Protection Act) in October 2000.

How do you apply for these visas?

The process is complex and not designed to be completed without an immigration attorney's guidance. **See page 2** of this fact sheet for information about non-profit organizations that provide free or low-cost assistance to individuals seeking to apply for a U or T visa.

Summary of U and T Visa Requirements

	U Visa	T Visa
Who is eligible	• Non-citizen victim of crime who has suffered severe mental or physical abuse as the result of a criminal activity*; AND • A law enforcement agency or other qualifying agency, including a judge has certified that the victim has cooperated with law enforcement or is willing to in the future in an investigation or prosecution; AND • The victim has information concerning the criminal activity (or if a minor under 16, a parent/next friend has information); AND • The criminal act violated U.S. law or occurred in the U.S. or its territories/possessions. **If the perpetrator of the crime is a spouse or parent, or is a lawful U.S. citizen or resident, the victim may also be eligible for assistance under a VAWA case.*	• Non-citizen victim of severe human trafficking; AND • The victim would face extreme hardship if forced to leave the United States; AND • Victim is willing to assist law enforcement in prosecuting the perpetrator(s). (This requirement may be waived if the victim is under 18, or if the victim is unable to cooperate due to physical or psychological trauma.)
Crimes covered	Crimes covered by the Section 1513(b)(3), INA Section 101(a)(15)(U)(iii) include:	To be eligible for a T visa, the victim must have suffered a "severe form of human trafficking" classified under one of the following categories: • **Sex trafficking** – The victim is forced, tricked, or coerced into selling sex acts for money or anything of value. (Forced or coerced prostitution.) If the victim is under 18 years of age, the law assumes that the victim was forced, tricked, or coerced. • **Trafficking that leads to debt bondage/peonage** – A victim is forced to work indefinitely (without any reasonable limits on services or time) to pay off the person who smuggled her into the United States. Typically the victim does not have access to information showing how much they have paid to date and what the remaining balance is. • **Trafficking that leads to involuntary servitude/slavery/ forced labor** –When a trafficker uses threats or physical force to make the

	· Rape · Torture · Trafficking · Incest · Domestic violence · Sexual assault · Abusive sexual contact · Prostitution · Sexual exploitation · Female genital mutilation · Being held hostage, peonage · Involuntary servitude · Slave trade · Restraint	· Kidnapping · Abduction · Unlawful criminal · False imprisonment · Blackmail · Extortion · Manslaughter · Murder · Felonious assault · Witness tampering · Obstruction of justice · Perjury, · *or* any similar activity in violation of federal, state, or local criminal law.	victim work. Threats can be physical harm or threats to report the victim to police or immigration.
	U Visa		**T Visa**
Length of visa	Recipients of a U-visa can stay in the U.S. for four years. After three years in the U.S., recipients are eligible to apply for lawful permanent residence (also called a "green card").		Recipients of the T-visa may stay in the United States for four years. Recipients may apply for permanent residence (a "green card"), but there are several requirements that must be met.
Family eligibility	Spouses, children, and parents of children under 16 are also eligible for a non-citizen U Visa. To be eligible, you must show that (1) the visa is necessary to avoid extreme hardship; or (2) a government official must certify that an investigation or prosecution would suffer without the assistance of the spouse, child, or parent of non-immigrant child. In some cases, a family member may qualify for their own U visa as an indirect victim of the crime.		If the victim is **under 21** years old, the following family members are also eligible for a visa: • Spouse; • Unmarried children under 21 years of age; • Parents; and/or • Unmarried sisters or brothers under 18. If the victim is **21 or older**, the following are eligible: • Spouse; and/or • Unmarried children under the age of 21.
Work eligibility	All U-visa recipients automatically receive a work permit after their visa is approved (if you applied within the U.S.). If you applied from abroad, you will be eligible for a work permit when you enter the U.S. Spouses, children and parents may also in some cases be eligible for a work permit.		All T-visa recipients automatically receive an employment authorization document (EAD), which allows the victim to work legally while in the United States.
Immigration Status	No immigration status is required. Victims can be undocumented or have a different type of visa and still be eligible for a U visa.		No immigration status is required. Victims can be undocumented or have a different type of visa and still be eligible for a T visa.

Ohio Resources:

Catholic Social Services of the Miami Valley – *Provides a range of refugee resettlement services.*
Phone: (937) 223-7217 • Website: http://www.cssmv.org

Catholic Charities of Southwest Ohio – *Services for refugees as well as asylees, secondary migration refugees and others.*
Phone: (513) 241-7745 • Website: http://www.catholiccharitiesswo.org/

Community Refugee and Immigration Services (Columbus) - *Provides professional immigration legal services to low- and moderate-income individuals at nominal fees.*
Phone: 614-235-5747 •Web: www.cris-ohio.com

International Institute of Akron – *Immigration counselors are accredited by the U.S. Department of Justice to represent clients before the U.S. Citizenship & Immigration Services (formally INS).*
Phone: 330-376-5106 • Web: www.iiakron.org

International Institute of Greater Toledo – *Immigration, citizenship, green cards, work permits, translation services, & more.*
Phone: (419) 241-9178 • Website: http://www.internationalinstituteoftoledo.com/

International Services Center (Cleveland) – *Provides a range of legal immigration services, including immigration counseling and representation before the CIS office, Immigration Court and Board of Immigration Appeals. Assists with immigrant visa petitions, asylum, victims of crime and domestic violence cases, citizenship preparation, and more.*
Phone: (216) 781-4560 • Website: http://internationalservicescenter.org/

Ohio Legal Services – *Statewide offices provide assistance with visas, deportation issues, and green cards.*
Phone: 1-866-529-6446 • Website: http://www.ohiolegalservices.org/

Ohio Refugee Services Program – *In addition to serving refugees and asylees, the program also serves victims of trafficking.*
Phone: 614-466-4815 •Web: http://jfs.ohio.gov/refugee/

This publication was supported in part by Grant # 2012-SW-AX-0002 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication/program/exhibition are those of the authors and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.



PREA

PREA & Working with Incarcerated Survivors
A Factsheet for Rape Crisis Advocates

Sexual Victimization of Incarcerated Individuals

It is widely accepted that sexual assault within correctional facilities is chronic and widespread; however, it is difficult to accurately measure the extent of the problem due to a lack of comprehensive research and underreporting. Incarcerated survivors often feel reluctant to report sexual assault due to shame, fear of exposure, fear of not being believed, fear of retaliation by the assailant, and fear of being targeted for future violence by others in the facility, among other concerns. A few statistics about prison rape:

- In a study of correctional facilities in the Midwest, approximately 1 in 10 males reported rape, and as many as 27% of females reported rape.[1]
- An estimated 9.6% of former state prisoners reported one or more incidents of sexual victimization during the most recent period of confinement in jail (1.8%), prison (7.5%) or a post-release community facility (0.1%). 5.4% reported an incident involving another inmate, while 5.3% reported an incident involving facility staff.[2]

Prison Rape Elimination Act

The Prison Rape Elimination Act (PREA) was passed by Congress in 2003 to address the chronic problem of sexual violence suffered by incarcerated individuals. The law created the National Prison Rape Elimination Commission (NPREC) and charged it with developing standards for the elimination of sexual abuse in four kinds of facilities: adult prisons and jails, lockups, community confinement facilities, and juvenile facilities. The law required the Department of Justice (DOJ) to review the NPREC standards, make revisions as necessary, and pass the final standards into law. The final rule was published on June 20, 2012, and became effective on August 20, 2012. PREA standards require confinement facilities to prevent, detect, and respond to sexual abuse through the creation and implementation of new and revised policies, practices, procedures, and professional partnerships.

The Role of the Rape Crisis Advocate

As part of meeting the requirements of PREA, confinement and correctional facilities are beginning to approach rape crisis centers in the community for collaboration. While corrections staff understand the culture of confinement, most do not understand the trauma of sexual assault. Rape crisis advocates can assist corrections staff in a variety of ways, including any or all of the following:

- Training corrections staff about the trauma of sexual assault
- Providing advocacy and support to inmate-survivors during forensic exams in community hospitals
- Providing advocacy and support to inmate-survivors within correctional facilities
- Leading support groups for inmate-survivors within correctional facilities
- Speaking with inmate-survivors via the crisis hotline

[1] *Stop Prisoner Rape (2006)*
[2] *U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics: "National Former Prisoner Survey: Sexual Victimization Reported by Former State Prisoners, 2008"*

Personal, Ethical and Practical Considerations

Most rape crisis advocates are not accustomed to working with incarcerated survivors, particular male survivors within correctional or confinement facilities. The thought of providing advocacy to this population may seem both simple and daunting to many advocates. A few things advocates should carefully think through and prepare for prior to serving incarcerated survivors include:

- Personal attitudes about incarcerated individuals and the crimes they've committed.
- Any ethical dilemmas and/or sense of personal discomfort about providing support and advocacy to an inmate survivor who has perpetrated acts of violence, including sexual assault and child abuse.
- The program's capacity to meet the needs of incarcerated survivors in addition to survivors from the community. Considerations include staffing/volunteer levels, travel, and funding restrictions.

Working Within the Prison Environment

More than any other site an advocate visits, correctional and confinement facilities prioritize order and safety. This priority impacts every activity that occurs within the facility, including rape crisis advocacy and/or support groups. Advocates who visit a prison or other correctional facility can expect the following restrictions and security measures, among others:

- Professional visitors often must be approved or cleared by facility staff prior to providing services.
- Many correctional facilities have restrictions on what visitors can and cannot wear.
- Advocates many not be permitted to bring in purses, keys, phones, or other personal items.
- Any literature/materials the advocate wants to share with the survivor may not be permitted, or they may be subjected to inspection and approval by facility staff.
- Depending on the facility, a staff member or guard may be required to accompany the advocate at all times, including while speaking with the inmate survivor. In the hospital setting, a guard may be required to stay with the inmate survivor at all times.

Collaborating with Corrections Staff

Prior to providing any formalized advocacy or support services to incarcerated survivors in a correctional facility, it is a good idea for advocates to meet with relevant staff members in order to:

- Share information about each other's roles, expectations, capabilities, and limitations. (Formal or informal cross-training can be particularly helpful).
- Discuss security procedures, requirements and limitations within the correctional facility. This may include allowable visitation times, meeting space, and confidentiality considerations.
- Establish and nurture mutual respect and collaborative working relationships between individual advocates and facility staff members.
- If possible, it is useful if the individual correctional facility and the rape crisis program can agree to a memoranda of understanding (MOU), a document outlining the activities and expectations of both the correctional facility and the rape crisis program in terms of providing advocacy and support to incarcerated survivors.

For additional information about PREA and serving inmate survivors, please visit the National PREA Resource Center website at www.prearesourcecenter.org.

Sexual Assault
DEMONSTRATION INITIATIVE
Enhancing Sexual Assault Services

Self-Care and Trauma Work[1]

When we choose to address systems of oppression, help those who have been victimized, and hear traumatic experiences, we might become weary or emotionally changed from the weight of the work. Feelings of burnout and stress in helping professions are a result of vicarious trauma and are not only normal, but to be expected. Organizational structures that reduce vicarious trauma are critical. In addition, individually we can employ methods that fit within our culture and faith to manage our own experiences with vicarious trauma. How we manage the physical, emotional, spiritual and intellectual responses to trauma can either help or hinder our ability to continue to do this work. By learning how to recognize when the work is affecting us in a negative way, we can learn how to manage stress and overwhelming feelings in a healthy way. When we are healthy, we can bring our best self to the work every day.

What is Vicarious Trauma?

Laura Van Dernoot Lipsky (2009) describes vicarious trauma as a "trauma exposure response." In, *Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others*, she explains the cyclical nature of vicarious trauma and the ways one can take care of themselves. She describes this process as being trauma stewardship: "the entire conversation about how we come to do this work, how we are affected by it, and how we make sense of and learn from our experiences" (Lipsky, 2009, p. 6).

Other terms for vicarious trauma are: provider fatigue, compassion fatigue, and/or secondary trauma. They all refer to the same experience of having exhausted hearts, minds, bodies, and souls from helping survivors through their painful experiences.

Some signs that you might be experiencing vicarious trauma include:

- Physical symptoms, such as changes or disturbances in appetite and/or sleep patterns and chronic illness
- Starting, resuming, or increasing use of caffeine, nicotine, alcohol, or drugs as a means of coping with or numbing out from work
- Experiencing intrusive thoughts or visualizations of client stories
- Withdrawing from or becoming very dependent on others and/or disturbed intimacy needs
- Feeling anxiety or frustration with clients and coworkers
- Feeling helpless or paralyzed, or becoming very controlling and regimented
- Avoiding your work or coworkers because you are feeling overwhelmed
- Having no reaction to stories that used to affect you or that friends and family find disturbing
- Emotionally distancing yourself from work frequently
- Laughing at humor you once would have considered offensive
- Feeling less available or sympathetic to the problems of friends or family members

[1]From "Vicarious Trauma" by Pennsylvania Coalition Against Rape, 2010, *Technical Assistance Bulletin, 5*(2). Copyright 2010 by Pennsylvania Coalition Against Rape. Adapted with permission.

- Feeling as though you have less energy or interest for things that you typically enjoy

What Can We Do?
Organizations should recognize that vicarious trauma affects staff both personally and professionally. Organizations can start by developing a plan for reducing vicarious trauma. This can include having regular check-ins for debriefing; supporting the development of staff capacity in the area of vicarious trauma through resources, education and training and creating outside opportunities for staff to engage in wellness-related activities.

Individuals can begin by recognizing that being affected by this work is normal. The very nature of anti-violence work is physically and emotionally taxing. Here are some suggestions on practices that you can begin incorporating in your daily life. Remember that when you tell yourself you don't have time for any of the following, that that is exactly when you should take the time. The following practices will help you return to your work day refreshed and renewed.

Start by being present. Being present is being aware and living in the moment, rather than dissociating (numbing out) from yourself. Ways to do this vary greatly, but you can start by Developing a mindfulness practice**.** Mindfulness is a technique that helps to cultivate an intentional awareness of the present moment, and consequently, helps us to develop more skillful and creative responses to life stressors. Engaging in simple practices such as beginning each day with a handful of deep and slow breaths or quietly repeating a phrase that brings peace or grounding to you are examples of a mindfulness practice. In moments throughout the day and especially when you feel stressed or overwhelmed, try this simple and quick technique. Sit in a safe and quiet space and close your eyes or hold a soft, unfocused gaze. Inhale deeply, feeling your shoulders inch up around your neck and exhale slowly, feeling your shoulders slowly release downward. Try this a few times, each time gently noticing how your body feels in that moment. By simply having an awareness of your feeling in that moment, you can ease feelings of tension and revisit a task or project with a greater sense of calm.

Choose your involvement. This is different from the old saying, "choose your battles." Choosing your involvement in various office activities gives you control over your own happiness instead of the other way around. By giving yourself permission to opt out of harmful practices, you can free your mind and heart of the extraneous stress you didn't realize you experience on a regular basis. Choose to maintain a positive outlook. A positive attitude can be contagious, even in the face of difficulty. By putting negative energy out to the world, it perpetuates negativity instead of inspiring healing. So, when those around you begin to go to a spot of negativity, try politely excusing yourself and going to a place you feel at peace. Soon, those around you will understand that you are not going to participate and will not burden your time and energy with pessimism.

Start an organizational practice of creativity. When creativity is diminished people often feel helpless and hopeless; as if what they do is not making a difference. Therefore, stimulating and fostering creativity helps renew that sense of achievement and brightness that is vital for workplace production.

> For example, decorate your office or workspaces to reflect your personal style. Often we forget about our physical space and how colors, textures, and stimuli in our surroundings can affect our mood. By incorporating plants, artwork, and lamps, a space can be transformed into a meditative and relaxing environment for all who enter. This also helps to set the stage for those we serve to feel more at home. To get all your coworkers involved in the make-over, Have an all-staff meeting and discuss ways to decorate that

will revitalize each work space. At that meeting, encourage each staff member to paint a picture to hang on their wall or somewhere in the building. Encourage family pictures, personal mementos from vacations, and radios at low volume

Create an organizational culture that reduces vicarious trauma. When we recognize that vicarious trauma is a normal reaction to this work and that organizations have a responsibility to create an atmosphere that reduces this experience, it can create a sense of organization-wide support that can help to remove any feelings of shame or inadequacy associated with the experience of vicarious trauma.

Create a safe and comfortable work environment through the way that offices and break rooms are set up and the security that is offered. Encourage self-care, continuing education and other methods of employee empowerment. Offer or encourage outside support from counseling, health and wellness services, or an Employee Assistance Program (EAP). When considering your organizational plan to reduce vicarious trauma, consider these ideas:

- Incorporate trauma-specific supervision into your supervision plans.
- Integrate discussion of vicarious trauma throughout all aspects of your work
- When recruiting, discuss self-care practices with job candidates.
- Include a section on vicarious trauma in staff orientation.
- Develop and deliver regular trainings on the topic.
- Provide regular resources on self-care and wellness.
- Create policies that support reducing vicarious trauma.

Make a Commitment to Reduce Vicarious Trauma

Now that you have recognized that the work you do may be affecting you, remember to take care of yourself in healthy and positive ways. Refreshing your mind and spirit will not only make you feel better, but will positively affect those around you. By working in the field of anti-violence we fight oppression on many forms and it eventually seeps into our hearts and minds. Recognizing this and taking care of ourselves is the first step to refreshing and sustaining our energy in the work.

Lipsky, L. V. N. (2009). *Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others.* San Francisco, CA: Berrett-Koehler.

© National Sexual Violence Resource Center and National Sexual Assault Coalition Resource Sharing Project 2012.
All rights reserved.

This project is supported by Grant No. 2009-TA-AX-K011 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

From the Sexual Assault Response Network of Central Ohio, OhioHealth's Survivor Advocacy Manual January, 2013

Tools for Watching Movies and Television Shows [iv]

Movies and TV shows that show rape, sexual assault, incest and child sexual abuse can be very difficult for survivors, co-survivors and advocates to watch. Use the suggestions here to make your TV and moviewatching experiences safer.

What kind of reactions might a survivor or advocate experience while watching movies or TV shows that show scenes of sexual assault?

Negative reactions can include:
Sadness, anger, anxiety, panic attacks, flashbacks, depression or irritability.

Sometimes we could have more positive reactions to seeing this kind of content.
Feeling validated, learning new ways of coping or feeling connected.

Why do movies and TV shows trigger such strong emotions?

- They frequently deal with topics that are especially relevant to survivors and advocates.
- They often portray graphic scenes of sexual assault or abuse that may call up painful memories for a survivor or remind an advocate of a survivor they worked with.
- Might not be prepared to see scenes of sexual assault, especially if that is not the main focus of the movie or TV show.
- Some movies or TV shows sensationalize survivors' experiences and emphasize their trauma without showing any of their healing process.
- For most movie and TV show producers, the first priority is to entertain, which means that they don't always focus on making an accurate portrayal of sexual assault and recovery.

How can I avoid having problems if I choose to watch movies or TV?

- Do your homework! Read up before watching it, many TV shows have a blurb in the TV Guide or other publications that will let you know what to expect.
- You can find movie reviews in the newspaper or online. Often (but not always) the review will mention especially graphic or upsetting content.
- Pay attention to the ratings (G, PG, PG-13, etc.), which are usually accompanied by a brief description of the reason for the rating.
- If the movie or TV show has content that may be hard for you to handle, consider not watching it, or watching it at a time of your choosing, rather than at its scheduled time.
- Ask yourself whether or not you really want to watch this movie or TV show.

It's easy to get caught up in a routine of watching TV or movies just because they're on. If you're not interested in the TV show or movie, consider skipping it.

- Don't watch something just to prove that you can handle it.
- Watch movies or TV shows that have upsetting content when you feel prepared to deal with those scenes. Do not let anyone rush you into watching something you do not feel prepared to watch.
- Monitor your viewing.
- Don't watch something just because it's on. Limit your viewing by only watching TV shows and movies that really interest you.
- Avoid channel-surfing. If you're just flipping through the channels, you're more likely to be caught off guard by material that could be upsetting.
- Consider renting movies with content that might be upsetting, rather than watching them in theaters.
- One of the advantages of watching movies and TV at home is that you have control over when you watch. If you're watching a show and you find that you're getting upset, it's okay to **turn the TV off** and find something else to do!
- Take a walk or go to the gym (exercise can be a great way to dispel feelings of anxiety and depression).
- Call a friend or family member to talk.
- Write in a journal or diary.
- Don't sit in front of the TV all day!
- It's possible to get very over-stimulated by watching TV continuously. Remember that you do not *have* to watch TV shows or movies. Watch because you want to watch, not because you feel like you have to or because watching TV has become a habit!

iv http://www.rainn.org/get-information/sexual-assault-recovery/challenges-for-survivors-movies-and-tv

Violence Against Women
http://vaw.sagepub.com

Rape Survivors' Experiences With the Legal and Medical Systems: Do Rape Victim Advocates Make a Difference?

Rebecca Campbell

VIOLENCE AGAINST WOMEN 2006; 12; 30
DOI: 10.1177/1077801205277539

The online version of this article can be found at:
http://vaw.sagepub.com/cgi/content/abstract/12/1/30

Published by:
SAGE Publications
http://www.sagepublications.com

Additional services and information for *Violence Against Women* can be found at:

Email Alerts: http://vaw.sagepub.com/cgi/alerts

Subscriptions: http://vaw.sagepub.com/subscriptions

Reprints: http://www.sagepub.com/journalsReprints.nav

Permissions: http://www.sagepub.com/journalsPermissions.nav

Citations (this article cites 11 articles hosted on the SAGE Journals Online and HighWire Press platforms):
http://vaw.sagepub.com/cgi/content/abstract/12/1/30#BIBL

Downloaded from http://vaw.sagepub.com at MICHIGAN STATE UNIV LIBRARIES on March 22, 2007
© 2006 SAGE Publications. All rights reserved. Not for commercial use or unauthorized distribution.

Violence Against Women
Volume 12 Number 1
January 2006 30-45
© 2006 Sage Publications
10.1177/1077801205277539
http://vaw.sagepub.com
hosted at
http://online.sagepub.com

Rape Survivors' Experiences With the Legal and Medical Systems

Do Rape Victim Advocates Make a Difference?

Rebecca Campbell
Michigan State University

This study used a naturalistic quasi-experimental design to examine whether rape survivors who had the assistance of rape victim advocates had more positive experiences with the legal and medical systems compared to those who did not work with advocates. Eighty-one survivors were interviewed in two urban hospitals about what services they received from legal and medical system personnel and how they were treated during these interactions. Survivors who had the assistance of an advocate were significantly more likely to have police reports taken and were less likely to be treated negatively by police officers. These women also reported less distress after their contact with the legal system. Similarly, survivors who worked with an advocate during their emergency department care received more medical services, including emergency contraception and sexually transmitted disease prophylaxis, reported significantly fewer negative interpersonal interactions with medical system personnel, and reported less distress from their medical contact experiences.

Keywords: *rape; rape crisis centers; rape victim advocates; sexual assault*

One of the enduring legacies of the 1970s feminist social movement was the creation of community-based rape crisis centers (RCCs). There are now more than 1,200 RCCs in the United States, and their staff and volunteers provide numerous services to survivors of rape, such as crisis intervention, medical and legal advocacy, and counseling (Campbell & Martin, 2001; Martin, 2005). Of these three basic services, social system advocacy is perhaps the most challenging for RCC staff (Campbell, 1996; Martin, 1997, 2005). Rape victim advocates assist survivors in hospital emergency departments (ERs) and police departments by guiding them through the process of medical forensic evidence collection and legal prosecution. At the same time, rape victim advocates are trying to prevent "the second rape" or "secondary victimiza-

Author's Note: I thank Shelley Mendel and Cherise Watkins-Jones for their assistance with data collection, Deb Bybee and Neal Schmitt for their advice regarding data analysis, and Cris Sullivan and Marisa Sturza for helpful comments on previous drafts of this article.

Downloaded from http://vaw.sagepub.com at MICHIGAN STATE UNIV LIBRARIES on March 22, 2007
© 2006 SAGE Publications. All rights reserved. Not for commercial use or unauthorized distribution.

tion"—insensitive, victim-blaming treatment from social system personnel that exacerbates the trauma of the rape (Campbell et al., 1999; Campbell & Raja, 1999, 2005; Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Madigan & Gamble, 1991; Martin & Powell, 1994; Williams, 1984). The job of the rape victim advocate, therefore, is not only to improve service delivery but also to stop secondary victimization. Although RCCs have been providing legal and medical advocacy services for decades, there is little research evaluating the effectiveness of rape victim advocates. The purpose of the current study was to address this gap in the literature by comparing rates of service delivery and secondary victimization for rape survivors who did and did not work with rape victim advocates.

The work of rape victim advocates is challenging as existing research suggests that most rape survivors do not receive needed services and are often treated insensitively by social system personnel. Within the legal system, studies of rape case processing suggest that approximately 50% of the time law enforcement personnel either do not take victims' reports or never forward their reports for investigation, and only 22% to 25% of reported rapes are prosecuted, 10% to 12% of which result in some type of conviction (Campbell, 1998a; Campbell et al., 2001; Frazier & Haney, 1996). Case attrition is widespread and problematic; however, prior research has also found that postassault contact with the legal system can be revictimizing. For example, rape survivors report that they are asked about their prior sexual histories, questioned about how they were dressed or behaving at the time of the assault, and are encouraged not to report or prosecute the assault. Victims consistently report that these kinds of behaviors are highly distressing and revictimizing (Campbell et al., 1999; Campbell & Raja, 2005). Similarly, prior research has found that most survivors of rape report feeling guilty, depressed, anxious, distrustful of others, and reluctant to seek further help after their interactions with legal system personnel (Campbell et al. 1999; Campbell et al., 2001; Campbell & Raja, 2005).

Experiences of rape survivors with the medical system can also be difficult. When rape victims seek postassault emergency medical care, most receive a medical exam and forensic evidence collection kit (70%; Campbell et al., 2001), less than one half receive information on the risk of pregnancy (40% to 49%) (Campbell et al., 2001; National Victim Center, 1992), and between 20% and 43% are able to obtain emergency contraception to prevent pregnancy (Amey & Bishai, 2002; Campbell et al., 2001). Approximately one third of survivors of rape receive information about the risk of sexually transmitted diseases (STDs) and HIV from the assault (Amey & Bishai, 2002; Campbell et al., 2001; National Victim Center, 1992), and between 34% and 57% receive medication to treat and/or prevent STDs (Amey & Bishai, 2002; Campbell et al., 2001). In addition to these gaps in service delivery, secondary victimization from the medical system may also be a problem for survivors of rape (Martin, 2005; Martin & DiNitto, 1987). Campbell and Raja (2005) found that 58% of survivors in their sample reported that they were distressed by doctors' and nurses' questions about their sexual histories, behavior before the assault, and how they were treated during the exam process. Most women reported feeling violated, depressed, and anxious after their contact with medical professionals (see also Campbell et al., 2001).

Downloaded from http://vaw.sagepub.com at MICHIGAN STATE UNIV LIBRARIES on March 22, 2007
© 2006 SAGE Publications. All rights reserved. Not for commercial use or unauthorized distribution.

These rates of legal case attrition and medical service delivery and secondary victimization come from studies of rape survivors who did not work with rape victim advocates, which raises the question: Can advocates make a difference? Are the experiences of rape survivors who have advocates any better? Few studies have explicitly tested this question. For example, in a statewide evaluation of RCC services, Wasco et al. (2004) found that survivors consistently rated advocates as supportive and informative. Yet being positively perceived does not necessarily mean that advocates are effective in promoting service delivery and preventing secondary victimization. More direct evidence of effectiveness comes from Campbell and Bybee's (1997) study of survivors of rape who had the assistance of an advocate during their hospital emergency department (ED) care. This study found higher rates of medical service delivery than what is typical in the literature: 82% received an exam, 70% information on pregnancy, 38% emergency contraception, 67% information on STDs, and 79% STD preventive antibiotic treatment. However, this study did not include a comparison group of survivors who did not work with advocates, which would have provided a more powerful test of advocates' effectiveness regarding service delivery. In a study of secondary victimization, Wasco, Campbell, Barnes, and Ahrens (1999) examined the relationship between social system contact and posttraumatic stress symptoms of rape survivors as a function of whether the victims had the assistance of an advocate. Although the number of victims in this study who had an advocate was quite small (21 in a sample of 102), they found that survivors who worked with advocates reported less distress after contacting the legal and medical systems. Taken together, the results of these studies suggest that rape victim advocates are beneficial; however, more direct comparison studies are warranted.

The purpose of the current study was to compare the service delivery and secondary victimization experiences of rape survivors who did and did not work with rape victim advocates to determine if survivors who worked with advocates received more services and had fewer negative interactions with social system personnel. Participants were recruited from hospital ERs because this is where most rape survivors receive immediate postrape medical care (Resnick et al., 2000). In addition, Resnick et al. (2000) found that victims who obtained medical care often did so after they had reported to the police and that law enforcement served as a conduit to medical care. Therefore, sampling in hospital EDs increases the likelihood that study participants would have contact with the legal and medical systems, which is consistent with the primary goal of the current study.

Two large, urban hospitals were selected for sampling that had several common characteristics. First, both were the primary hospital in their respective police precincts where law enforcement took rape victims for treatment (if the victim first presented to the police). Second, if a rape victim came to the hospital ED without prior contact with the police, both hospitals had policies to call the police, and then the survivor was given the choice of whether to talk to the police. These two features suggest that the sites sampled for the current study are typical with respect to how communities in other national studies respond to rape victims. Third, the hospitals were comparable with respect to (a) number of rape victims served per year, (b) having doctors

Downloaded from http://vaw.sagepub.com at MICHIGAN STATE UNIV LIBRARIES on March 22, 2007
© 2006 SAGE Publications. All rights reserved. Not for commercial use or unauthorized distribution.

perform the rape exam and forensic evidence collection procedures (rather than sexual assault nurse examiner [SANE] nurses), and (c) serving a racially mixed population with high concentrations of patients who were Medicaid eligible. The primary difference between the two hospitals was that one had a policy to page rape victim advocates from a local RCC to come assist survivors of rape throughout their ER visit (Site #1) and the other did not (Site #2). This naturalistic quasi-experimental design allows for direct comparisons between the rape survivors who worked with a rape victim advocate (Site #1) and those who did not (Site #2).

The advocates serving the Site #1 hospital were paid staff and volunteers from an urban RCC. They had completed a 40-hour training program that included instruction on the psychological and physical health impact of sexual assault, victims' legal rights, the steps of legal prosecution, and the process of medical forensic evidence collection. In this training, the advocates also learned how to assess the survivors' needs for services and work on their behalf to obtain those resources if they were not forthcoming during the exam process. RCC staff also instructed the advocates to intercede when social system personnel engaged in behaviors or pursued lines of questioning that could be distressing to the survivors. The hospital ED staff at Site #1 paged the RCC as soon as they knew they had a victim seeking treatment and would typically wait until the advocate arrived before performing the rape exam. The advocates were usually present for the exam to support the survivor and clarify the information presented by the doctors and nurses. Survivors usually talked with the police after the exam and, hence, had the support of an advocate for that process as well.

To assess how advocates may influence the experiences of rape survivors with the legal and medical systems, victims in each hospital were interviewed right before their discharge about what had just happened in their contact with the medical and law enforcement personnel. Three domains were assessed: (a) service delivery: what services the survivors did or did not receive from legal and/or medical personnel. It is important to note that the use of the term *service delivery* in the context of victims' experiences with the legal system does not imply that all victims want complete trial process. Rather, the term refers to the actions taken by legal system personnel to process reported rape cases; (b) secondary victimization behaviors: whether victims encountered specific behaviors and/or actions from service providers that were distressing; and (c) secondary victimization emotions: whether survivors felt various forms of distress (e.g., self-blame, depressed, violated) after their contact with social system personnel. Rates of service delivery and secondary victimization were compared across sites to assess the effectiveness of rape victim advocates.

Method

Sample

In Site #1 (the hospital that worked with rape victim advocates), 38 rape survivors sought treatment during the 6-month period of time the current study was conducted, and 36 agreed to participate in the study (95% response rate). All 36 survivors from

Downloaded from http://vaw.sagepub.com at MICHIGAN STATE UNIV LIBRARIES on March 22, 2007
© 2006 SAGE Publications. All rights reserved. Not for commercial use or unauthorized distribution.

Site #1 worked with a rape victim advocate. Of these victims, 17 also talked with police either before arriving at or during their hospital care. In Site #2 (the hospital that did not work with rape victim advocates), 46 victims sought treatment during the time of the current study, and 45 agreed to participate (98%). Of these 45 victims, 28 had contact with police. In sum, 45 survivors had contact with the legal system (17 from Site #1 and 28 from Site #2), and 81 had contact with the medical system (36 from Site #1 and 45 from Site #2). All 81 rape survivors in the current study were female, and more than one half were African American (52%), 37% were White, 8% were Latina, and 3% were multiracial. The average age was 26.12 years (SD = 3.45). Most of the women had a high school education (51%). Consistent with prior research, most of the assaults were committed by someone known to the victim (acquaintance, date, marital), did not involve the use of a weapon (74%), and did not result in physical injuries to the victim (62%). Of the women, 22% had been using alcohol at the time of the assault.

Procedure

The principal investigator (PI) worked collaboratively with the staff of both hospitals to develop uniform recruitment and data collection procedures that would ensure reliable access to rape survivors without interfering with their medical care. Consistent with the sites' normal protocols for responding to rape survivors, hospital staff would first call the police (if the police were not already accompanying the victim to the ER), then page a rape victim advocate (Site #1 only), and then page the research team. While the victim was receiving medical care and/or reporting to the police, the research team member who had been paged to the hospital waited at the nurses' station and did not have contact with the survivor or witness her interactions with system personnel. While the survivor was waiting for her discharge papers from the hospital, a nurse approached her and asked her if she would be willing to participate in a brief interview about her experiences in the ED. She was told the interview would be conducted by a female researcher who was not affiliated with the hospital or the police. If she agreed, only then was the researcher allowed to have contact with the victim. The interview was conducted with the rape survivor during the waiting time before discharge.

Measures

An orally administered checklist was used for data collection, and its administration was tape-recorded with the permission of the participants (100% agreed to tape recording). In addition to collecting basic demographic and assault characteristics, the checklist was designed to capture three kinds of information. First, service delivery was assessed: What services were provided to the rape survivors in their contact with the legal and/or medical systems? The PI reviewed police and hospital protocols and consulted with officers, doctors, nurses, and rape victim advocates to find out what services could be offered to rape survivors. In the current study, three steps in legal case processing were studied: whether a police report was taken, whether an investiga-

Downloaded from http://vaw.sagepub.com at MICHIGAN STATE UNIV LIBRARIES on March 22, 2007
© 2006 SAGE Publications. All rights reserved. Not for commercial use or unauthorized distribution.

tion was or would be conducted, and whether law enforcement personnel provided referrals to survivors of rape for other community resources. There are other actions that could be taken by the legal system (e.g., arrest, prosecution); however, the informant groups reported that the three previously mentioned services were the only services that could be provided by the time data were collected. For the medical system, 16 services were examined (see Table 2 for a complete list). For each service (legal or medical), the survivors were asked, "Did (service) occur? Did you receive (service)?" and the respondents' answers were coded yes or no. If the participants responded no to a particular service, the interviewers were trained to probe further to find out whether the victim did not want the service (hence, not receiving it was consistent with the victim's wishes) or whether the victim wanted the service, but it was not provided. In the current study, when services were not provided, it was usually instances of the victim's wanting the service, but it was not provided (93% to 97% of the time, across all services).

Second, secondary victimization behaviors were assessed. Because current definitions of *secondary victimization* emphasize the behaviors of social system personnel, participants were asked whether they encountered specific actions. To generate this list of secondary victimization behaviors, formative research was conducted with multiple informant groups (Campbell, 1996, 1998b). Interviews and focus groups were conducted with police officers, prosecutors, doctors, nurses, RCC staff, rape victim advocate volunteers, and rape survivors to find out what specific behaviors of social system personnel might be upsetting to survivors of rape. In the current study, 14 behaviors were assessed for the legal system, 12 for the medical system. The questions were not the same across systems because the formative research revealed that assessment needed to be tailored to each system because of the inherent differences in the roles and functions of the legal and medical systems (see Tables 1 and 2 for a complete list). Consistent with prior studies on this topic (Campbell et al., 2001; Campbell & Raja, 2005), these behaviors were not labeled as secondary victimization during assessment; participants were simply asked whether the actions occurred. For each behavior, rape survivors were asked, "Did you experience (behavior)? Did this (behavior/action/comment) happen?" Answers were coded yes or no. To check whether it was reasonable to conceptualize these behaviors as secondary victimization, distress ratings were also collected from the survivors of rape. If a survivor reported that she encountered one of these behaviors, she was also asked to rate how distressing it was to encounter that behavior on a 1 to 5 scale (1 = not distressed, 2 = a little distressed, 3 = some distress, 4 = quite a bit of distress, 5 = a great deal of distress). All behaviors were rated as 3 or higher by all survivors who encountered them ($M = 4.22$, $SD = .47$).

Finally, secondary victimization emotions were assessed. Secondary victimization has been defined as insensitive and victim-blaming treatment by social system personnel that leaves victims feeling distressed. In the current study, eight secondary victimization emotions were assessed for the legal and medical systems, including feeling guilty, depressed, anxious and/or nervous, distrustful of others, and reluctant to seek further help as a result of contact with either the legal or medical systems. Rape survi-

Downloaded from http://vaw.sagepub.com at MICHIGAN STATE UNIV LIBRARIES on March 22, 2007
© 2006 SAGE Publications. All rights reserved. Not for commercial use or unauthorized distribution.

vors were asked, "Did you feel (emotion) after your contact with the police officer/hospital staff? Did you feel this as a result of your contact with the police/hospital staff?" The participants' answers were coded yes or no.

Results

Legal Case Processing and Secondary Victimization

Differences in proportions tests, with Bonferroni corrections to control Type I error, were used to compare the endorsement rates of rape survivors for each service across the two sites (Downie & Heath, 1983). The differences in proportions test is quite conservative with sample sizes less than 100 (Downie & Heath, 1983), and coupled with a Bonferroni correction, Type I error may be adequately controlled, but at the risk of a Type II error. To balance these competing risks, the Bonferroni tests were grouped by substantive focus (Tabachnick & Fidell, 2001) (see Table 1). As Table 1 shows, police reports were significantly more likely to be taken in Site #1 where victims had the assistance of an advocate (59%) as compared to Site #2 (41%) (z [44] = 2.43, $p < .02$). Most reported cases were not investigated further or were not likely to be investigated (24% in Site #1, 8% in Site #2). A trend emerged suggesting that investigations were slightly more common in Site #1 than in Site #2 (z [44] = 2.02, $p < .05$). Most rape survivors were not given referrals by police officers to other community services: 6% in Site #1, 11% in Site #2 (no significant differences across sites).

Consistent with prior research on legal secondary victimization, some behaviors were commonly encountered, others were infrequent. Most rape survivors in both sites stated that they were discouraged from filing a police report; however, this was significantly more likely to happen in Site #2 (where rape victim advocates were not present): 81% in Site #2, 59% in Site #1 (z [44] = 2.42, $p < .01$). Similarly, many rape survivors reported that police officers were reluctant to take their report (although they did so); however, this was significantly more likely to happen in Site #2 as compared to Site #1: 79% vs. 35% (z [44] = 3.11, $p < .01$). It was less common for officers to refuse to take the report (e.g., officers stating that they would not take a report because they thought the victim was lying); however, again, this occurred more frequently in Site #2 where rape victim advocates were not involved: 43% versus 18% (z [44] = 2.39, $p < .01$). Most rape survivors who did not work with rape victim advocates (57%) were told by police officers that their cases were not serious enough to pursue further in the criminal justice system; the women who had the assistance of an advocate were significantly less likely to encounter this response (29%) (z [44] = 2.47, $p < .01$). In Site #2, it was typical for police officers to ask rape survivors if they had a prior relationship with the perpetrator (86%); however, this was less commonly asked in Site #1 (47%) (z [44] = 2.13, $p < .02$). Slightly less than one half of the rape survivors in Site #2 were asked about their prior sexual history by the police officers (46%), and this was significantly less common in Site #1 (12%) (z [44] = 2.83, $p < .008$). Finally, 31% of the women in Site #2 were asked by police officers if they had responded sexually to

Downloaded from http://vaw.sagepub.com at MICHIGAN STATE UNIV LIBRARIES on March 22, 2007
© 2006 SAGE Publications. All rights reserved. Not for commercial use or unauthorized distribution.

the assault (e.g., asked whether they had an orgasm from the assault); this line of questioning was significantly less likely to occur in Site #1 (6%) (z [44] = 2.73, $p < .008$).

After their contact with the legal system, most rape survivors reported experiencing multiple kinds of distress. As can be seen in Table 1, almost all secondary victimization emotions had endorsement rates of more than 50%. Some emotions were nearly ubiquitous: 82% of the rape survivors in Site #1 and 93% of the victims in Site #2 stated that they felt violated after their contact with the legal system. Most also said that they felt disappointed (88% in Site #1 and 93% in Site #2). Some emotions, though still typical, were more likely to be reported by the women who did not work with a rape victim advocate. For instance, 83% of the survivors in Site #2 reported that they felt bad about themselves after their contact with the legal system. This was also common in Site #1 (60%) but was more typical in Site #2 (z [44] = 2.41, $p < .01$). Similarly, women in Site #2, who did not have the assistance of an advocate, were more likely to report feeling guilty (86%) or depressed (88%) than the survivors in Site #1 (59% and 53%, respectively) (z [44] = 2.36, $p < .01$; z [44] = 2.40, $p < .01$). Finally, most women in Site #2 stated that they were reluctant to seek further help after their experiences with the legal system (89%), which was significantly higher than those who reported this sentiment in Site #1 (61%) (z [44] = 2.33, $p < .01$).

Medical Service Delivery and Secondary Victimization

Differences in proportions tests with Bonferroni corrections were used to compare survivors' experiences with the medical system across the two sites. As can be seen in Table 2, some medical services were consistently provided to survivors, such as the rape exam, forensic evidence collection, and STD prophylaxis (medication for any treatable STDs that may have been contracted in the assault). However, several services were offered to less than one half of the rape survivors, including information on the risk of HIV from the assault, pregnancy testing, emergency oral contraception, testing for STDs and/or HIV, HIV prophylaxis, information on the health effects of rape, information on follow-up care, and community referrals. Some services were consistently more likely to be provided by medical professionals to survivors in Site #1, who had the assistance of a rape victim advocate. These women were significantly more likely to receive information on STDs (72% vs. 36%; z [80] = 2.67, $p < .008$), were somewhat more likely to receive information on the risk of HIV specifically (47% vs. 24%; z [80] = 2.09, $p < .05$), and were significantly more likely to receive STD prophylaxis (86% vs. 56%; z [80] = 2.50, $p < .008$) than were the women in Site #2 (who did not have an advocate). The victims who worked with advocates received more pregnancy-related services than the survivors who did not have the assistance of an advocate. Specifically, they were somewhat more likely to be tested for pregnancy (42% vs. 22%; z [80] = 2.01, $p < .05$) and were significantly more likely to receive emergency contraception to prevent pregnancy (33% vs. 14%; z [80] = 2.20, $p < .02$).

The rates of endorsement for the secondary victimization behaviors were generally low (most under 50%, see Table 2). For example, in only 24% of the cases in Site #1 and 36% of the cases in Site #2 did hospital staff refuse to conduct the medical exam

Downloaded from http://vaw.sagepub.com at MICHIGAN STATE UNIV LIBRARIES on March 22, 2007
© 2006 SAGE Publications. All rights reserved. Not for commercial use or unauthorized distribution.

and/or forensic evidence collection. These refusals were not because of the medical provider's training and/or expertise (e.g., one provider refused so that someone with more or less training could do the exam) or his or her gender (e.g., one provider refused because the victim wanted a provider of the opposite sex). Exams and evidence collection were refused when hospital staff said that the assault occurred "too long ago," even though by the victims' accounts all sought services within 96 hours, which is within the time frame for forensic work (International Association of Forensic Nursing, 2005). During the exam process, the victims seen in Site #2 often reported that they were treated impersonally or coldly (69%), which was less commonly reported by the survivors treated in Site #1 (36%; z [80] = 2.51, $p < .01$). The women at Site #2 were somewhat more likely to be asked about how they were dressed at the time of the assault compared with the survivors treated at Site #1 (48% vs. 28%; z [80] = 2.24, $p < .05$). Most of the survivors in Site #2 were asked about their prior sexual histories (73%), which was also common, though statistically less likely in Site #1 (44%; z [80] = 2.47, $p < .008$). Of the survivors in Site #2, where no advocate was present, 20% were asked if they had responded sexually to the assault; this question was significantly less likely to be asked by the medical staff in Site #1 (3%; z [80] = 2.53, $p < .008$). The survivors' rates of endorsement for the secondary victimization emotions were quite high (72% or higher). The women treated in Site #2, without the assistance of a rape victim advocate, were more likely to report blaming themselves for the assault post-contact (82% vs. 54%; z [80] = 2.33, $p < .01$) and were significantly more likely to state that they were reluctant to seek further help (91% vs. 67%; z [80] = 2.40, $p < .01$) than were the women in Site #1.

Discussion

RCC staff and volunteers have been providing legal and medical advocacy for rape survivors for decades. However, there have been few empirical studies evaluating the effectiveness of the advocates' intervention. The current study used a naturalistic quasiexperimental design to compare the outcomes of victims who worked with rape victim advocates with those who did not. Rape survivors who worked with advocates reported receiving more services from the legal and medical systems. Previous research suggested that police officers take reports of rape survivors only 50% of the time (Campbell et al., 2001); however, the victims who worked with advocates had reports taken 59% of the time. Rates of medical care service delivery in this research were consistent with Campbell and Bybee's (1997) study of rape survivors who had the assistance of an advocate during their hospital ED care: Approximately 70% received an exam, information on pregnancy, information on STDs, and STD preventive antibiotic treatment. Most survivors did not receive emergency contraception (about one third); however, this rate is common for advocate-assisted cases and is significantly higher than for women who did not work with an advocate. Beyond service delivery, most survivors who worked with advocates reported less secondary victimization from legal and medical system personnel, and less post-system-contact dis-

Downloaded from http://vaw.sagepub.com at MICHIGAN STATE UNIV LIBRARIES on March 22, 2007
© 2006 SAGE Publications. All rights reserved. Not for commercial use or unauthorized distribution.

Table 1
Rates of Legal Service Delivery and Secondary Victimization as a Function of Whether the Rape Survivor Worked With a Rape Victim Advocate (in percentages)

	Rape Survivors Who Worked With a Rape Victim Advocate	Rape Survivors Who Did Not Work With a Rape Victim Advocate
Legal—Services (3)		
Police report	59*	41
Investigation	24[a]	8
Referrals	6	11
Legal—Secondary victimization behaviors (14)		
Discouraged filing a report	59	81[b]
Reluctant to take a report	35	79[b]
Refused to take a report	18	43[b]
Told case was not serious enough to pursue	29	57[b]
Did not explain steps of reporting/prosecuting	18	21
Asked why with perpetrator	47	61
Asked if had prior relationship with perpetrator	47	86[b]
Questioned the way dressed	41	46
Questioned behaviors/choices	35	43
Questioned about prior sexual history	12	46[b]
Questioned why memories were vague or scattered	12	21
Questioned if resisted perpetrator	82	86
Questioned if responded sexually to the assault	6	31[b]
Asked if willing to take a lie detector test	6	18
Legal—Secondary victimization emotions (8)		
Felt bad about self	60	83[b]
Guilty and/or blame self	59	86[b]
Depressed	53	88[b]
Nervous and/or anxious	47	47
Violated	82	93
Disappointed	88	93
Distrustful of others	47	57
Reluctant to seek further help	61	89[b]

Note: For the three legal service delivery tests, only alpha levels $p < .02$ are considered statistically significant. For the legal secondary victimization tests, the five behaviors pertaining to the process of reporting and prosecuting a rape were grouped and alphas $p < .01$ are significant; the six behaviors relating to the survivors' behaviors at the time of the assault were grouped, alphas $p < .008$ are significant; and the three questions regarding the survivors' prior relationship with the assailant were grouped, alphas $p < .01$ are significant. For the legal secondary victimization emotions tests, the four emotions pertaining to guilt, depression, and anxiety were grouped, alphas $p < .01$ are significant; the four emotions relating to violation and reluctance to seek further help were grouped, alphas $p < .01$ are significant.

a. Denotes a trend difference.

b. Denotes a statistically significant difference.

Downloaded from http://vaw.sagepub.com at MICHIGAN STATE UNIV LIBRARIES on March 22, 2007
© 2006 SAGE Publications. All rights reserved. Not for commercial use or unauthorized distribution.

tress than those who did not have the assistance of advocates. Secondary victimization has been linked with a variety of negative health outcomes, such as increased psychological distress, physical health symptomatology, and sexual health risk-taking behaviors (Campbell et al., 1999; Campbell et al, 2001; Campbell, Sefl, & Ahrens, 2004). Thus, a reduction in secondary victimization may have important long-term benefits for rape survivors. These findings regarding service delivery and secondary victimization provide some of the strongest evidence to date that RCC services are beneficial to rape survivors.

Whereas the design of the current study allowed for a direct comparison of victims' legal and medical system experiences as a function of whether they had an advocate, random assignment was not possible in this research. In the process of planning the current study, the PI met with staff from multiple hospitals in a major metropolitan city to explore design options. None would allow random assignment of advocates. Those that had policies to work with advocates felt it would be unethical to randomly assign victims in the ED to have the assistance of the advocate. Their perception was that advocates were tremendously helpful to survivors and that not providing this assistance would be a disservice to their patients. Hospitals that did not work with advocates were not interested in bringing them in to work with some patients, but not others. Without random assignment, either across sites or within sites, a quasi-experimental design was needed. It was also not possible to conduct a within-site quasi-experimental study as none of the hospitals used advocates only some of the time (they either consistently worked with advocates or did not). Yet it was discovered that two hospitals in this city were very similar on multiple characteristics (both were located in racially mixed neighborhoods, both served high concentrations of patients who were Medicaid eligible, and both had similar protocols for responding to victims of rape), except for their policies and practices regarding rape victim advocates: One routinely worked with rape victim advocates, the other did not. These similarities provided a solid methodological foundation for the current study; however, without random assignment, cross-site differences may be because of multiple factors, advocate involvement only one among many.

Therefore, it is important to explore what other factors, besides advocate involvement, could explain the differences in service delivery and secondary victimization rates across the sites (see Cook & Campbell, 1979). Four alternative explanations were examined. First, service providers' demographics, such as age, race and/or ethnicity, and education level, may influence how they respond to rape survivors, and if the hospitals varied significantly in provider demographics, this could account for site differences. To test this possibility, all social system personnel with whom the survivor interacted were also interviewed (see Campbell, in press), and there were no significant differences between sites with respect to their service providers' demographic characteristics. Thus, if providers' demographics influence their work with rape survivors, it appears that such effects would be consistent across sites.

Second, the degree of training legal and medical system personnel have had about sexual assault may influence their responses, as would their levels of experience working with rape survivors. In the interviews with system personnel, all participants were

Downloaded from http://vaw.sagepub.com at MICHIGAN STATE UNIV LIBRARIES on March 22, 2007
© 2006 SAGE Publications. All rights reserved. Not for commercial use or unauthorized distribution.

asked to rate their perceived awareness of the issue of sexual assault and their experience working with rape survivors (Campbell, in press). Again, there were no significant differences across sites. To further explore the possible impact of training and experience, the directors of both hospital ERs were contacted to find out when their staff had last been trained on sexual assault and how many rape cases their staff had responded to within the past year. Both hospitals had not had training on sexual assault within the past 5 years, and there were no significant differences between the two sites with regard to the number of rape cases processed each year. Similar data were collected from the deputy chief of police who oversaw the two police precincts that served these hospitals. Again, there were no differences across sites with respect to police training or number of reported rapes the officers had responded to within the past year.

Third, it is possible that the policies and procedures for each hospital and each police precinct were fundamentally different, which would account for the varied experiences rape survivors had in each site. This issue was more difficult to examine as neither hospital nor police precinct had good written documentation explaining their response protocol for rape cases. Both hospitals' protocols stated that they followed state law regarding forensic evidence collection. As noted previously, Site #1 had a policy, unwritten but consistently followed, to page rape victim advocates to assist survivors in the ED, and this was the only identifiable difference between the sites. Both police precincts' operations manuals outlined a standard procedure for responding to victims of violent crime, and there was no other written evidence that suggested differential policies. Yet previous research has found that the decision-making processes of legal personnel are cultural and quite specific to their units (Frohmann, 1991, 1997, 1998; Kerstetter & Van Winkle, 1990; Martin & Powell, 1994), which may not be reflected in written policies, even if detailed versions existed. However, something was undoubtedly different between the two sites because one had a standing relationship with an RCC and engaged in what Martin and Powell (1994) termed *responsive processing* by providing victim-assistance resources. Previous research has shown that RCCs can create institutional change (Martin, DiNitto, Byington, & Maxwell, 1993; Schmitt & Martin, 1999), so it is possible that the rape victim advocates in Site #1 are representative of an ongoing institutional social cultural dynamic, rather than a force for change in individual encounters between victims and social system personnel.

Finally, it is possible that the victims themselves and/or the characteristics of the sexual assaults may have been different across the two sites. Perhaps one hospital treated more of some kinds of survivors or types of rape than the other, and such differences prompted alternative system responses. Demographic and assault characteristics were collected in the survivors' interviews, and cross-site comparisons yielded no significant differences. Taken together, these findings suggest that individual demographics, assault characteristics, system personnel's training and experience, and site policies and procedures were consistent across data collection sites and, thus, may not explain the differences in service delivery and secondary victimization rates across sites. However, one key alternative interpretation cannot be ruled out: The service pro-

Downloaded from http://vaw.sagepub.com at MICHIGAN STATE UNIV LIBRARIES on March 22, 2007
© 2006 SAGE Publications. All rights reserved. Not for commercial use or unauthorized distribution.

Table 2
Rates of Medical Service Delivery and Secondary Victimization as a Function of Whether the Rape Survivor Worked With a Rape Victim Advocate (in percentages)

	Rape Survivors Who Worked With a Rape Victim Advocate	Rape Survivors Who Did Not Work With a Rape Victim Advocate
Medical—Services (16)		
Rape exam	89	76
Forensic evidence collection	89	76
Detection and/or treatment of injuries	61	56
Information on risk of pregnancy	72	56
Information on risk of STDs	72[b]	36
Information on HIV specifically	47[a]	24
Tested for pregnancy	42[a]	22
Emergency oral contraception	33[b]	14
Tested for STDs	14	13
Tested for HIV	8	13
STD prophylaxis	86[b]	56
HIV prophylaxis	19	16
Information on psychological effects of rape	6	4
Information on physical health effects of rape	6	4
Information on follow-up treatment	11	4
Referrals	14	7
Medical—Secondary victimization behaviors (12)		
Refused to conduct exam	24	36
Refused to do forensic evidence collection	24	36
Did not explain rape exam procedures	17	22
Impersonal and/or detached interpersonal style	36	69[b]
Asked why with perpetrator	44	58
Asked if had prior relationship with perpetrator	56	53
Questioned the way dressed	28	48[a]
Questioned behavior and/or choices	36	44
Questioned about prior sexual history	44	73[b]
Questioned why memories were vague or scattered	8	7

(continued)

viders in Site #1 simply told victims what they wanted to hear because of the presence of the rape victim advocate but did not actually follow through with more complete service. For example, law enforcement personnel may have said that a case would be investigated in the presence of the advocate; however, in fact, they did not pursue the case. Given the scope of the current study, it was not feasible to conduct follow-up assessments through police records, and this remains a limitation of the current work. In addition, it was not possible to identify the specific actions taken by the advocates

Downloaded from http://vaw.sagepub.com at MICHIGAN STATE UNIV LIBRARIES on March 22, 2007
© 2006 SAGE Publications. All rights reserved. Not for commercial use or unauthorized distribution.

Table 2 (continued)

	Rape Survivors Who Worked With a Rape Victim Advocate	Rape Survivors Who Did Not Work With a Rape Victim Advocate
Questioned if resisted perpetrator	83	87
Questioned if responded sexually to assault	3	20[b]
Medical—Secondary victimization emotions (8)		
Felt bad about self	72	89
Guilty and/or blame self	54	82[b]
Depressed	81	93
Nervous and/or anxious	86	96
Violated	92	96
Disappointed	78	93
Distrustful of others	69	78
Reluctant to seek further help	67	91[b]

Note: For the Bonferroni corrections of the medical service delivery tests, the three services pertaining to the rape exam and injury treatment were grouped, alphas $p < .02$ are statistically significant; the three items related to pregnancy were grouped, alphas $p < .02$ are significant; the six questions regarding HIV/STDs were grouped, alphas $p < .008$ are significant; and the four items regarding health effects and follow-up treatment were grouped, alphas $p < .01$ are significant. For the medical secondary victimization tests, the four behaviors pertaining to rape exam were grouped and alphas $p < .01$ are significant; the six behaviors relating to the survivors' behaviors at the time of the assault were grouped, alphas $p < .008$ are significant; and the two questions regarding the survivors' prior relationship with the assailant were grouped, alphas $p < .03$ are significant. For the medical secondary victimization emotions tests, the four emotions pertaining to guilt, depression, and anxiety were grouped, alphas $p < .01$ are significant; the four emotions relating to violation and reluctance to seek further help were grouped, alphas $p < .01$ are significant. STDs = sexually transmitted diseases.

a. Denotes a trend difference.

b. Denotes a statistically significant difference.

that may have contributed to higher rates of service delivery and lower rates of secondary victimization across the sites. Nevertheless, the comparative data collected in the current study suggest that rape victim advocates and the RCCs they represent have had a positive impact on the experiences of rape survivors with the legal and medical systems.

In light of these findings, RCCs should continue to work toward widespread availability of rape victim advocates' services. Presenting evaluation data—either internal evaluations conducted by individual agencies or academic research studies—that speak to the effectiveness of rape victim advocates might help strengthen ties between RCCs and the legal and medical systems. It may also be useful to reexamine commonly used protocols for bringing advocates into hospital EDs to assist rape survivors. Several of the hospital ED directors contacted for participation in the current study mentioned that the so-called page-and-wait method for requesting an advocate was cumbersome, and this was a major deterrent to using RCC services. In addition to building stronger relationships with community service providers, RCCs may want to

Downloaded from http://vaw.sagepub.com at MICHIGAN STATE UNIV LIBRARIES on March 22, 2007
© 2006 SAGE Publications. All rights reserved. Not for commercial use or unauthorized distribution.

reenergize their efforts to reach out directly to the women in their communities to publicize their services. Other research on postassault community help-seeking experiences of rape survivors has found that many women do not know about RCCs and do not work with rape victim advocates (Campbell et al., 2001; Wasco et al., 1999). Further efforts to advertise RCCs' services and their effectiveness could be beneficial so that survivors (or their family, friends, or significant others) could request advocacy services if they are not forthcoming. Rape victim advocates appear to provide numerous benefits and can prevent serious negative consequences for rape survivors, and it is important that future research and policy efforts continue to find ways to improve the accessibility and availability of advocates' services.

References

Amey, A. L., & Bishai, D. (2002). Measuring the quality of medical care for women who experience sexual assault with data from the National Hospital Ambulatory Medical Care Survey. *Annals of Emergency Medicine*, *39*, 631-638.

Campbell, R. (1996). [Unpublished field notes from interviews with 20 rape survivors]. East Lansing: Michigan State University.

Campbell, R. (1998a). The community response to rape: Victims' experiences with the legal, medical, and mental health systems. *American Journal of Community Psychology*, *26*, 355-379.

Campbell, R. (1998b). [Unpublished field notes from interviews with 30 sexual assault community service providers]. Chicago: University of Illinois.

Campbell, R. (in press). "What really happened?" A validation study of rape survivors' help-seeking experiences with the legal and medical systems. *Violence and Victims*.

Campbell, R., & Bybee, D. (1997). Emergency medical services for rape victims: Detecting the cracks in service delivery. *Women's Health*, *3*, 75-101.

Campbell, R., & Martin, P. Y. (2001). Services for sexual assault survivors: The role of rape crisis centers. In C. M. Renzetti, J. L. Edleson, & R. K. Bergen (Eds.), *Sourcebook on violence against women* (pp. 227-241). Thousand Oaks, CA: Sage.

Campbell, R., & Raja, S. (1999). The secondary victimization of rape victims: Insights from mental health professionals who treat survivors of violence. *Violence and Victims*, *14*, 261-275.

Campbell, R., & Raja, S. (2005). The sexual assault and secondary victimization of female veterans: Help-seeking experiences in military and civilian social systems. *Psychology of Women Quarterly*, *29*, 97-106.

Campbell, R., Sefl, T., & Ahrens, C. E. (2004). The impact of rape on women's sexual health risk behaviors. *Health Psychology*, *23*, 67-74.

Campbell, R., Sefl, T., Barnes, H. E., Ahrens, C. E., Wasco, S. M., & Zaragoza-Diesfeld, Y. (1999). Community services for rape survivors: Enhancing psychological well-being or increasing trauma? *Journal of Consulting and Clinical Psychology*, *67*, 847-858.

Campbell, R., Wasco, S. M., Ahrens, C. E., Sefl, T., & Barnes, H. E. (2001). Preventing the "second rape": Rape survivors' experiences with community service providers. *Journal of Interpersonal Violence*, *16*, 1239-1259.

Cook, T. D., & Campbell, D. T. (1979). *Quasi-experimentation: Design and analysis issues for field settings*. Boston: Houghton Mifflin.

Downie, N. M., & Heath, R. W. (1983). *Basic statistical methods* (5th ed.). New York: Harper & Row.

Frazier, P. A., & Haney, B. (1996). Sexual assault cases in the legal system: Police, prosecutor, and victim perspectives. *Law and Human Behavior*, *20*, 607-628.

Frohmann, L. (1991). Discrediting victims' allegations of sexual assault: Prosecutorial accounts of case rejections. *Social Problems*, *38*, 213-226.

Downloaded from http://vaw.sagepub.com at MICHIGAN STATE UNIV LIBRARIES on March 22, 2007
© 2006 SAGE Publications. All rights reserved. Not for commercial use or unauthorized distribution.

Frohmann, L. (1997). Convictability and discordant locales: Reproducing race, class, and gender ideologies in prosecutorial decision making. *Law and Society Review*, *31*, 531-556.
Frohmann, L. (1998). Constituting power in sexual assault cases: Prosecutorial strategies for victim management. *Social Problems*, *45*, 393-407.
International Association of Forensic Nursing. (2005). *Database of the International Association of Forensic Nurses*. Retrieved May 1, 2005, from http://www.forensicnurse.org
Kerstetter, W., & Van Winkle, B. (1990). Who decides? A study of the complainant's decision to prosecute in rape cases. *Criminal Justice and Behavior*, *13*, 268-283.
Madigan, L., & Gamble, N. (1991). *The second rape: Society's continued betrayal of the victim*. New York: Macmillian.
Martin, P. Y. (1997). Gender, accounts, and rape processing work. *Social Problems*, *44*, 464-482.
Martin, P. Y. (2005). *Rape work: Victims, gender, and emotions in organization and community context*. New York: Routledge.
Martin, P. Y., & DiNitto, D. M. (1987). The rape exam: Beyond the hospital emergency room. *Women and Health*, *12*, 5-28.
Martin, P. Y., DiNitto, D. M., Byington, D., & Maxwell, S. (1992). Organizational and community transformation: The case of a rape crisis center. *Administration in Social Work*, *16*, 123-145.
Martin, P. Y., & Powell, R. M. (1994). Accounting for the second assault: Legal organizations' framing of rape victims. *Law and Social Inquiry*, *19*, 853-890.
National Victim Center. (1992). *Rape in America: A report to the nation.* Arlington, VA: Author.
Resnick, H. S., Holmes, M. M., Kilpatrick, D. G., Clum, G., Acierno, R., Best, C. L., et al. (2000). Predictors of post-rape medical care in a national sample of women. *American Journal of Preventive Medicine*, *19*, 214-219.
Schmitt, F. E., & Martin, P. Y. (1999). Unobtrusive mobilizing by an institutionalized rape crisis center: "All we do comes from victims." *Gender & Society*, *13*, 364-384.
Tabachnick, B. G., & Fidell, L. S. (2001). *Using multivariate statistics* (4th ed.). Boston: Allyn & Bacon.
Wasco, S. M., Campbell, R., Barnes, H., & Ahrens, C. E. (1999, June). *Rape crisis centers: Shaping survivors' experiences with community systems following sexual assault.* Paper presented at the Biennial Conference of the Society for Community Research and Action, New Haven, CT.
Wasco, S. M., Campbell, R., Howard, A., Mason, G., Staggs, S., Schewe, P., et al. (2004). A statewide evaluation of services provided to rape survivors. *Journal of Interpersonal Violence*, *19*, 252-263.
Williams, J. E. (1984). Secondary victimization: Confronting public attitudes about rape. *Victimology: An International Journal*, *9*, 66-81.

Rebecca Campbell, Ph.D., is an associate professor of community psychology and program evaluation at Michigan State University. Her research examines how the legal, medical, and mental health systems respond to the needs of rape survivors. Her current projects are collaborative evaluations of sexual assault nurse examiner (SANE) programs. She is the author of Emotionally Involved: The Impact of Researching Rape (2002), which won the Distinguished Publication Award of the Association for Women in Psychology in 2002.

Downloaded from http://vaw.sagepub.com at MICHIGAN STATE UNIV LIBRARIES on March 22, 2007
© 2006 SAGE Publications. All rights reserved. Not for commercial use or unauthorized distribution.

Revised February 2011

Ohio Protocol For Sexual Assault Foresnic and Medical Examination

Office of Healthy Ohio
Bureau of Health Promotion and Risk Reduction

Sexual Assault and Domestic Violence Prevention Program



Ohio Attorney General's Office
Bureau of Criminal Identification
and Investigation

Ohio Alliance to
End Sexual Violence

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
Ohio Chapter

Ohio Chapter
International Association
of Forensic Nurses

Ohio Chapter American
College of Emergency Physicians

Ohio Department of Health
John R. Kasich, Governor
Theodor E. Wymyslo, M.D., Director of Health

Ohio Protocol for Sexual Assault Forensic and Medical Examination

For more information or to receive a paper copy of this Protocol, contact:

Sexual Assault and Domestic Violence Prevention Program
Bureau of Health Promotion and Risk Reduction
Ohio Department of Health
246 North High Street, 8th Floor
Columbus, Ohio 43215
(614) 466-2144
http://www.odh.ohio.gov/odhPrograms/hprr/sadv/sadvprev1.aspx

Debra Seltzer Program Administrator
Joyce Hersh Women's Health Coordinator
Beth Malchus Rape Prevention Coordinator
Amanda Suttle Rape Prevention Coordinator

Copies of all or part of this protocol can be mailed as an unbound copy upon request. Samples of forms and patient handouts can be adapted to include agency or community specific information. Contact staff listed above to receive Microsoft Word documents by e-mail or computer disk that will allow you to create the necessary documents. Copies of the protocol can be downloaded from the internet:

http://www.odh.ohio.gov/odhPrograms/hprr/sadv/sadvprev1.aspx

The Ohio Department of Health (ODH) is in the process of formalizing a permanent review committee to provide on-going revisions to the protocol, assist with implementation of the protocol, identify training needs and evaluate the effectiveness of the protocol. ODH is interested in learning what information in the protocol is useful and what additional information you would like to include in future revisions. Your feedback is an important and an essential part of making this protocol an effective tool. Your feedback will be provided to the review committee. Please submit your feedback to: BHPRR@odh.ohio.gov. Please put "Protocol for Sexual Assault" in the subject line.

Acknowledgements

This protocol was originally developed in 1991 by **Ruth Gresham, Janice Rench** and **Lynn Helbling Sirinek**, working with an Ohio Advisory Committee under sub-contract with the Ohio Coalition On Sexual Assault (OCOSA) for ODH. A 1999 revision was completed with assistance from Sexual Assault Nurse Examiner (SANE) programs across the state, OCOSA, the Ohio Chapter of Emergency Room Physicians (OACEP), staff from the Attorney General's Ohio Bureau of Criminal Identification and Investigation office and Crime Victim Services offices and staff of the ODH Sexual Assault and Domestic Violence Prevention Program. Representatives of these same agencies served on the 2002, 2004 and the 2011 protocol update committee.

This revised protocol results from a review of the National Protocol for Sexual Assault Medical and Forensic Examination and best practices from other states and a number of experts throughout Ohio. ODH is grateful to all of these individuals who gave a considerable amount of guidance, time and effort in working to produce this Protocol. We believe this Protocol will enhance the ability of Ohio health care practitioners, along with the entire sexual assault response team to treat and support all survivors with a standard of care that is compassionate and consistent.

Individuals serving on the review committees for previous editions of the protocol are available upon request to ODH.

Members of the 2011 protocol review are:

Elizabeth Benzinger, PhD, Ohio Attorney General's Office, Bureau of Criminal Identification and Investigation

Samantha Black, RN, SANE-A, LNC, Mt. Carmel Health

Carol Buscher, RN, MSN, CEN, SANE-A, UC Health Alliance

Sharon Dickman, RN, BSN, MSNC, SANE-P, Cincinnati Children's Hospital

Ruth Downing, RN, MSN, CNP, SANE-A, Forensic Health Care Consulting

Diane Docis, BS, MEd, University of Toledo

Jodi Flynn, RN, MSN, SANE-A, SANE-P, D-ABMDI, Ashland University, Dwight Schar College of Nursing

Lindsay Fello-Sharp, Cleveland Rape Crisis Center

Peg Calvery-Grignon, BA, Education, AVERT, Genesis House Domestic Violence Center

Cathy Harper-Lee, Executive Director, The Justice League of Ohio

Christina Hinkle, RN, BSN, SANE-A, UC Health Alliance, University Hospital

Sandra Huntzinger, MSW, Ohio Attorney General's Office, SAFE Program

Jennifer Markowitz, RN, ND, WHNP-BC, SANE-A, DF-IAFN, DOVE Program, Summa Health System

Heather Herron Murphy, BA, Registered Advocate- Senior Standing, Sexual Assault Response Network of Central Ohio

Nancy Radcliffe, BA, Helpline of Delaware and Morrow

Alison Rerko, RN, SANE-A, SANE-P, Fairview Hospital

Stephanie Smith-Bowman, MSW, LSW, Sexual Assault Response Network of Central Ohio

Deb Zang, RN, BSN, Emergency Nurses Association, Ohio State Council, Inc

Staff of the ODH Sexual Assault and Domestic Violence Prevention Program:

Debra Seltzer, MPA, Program Administrator

Joyce Hersh, BA, MS, Women's Health Coordinator

Beth Malchus, BS, Rape Prevention Coordinator

Amanda Suttle, MPH, Rape Prevention Coordinator

Robert Shapiro, M.D., Philip V. Scribano, D.O. and **Kathi Makoroff, M.D.** for working with the Committee on Child Abuse and Neglect of the Ohio Chapter of the American Academy of Pediatrics, provided leadership in the development of the pediatric protocol included in this edition.

Several individuals provided additional expertise in the review and writing of the protocol. These include **Elizabeth Benzinger, Samantha Black, Joyce Hersh, Sandra Huntzinger, Beth Malchus** and **Debra Seltzer.** Additional thanks to **Christina Hinkle** and UC Health's staff for sharing their policies and procedures for handling an anonymous kit. Special thanks to the ODH Office of Healthy Ohio Administrative Professionals, Office of Public Affairs, and General Counsel for their assistance in preparing the final draft and layout for this protocol revision.

Table of Contents

Acknowledgement ii

Adult and Older Adolescent Protocol 1

Definition 1

Policy 2

Overarching Issues 2
- 1. Coordinated Team Approach 2
- 2. Victim Centered Care 3
- 3. Sexual Abuse/Hospital Advocate/Support Person/Interpretative Services 4
- 4. Minor Patient 6
- 5. Reporting to Law Enforcement 8
- 6. Anonymous Reporting Procedures 8

Operational Issues 10
- 1. Facilities 10
- 2. Protocol Coordinator 12
- 3. Training . 12
- 4. Equipment 13

Protocol Procedure 15

Section I: Intake and Triage 15

Section II: Informed Consent 16

Section III: Patient Medical History/Abuse History Assessment 17
- 1. Documentation 17
- 2. Special Considerations 18
- 3. Patient Medical History 18
- 4. Patient Assault/Abuse History 19
- 5. Assessment of Intimate Partner Violence Screening 20

Section IV: Evidence Integrity 21

Section V: Medical Considerations and Testing 22
- 1. Suspected Drug Facilitated Sexual Assault/Toxicology Blood/Urine 22
- 2. Sexually Transmitted Infections 24
- 3. Emergency Contraception 25

Section VI: Post Examination Procedure 26
1. Medical Personnel 26
2. Hospital Advocates/Support Person, Law Enforcement, Victim Witness Advocates and Other SART Representatives 27

Section VII: SAFE Program, Billing and Crime Victims Compensation Program 29
1. SAFE Program 29
2. Ohio Crime Victims Compensation Program 29

Section VIII: Resources 30
1. National 30
2. State of Ohio 30

Definitions for Detailed Instructions 31

Detailed Instructions 32

Appendices

1. Model Community SART Protocol — Appendix 1
2. Ohio SART Training Information — Appendix 2
3. Ohio Crime Victim's Rights Handout — Appendix 3
4. Sample Notification Letter for Hospitals/Facilities to Send After Examining A Minor Without Parental Consent — Appendix 4
5. Criteria for Ohio SAFE Program – Competency Requirements for For Physicians Conducting Child Sexual Abuse Evaluations — Appendix 5
6. Patient Handouts — Appendix 6
   - Information You Should Know As A Sexual Assault Survivor
   - Helping Your Child: A Note To Parents and Caregivers
   - Caring for Yourself: A Note to Survivors
   - After Care Information and Resources
   - Document of Care
7. Sample Quality Assurance Tools — Appendix 7
8. Specific Knowledge and Skill Set Beneficial for Health Care Professionals Conducting a Forensic Exam — Appendix 8
9. Drug Facilitated Sexual Assault Protocol — Appendix 9
10. Sexual Assault Evidence Collection Kit
    - Kit Specifications — Appendix 10 – Page 1
    - Ordering Information — Appendix 10 – Page 5
    - Instructions, Forms and Labels — Appendix 10 – Page 7
11. Sample Medical History Form — Appendix 11
12. HIV
    - Prophylactic information — Appendix 12 - Page 1
    - Ohio Test Sites — Appendix 12– Page 8
13. Emergency Contraception
    - Terms — Appendix 13 – Page 1
    - Fact Sheet Sample – for obtaining consent — Appendix 13 – Page 5
14. Outline of the Criminal Justice System — Appendix 14

15. Ohio Attorney General Sexual Assault Forensic Examination Payment Program
Letter to Hospital Administrators Appendix 15 – Page 1
Billing Procedures Appendix 15 – Page 3
Reimbursement Request Form Appendix 15 – Page 5
For Sexual Assault Victim/Survivors –
Information About Your Medical Bill Appendix 15 – Page 7

16. Provisions within the Ohio Revised Code Dealing with Sexual Assault Appendix 16

17. Emergency Medical Services Protocol for Sexual Assault Appendix 17

18. Male Survivors of Sexual Assault Appendix 18

19. Child Assault Reporting Guidelines Appendix 19

Protocol For The Treatment Of Adult and Older Adolescent Sexual Assault Patients

Definitions

Sexual assault: For the purposes of this protocol, "sexual assault" encompasses a wide range of criminalized sexual conduct, including rape and sexual battery. Division (A) of the Ohio Revised Code (O.R.C.) section 2907.01 defines "sexual conduct" as "vaginal intercourse between a male and female; anal intercourse, fellatio and cunnilingus between persons regardless of sex; and, without privilege to do so, the insertion, however slight, of any part of the body or any instrument, apparatus, or other object into the vaginal or anal opening or another. Penetration, however slight, is sufficient to complete vaginal or anal intercourse." This protocol doesn't attempt to address the legalities of sexual assault; instead, sets forth the manner in which a health care provider is to approach the examination of an alleged sexual assault victim/patient while maintaining the dignity of the victim/patient and the integrity of the process. A list of ORC citations relevant to sexual assault can be found in Appendix 16 and at http://codes.ohio.gov.

The completed **Sexual Assault Evidence Collection Kit** is considered biological evidence, defined by the O.R.C. 2933.82(A) (1) (a) (i), and must be turned over to the law enforcement agency with jurisdiction where the crime occurred. Beginning in 2010, Ohio law specifies retention times for biological evidence. O.R.C. 2933.82(B). The best practice for all hospitals is to establish within the community Sexual Assault Response Team (SART) protocol an agreement with the county prosecutor and local law enforcement agencies regarding the storage and disposition of kits. A contingency plan for the handling of anonymous kits, and kits whose proper jurisdiction is unknown or is outside of the county should also be included in the SART protocol.

The following protocol was developed by the Ohio Department of Health in conjunction with: Ohio Attorney General's Office, Bureau of Criminal Identification and Investigation, Ohio Chapter of the American College of Emergency Physicians, Ohio Chapter of the International Association of Forensic Nurses, Ohio Committee on Child Abuse and Neglect of the American Academy of Pediatrics, Ohio Chapter and other identified experts. The protocol is issued under the authority of the **Ohio Public Health Council,** which is charged by the Ohio General Assembly to establish procedures for gathering evidence related to sexual assault. O.R.C. 2907.29.

Policy

This protocol has been developed from the recommendations of Ohio experts based on best practices and the National Protocol for Sexual Assault and Medical Forensic Examinations. It is intended to be used by health care providers to ensure comprehensive care of sexual assault patients. Priority medical/forensic care is to be provided to the sexual assault patient with sensitivity, culturally appropriate and respectful manner regardless of when the sexual assault occurred. The type of care received will start her/him on the process of becoming a survivor.

If the examination occurs within 96 hours (four full days) after an attack, evidence should always be collected. There are cases in which evidence should be collected beyond 96 hours. Examples include cases where the victim/patient has been unconscious or sedentary, where the sexual assault is due to a cognitive disability and victim/patients are unable to give an accurate timeline or where an exam may corroborate chronic injury or excessive force related to the sexual assault. Clear documentation, specific to the case, as to the need for an examination beyond 96 hours must be made to justify the exam on the SAFE reimbursement request form.

Ohio has chosen to align with the National Protocol for Sexual Assault and Medical Forensic Examinations by recommending health care providers [physician, nurse practitioner or Sexual Assault Nurse Examiner (SANE)], with specialized education, training and experience in the evaluation and treatment of the sexual assault patients, complete the examination and provide treatment for this patient population.

Overarching Issues

1. Coordinated Team Approach

Ohio communities should ensure that all victims/patients have access to medical services, law enforcement, prosecutor and advocacy services. Use of a coordinated, multi-disciplinary approach in conducting the medical forensic examination can enable victims to gain access to comprehensive immediate care, help minimize trauma they may be experiencing and encourage the use of community resources. Such a response enhances public safety by facilitating investigation and prosecution; thereby, increasing the likelihood that offenders will be held accountable for their behavior and future sexual assault will be prevented. Raising public awareness about the existence and benefits of a coordinated, multi-disciplinary response to sexual assault may lead more victims/patients to disclose the assaults and seek the help they need for healing.

The Ohio Sexual Assault Task Force (OSATF) created a model community response protocol that is a template designed to define the different roles for the key responders making up the sexual assault community response team. Each community is unique and it is critical that each component be adapted by their local responding service providers.

In addition to establishing a local response protocol, communities are encouraged to implement a sexual assault response team (SART) to ensure a coordinated approach to this issue. Please refer to **Appendix 1 Model for Community SART Protocol** and **Appendix 2 Ohio SART Training Information**. The community protocol should clearly outline the abilities and responsibilities of each team member and their limitations in order to foster a cohesive and consistent team approach. Cross-training of all SART members is strongly encouraged. Understanding the importance and role of each member prior to the patient's arrival improves the overall response to the patient's needs. The community protocol should also address how disagreements between SART members are resolved to minimize the impact on the victim/patient.

In communities with both rape crisis based and prosecutor/law enforcement based victim advocates, it is best practice that the rape crisis center advocate respond at the hospital and make appropriate referrals to the prosecutor or law enforcement advocate if/when the victim/patient/survivor is engaged with the legal system. Guidelines on how the two organizations work together should be clearly written within the community response protocol.

2. Victim Centered Care

It is critical to respond to individuals disclosing sexual assault in a timely, culturally appropriate, sensitive and respectful manner. Every action should be taken by medical services, law enforcement, prosecutor and advocacy services during the exam helps facilitate the victim/patient's (hereinafter known as "patient") care and healing and/or the investigation (if the patient chooses to report to law enforcement).

Sexual assault patients should be viewed as "priority emergency cases" and be provided the necessary means to ensure patient privacy. The patient should be given priority for a room assignment in a private area. The medical or nursing examiner should recognize that every minute the patient spends waiting for a forensic medical exam there may be a loss of evidence and undue trauma.

As with all traumas, each individual has her/his way of coping in accordance to her/his cultural beliefs, values and norms. Sexual assault is certainly no different, and in the aftermath of an assault a patient may present exhibiting a wide range of emotions. Some patients may appear calm, indifferent, submissive, angry, uncooperative or even hostile to those trying to help. They may also giggle or laugh at seemingly inappropriate times. Because everyone reacts differently following a sexual assault, a victim should be allowed to express their emotions in a non-judgmental and supportive environment. It is vital that all first responders understand that there isn't any "right" or "wrong" way for a victim to respond following an assault. A patient's emotional reaction should in no way influence the quality of care given. How a patient presents emotionally at the hospital is in no way indicative of the degree of seriousness of the assault, nor should it be taken as evidence that an assault did or did not occur.

While reactions to a sexual assault may vary significantly for each individual, there are certain common feelings and fears that many patients face including:

- Fear of not being believed
- Fear of being blamed for the assault
- Fear that the offender may return and/or retaliate
- Fear of loss of support by primary caregiver or personal care attendant if either is the perpetrator
- Fear of unknown medical and/or criminal justice processes
- Fear of friends and family finding out
- Fear of being labeled a 'victim'
- Feelings of shame and/or embarrassment
- Feelings of guilt
- Feeling suspicious and/or hyper-vigilant
- Feeling unsafe or scared
- Feeling a loss of control

It is the duty and obligation of the responding medical, law enforcement, prosecutor and advocacy services (i.e., SART team members) to address these concerns in a way that is appropriate and respectful to the needs of the patient.

See Appendix 3 for Ohio Crime Victim's Rights Handout and link to Picking up the Pieces document handed out by law enforcement.

3. Sexual Abuse/Hospital Advocate/Support Person/Interpretative Services

In all instances the hospital or medical facility (hereinafter known as "hospital"), responding health care provider or SART coordinator shall immediately call a trained advocate from the local rape crisis center or victim/witness services to the hospital to meet with the patient. It is the responsibility of the hospital to identify the appropriate local advocacy center. If the hospital/clinic does not have local resources then staff should call in the hospital's social work personnel to work with the patient. The patient may also designate a friend, family member, someone from a place of worship or someone from her/his community as a designated support person.

The advocate/support person (hereinafter known as "support person") should be introduced to the patient. The support person will explain their role and the benefits of having additional support during the exam. The patient should be allowed to choose whether or not to speak with the support person. Having the support person present at

the hospital allows the patient more access to the resources and support offered by the local crisis center. Confidential patient record information should not be shared with the support person unless it is done so by the patient, thus avoiding any medical records confidentiality issues. Also, at any time throughout the treatment and evidence collection process, the patient should be asked if they would like to decline further interaction with the advocate/support person and/or request that person to leave.

There is no Ohio law that prohibits a patient from having a support person present during the medical/forensic examination or during the law enforcement interview. The hospital must request an interpreter be present, with prior notification to the patient to ensure communication access during medical services, law enforcement, prosecutor and advocacy services in the emergency department. The patient has the right to not utilize any sign language or foreign language interpreter and place a new request for an alternate interpreter due to genuine concerns in their translating ability or conflict of interest. Honor the patient's request by making necessary arrangements to contact the interpreting agency to secure another interpreter. It may take up to an hour before another interpreter arrives at the emergency department. The patient has a right at all times to determine who she/he would like present, including the interpreter during all stages of the medical and law enforcement interviewing process.

NOTE: If there is an indication that the assault took place in the context of a domestic violence situation and the suspected perpetrator is present, every effort should be made to assess and examine the patient without the suspected perpetrator in the room. The suspected perpetrator could be a primary caregiver (family and friends) or personal care attendant who provides daily living care services to people with disabilities, or adults in their senior years.

Rape crisis center's hospital advocates are specially trained to provide patients with free, confidential, non-judgmental, emotional support, information and resources so the patient can make informed decisions about their care and their reporting options following the exam. In accordance with the ODH Rape Prevention Program Standards, all advocates should complete 20 hours of initial sexual assault training, and have five additional hours of preparation via role-plays, observation of experienced advocates, and provision of medical advocacy while being supervised. The advocate must be familiar with the dynamics of sexual assault and relevant community resources, as well as how medical services, law enforcement, prosecutor and social services respond to patients of sexual assault. The advocate should receive training in the policies and procedures of the local hospital and a tour of their emergency department. All medical advocates should be supervised and evaluated by a coordinator at the local rape crisis center. (See Appendix 1 Model for Community SART Protocol).

Interpretative Services:
For communication access, either the hospital or SART coordinator should immediately request a sign language or foreign language interpreter if the patient utilizes American Sign Language or any other native language from her/his country of origin. The health care professional should respectfully inform the patient that a request has been made for interpretative services. It is important to directly inquire of any need for adaptive technology for patients with sensory, cognitive, developmental, and mental disability to ensure barrier-free access to medical services, law enforcement, prosecutor and advocacy services in the emergency department in compliance with the American Disabilities Act.

Patients Decline of Support Person or Interpretative Services:
If the patient chooses not to have a support person, the health personnel and law enforcement should repeat the offer to call a support person and/or interpreter periodically throughout the medical examination and law enforcement interviewing process.

The patient has a right to decline usage of a professional interpreter during medical services, law enforcement, prosecutor and advocacy services in the emergency department. To ensure communication access, confer with the patient as to the best communication method. Family or friends should not be used to provide interpretative services. Only a certified interpreter with extensive training and certification from a college and professional body can adequately facilitate communication between the patient and multi-disciplinary team in the hospital.

4. Minor Patient

Consent:
The minor patient does not need to have the written consent of a parent or legal guardian before proceeding with the examination. O.R.C. 2907.29. It is recommended that any patient age 15 and younger should be treated according to the Pediatric Sexual Abuse Protocol and in a pediatric facility. According to O.R.C. 2907.29, parents or guardian must be notified in writing after the exam. See **Appendix 4 Sample Notification Letter for Hospitals/Facilities** to send after examining a minor what parental consent.

In cases where the reported perpetrator is not the parent or guardian, it is recommended that the minor be encouraged to notify their parent or guardian at the time of the hospital/facility visit, if appropriate. Best practice is for medical personnel to advise the minor patient of the requirement to send the treatment notification letter to a parent or legal guardian and the approximate date when it will be mailed.

In cases where the alleged perpetrator is also the parent or guardian who will receive the notification, the county Department of Job and Family Services (JFS), law enforcement agency involved, and the minor child should all be advised of the nature of the notification letter and the approximate date when it will be mailed. Coordination with the county's JFS and Children Service Program must be done to insure the safety of the minor.

In cases of child sexual abuse, safety issues need to be considered before notifying the parent or guardian. Especially, if, in the opinion of medical personnel, such notification is likely to endanger or cause harm to the minor. When a minor is examined at the request of the county JFS, it shall be the responsibility and discretion of that department, to notify the parents/guardians who are the alleged perpetrators, while taking into account safety issues. Although the ORC and ODH adult sexual assault protocol state a minor's parent or guardian must be notified after a sexual assault/abuse examination, staff should follow directions given by local law enforcement and child protective services in cases where the suspected abuser is a parent or guardian.

The hospital is obligated under Ohio law (O.R.C. 2151.421) to report alleged or suspected sexual abuse of a minor whether or not the patient or their family chooses to speak with law enforcement. It is considered best practice that medical personnel **must** inform the minor patient they are legally mandated to report to law enforcement and/or JFS. **NOTE:** An adult may remain anonymous, but the sexual assault must be reported to law enforcement.

Personal health information concerning the sexual abuse and/or identity of the sexual assault patient shall not be given to the media or any other person(s) seeking information without the written consent of the patient or legal guardian.

Distinct Usage of the Adult Protocol:
This protocol can be used with a patient aged 16 and over with no cognitive disabilities. For the minor patient age 16 and 17 years old without cognitive disabilities, the health care professional will evaluate patient history to determine if the assault occurred more than 96 hours prior to the exam. If the assault occurred more than 96 hours, then the adult protocol cannot be used and the genital exams must be performed by an approved physician, advance practice nurse or registered nurse who is an expert in child sexual abuse. **(Appendix 5 Criteria for Ohio SAFE Program — Competency Requirements for Physicians conducting Child Sexual Abuse Evaluations).**

Parents or legal guardians accompanying the minor patients have a right to choose either pediatric or adult facility for exam or treatment.

It is recommended that patients under 21 years of age with cognitive disabilities be seen at a pediatric facility. However, parents or legal guardians accompanying the patients have a right to choose either pediatric or adult facility for exam or treatment.

Unwilling Minor:
If an unwilling minor is presented for a sexual assault exam by a parent or guardian, the exam should not be conducted unless the minor agrees to: submit to the exam without necessity of restraints or sedation; and after discussion with the health care provider who will be conducting the exam. If the parent or guardian presents a court order for a forceful examination, consult your hospital/facility legal counsel.

5. Reporting to Law Enforcement

Many sexual assault patients who come to hospital or other exam sites for a sexual assault examination choose to report to law enforcement. Reporting provides the criminal justice system with the opportunity to offer immediate protection for the victim, collect evidence from all crime scenes, investigate the case, arrest a suspected offender and prosecute if there is sufficient evidence. All patients need to know that even if they are not ready to report at the time of the exam, the best way to preserve their option to report later is to have the exam performed. Additionally, patients need to know law enforcement cannot mandate or request they take a polygraph, voice stress analyzer, or other truth telling test as a precursor to taking a report and conducting a thorough investigation. O.R.C. 2907.10.

Regardless of the adult patient's decision to report, it is the responsibility of medical personnel to inform the patient that law enforcement must be notified that a sexual assault has been reported to the hospital in accordance to the O.R.C. This should be done after the patient has been deemed medically stable. The law, O.R.C. 2921.22(A) and (B), does not require that the adult patient's name be given, but states that any person knowing that a felony has been or is being committed shall report it to law enforcement authorities.

6. Anonymous Reporting Procedure

Medical personnel and/or hospital support person should inform the adult patient of her/his right to decide whether or not to speak to law enforcement personnel. If the patient decides not to report the sexual assault, the hospital/facility may simply provide the date and general location of the assault to the law enforcement agency having jurisdiction without giving the patient's name, address or other identifying information.

The best time for the individual to make the decision to report to law enforcement may not be immediately after the assault. The final decision to report can be deferred, but

the evidence collection, generally speaking, cannot. Recognizing the dual importance of being sensitive to the needs of the patient and the timely collection and preservation of evidence, the anonymous reporting procedure was developed. Patients may maintain their anonymity from law enforcement until such time as they decide to report the crime.

The evidence is collected in accordance with the *Ohio Department of Health Protocol for The Treatment of Adult Sexual Assault Patients* (Fifth Edition, 2011), except that the identity of the patient is not documented on any specimens or paperwork provided in the Sexual Assault Evidence Collection Kit. The following unique identification number is created and used in place of the patient's name on all specimens and paperwork: patient's birth date plus the last four digits of the medical record. (e.g., May 23, 1963 and the last 4 numbers of the medical record 1234 – 052319631234). Hospitals and facilities may create their own system.

The anonymous kit is considered biological evidence (defined by O.R.C. 2933.82 [A]) and is to be kept in locked storage and turned over to the law enforcement agency with jurisdiction where the crime occurred. (See definitions, *Sexual Assault Evidence Collection Kit*, page 1). Beginning in 2010, Ohio law specifies a retention time for biological evidence, although anonymous kits are not specifically addressed. The best practice is for the hospital to establish an agreement with the county prosecutor and local law enforcement for handling anonymous kits that is part of the local community protocol. A contingency plan for handling anonymous kits whose proper jurisdiction is unknown or is outside of the county should be included in the local protocol.

The anonymous patient ultimately **chooses whether or not to report** the crime to law enforcement. The patient is provided information about this option both verbally and in writing before the consent for an anonymous kit collection can occur.

The anonymous patient will have received upon hospital discharge the kit's unique identification number recorded on the consent form to be stored with the medical record. This will be recorded on the after care information handouts. **Appendix 6.** The patient will then provide their unique identification number to law enforcement so the evidence may then be associated with the reporting victim. At this time, an investigation of the crime, including the examination of the evidence, may commence. Additionally, the anonymous patient is informed about the retention time established in the agreement with the county prosecutor and local law enforcement and found in the local community protocol.

An Anonymous Kit cannot be completed by anyone under the age of 18.

As part of developing a community sexual assault response protocol, the SART must include this as one of their procedure. Each community may expand the number of days a collected kit will be stored (e.g., ninety days, twenty years), but it cannot be less than sixty days.

Operational Issues

This protocol is to be used by health care providers to ensure comprehensive care of adult sexual assault patients across the state of Ohio. The findings in the exam and collected evidence provide information to help reconstruct the details about the events in question in an objective and scientific manner. A timely, effectively performed medical forensic examination can potentially validate and address the patients' concern regarding a sexual assault while minimizing the trauma. At the same time, it can increase the likelihood that evidence collected will aid in criminal case investigations, resulting in sex offenders being held accountable and ensuring effective justice for all Ohioans.

Priority medical/forensic treatment and provision of care to the adult sexual assault patients should always be given regardless of when the sexual assault occurred. If it is within 96 hours (four full days) after an attack, evidence should always be collected on an adult. Research and evidence analysis indicates that some evidence may be available beyond 96 hours after the assault. Decisions about whether to collect evidence should be made on a case-by-case basis, guided by the knowledge that outside time limits vary due to factors such as the location of the evidence and type of sample collected. Cases in which evidence should be collected beyond 96 hours occur where an exam may corroborate chronic injury, excessive force or significant trauma. The examiner must provide written justification for evidence collected beyond 96 hours in order to receive payment for the examination through the SAFE program.

1. Facilities

The Joint Commission requires emergency and ambulatory care facilities to have established policies for identifying and assessing possible patients of rape and other sexual molestation. It also requires staff to be trained on these policies. As part of the assessments process, JCAHO requires facilities to define their responsibilities related to collection and preservation of evidentiary materials. Sexual assault examiner programs are helping many health care facilities to carry out these requirements. Facilities should also familiarize themselves with the Federal Emergency Treatment and Active Labor Act (EMTALA), which requires hospitals to provide a medical screening examination to anyone who comes into the emergency department to determine whether an emergency condition exists. Facilities should also be familiar with the O.R.C. sections 2907.27 - 2907.30, 2921.22 and 2151.421 Medical Assistance to Victims of Sexual Assault.

Factors the site and community SART should address in their local protocol:

- Safety and security for patient and staff.
- Physical and psychological comfort of patients.
- Capacity with adaptive technology and appropriate medical equipment (such as height and width of examining table for individuals with mobility disabilities) to ensure barrier free access for patients with disabilities.
- Availability of examiners with advanced education and clinical experience.
- Access to pharmacy for medications.
- Access to medical support services for care of injuries.
- Access to lab services.
- Access to equipment and supplies needed to complete the exam (e.g., sexual assault evidence collection kit, new replacement clothing, digital camera).
- Access to community, state and national resources to address aftercare, including emotional and psychological needs.
- Ability to maintain confidentiality amongst staff members and the SART members who are directly involved with the evidence collection, investigation and medical care of the victim. The facility should maintain a "no information" policy when dealing with the members of the media.
- Ability to maintain "chain of custody" of evidence which includes a locked storage area if police are not immediately available to pick up the evidence.
- Use of written community protocol outlining (i.e., SART) a coordinated multi-discipline response to the survivor that includes law enforcement, rape crisis advocates, prosecution and other community organizations.
- Use of a written agreement as part of the community protocol with the county prosecutor and local law enforcement agencies regarding the storage and disposition of both sexual assault evidence collection kits that are labeled with the survivor's name or with an anonymous identification code.
- Ability to implement quality improvement measures to identify, evaluate, resolve and monitor actual and potential problems in the multi-disciplinary response to the patient, exam process, investigation and prosecution outcomes. **(See Appendix 7 for Sample Quality Assurance Tools**).

2. Protocol Coordinator

Effective January 1, 2012, each facility must designate at least one licensed medical professional who is a full time employee (e.g., Emergency Department Director, Head nurse, SANE Nurse). This person has training on the Ohio Protocol for Sexual Assault Forensic and Medical Examinations (Third Edition) to assume responsibility for:

- Acting as an official representative and facility liaison in communicating and working collaboratively with the Ohio Attorney General's Office, ODH and other local and state community organizations (e.g., local Rape Crisis or Domestic Violence Shelter, Ohio Alliance to End Sexual Violence).
- Acting as an official representative and facility liaison with the Ohio Attorney General's Office for filling out and responding to questions regarding the SAFE reimbursement form.
- Acting as an official representative who is familiar with all submitted sexual assault cases.
- Monitoring facility services to improve the quality of patient care and to assure that the services used to conduct the Ohio Protocol for Sexual Assault Forensic and Medical Examinations are provided in a safe and efficient manner. (**See Appendix 7 for sample Quality Assurance Tools**).
- Maintaining quantitative and qualitative case review of staff conducting the sexual assault and medical examinations that includes patient and local SART feedback.
- Assuring that staff conducting the sexual assault and medical examinations are trained on the protocol and are keeping within federal and state laws, rules, regulations, policies and procedures.
- Ensuring law enforcement has received the Sexual Assault Evidence Collection Kit.

3. Training

It is critical that health care providers conducting the sexual assault medical forensic exam are committed to providing compassionate and quality health care, collecting evidence in a thorough and appropriate manner and testifying in court, if needed. Their commitment should be grounded both in an understanding that sexual assault is a serious crime that can have a profound, negative effect on those victimized and in recognition of the role of advanced education and clinical experience in building competency to perform the exam. ODH recognizes that the sexual assault medical forensic examinations are complex and time-consuming procedure and recommends that health care providers, ideally SANEs, performing the exam have specific knowledge and skills that can guide them through these exams. **Appendix 8 identifies the National Protocol for Sexual Assault Medical Forensic Examination: Adult/Adolescents recommended examples of specific knowledge skills and attitudes that are beneficial for health care conducting the exam.**

A SANE is defined as an RN with specialized training that meets the International Association of Forensic Nursing (IAFN) standards for adult/adolescent patients and, if appropriate, pediatric patients. A SANE provides comprehensive care to sexual assault survivors, demonstrates competency in conducting a forensic exam to include evaluation for evidence collection, has the expertise to provide effective courtroom testimony and shows compassion and sensitivity to survivors of sexual assault.

4. Equipment and Supplies

The health care examiner should have knowledge necessary to properly use all equipment and supplies required during the exam including medication. Additionally, it is important that the examiner and the responders involved in sexual assault cases stay abreast of the latest research on the use of equipment and supplies.

The following equipment and supplies should be readily available for the exam:

- A copy of the Ohio Protocol for Sexual Assault Forensic and Medical Examination.
- Standard exam room equipment and supplies for physical assessment and evidentiary pelvic exam. The needs for patients with disabilities must be taken into account to ensure barrier-free access to medical services. Related supplies might include tweezers, tape, nail clippers and scrapers, scissors, dental floss, collection paper, saline solution or distilled water, extra swabs, slides, containers, paper bags and pens/pencils.
- Comfort supplies for patient, even if minimal. Suggested items: clean and ideally new replacement clothing, toiletries, food, drink and access to a phone in as private a location as possible. It is also important during the exam process to help the patient obtain items they request related to their spiritual healing (e.g., Bible, Koran, a religious or spiritual leader) before, during or after the exam.
- ODH sexual assault evidence collection kit or other kit that meets the standards of the ODH sexual assault protocol and the specification of the ODH kit. (See Appendix Recommended Sexual Assault Kits).
- A method or device to dry evidence. Drying evidence is critical to preventing the growth of mold and bacteria that can destroy an evidentiary sample. The ODH kit's design also aids in the drying process.
- A camera and related supplies (using the most up-to-date technology possible) for forensic photography during the initial and follow-up examinations. Related supplies might include film, batteries, a flash and an inch scale or ruler for size reference. (See Protocol Section VI Evidence Integrity).

- Testing and treatment supplies needed to evaluate and care for the patient medically (follow exam facility policies). Also, testing supplies may be needed for forensic purposes that are not included in the evidence collection kit (e.g., supplies for toxicology).
- An alternate light source (using the most up-to-date technology possible) can aid in examining patients' bodies, hair and clothing. It is used to scan for evidence such as dried or moist secretions, fluorescent fibers not visible in ambient light and subtle injuries.
- A locked storage area if police are unavailable to pick up the evidence immediately (e.g., file cabinet). **Do not store kit or clothing in the refrigerator.**
- An anoscope may be used in cases involving anal/rectal trauma.
- A colposcope with photographic capability and/or other type of digital technology. Although injuries can be detected visually by examiners without a colposcope and/or digital technology, it is an important asset in the identification of microscopic trauma. Photographic equipment, both still and video can be attached for forensic documentation.

Protocol Procedure:

Section I: *Intake and Triage*

Upon arrival to the hospital, the sexual assault patient should be viewed as a priority patient and given immediate privacy in a designated area. This patient should be seen by hospital personnel within 15 minutes of arrival or as soon thereafter as possible. Hospital personnel should immediately implement the following protocol:

- Give priority for room assignment in a private area as well as a waiting area for family members, friends and law enforcement interviews.
- Elicit sufficient information to complete the hospital registration process quickly and in private, if possible.
- Respond to acute injury, trauma care and safety needs of the patient before collecting evidence.
- Instruct the patient to not use bathroom facilities, wash, change clothes, smoke, drink or eat until initially evaluated by a forensic examiner, unless necessary for treating acute medical needs. If use of the bathroom is necessary, the patient should be informed that evidence may be present in the genital and anal areas and to take special care not to wash or wipe away those secretions until after the evidence has been collected.
- Collect urine specimens immediately if there is any indication of drug-facilitated sexual assault. (**See Appendix 9 DFSA Protocol**).
- Maintain hospital policy stipulating who will be notified immediately when a sexual assault patient presents in the emergency department. If there is no SANE program in place, then the hospital must designate a specialist with training in the sexual assault protocol to coordinate services to the patient. If there is a SANE program available in the community the patient should be given the option of going to that facility. (**Note:** if patient chooses to go to SANE facility a brief examination should occur ensuring that the patient has no emergent medical needs in order to ensure compliance with EMTALA regulations). ***This initial exam is not billable to the SAFE program.***
- Immediately call a hospital advocate from the local rape crisis center to come to the hospital and meet with the patient. If the hospital area does not have access to a local rape crisis program then someone from the hospital's social services shall be called to provide support. **See Overarching Issues, 2. Sexual Abuse/Hospital Advocate/ Support Person page.**
- Assess and respond to safety concerns such as threats to patients and staff, upon the patient's arrival at the exam site.
- Assess patient's need for immediate medical or mental health intervention.
- Ensure that emotional support is also offered to the patient's family and/or friends who are present.

Section II: *Informed Consent for Examination and Release of Evidence.*

The protocol requires you to seek both verbal and written consent of the patient prior to conducting the medical evaluation, medical treatment and evidence collection, and releasing information and forensic evidence to the law enforcement agency. Informed consent should be an on-going educational process throughout the exam. Additionally, under Ohio law, (ORC 2907.29), all patients reporting a sexual assault must "be informed of available venereal disease, pregnancy, medical and psychiatric services." The "Consent for Exam and Release of Evidence" form is provided in the Sexual Assault Evidence Collection Kit, and a copy can be found in **Appendix 10**.

To begin the informed consent process, medical personnel should provide the "Information You Should Know As A Survivor of Sexual Assault" handout from the ODH Sexual Assault Evidence Collection Kit to the patient. **See Appendix 6**.

Throughout the forensic exam, the procedures should be fully explained so the patient understands what is being done and why. The patient should be encouraged to ask questions and be informed of her/his right to withdraw consent at any point during the exam. If the patient expresses resistance to the procedure, the medical examiner should immediately discontinue that portion of the exam and consider going back if the patient agrees. If the patient is under guardianship and the guardian wants the exam to proceed but the individual expresses resistance to the procedure, consult your hospital/facility's legal counsel.

Note: If the patient withdraws consent of any portion of the exam this should be documented fully on the forensic collection envelop label.

Hospitals should follow their usual procedures for obtaining consent for all tests and treatment necessary outside the forensic exam including extraordinary cases, e.g. for severely injured or incoherent patients.

Any personal health information concerning the sexual abuse and/or identity of the sexual assault patient shall not be given to the media or any other person(s) seeking information without the written consent of the patient or legal guardian.

Patients who do not want to file police report (must be 18 years or older)
If the patient declines consent for the evidence collection, even after being presented with the anonymous reporting option (see Overarching Issues, 6. Anonymous Reporting) they should be examined for injuries and other medical concerns such as possible pregnancy and exposure to HIV/AIDS and other sexually transmitted infections. This examination is the financial responsibility of the patient and they should be so informed. If the patient is uninsured and unable to pay for this treatment, a referral to an appropriate health facility or clinic should be made for follow-up care.

If, once all options have been explained, the patient declines to report the sexual assault to law enforcement, or to participate in future possible prosecution, this decision should be respected. The individual will benefit from making the decision and regaining a sense of control.

Anonymous Kit Consent (patients must be 18 and older)
If the patient requests an anonymous kit, she/he should be advised a de-identified kit with a unique identification number will be given to law enforcement where the crime has occurred. This kit will be locked in storage. Assure the patient that the kit will be completely de-identified and no photos will be turned over to law enforcement until permission is given by them.

The patient should be told she/he will be provided with the kit's unique identification number at the end of the evidence examination. Assure the patient that she/he ultimately decide to make a report to law enforcement. She/He will need to provide the law enforcement agency with this number so the evidence may then be associated with their case. Additionally, the patient should be informed about the retention time established in the agreement with the county prosecutor and local law enforcement and found in the local community protocol.

Section III: *Patient Medical History/Assault/Abuse History Assessment (including domestic violence assessment)*

1. Documentation

Healthcare professionals should write objective information only relating to treatment needs of the patient and not make judgments about "emotional state." In collecting patient demographic, any documentation on classification of disability, whether observed or self-reported, needs to be discussed and clarified with the patient in a respectful manner with appropriate usage of Persons First Language. The patient has the right to choose to self-disclose and reinforce preferred self-identification in regards to their intellectual, emotional, mental, and physical status.

Healthcare professionals should quote the patient using only the exact statements given. Do not paraphrase or clean up language. Do not make judgments or statements about whether or not the rape or sexual assault occurred. Use terms such as "reported" or "stated" rather than "alleged," "probable," or "possible." This is necessary to maintain neutrality of documentation. Remember 'rape' is a legal conclusion.

All written information must be legible and in ink. There should be documentation if a medical interpreter was used, including name of the interpreter and language used (e.g., American Sign Language, Spanish, Somali, Russian, etc…).

2. Special Considerations

Depending upon the type of sexual assault, semen may be present in the mouth, vagina/penis and anal area. However, embarrassment, trauma or a lack of understanding of the nature of the assault may cause a victim to be vague or mistaken about the type of sexual contact that actually occurred. For these reasons, and because there also can be leakage of semen from the vagina or penis onto the anus, even without anal penetration, it is recommended that the patient be encouraged to allow examination of all three orifices and specimens collected from them. In cases where a patient insists that contact or penetration involved only one or two orifices (or in some circumstances, no orifices at all), a complete examination should still be requested of the patient. At a minimum, external anal swabs only need be collected during the genital exam. However, ultimately the patient may decline to have swabs collected.

This "right to decline" serves to reinforce a primary therapeutic principle — that of returning control to the patient who has been victimized. If the patient declines a step, this should be properly documented on the evidence collection envelope to ensure hospital compliance with the protocol and eligibility for reimbursement.

3. Patient Medical History

Obtain patient's medical history. A sample medical history form for collecting this information is provided in **Appendix 11 Sample Forms**. Alternately, hospital triage forms which cover the following items may be used in its place.

1. Patient demographic and personal information.
2. Other individuals accompanying the patient.
3. Vital signs (as warranted).
4. Allergies.
5. Last tetanus.
6. Current medications.
7. Acute illnesses.
8. Past surgeries.
9. Last menstrual period.
10. Gravida.
11. Para.
12. Contraception used.
13. Approximate weight/height.
14. Family physician.
15. Gynecologist.
16. The names of medical health care providers performing the exam should be noted on the medical history form.

4. Patient Assault/Abuse History

The sexual assault history must be documented in duplicate on the form provided in the Sexual Assault Evidence Collection Kit. The original should be retained with the medical record. The copy goes to the forensic lab with the Sexual Assault Evidence Collection Kit. If any additional copies are needed they will need to be copied by the hospital.

See recommended form in Sexual Assault Evidence Collection Kit; a copy can be found in Appendix 10. *A medical form which covers the following items may be used in its place.*

1. Time, date and place of the assault.
2. Date and time of the exam.
3. Sex, number and relationship of assailant(s), if known.
4. Was the assailant injured or bleeding?
5. Type of penetration, if any.
6. Indicate places on the body that were kissed, bitten, licked, sucked or any other oral contact.
7. Did assailant use lubrication such as saliva on any part of the body?
8. Did the patient douche, change clothes, bathe, urinate, defecate, vomit, brush teeth, rinse mouth, etc. since the assault?
9. Was patient menstruating at time of assault? At time of exam?
10. Was a tampon present at time of assault? At time of exam?
11. Was a condom used?
12. Has there been consensual sexual activity within 96 hours?
13. Narrative history (as described by the patient):
    - The narrative history is documented in direct quotations from the patient. Use only objective data. Along with the verbal medical history, document the objective data that is observed such as poor eye contact, inability to hold attention, loud speech, crying, etc. Record the patient's description of the assault. Do not record your subjective observations.
    - Print or write legibly as this information is critical to the investigation.
    - Type of weapon used, if any.
14. Description and condition of clothing (e.g. torn, dirty, bloody, etc.)

5. Assessment of Intimate Partner Violence Screening

Intimate partner violence (IPV), (also known as domestic violence), is a significant, preventable public health problem that impacts at least 32 million Americans each year. IPV occurs when physical, sexual or emotional injuries are intentionally inflicted by a current or former partner. Forms of IPV include sexual assault, rape and stalking. IPV can impact heterosexual and same-sex couples; teens and adults. Previous studies indicate that as many as 50 percent of adult women screened in an emergency department setting had been patients of IPV and 38-46 percent of adolescents report abuse from an intimate partner.[1]

The Partner Violence Screen[2], developed and validated for use in emergency departments, is an efficient screening tool for interpersonal violence. This tool, or a similar series of questions, may be used to determine if the patient or patient's family would benefit from resources to support patients of IPV.

Partner Violence Screen

1. Have you been hit, kicked, punched, choked or otherwise hurt by someone in the past year?
   ☐ Yes ☐ No
   If so, by whom?
   ☐ Person in current relationship
   ☐ Person from previous relationship
   ☐ Someone else
2. Do you feel safe in your current relationship?
   ☐ Yes ☐ No ☐ Currently not in a relationship
3. Is there a partner from a previous relationship that is making you feel unsafe now?
   ☐ Yes ☐ No

It is important that your questions about IPV not put the patient at increased risk for harm. Therefore, questions should be asked privately, away from a potential abuser (partner, family member, friend, primary caregiver, or personal care attendant) or anyone who may reveal your patient's answers to an abuser. You must make resources regarding domestic violence shelters available to the patient. If the patient desires to return home in spite of IPV, provide information regarding a safety plan before discharge. Be respectful of patient's decision to return to the abusive situation. She/He is the only person who can determine their safety.

Resources:

National Domestic Violence Hotline: 800-799-SAFE (800-799-7233)
National Network to End Domestic Violence: 202-543-5566
Ohio Domestic Violence Network: 800-934-9840
ACTION OHIO Coalition for Battered Women: 888-622-9315

Written Information:
List of Ohio Domestic Violence Shelters:
http://www.actionohio.org/dvshelter.htm
Safety Plan:
http://www.ncadv.org/protectyourself/Safety_Plan130.htm
Teens Heath: Abuse:
http://www.teenshealth.org/teen

Section IV: *Evidence Integrity*

Maintaining the chain of custody (or chain of evidence) is as important as collecting the proper evidence. The custody of the evidence in the collection kit, as well as any clothing or other collected items must be accounted for from the time it is initially collected until it is admitted into evidence at a trial. Complete documentation is also essential and must include the signature of everyone who has had possession of the evidence from the health care professional who collected it to the individual who brings the evidence into the courtroom.

- If this proper chain of custody is not maintained, the evidence may be inadmissible.
- Maintaining the chain of custody is critical to prevent any possibility of evidence tampering and deterring defense counsel from raising the issue of reasonable doubt on the basis of evidence integrity.
- Both signatures of the chain of evidence document are necessary for any transfer —one from the person releasing the evidence and the second from the person receiving it.

It is very important to follow the directions provided in the Sexual Assault Evidence Collection Kit and to maintain the chain of custody. Follow the Procedure for Evidence Collection **checklist (18 steps) found in Appendix 10 and the Detailed Instructions for the ODH Sexual Assault Evidence Collection Kit in Section V** which follows this section. These instructions are also included in the evidence collection kit.

A. The medical examiner must adhere to all written and or accepted workplace protocols regarding the collection of sexual assault evidence collection and maintaining chain of custody.

B. The medical examiner must complete and sign the forensic laboratory chain of custody collection form included in the sexual assault evidence collection kit.

C. All evidence collected is the property of law enforcement. Once the evidence collection forms and kit have been completed, they should be handed over to law enforcement.

Community sexual assault protocols should specify procedures for handing over of evidence. This may include using Fed-Ex services and requiring a signature by the local law enforcement as receipt of delivery from the hospital.

See Appendix 1 for Model Community SART Protocol.

D. If the police are unavailable to pick up the evidence, the medical examiner must place it in a locked storage area, preferably with signed access. **(Do not refrigerate kits)**. When the police arrive, the examiner can sign for the stored evidence and personally hand it to law enforcement personnel.

E. All photographs should be taken by a forensically trained medical staff or law enforcement photographer. If a law enforcement photographer is not available, photos should be taken by a trained forensic staff member or forensic nurse.

   Close-up photos should be taken of the patient's face and trauma areas with a measuring device to document the size of the injury (cut, bruise, scratch, etc.). The photos should be identified (labeled) with the patient's name, hospital/facility number and date. It is recommended that genital photos be taken when indicated by trained forensic staff members or the forensic nurse.

   The law enforcement photographer is responsible for documenting the patient's face and full body photographs. Forensically trained medical staff is responsible for photo documentation of any evident trauma including genital photographs.

   Two sets of photos are recommended. Both sets remain with the medical records unless a law enforcement agency requests the trauma photos for their files. One set should be given to the law enforcement agency with a proper release form.

F. The law enforcement agency may ask for additional tests and/or specimens. As with all tests, the patient's consent must be obtained if any such additional tests are performed or specimens taken.

Section V: *Medical Considerations and Testing*

Each patient should be assessed and treated as a unique individual. The following tests should be discussed and recommended based on the patient's needs. As with all patients, note all treatments given and any tests completed in the Patient Medical Record.

1. Suspected Drug Facilitated Rape/Toxicology Blood/Urine – See Appendix for Drug Facilitate Sexual Assault Protocol

A. There are a number of ways in which the use of alcohol or drugs may contribute to an act of sexual assault. The substance most frequently involved in sexual assaults is alcohol, something the victim may consume voluntarily. Increasingly, cases have

been reported in which the perpetrator surreptitiously administers a drug to the victim, most often through adding it to a drink, in order to incapacitate her/him so that she/he is unable to prevent the assault. There are several dozen different drugs which are known to be used for this purpose.

B. The medical personnel conducting the exam should assess the assault history to determine whether any indicators of drug impairment exist (see following list of symptoms). Ideally, the patient should not urinate until after the evidence has been collected. Since these drugs can metabolize very quickly, the timeliness of the specimen collection is important. The sooner a urine specimen is obtained after the assault, the greater chance of detecting drugs.

C. If the patient presents with any of these symptoms please refer to **Appendix 9:** Drug Facilitated Sexual Assault Protocol:

1. Confusion
2. Decreased heart rate
3. Dizziness
4. Drowsiness
5. Impaired judgment
6. Impaired memory
7. Lack of muscle control
8. Loss of consciousness
9. Nausea
10. Reduced blood pressure
11. Reduced inhibition

References:

Nora Fitzgerald and K. Jack Riley, Drug Facilitate Rape: Looking for the Missing Pieces, National Institute of Justice Journal, April 2000.
http://www.ncjrs.gov/pdffiles1/jr000243c.pdf

Marc LeBeau, et al, *Recommendations for Toxicological Investigations of Drug-facilitated Sexual Assaults*, Journal of Forensic Sciences, Volume 44, pages 227-230, 1999.

Marc LeBeau, *Toxicological Investigations of Drug-Facilitated Sexual Assaults*, Forensic Science Communications, Volume 1 Number 1, April 1999.
http://www.fbi.gov/hq/lab/fsc/backissu/april1999/lebeau.htm

2. Sexually Transmitted Infections

Contracting Sexually Transmitted Infections (STIs) also referenced as Sexually Transmitted Diseases, from an assailant is a typical concern of sexual assault patients. The health care providers must offer and encourage prophylactic treatment at the time of the exam. It may reduce the need for more expensive/extensive treatment than if the STI is discovered at a later time.

When using the adult protocol, testing for STIs is not recommended. Medical personnel must offer all patients information about the risks of STIs including: gonorrhea, Chlamydia, trichomonas, syphilis, HIV and hepatitis with consideration on presenting information in a visual manner for full comprehension. The information should include: what to do if the symptoms occurs after the exam and referrals to free and low-cost testing, counseling and treatment within their community

When the patients is offered prophylactic treatment by the health care provider, the patient should be aware of the benefits and consequences of taking prophylactics against STIs and be able to make their own decisions about treatment. Prophylactic treatment should be based on current guidelines from the Centers for Disease Control and Prevention (CDC) online at http://www.cdc.gov/std or by calling 888-232-3228.

If the patient declines prophylactic treatment at the time of the initial exam, document the patient's decisions and rationales in their medical record.

Although the patient may be reluctant to go for follow-up exams for STIs, such exams are essential. They provide an opportunity to detect new infections acquired during or after the assault, complete hepatitis B immunization, if indicated, and complete counseling and treatment for other STIs. The CDC recommends a follow-up appointment within one to two weeks of the assault. In some communities the support personnel may be available to accompany patients to these follow-up appointments.

A. Hepatitis B virus (HBV) and Postexposure Prophylaxis

See CDC recommendations related to HBV diagnosis, treatment, prevention, postexposure immunization, prevaccination antibody screening, postexposure prophylaxis and special considerations. Centers for Disease Control and Prevention (CDC) online at http://www.cdc.gov/std or by calling 1-888-232-4636.

Medical personnel must stress to patients receiving the HBV vaccine the importance of following up for administration of doses as scheduled for full protection. Support personnel should also be educated about the possibility of patients receiving prophylaxis HBV and encourage those who start the vaccine regimen to follow-up for required additional doses.

B. Risk for Acquiring HIV Infection

Medical personnel must discuss with the patient their concerns regarding the possibility of contracting HIV. As with other STIs, patients should be offered information about HIV risks, symptoms and the need for immediate examination if the symptoms arise. HIV/AIDS testing must be discussed including the difference between anonymous and confidential testing. Local referrals for testing and counseling should be provided. The statewide AIDS/HIV/STD hotline can provide a listing of local HIV/AIDS test sites. There telephone number is 1-800-332-2437. More information about the hotline can be found in **Appendix 12**.

Given the special circumstances pertaining to HIV Post-Exposure Prophylaxis (PEP), further information and a suggested algorithm are included in **Appendix 12.** Additional information is available from the CDC online at http://www.cdc.gov/std and the PEPline on-line at: http://www.nccc.ucsf.edu/Clinical_Resources/PEPGuidelines.html

C. Resources for HIV and Hepatitis B and C

National Perinatal HIV Consultation and Referral Hotline: 888-488-8765
National HIV Telephone Consultation Service: 800-933-3413
National Clinicians' Post-Exposure Prophylaxis Hotline for HIV and hepatitis B and C (PEPline) 888-488-4911

3. Emergency Contraceptives

In accordance with O.R.C. 2907.29, medical personnel **must** discuss and offer all legal options for possible pregnancy, including emergency contraception with all (female) patients of child-bearing age who have not had a hysterectomy or permanent sterilization. Information should be given to the victim about the risks as well as the medications that can be taken to help prevent pregnancy. This emergency contraception information must be provided as an important part of the treatment and healing process for the patient. Treatment is at the discretion of the authorized health care provider with the permission of the patient.

Emergency prophylactic treatment should be based on current medical practice, which is available online at http://www.cdc.gov. Emergency prophylactic treatment should be started within 72 hours for the best chance of working but can be started up to 120 hours (5 days) afterward and still be effective. Medical personnel should inform the patient that some medications may lessen the effectiveness of emergency contraception and determine if the patient is taking such medication.

If the patient wishes to receive emergency contraception, and the institution or physician is precluded from providing it, a referral **must** be provided to the patient and available within 72 hours after the assault occurred to another physician, health care institution or agency. Refer to **Appendix 13** for patient information regarding emergency contraceptive.

Section VI: *Post Examination Information*

Medical personnel have important tasks to accomplish prior to discharging the patient, as do hospital advocates/support person and law enforcement (if patient has requested involvement). The responding medical, legal, and advocacy services (i.e., SART team) should coordinate their activities as much as possible to reduce the repetition and avoid further overwhelming the patient. These activities should be part of the community sexual assault protocol.

1. Medical Personnel

Medical personnel, preferably the examiner should address issues related to medical discharge and follow-up care. The medical personnel should check all forms for completeness of information and signatures. Procedures for handling the paperwork should follow the policies of the protocol and medical facility.

A. Make sure patients medical and mental health needs related to the assault have been addressed. Instruct the patient on the importance of medical follow-up. Give patient the telephone number of a local rape crisis center and/or counseling agency(ies) which can provide follow-up services related to the sexual assault.

B. Let the patient know that neither she/he nor her/his insurance company should be billed for the evidence collection or the cost of any antibiotics administered as part of the examination. She/he may be billed for other associated medical care provided (i.e., emergency contraceptives, blood work, x-rays). Any of these costs, if not covered by insurance, may be covered by the Victims of Crime Compensation Program.

C. Make a referral available to provide emergency contraception to patient within 72 hours after the assault occurred if the facility cannot provide this on site.

D. Provide the patient with the completed "After Care Information for Sexual Assault Survivor" handout (patient discharge information) along with the "Common Reactions and Follow up Services for the Sexual Assault Survivor" handout. Note all referrals, treatment received and medication doses to be taken on the "After Care Information" handout. She/he should also be given a verbal explanation of the after care instructions and offered a final opportunity to explore any acute concerns prior to discharge. If the patient is admitted to the hospital, both pages are to remain with her/him. (**See Appendix 6 Patient Handouts**).

E. Assist Anonymous Reporting patient with the procedure for reporting to law enforcement. Show the patient where their sexual assault collection number is located on the "Follow-up Services for the Sexual Assault Survivor" handout. Reinforce the retention expiration date for their kit. This date should also be placed on the "Follow-up Services for the Sexual Assault Survivor" handout.

F. Assist the patient with follow-up medical and mental health appointments for the patient to document developing or healing injuries and complete resolution of healing. Appointments may also be needed to address on-going medical concerns. If appointments are not scheduled, at least indicate which appointments are needed on the "After-Care Information" form. Make it clear that patients do not have to disclose the assault to receive follow-up medical care. Follow-up appointments may include:

- Locations for follow-up tests and treatment for syphilis, gonorrhea, chlamydia and hepatitis. Be sure the patient understands that no tests have been given and they need to arrange for follow-up testing.
- Locations for anonymous HIV/AIDS testing in three and six months.
- Contacting law enforcement or rape crisis center if additional bruises appear and new photographs and documentation must be done.

G. Document that a safety plan has been developed for patient at discharge. Safety planning can be done with the hospital advocate or the hospital social worker.

2. Hospital Advocates/Support Person, Law Enforcement, Victim Witness Advocates and Other SART Representatives

Involved SART team members should come to agreement about who is responsible for the following steps. This should be written in the community protocol.

A. Help patients plan for their safety and well-being. Assist the patients in considering things such as:

- Where are they going after being discharged? With whom? Will these individuals provide them adequate support? Is there anyone else they would like to contact? (Provide information about available community resources and write down on the After Care Form. Help the patient make contact if needed).
- Do they need transportation?
- Will their living arrangements expose them to threat of continued violence or harassment? Is there a need for emergency shelter or alternative housing options? (Provide options and help obtain if needed).
- Are they eligible for protection orders? (Provide information and help obtain if desired).

- Is there a need for enhanced security measures? (Discuss options and help obtain if desired).
- If they feel unsafe, what will they do to get help? (Discuss options and help them develop a plan).

Planning must take into account the needs and concerns of specific populations. For example, if patient with physical disabilities requires shelter, the shelter must be accessible and staff able to meet their needs. If there is a need for a personal care attendant to support daily living needs and activities at a shelter, its important involve the patient in the process of contacting a disability-related community resource to assist with this. The patient has a right in their choice that they feel safe with a personal care attendant while returning home or going to a shelter. If a patient was living in an institutional setting has been assaulted by another resident, staff person or person who has easy access to residents, the institution should offer alternative living arrangements and reduce the likelihood that the patient comes into contact with the assailant again.

B. Explain advocacy and counseling services available within the community. Also explain that an advocate can be available throughout the exam, police interview and court process.

C. Make the patient aware that it is their decision whether to report their case and talk with law enforcement officials and prosecutors.

D. Explain the investigation process. (**See Appendix 14 for outline of criminal justice system**). If law enforcement is involved, inform the patient that investigators will request an interview with them. If not already done, explain the criminal justice process and victims rights. Law enforcement should provide a copy of the "Picking up the Pieces" handout to the patient. The law enforcement officer should write contact information on the "After Care Information" form. The patient should be encouraged to call their investigator with any new relevant information, if new signs of injuries appear, about suspect's compliance with protection orders or bond conditions, if suspect tries to contact them, or other related questions or concerns.

E. Explain the community's protocol for handling anonymous kits. Information should include how long a collected kit will be stored with law enforcement and a mechanism for the patient to notify law enforcement to retrieve the kits for investigation.

Section VII: *Sexual Assault Forensic Examination Program, Billing and Crime Victims Compensation Program*

1. Sexual Assault Forensic Examination (SAFE) Program

The Ohio Revised Code 2907.28 (B) states that "no costs incurred by a hospital or emergency facility" for the collection of forensic evidence in sexual assault cases, "Including the cost of any venereal diseases (known as Sexually Transmitted Infections) antibiotics administered as part of the examination," "shall be billed or charged directly or indirectly to the victim or the victim's insurer." Physicians and other medical providers shall not seek reimbursement for services provided during a medical examination of a patient of sexual assault for the purpose of gathering physical evidence for a possible prosecution from the hospital or other facility where the exam was conducted and not bill the SAFE program or the patient of patient's insurance.

The Attorney General's SAFE Program will reimburse facilities for the cost incurred in conducting a medical examination of a victim of sexual assault for the purpose of gathering physical evidence for possible prosecution. For more information about the reimbursement program, contact the office of the Attorney General at 1-(800) 582-2877 or (614) 466-5610. (Also see Appendix 15 for instructions for reimbursement for the SAFE Program.)

2. Ohio Crime Victims Compensation Program

The patient should be informed that they are responsible for the cost of other medical tests (not included in the sexual assault exam) or treatment needed as a result of the assault. If the patient is uninsured and unable to pay for this treatment, the hospital should provide as much immediate care as possible and make a referral to an appropriate health care facility or clinic follow up care. Expenses not covered by insurance may be costs eligible for reimbursement from the Ohio Crime Victims Compensation program. (See Appendix 15 for more information about the compensation program).

In order to qualify for this program, the patient must meet necessary criteria and report the crime to law enforcement within 72 hours, or show a good reason for a delay. Explain to the patient that a community or prosecutor-based advocate can assist with the application for compensation. The Ohio Crime Victims Compensation program may cover costs for any part of such treatment not covered by insurance. Information about the Ohio Crime Victims Compensation program should be given to the patient prior to leaving the hospital. See Appendix 6, After Care Information, and Appendix 16 ORC Section 2742.51 through 2743.72.

Section VIII: Resources

1. National

National Domestic Violence Hotline 1- (800) 799-7299
http://www.ndvh.org

National Organization for Victim Assistance 1-(800) 879-6682
http://www.trynova.org

Nation Sexual Violence Resource Center 1-(877) 739-3895
http://www.nsvrc.org

National Victim's Resource Center 1-(800) 627-6872
http://www.ncvc.org/ncvc/Main.aspx

Rape, Abuse, & Incest National Network (RAINN) Hotline 1-(800) 656-4673
http://www.rainn.org

2. State of Ohio

Action Ohio: Coalition for Battered Women
(614) 825-0551
http://www.actionohio.org

The Justice League of Ohio
(614) 848-8500
http://www.thejusticeleagueohio.org

International Association for Forensic Nurses, Ohio Chapter
http://www.ohiafn.org

Ohio Alliance to End Sexual Violence
(614) 233-3301
Toll-Free: (888) 886-8388
http://www.oaesv.org/contact.html

Ohio Attorney General's Office
SAFE Program
(614) 995-5415
http://www.ag.state.oh.us/victim/index.asp

Ohio Department of Health
Sexual Assault and Domestic Violence Prevention Program
(614) 466-2144
http://www.odh.ohio.gov/odhPrograms/hprr/sadv/sadv1.aspx

Ohio Domestic Violence Network
1-(800) 934-9840
http://www.odvn.org

Other:

For local assistance, check your telephone directory. For local emergency assistance call 911 or the Sheriff's Office, the local Police Department or the Ohio State Highway Patrol in the area or 1-(877) 7PATROL(772-8765) for emergency services from the State Police.

Definitions Detailed Instructions

1. The following definitions apply to the evidence collection:
    a. **Air dry** – Dry at room temperature. Do not use any heat. Keep away from direct sunlight.
    b. **Sealing envelopes** – Do not lick the flaps of envelopes. If necessary, use a damp sponge or paper towel to moisten envelope flaps. Use patient identification stickers as a seal over each fastened envelope flap. Use paper envelopes only; never plastic.
    c. **Slightly moisten** – Use just enough sterile saline or distilled water to facilitate collection of a dried external stain or prevent discomfort during the vaginal and rectal examination. Flooding the swabs decreases their absorbing power and should be avoided.
    d. **Swabbing** – When swabbing a stain or body cavity, allow the swab to soak up as much as possible in order to maximize the recovery of evidence.

2. Step by step instructions follow (as they will appear in the kit instructions).

Detailed Instructions

(Recommended Order)

Ohio Department of Health Sexual Assault/Abuse Evidence Collection Kit

Please proceed in numerical order and complete all steps. The patient may not remember or may not be able to discuss certain aspects of the assault at the time of examination. Important evidence may be lost if all steps are not completed. However, it is also very important for the patient to resume control. Therefore, if the patient declines a step, write "patient declined" on the collection envelope and go on to the next step.

It is important to follow instructions and write legibly as these items may be used in court to prosecute a sexual offense. Remove strips to seal envelopes (**do not lick**).

- Please DO NOT use staples.

The **Assault History** form is required by the ODH Protocol. An institutional form of the same content may be substituted.

A sample Medical History form may be found in the protocol, **Appendix 12.** An institutional form of the same content may be substituted. **Do not place this in the kit.**

Step 1: Intake and Triage

The sexual assault survivor should immediately be placed in a private waiting area. The hospital advocate and the health care provider conducting the exam should be notified immediately. The survivor should be seen within 15 minutes of arrival. The survivor should not disrobe at this time. Clothing will be collected during the exam and evidence collection. The hospital advocate and the examiner should be notified immediately.

Step 2: Informed Consent for examination and release of evidence to police

Allow the patient or parent/guardian to read **Information You Should Know as a Survivor of Sexual Assault.** Explain to the patient what the sexual assault exam will entail. Explain to the patient that they can withdraw their consent at anytime.

Complete and have the patient or guardian sign the **Sexual Assault Exam Consent, Release of Evidence Consent, and Photography Consent** form.

Anonymous Kit Consent (patient must be 18 and older)

If the patient is unsure about reporting to law enforcement at this time, discuss the anonymous kit collection option. The patient should be advised a de-identified kit with a unique identification number will be given to law enforcement where the crime has occurred. This kit will be locked in storage. Assure the patient that the kit will be completely de-identified and no photos will be turned over to law enforcement until permission is given by them.

The patient should be told she/he will be provided with the kit's unique identification number at the end of the evidence examination. Assure the patient that she/he ultimately decide to make a report to law enforcement. She/He will need to provide the law enforcement agency with this number so the evidence may then be associated with the evidence. Additionally, the patient should be informed about the retention time established in the agreement with the county prosecutor and local law enforcement and found in the local community protocol.

See the Protocol Procedure, Section II Informed Consent

The release is not necessary for child abuse cases.

Step 3: Patient Medical history

Most providers use a standardized medical history form. A downloadable model from can be found on the ODH Website at http://www.odh.ohio.gov/odhPrograms/hprr/sadv/sadvprev1.aspx or in **Appendix 12**. Please DO NOT place the medical history form in the kit. This is for hospital records only.

Step 4: Abuse/Assault History Form

The ODH Protocol requires that a readable copy of this information be placed in the kit. Please write legibly.

This form is provided in the kit and is also found **in the protocol, Appendix 10**. Although discouraged, an institutional form may be substituted provided that it contains all of the same information and is readable.

Complete the first two pages of the **Assault History** form. In the **Patient Narrative** section, record the patient's description of the assault. Pay particular attention to information that will assist you in locating injuries and body fluid evidence such as semen, saliva and vaginal secretions. **Do not record** your subjective observations and opinions. Use quotation marks when recording the patient's own words. See protocol procedure section III, Patient Medical /Abuse/Assault History, 1.

The rape crisis advocate/hospital support person, family member or other support person may remain in the room during the examination, if the patient so desires.

Step 5: DFSA Urine.

Consider collecting urine samples for toxicological screening for drug facilitated sexual assault if unexplained impairment or gaps in patient recall exist. **Refer to Appendix 9, Drug Facilitated Sexual Assault Protocol and Protocol Procedures, Section V Medical Considerations and Testing. Refer to the ODH Sexual Assault Protocol Section VII for testing instructions.**

Step 6: Cut Head Hair Standards ✂

Using clean scissors, cut a combined total of 10 – 15 hairs from various areas of the head. Cut NEXT to the skin. Place the head hairs in the envelope provided. Label and seal the envelope.

Step 7: Oral Swabs and Smear

Collect four oral swabs **regardless of the assault history**. If necessary, slightly moisten the swabs with sterile water or saline. Rub two swabs back and forth between the left cheek and lower gum and as far back on the tongue as possible without triggering the gag reflex. Using two more swabs, repeat for the right side.

Use any one of the swabs to make the smear. Make the smear by rolling the swab forward and back once in the center of the pre-labeled slide. **Do not discard the swab.** Do not use any fixative on the slide. Air dry the smear and place it in the slide mailer. Place the slide mailer in the envelope. Air dry all four oral swabs in the boxes (2 swabs/box). Close the boxes and place in the envelope. Label and seal the envelope.

B. Children Only: Step 7A: Oral Culture for Gonorrhea

If indicated, culture the pharynx for gonorrhea.

- Non-culture tests, such as ELISA and DNA probes, may not be acceptable as evidence of infection in a court of law.
- Do not use swabs with wooden applicators.
- Do not place cultures in the kit box—send to the hospital lab.

Step 8: DNA Reference Standard

Collect one oral swab. Rub between the cheek and UPPER gum line. Place in box and air dry. Close box and place in envelope. Label and seal envelope.

Step 9: Fingernail Scrapings, Swabbing and Cuttings

Scrape or swab under the patient's nails using the orange stick or swabs provided in the nail scrapings envelope. Moisten the swabs to collect dry material. Collect the scrapings or swabbings into the envelope. Be sure to dry the swabs before packaging. If a fingernail is broken, using clean nail clippers, clip off the broken end and place it into the envelope. Label and seal the envelope.

Step 10: Underwear Collection

The underwear WORN TO THE EXAM must be placed in the kit. If no underwear, collect intimate item worn next to the body such as tights or pantyhose. If pants worn next to the body, note that on this bag and place the empty bag in the kit. If a panty liner or pad is in place, leave it attached to the underwear. Collect the jeans or pants at Step 11.

If the patient is not wearing the clothing worn at the time of the assault, it is still necessary to collect the items that are in direct contact with the genital area (underpants/pantyhose). Inform the law enforcement officer so that the clothing worn at the time of the assault can be retrieved from the patient's home.

Step 11: Clothing Collection (three bags)

Collect any bra or outer garments worn during or immediately after the assault, even if no damage or staining is apparent. As the patient disrobes, place one garment item in each bag.

- Do not shake out the garments, as evidence such as hairs and fibers may be lost.
- Do not cut through any existing holes, rips or stains in the patient's clothing.

Place your initials or other identifying mark on the clothing labels or on a piece of tape attached to the area where the clothing label is normally located. Label and seal the bags with the security seals provided.

- If any of the items are wet or damp, inform the law enforcement officer to ensure that the clothing can be properly air dried.

Step 12: Dried Stains

Collect potential semen or saliva stains by slightly moistening one or two swabs with sterile water or saline and swabbing the area.

- A Wood's lamp or other alternate light source may be helpful in examining the patient's body for dried semen stains.
- Saliva stains will not be visible under alternate light sources. Listen carefully to the patient's account of the incident to determine where saliva stains may be located and swab accordingly.
- If cunnilingus may have occurred, or if the perpetrator may have used his saliva as a lubricant, swab the external vaginal area in addition to collecting internal vaginal swabs.
- Collect each stain in a separate envelope.
- Ask if the assailant used his/her mouth anywhere on the patient or used his/her saliva as a lubricant. Swab these areas as above. Swab and photograph any bite marks.
- Label and seal envelope.

Step 13: Pubic Hair Combings or Collection of Stray Hairs found near Genital or Anus Area

With the patient standing, hold the envelope under the pubic area and use the comb provided to comb through the pubic hairs several times. Comb directly into the envelope. Place the comb into the envelope. If pubic hair not present, collect any stray hairs from the genital area. Label and seal the envelope. If the patient does not have pubic hairs, please note this on the envelope.

Step 14: Cut Pubic Hair Standards ✂

After completing Step 10 above, using clean scissors, **cut** a combined total of 10 – 15 hairs from various areas of the pubic region. Cut as close to the skin as possible. Place the pubic hairs in the envelope provided. Label and seal the envelope.

Step 15: Anal/Perianal Swabs and Smear

Collect four anal or perianal swabs **regardless of assault history.** See additional discussion in the protocol. If necessary, the swabs may be slightly moistened with sterile water or saline. If there is no evidence or report of anal penetration, it is acceptable to swab the perianal area rather than inserting the swabs.

Use any one of the swabs to make the smear by rolling the swab forward and back once in the center of the pre-labeled slide. **Do not** discard the swab. **Do not** use fixative on the slide. Air dry the smear and place it in the slide mailer. Place the slide mailer in the envelope. Air dry all four anal/perianal swabs in the boxes (2 swabs/box). Close the boxes and place in the envelope. Label and seal the envelope.

C. Children Only: Step 15A: Anal/Perianal Cultures

If indicated, culture the anus for gonorrhea and Chlamydia.

- Non-culture tests, such as ELISA and DNA probes, may not be acceptable as evidence of infection in a court of law.
- Do not use swabs with wooden applicators.
- **Do not place cultures in the kit box**—send to the hospital lab.

Step 16: Vaginal/ Penile Swabs and Smear

For females: Collect four vaginal swabs **regardless of assault history.** Collect two swabs at a time, swabbing any pooled fluid and the cervical area.

Use any one of the swabs, make the smear by rolling the swab forward and back once in the center of the pre-labeled slide. **Do not** discard the swab. **Do not** use any fixative on the slide. Air dry the smear and place it in the slide mailer. Place the slide mailer in the envelope. Air dry all four vaginal or penile swabs in the boxes (2 swabs/box). Close the boxes and place in the envelope. Label and seal the envelope.

- If a tampon is present, air dry and place in a **Step 5** envelope. Label and seal the envelope.

- If cunnilingus may have occurred, or if the perpetrator may have used his saliva as a lubricant, swab the external vaginal area including labia minora in addition to collecting internal vaginal swabs. Place the external vaginal area swabs into a Step 12 (Dried Stains) envelope.

For males: Collect four penile swabs. Slightly moisten the swabs with sterile water or saline and swab the glans and shaft of the penis using two swabs at a time. Follow the instructions above for smears and packaging. **DO NOT INSERT SWABS INTO THE MALE URETHRA.**

For pre-pubertal females: Swab the external genitalia and labia minora with four slightly moistened swabs and make a smear as above.

- A speculum examination is almost never indicated on a prepubertal female and may add to the child's trauma. A speculum examination that is indicated for extensive injury should only be performed at a pediatric hospital under general anesthesia.

D. Children Only: Step 16A: Vaginal/Penile Cultures

If indicated, culture the vagina or urethra and Chlamydia.

- Non-culture tests, such as ELISA and DNA probes, may not be acceptable as evidence of infection in a court of law.
- Do not use swabs with wooden applicators.
- **Do not place cultures in the kit box**—send to the hospital lab.

Step 17: Document Injuries

Complete the third page of the **Assault History** form during your assessment. Take photos of the patient to assist recall and to document any physical injuries. Do not place photos in kit. Keep these photos with your records. Using the anatomical outlines provided, indicate all signs of physical trauma — e.g. bruises, scratches, marks, discolorations (size and color) or bite marks on any part of the patient's body.

The use of a Wood's Lamp or other alternate light source, colposcope or toluidine blue dye to help visualize stains and injuries is essential. The use of toluidine blue dye in sexual assault examination is helpful for the identification of microscopic injury and requires special training.

Step 18: Prophylaxis and Patient Information Packet

Give the handout packet to the patient. **(See Appendix 6)**
Refer to the ODH Sexual Assault Protocol for more information on follow up care.
For anonymous kit requests, make sure the patient receives their unique identification number and the retention time established by the local jurisdiction where the crime occurred.

Discuss STI and pregnancy prophylaxis with the patient as applicable. See Protocol Procedure, Section V, Medical Considerations and Testing, 2. Sexually Transmitted Infections and Emergency Contraceptives.

Step 19: Pack Up the Evidence Kit and Refrigerate DFSA Kit if Collected

1. Verify that all of the information requested on the collection envelopes and forms has been completed and that all of the envelopes are sealed.
2. Place the Assault History form into the kit. **Do not put the consent form inside the sexual assault examination evidence kit.**
3. Place all collection envelopes and the underwear bag (whether these items have been collected or not) into the kit. **Do not put the DFSA kit inside the sexual assault examination evidence kit.**
4. Using the seal provided, seal and initial the kit, and fill out all of the information requested on the box lid. This information is required.
5. Complete the top portion of the Chain of Custody forms (found at the bottom of the Step 2 Chain of Custody form and on the lid of the kit box). Hand the sealed kit and sealed paper bags to the law enforcement officer and have him/her complete the bottom portion of both Chain of Custody forms. One copy of the Chain of Custody form stays at the hospital in the medical record. One copy is given to the law enforcement officer.
6. If the evidence is not immediately released to law enforcement, the kit and clothing should be stored in a secure area according to the local protocol.
7. If the DFSA kit is not immediately released to law enforcement, the DFSA kit is stored in a secured refrigerator according to the local protocol.

This completes the evidence collection steps associated with the kit. See the Ohio Sexual Assault Protocol for the remaining steps. Be sure to complete and/or review with the patient the instructions for Section IV, *Evidence Integrity, Section VI Post Examination Information, and Appendix 9, DFSA Protocol.*

STRATEGIES in Brief

ÆQUITAS

Issue # 17 | March 2013

Presence of Victim Advocate During Sexual Assault Exam Summary of State Laws

Charlene Whitman, JD[1]

Following a sexual assault report, victims are propelled into the criminal justice system and faced with an array of strangers, each with his or her own role in the response, investigation, or prosecution of the crime. Victims are often interviewed by multiple people, including police officers, doctors, nurses, social workers, and prosecutors. To help victims cope with these challenges, some state legislatures have passed laws providing them with the right to have a victim advocate or personal representative present during such interviews to offer support. This article focuses specifically on the victim's right to have an advocate present during a medical forensic exam. To date, only eight states — California, Florida, Iowa, New Jersey, New York, Oregon, Texas, and Washington — have enacted laws to provide victims with this right.[2] For more information, readers can consult a statutory compilation created by AEquitas: The Prosecutor's Resource for Crimes Against Women. The compilation is current as of December 2012.[3]

RATIONALE

While health care providers are often the point of entry for victims seeking assistance immediately following an assault, advocates play an important role for victims of sexual assault by providing support and guidance, regardless of whether or not they decide to report the crime to police. Therefore, the medical exam offers a good opportunity to provide victims with an advocate for emotional support. Advocates can also answer any questions the victim might have regarding the exam and the victim's continuing role in the investigation and prosecution of the assault, should the victim choose to report.

Another reason to provide an advocate is that many victims experience the exam itself as traumatic. As stated in the Texas law: "Many victims report the exam as a second assault."[4] The legislative history of the Texas statute explains that the presence of an advocate, who is trained to provide comfort and support for a victim, may help minimize the traumatic impact of the medical forensic exam. The remainder of this article will focus on the eight states that specifically provide a victim with the right to have an advocate or personal representative present during the medical forensic exam.

VICTIM NOTIFICATION

Among the eight states that provide for the presence of a victim advocate, there are different approaches to how the law extends this right to a victim. In California, Texas, New Jersey, and New York, state law requires that medical personnel inform sexual assault victims of their right or opportunity to have a victim advocate present during the medical forensic exam. This statutory requirement represents a proactive approach on behalf of the legislature, providing support for victims of sexual assault. By contrast, the laws in Florida, Iowa, Oregon, and Washington provide only that a victim has *the right* to have a victim advocate present. In these states, the burden to request an advocate for the medical forensic exam lies with the victim.

Under California law, the health care provider[5] must inform the victim, either orally or in writing, of their right to have a sexual assault counselor and one other support person present during the exam.[6] Health care providers are required to give victims notice of this right before they begin the exam. The right to have a counselor present may be restricted only if either a law enforcement officer or the health care provider determines that the presence of the person serving in this role would be detrimental to the purpose of the exam.

Texas law requires that a health care provider offer a victim of sexual assault the right to have a sexual assault advocate present during any medical forensic exam to which she has consented.[7] As in California, the health care provider must inform the victim of this right before beginning the exam. Texas law also establishes that the health care provider has the discretion to exclude a sexual assault advocate from an exam if the advocate interferes with or delays emergency medical treatment of a victim.

Similarly, New Jersey and New York require that the health care provider notify a victim of sexual assault of the opportunity and availability for an advocate to be present during the medical exam.[8] New Jersey law assigns this responsibility to the Sexual Assault Nurse Examiner program coordinator to provide "the opportunity to … speak with a rape care advocate prior to and during any medical procedure".[9] New York requires that, upon admittance or commencement of treatment that the hospital "shall advise the victim of the availability of the services of a local rape crisis or victim assistance organization, if any, to accompany the victim through the sexual offense examination."[10] Both New Jersey and New York provide for an exception where emergency medical care is necessary.

NO NOTIFICATION REQUIRED

The laws of Florida, Iowa, Oregon, and Washington have established the victim's right to have an advocate present during the medical forensic exam, but do not specifically require the medical professional to notify the victim of this right. Florida law provides for the presence of a victim advocate during any medical forensic exam upon the request of the victim or the victim's parent, guardian, or lawful representative.[11] When requested to do so, the health care provider is required to permit an advocate from a certified rape crisis center to attend any medical forensic exam.

Iowa allows a victim counselor to be present during any "proceeding related to the offense."[12] The statute defines any "proceeding related to the offense" to include exams of the victim for injuries related to the charged offense at an emergency medical facility where surgery is not required. Additionally, the role of victim counselor is defined as a certified counselor who works at a crime victim center, and whose primary purpose is to render advice, counseling, and assistance to the victims of crime.[13] Going one step further than the Florida law, Iowa's statute provides that a victim counselor who is present at the request of the victim *shall not be denied access* to any proceedings related to the offense.[14]

Oregon law provides for any victim over the age of 15 to request an individual to be his or her "personal representative."[15] This personal representative may accompany the victim throughout the various stages of the investigation and prosecution, including a medical forensic exam. Oregon, like Iowa, prohibits health care providers from preventing a personal representative from accompanying a victim unless the representative's presence would somehow compromise the exam.[16] This Oregon statute also governs the effect of the admissibility of evidence related to the presence of a victim advocate. Specifically, the law states that there are no grounds for excluding otherwise admissible evidence based on whether or not a personal representative was allowed to be present during a medical forensic exam. Additionally, the fact of whether or not a victim requested a personal representative to be present during the exam may not be used as evidence in a criminal case.

Finally, Washington state law permits a personal representative of the victim's choice to accompany the victim to the hospital or other health care facility and to be present during the sexual assault exam.[17] This law is part of the Victims of Sexual Assault Act, which states that: "because of the lack of information, training, and services, the victims of sexual assault are not receiving the assistance they require in dealing with the physical and psychological trauma of sexual assault."[18] The Victims of Sexual Assault Act was enacted to provide education and services to victims throughout the process of a criminal investigation and prosecution and to serve the long-term goals of victim recovery and crime prevention.

CONCERNS AND CAUTIONS

While the presence of an advocate (or a personal representative) during a medical forensic exam can be very helpful for victims, there are some concerns from a prosecutor's perspective. For example, some prosecutors are concerned that the presence of a victim advocate might defeat patient-doctor privilege. Others question whether the victim's privacy interests are being protected. Many states address these concerns by providing for legal privilege between the victim and an advocate, counselor or representative, at least within the context of a sexual assault case. This legal privilege means that a victim advocate, counselor, or representative many not be compelled to testify to or disclose communications with the victim, made in a professional capacity.[19] Of the eight states that have codified the right to have a victim advocate present during the medical forensic exam, seven (California, Florida, Iowa, New Jersey, New York, Texas and Washington) also have laws protecting this privilege of communication between a victim of sexual assault and their advocate, counselor or representative.

CONCLUSION

It is critical to offer services to sexual assault victims as soon as possible. Allowing for an advocate to be present during the medical forensic exam provides immediate support and also presents the opportunity for victims to be informed of additional resources that are available to them to assist in their recovery. Therefore, it is considered best practice to offer victims the option of having an advocate present during a medical forensic exam, regardless of whether there is a statutory requirement. This best practice is recommended in the *National Protocol for Sexual Assault Medical Forensic Examinations*[20] as well as many state protocols for sexual assault response. The *National Protocol* calls for victim-centered care during the exam process, and specifically recommends that the nurse examiner "understand the importance of victim services within the exam process [and] involve victim service providers/advocates in the exam process (including the actual exam) to offer support, crisis intervention, and advocacy to victims, their families, and friends."[21]

The legislatures of California, Florida, Iowa, New Jersey, New York, Oregon, Texas, and Washington have provided a valuable legal tool for victim advocates and health care providers to offer guidance and support for victims of sexual assault. For the full text of these state laws and other legal issues faced by advocates and victims of sexual assault please see http://www.aequitasresource.org/library.cfm.

ENDNOTES

[1] Charlene Whitman is an Associate Attorney Advisor at AEquitas: The Prosecutors' Resource on Violence Against Women. This article has been revised, since its original publication, to reflect changes in the law.

[2] These eight states also ensure the right to have a victim advocate present during other proceedings within the criminal context. In fact, this is true for the majority of U.S. states, which provide for sexual assault victims to have an advocate present at any interview with police or prosecutors. However, a review of the laws addressing this right is beyond the scope of this article.

[3] This and other resources are available upon request at http://www.aequitasresource.org/library.cfm.

[4] Commentary in support of Tx. B. An., H.B. 1234, May 2, 2001.

[5] This article uses the term "health care provider." For state-specific terminology (and a definition of which personnel are included in the definition), see the law and practices for your jurisdiction.

[6] CAL. PEN. CODE § 264.2(b).

[7] TEXAS CODE CRIM. PROC. ANN. ART. 56.045

[8] N.J. STAT. ANN. § 52:4B-52(h)(2011); N.Y. PUB. HEALTH LAW § 2805-I(3)(2012).

[9] N.J. STAT. ANN. § 52:4B-52(h)(2011).

[10] N.Y. PUB. HEALTH LAW § 2805-I(3)(2012).

[11] FLA. STAT. ANN. § 960.001(1)(u).

[12] IOWA CODE ANN. § 915.20(1).

[13] IOWA CODE ANN. § 915.20(1)(a).

[14] IOWA CODE ANN. § 915.20(2).

[15] OR. CODE §147.425.

[16] *Id.*

[17] WASH. REV. CODE ANN. § 70-125.060.

[18] WASH. REV. CODE ANN. § 70.125.020.

[19] For more information, AEquitas has created a statutory compilation titled, *Victim Privilege by Practitioner*, which is current as of July 2010 and available, upon request, at http://www.aequitasresource.org/library.cfm.

[20] Office on Violence Against Women, United States Department of Justice (2004, September). *A National Protocol for Sexual Assault Medical Forensic Examinations (Adults/Adolescents)*. Washington DC (NCJ 206554).

[21] *Id.*

© 2013 AEquitas. All rights reserved.

Updated and reprinted with permission from Sexual Assault Report, Volume 14, Number 6 (July/August 2011), published by Civic Research Institute. All Rights Reserved. This article was supported by Grant No. 2009-TA-AX-K024 awarded by the U.S. Department of Justice, Office on Violence Against Women (OVW). The opinions findings, conclusions, and recommendations expressed in this publication are those of the author and do not necessarily reflect the views of OVW.

1100 H Street NW, Suite 310 • Washington, DC 20005
P: 202-558-0040 • F: 202-393-1918

Ohio Alliance to End Sexual Violence
Phone: 216-658-1381 / 888-886-8388 Email: info@oaesv.org

CRIMINAL JUSTICE FACT SHEET FOR SURVIVORS

Legal Resources: Anti-Stalking Orders and Protection Orders

If the perpetrator is an adult:
If the perpetrator is charged with a sexually oriented offense, Felonious Assault, Aggravated Assault, Assault, Aggravated Menacing, Menacing by Stalking, Menacing, or Aggravated Trespass (or a municipal ordinance substantially similar), the survivor may request that the prosecutor file a *criminal protection order* on the survivor's behalf.

If no charges are filed, or if the survivor chooses not to report the crime, a survivor may still seek a *Civil Stalking Protection Order* or *Sexually Oriented Offense Protection Order*. Both orders are available in an *ex parte* hearing (an emergency hearing in front of a judge, with only the survivor present). However, the perpetrator has the right to request a full hearing where he/she is present.

If the perpetrator is a juvenile:
Civil protection orders are also available in instances where the perpetrator is a juvenile. It is not necessary that criminal charges be filed against the juvenile. Civil orders are available if a juvenile has committed specific behavior under the law, such as behavior that is considered a sexually oriented offense, aggravated assault, aggravated menacing, aggravated trespass, assault, domestic violence, felonious assault, menacing, or menacing by stalking. The survivor may complete the protection order form (even if they themselves are a minor) or a parent or other adult household member may file on behalf of the minor.

Forms and further information:
While it is not necessary that an attorney complete and file the forms, it is often more effective to work with a court advocate or lawyer. See the sidebar at right for information about free legal resources in your community.

- Forms & information on orders against adult perpetrators: http://www.supremecourt.ohio.gov/JCS/domesticViolence/protection_forms/stalkingForms/
- Forms & information on orders against juvenile perpetrators: http://www.supremecourt.ohio.gov/JCS/domesticViolence/protection_forms/juvenileForms/

Free Legal Resources

Legal advocates
Legal advocates are trained volunteers who can assist survivors with completing and filing protection orders. Advocates are not attorneys and cannot give legal advice.

To find a Legal Advocate in your community, visit http://www.oaesv.org/support-by-county.html or call the Ohio Alliance to End Sexual Violence at (888)-886-8388.

The Justice League of Ohio
The Justice League of Ohio provides free legal assistance and representation for victims to protect and uphold victim rights. For more information, visit http://tjlo.org/

Legal Aid Offices
Legal Aid can assist survivors who qualify for assistance. A directory of Ohio Legal Aid offices is available here: http://www.ohiolegalservices.org/programs).

Pro Bono Attorneys
Contact your local bar association for pro bono referrals. Ohio associations are listed here: http://www.americanbar.org/groups/bar_services/resources/state_local_bar_associations/oh.html

This document in its entirety was published by the Ohio Alliance to End Sexual Violence (OAESV) through a Victims of Crime Act grant award administered by the Ohio Attorney General's Office

Sources: National Center for Victims of Crime, "The Criminal Justice System", available at http://www.victimsofcrime.org/, last visited (DATE); Ohio State Bar Association, "The Law and You – Chapter 4 - Criminal Law," https://www.ohiobar.org/General%20Resources/Law_and_You_04.pdf; AARDVARC (An Abuse, Rape, and Domestic Violence Aid and Resource Collection), http://www.aardvarc.org/victim/court.shtml; Ohio Attorney General's Office, "Picking up the Pieces: Helping Crime Victims Rebuild Their Lives," available at http://www.ohioattorneygeneral.gov/.

Frequently Asked Questions

If the prosecutor pursues charges, how long will the criminal justice process take?
There is no set amount of time, since it can depend on factors such as the resources of the jurisdiction where the crime took place and the type of crime the perpetrator is charged with. However, under the law there are limits to the time it can take between an arrest and a trial. (See "How does the criminal justice process work?" on the next page). Unfortunately, the process often takes much longer than many survivors anticipate. One factor that can slow the process is the issuance of *continuances*—court-ordered delays of judicial hearings. A legal advocate or prosecuting attorney can work on your behalf to try and limit the number of continuances (if possible).

What is a Legal Advocate?*
A court/legal advocate acts on behalf of and in support of a survivor who is making legal decisions. Advocates do not provide legal advice, but rather share information, answer questions, and help guide a survivor through the criminal justice process. These services are provided free of charge. To find out what legal advocacy services are available in your county, visit http://www.oaesv.org/support-by-county.html or call the Ohio Alliance to End Sexual Violence at (888)-886-8388. (See note below).

What is the Victim Compensation Fund?
The state of Ohio administers the Ohio Victims of Crime Compensation fund to reimburse victims who have been physically injured or emotionally harmed by criminal acts.

Eligibility: The program is designed as a "fund of last resort", meaning that all other forms of financial assistance (including insurance) must be exhausted in order to be eligible. In addition, the victim must report and cooperate with law enforcement in order to receive funds. (Note that the prior requirement that victims report within 72 hours and file within two years has been eliminated.)

Victims are not eligible for funds if they have been convicted of a felony, of child endangerment, or of domestic violence in the previous ten years. In addition, if a victim was engaged in misconduct when the crime occurred, they cannot receive funds.

What the funds cover: medical expenses; lost wages; counseling for immediate family members for victims of homicide, domestic violence, or sexual assault; travel costs to attend court proceedings; legal representation for applying for protection orders; crime scene clean up; replacement of clothing damaged due to assessment or medical treatment; the cost of visual, hearing, dental, or mobility aids, and the cost of items taken as evidence. There are caps on some funds. Payments cannot be made for pain and suffering or for stolen, damaged, or lost property.

For more information or to apply online: http://www.ohioattorneygeneral.gov/Services/Victims

*Note: Community-based Legal/Court Advocates, such as from rape crisis centers and social service agencies, advocate strictly for the survivor and his/her wishes. Prosecutor-based Legal/Court Advocates (i.e. those employed by and housed within the Prosecutor's Office/Court) advocate for the successful prosecution of the case, which may or may not conflict with the survivor's needs and wishes.

Sources: National Center for Victims of Crime, "The Criminal Justice System", available at http://www.victimsofcrime.org/, last visited (DATE); Ohio State Bar Association, "The Law and You – Chapter 4 - Criminal Law," https://www.ohiobar.org/General%20Resources/Law_and_You_04.pdf; AARDVARC (An Abuse, Rape, and Domestic Violence Aid and Resource Collection), http://www.aardvarc.org/victim/court.shtml; Ohio Attorney General's Office, "Picking up the Pieces: Helping Crime Victims Rebuild Their Lives," available at http://www.ohioattorneygeneral.gov/.

How does the criminal justice process work?

Reporting the Crime:

- ✓ **Reporting.** A survivor can choose whether to report the crime. If witnesses or other parties observed the crime, they may also report to police. *Note:* reporting is not the same as prosecuting; the prosecuting attorney ultimately decides whether to prosecute.
- ✓ **Investigation.** Law enforcement will investigate the crime so they can gather enough evidence to arrest a suspect.
- ✓ **Arrest or citation.** If officers are able to gather enough evidence, they may arrest the suspect or issue a citation asking the suspect to appear in court. Even if law enforcement officials are not able to gather enough evidence, they may still keep the case open.

Prosecution and Pretrial:

- ✓ **Charges.** The prosecutor will examine the evidence and determine whether to file written charges (a complaint) or to release the accused.
- ✓ **First Court Appearance.** If the prosecutor files formal charges, the defendant will appear before a judge and be informed about the charges against him or her and the defendant's rights. If the defendant does not have an attorney and cannot afford one, the court will appoint an attorney or a public defender.
- ✓ **Bail or Bond.** A judge may decide to release the defendant on bail, bond, or "own recognizance" (no bail is issued but defendant promises to return to court). When issuing bail, the court considers factors such as the nature of offense, evidence, employment status, drug use, mental condition, ties to the community, and convictions. A defendant can post bail with cash or other valuables (such deeds to property).
- ✓ **Grand Jury or Preliminary Hearing.** Ohio's constitution requires that in a felony case, a prosecutor file an information statement showing that there is "probable cause" to believe the accused committed the crime, or a *grand jury* must hand down an indictment. A panel of citizens examines the evidence and decides whether to issue an indictment (charge) for the crime. The victim may need to testify, but the defendant is not present.
- ✓ **Arraignment.** A judge will inform the defendant of the charges against him or her and their rights as a defendant. The defendant will plead either guilty, no contest (accept the penalty without guilt), or not guilty. If the defendant pleads guilty or no contest, no trial is held and the defendant will be sentenced. If the defendant pleads not guilty, there is a plea agreement or trial.

Trial or Plea Deal (Adjudication):

- ✓ **Plea Deal.** The vast majority of criminal cases in the United States are resolved with a plea agreement. In a plea deal, the defendant will plead guilty to one or more charges, sometimes in return for charges being dropped, lesser charges, or the recommendation of a lenient sentence.
- ✓ **Trial.** If the defendant does not accept a plea deal there will be a trial. The trial will either be before a judge (a *bench trial*) or a jury (*jury trial*).
  - **Right to a speedy trial:** Under Ohio law, the following are the maximum time limits for a hearing or trial after an arrest or summons service:
    - 30 days for trial in mayors' courts or minor misdemeanors in any court;
    - 45 days for misdemeanors carrying a maximum penalty of 60 days in jail;
    - 90 days for more serious misdemeanors;
    - 15 days for preliminary hearings in felony cases;
    - 270 days for trials in felony cases.

Sources: National Center for Victims of Crime, "The Criminal Justice System", available at http://www.victimsofcrime.org/, last visited (DATE); Ohio State Bar Association, "The Law and You – Chapter 4 - Criminal Law," https://www.ohiobar.org/General%20Resources/Law_and_You_04.pdf; AARDVARC (An Abuse, Rape, and Domestic Violence Aid and Resource Collection), http://www.aardvarc.org/victim/court.shtml; Ohio Attorney General's Office, "Picking up the Pieces: Helping Crime Victims Rebuild Their Lives," available at http://www.ohioattorneygeneral.gov/.

Post-Trial:

- ✓ **Sentencing.** Depending on the nature and degree of the crime, a judge may be required to abide by sentencing requirements mandated by Ohio law; in other instances, the judge may have the discretion to decide the length of a jail or prison sentence, or may have the ability to sentence the offender with restitution or fines (reimbursing the victim or paying the court) or probation.
  - In felony cases, the court is required by Ohio law to mandate the preparation of a ***victim impact statement***, a verbal or written statement describing the emotional, psychological, physical, and mental harm suffered, any economic losses sustained, compensation requested and recommended penalty. This statement is not usually made public and is not shared with the defense without the victim's consent.
- ✓ **Probation or Parole.** In some instances, a judge may place an offender on probation, and offenders who serve part of their sentence may in some instances be eligible for parole.
- ✓ **Appeal.** If the defendant is found guilty at trial, the offender has the right in Ohio to appeal.

What are my rights as a victim?

Article 1, section 10a of Ohio constitution articulates the rights of crime victims in Ohio:

> Victims of criminal offenses shall be accorded fairness, dignity, and respect in the criminal justice process, and, as the general assembly shall define and provide by law, shall be accorded rights to reasonable and appropriate notice, information, access, and protection and to a meaningful role in the criminal justice process.

Law enforcement officers are obligated by law to provide a victim of crime with a publication detailing victim rights. Among the rights a victim is entitled to:

- the right to appoint a representative during criminal proceedings
- the right to receive the investigating officer's contact information
- the right to notification when a suspect is arrested or released
- the right to employment protections during criminal proceedings
- the right to communicate with the prosecutor
- freedom from intimidation
- freedom from delay
- the right to make a victim impact statement
- the right to be present at trial
- reasonable return of property
- *and more…*

Special Rights for Sexual Assault Survivors:

There are special rights afforded to sexual assault survivors: If there is a medical exam to gather evidence, the Attorney General's Sexual Assault Forensic Examination (SAFE) program covers the cost of the exam and antibiotics to prevent sexually transmitted infections. Survivors can also request that the offender be examined for communicable disease. Survivors can request that no information from the police report be released until there is a preliminary hearing or arraignment, or until the case is dismissed. Also, should the judge hold a closed hearing for the survivor to answer sexual history questions, the survivor may request an attorney (and one can be appointed if the survivor cannot obtain counsel).

For more information about victim rights:
Office of Justice Programs – Victim Law: https://www.victimlaw.org/
Ohio Attorney General's Office: http://www.ohioattorneygeneral.gov
The Justice League of Ohio: http://tjlo.org/
National Crime Victim Law Institute: http://law.lclark.edu/centers/national_crime_victim_law_institute/

Sources: National Center for Victims of Crime, "The Criminal Justice System", available at http://www.victimsofcrime.org/, last visited (DATE); Ohio State Bar Association, "The Law and You – Chapter 4 - Criminal Law," https://www.ohiobar.org/General%20Resources/Law_and_You_04.pdf; AARDVARC (An Abuse, Rape, and Domestic Violence Aid and Resource Collection), http://www.aardvarc.org/victim/court.shtml; Ohio Attorney General's Office, "Picking up the Pieces: Helping Crime Victims Rebuild Their Lives," available at http://www.ohioattorneygeneral.gov/.

Protecting Ohio's Families

OHIO ATTORNEY GENERAL

SEXUAL ASSAULT KIT COMMISSION

"If a crime was committed, the kit should be submitted."

MIKE DEWINE

★ OHIO ATTORNEY GENERAL ★

www.OhioAttorneyGeneral.gov

The Attorney General's Recommended Policy on Submission of Sexual Assault Kits

The state should test all sexual assault kits in any case in which a sexual assault occurred, regardless of whether the case is ultimately prosecuted. This presumption in favor of testing ensures that sex offender DNA will be uploaded into state and federal law enforcement databases even if the offender cannot be prosecuted. The only time a kit should not be submitted to a crime lab is if the referring agency cannot conclude that a sexual assault probably occurred. Every day, law enforcement officers in Ohio determine whether crimes probably occurred by looking at factors such as the factual allegations, the circumstances of the case, the credibility of the witnesses, and information they develop on the suspects. **If an officer concludes that a sexual assault probably was committed, the agency should submit the kit to a crime lab for testing**.

This policy will increase the number of kits submitted to the Bureau of Criminal Investigation (BCI), potentially by 200 percent. BCI will meet the challenge of testing as many as 2,000 new kits per year by expanding its DNA capacity.

This recommendation applies equally to any kits in law enforcement possession, regardless of when the kits were collected. Any kit, whether collected 10 days ago or 10 years ago, should be submitted to a crime lab. There is no reliable data on how many of Ohio's sexual assault kits are outstanding because there has never been a centralized way to track kits. They are distributed to private medical facilities, which then may send them to local law enforcement agencies. Those agencies may, but don't always, submit them to crime labs. Without supply-chain tracking, no one knows how many thousands of kits may be sitting on shelves in hospitals or law enforcement agencies.

While we do not know the outstanding balance of cases from prior years, BCI is committed to testing every kit, regardless of when it was collected. BCI will accomplish this by hiring four additional forensic scientists. These dedicated scientists will work solely on pre-2011 kits. This commitment will allow BCI to test 1,500 outstanding cases in the *first* year and 3,000 cases every year after that without adding a single day of delay to current DNA requests.

The presumption that a kit will be tested if a sexual assault occurred is simple, clear to apply, and ensures the greatest protection for Ohioans. We have considered and rejected the "test-everything" approach adopted by other states. But we also have considered and rejected the status quo. This policy represents a balanced, effective approach to the testing of sexual assault kits. Combined with increased capacity and advanced investigative training, it is the best policy for Ohio.

Proposed Standard for Submission of Current Cases

The Attorney General recommends that law enforcement agencies adopt policies that favor the submission and testing of current kits in cases in which a sexual assault probably occurred.

The Attorney General's recommendation can be phrased simply as: If a crime was committed, the kit should be submitted. This recommendation is easy to apply, will continue to enhance the Ohio and Federal Combined DNA Index System (CODIS), and recognizes the changing role of DNA evidence in modern policing. At its core, this policy prevents any probable offender's DNA from getting "lost in the system." The policy ensures a robust and comprehensive database of probable offenders that will enhance law enforcement apprehension efforts.

When a sexual assault kit is collected, the DNA sample it contains can be uploaded to CODIS as long as the submitting agency determines that a crime "probably occurred." That sample may return a match to a known suspect. But even if it does not, the existence of that sample may be relevant in a future criminal investigation. Every sample contained in CODIS increases its effectiveness as a law enforcement tool. That is why law enforcement agencies should submit every kit for testing if they determine a crime probably occurred.

Conversely, if a law enforcement agency cannot determine that a crime probably occurred, no kit should be submitted. This is because the results cannot be uploaded into CODIS unless a crime probably was committed. Whether "a crime probably occurred" is imprecise, but it is functionally identical to a more familiar phrase: whether there is probable cause to believe an offense was committed.

There are various reasons why an agency might be unable to conclude that a crime probably occurred. For example:

- Facts asserted by the victims do not meet the statutory elements of a sexual assault offense.
- A known suspect conclusively establishes an alibi.
- Based on all available witness statements, no objective officer could believe a sexual assault was committed.

It is important to note that this policy recommends submission *independent of the decision to charge or prosecute* a suspect. That is, regardless of whether the suspect is ultimately charged or prosecuted, the law enforcement agency should submit the kit for testing if there is probable cause to believe an offense was committed. This is because — regardless of whether a trial or conviction occurs — it is beneficial to have *all* probable offenders' DNA in CODIS.

BCI: Meeting the Challenge

Sexual assault kits have become part of the landscape of sexual assault investigations, and the state's crime lab needs to increase its capacity to handle the number of kits being generated. That is why BCI is building an infrastructure that will allow it to dramatically increase its testing capacity. This commitment ensures that no DNA test will be delayed because of these new submission standards.

Further, BCI has adopted a specific plan for addressing Ohio's outstanding kits: It will hire four additional forensic scientists whose only role will be to test pre-2011 kits. In the first year of operation, this unit will test up to 1,500 sexual assault kits. And it will test 3,000 kits every year after that until there are no more outstanding kits.

Education Matters: A Multidisciplinary Approach

The physical and personnel investments that BCI is making are only as effective as the participation from local law enforcement agencies. That is why the Attorney General's Sexual Assault Kit Commission encourages local law enforcement agencies to follow consistent, statewide approaches to investigating sexual assault cases and submitting sexual assault kits. The Ohio Attorney General already has trained 900 first responders, law enforcement officers, and prosecutors on advanced topics in sexual assault investigation and is constantly expanding its course availability and offerings.

OPOTA: Leading the Way in Education

The Ohio Peace Officer Training Academy (OPOTA), in conjunction with subject matter experts from BCI and the Sexual Assault Response Training Team, part of the Attorney General's Crime Victim Section, have focused not only on the "how" of sexual assault investigations, but also on the "who." OPOTA's new training courses emphasize law enforcement interaction with victims, victim advocates, and medical personnel in sexual assault investigations.

In the past year, OPOTA has held four one-day regional trainings on sexual assault investigation, reaching more than 500 officers. This training focuses heavily on personal interaction with victims, advocates, and sexual assault nurse examiners (SANEs).

Also, OPOTA and the Crime Victim Section are in the process of producing an online *eOPOTA* course that will make this same victim-focused training available to every law enforcement officer in Ohio. As with all *eOPOTA* courses, the training will be available 24 hours a day and is completely free for any officer. OPOTA's courses also will cover the submission of sexual assault kits and the collection and submission of known subject samples.

Finally, OPOTA is overhauling its intensive three-day Sexual Assault Investigator Training to include two full days devoted to SANE and crime victim advocate interaction and interviewing concerns.

Crime Victim Section: Statewide Reach, Victim Focused

In 2009, the Ohio Attorney General's Crime Victim Section assembled the Sexual Assault Response Training Team (SARTT). Composed of multidisciplinary subject matter experts, SARTT is the only statewide training team focused on sexual assault response. SARTT focuses on training first-responder teams to handle complex sexual assault cases, thus reducing gaps in services to victims. SARTT has trained more than 200 first responders in its two-day Non-Stranger Sexual Assault: Profile of a Case trainings and 100 in its Underserved/Marginalized Victims of Sexual Assault course. It also has trained 70 prosecutors and law enforcement officers in its Prosecuting the Non-Stranger Rapist course. With nearly 400 first responders and law enforcement personnel receiving sophisticated sexual assault victim training, SARTT is equipping Ohio's criminal justice system with the skills necessary to protect some of our most vulnerable victims.

SARTT's experts are available for consultation and are constantly updating and expanding their trainings.

BCI: Clear Standards for Submission

When a sexual assault kit is submitted to BCI for testing, it will be subject to prioritization based on its investigative or prosecutorial urgency. Agencies that deal with a large number of kits should consider adopting policies for internal prioritization. This is the best way to ensure that agencies' kits are processed in a timely manner.

- Immediate Priority: Sexual assault kits in unknown offender cases. Examples: Investigations of violent sexual assaults with an unknown suspect and a known prosecution witness. Active investigations of serial sexual assaults or sexual assaults that fit a pattern.

- High Priority: Sexual assault kits in open cases with known trial dates and cases that involve child, elderly, or developmentally disabled victims.

- Regular Priority: Sexual assault kits in open cases that are worked oldest to newest. Examples: Investigations of sexual assault with a known suspect and a known prosecution witness. Investigation of a sexual assault case with a known suspect who admits the sexual activity but denies lack of consent, recantation cases, and cases that may not be prosecuted regardless of the test results.

Low Priority: Sexual assault kits in closed cases. Cases in which the information is not likely to be probative or informative, such as anonymous witness cases in which the originating party cannot be contacted by law enforcement through any method. Cases deemed not prosecutable, but in which a crime probably occurred.

Contact Information

If you have questions about this policy, please contact:

Matthew A. Kanai, General Counsel for Law Enforcement
614-466-9595
Matthew.Kanai@OhioAttorneyGeneral.gov

*To learn about lab submission, the testing process, or CODIS, please contact **BCI**:*

Ron Dye, Laboratory Director
740-845-2554
Ronald.Dye@OhioAttorneyGeneral.gov

*To learn about or schedule sexual assault investigation training, please contact **OPOTA**:*

Bob Fiatal, Executive Director
740-845-2700
Robert.Fiatal@OhioAttorneyGeneral.gov

John Green, Deputy Director of Regional Training
740-845-2700
John.Green@OhioAttorneyGeneral.gov

*To learn about or bring SARTT training to your area, please contact the **Crime Victim Section**:*

Sandy Huntzinger, Victim Service Coordinator
614-466-4797
Sandra.Huntzinger@OhioAttorneyGeneral.gov

Ohio Alliance to End Sexual Violence

Civil Legal Issues for Sexual Assault Survivors

Information & Resources

Criminal Justice System versus Civil Law

When the crime of sexual violence occurs, the role of the criminal justice system is to investigate and, if warranted, prosecute the crime. It is the only avenue by which a perpetrator can be held criminally accountable. Civil Law, on the other hand, has the capacity to address numerous ancillary issues related to the crime of sexual violence, including privacy, safety, employment, education, housing, immigration and financial concerns stemming from the victimization.

Pros & Cons of Criminal versus Civil Law:

	Criminal Justice System	*Civil Legal System*
Pros	▪ Capacity to prosecute the offender ▪ There is no direct financial cost to the survivor ▪ There are some privacy protections	▪ Capacity to address multiple issues ▪ The survivor has greater control over the process ▪ Standard of proof is less stringent
Cons	▪ Successful prosecution nearly always requires survivor's participation ▪ Often a long, difficult process over which the survivor has little control ▪ Standard of proof is stringent	▪ Does not hold the perpetrator criminally accountable for the original crime ▪ The survivor must find, and often pay for, his/her own attorney ▪ There are fewer privacy protections

Confidentiality versus Privilege

Confidential communication is private communication that is not shared publicly. It could potentially be revealed if subpoenaed by a court of law. **Privileged** communication is private communication that occurs within legally-protected relationships. It generally cannot be revealed in court. In Ohio:

- Communication with a Prosecutor is not confidential or privileged
- Communication with a private attorney is privileged
- Communication with a rape crisis advocate is confidential, but not privileged

Who's Representing Who?

Most people assume that a Prosecutor in a criminal case represents the interests of the survivor, but this is not true. The Prosecutor represents the State of Ohio. The survivor is a witness for – not a client of – the Prosecutor. Similarly, victim-witness advocates are employees of the Prosecutor's Office. They also represent the State, not the survivor. Communication with a Prosecutor or victim-witness advocate is not privileged or confidential. Only private or civil legal attorneys hired by survivors represent the interests of survivors.

General Resources on Civil Legal Issues & Assistance

Victim Rights Law Center: http://www.victimrights.org/

WomensLaw.org (National Network to End Domestic Violence): http://womenslaw.org/

Ohio Legal Services: http://www.ohiolegalservices.org/public/legal_problem

Ohio Legal Assistance Foundation: http://www.olaf.org/

Specific Civil Legal Concerns & Resources

Privacy

Many survivors of sexual violence have concerns about the privacy of and access to their personal information, as well as information/documentation regarding their victimization. Federal law protects personal health information contained in medical records, and in mental health records from licensed counselors and social workers. Rape Crisis records are confidential, but can be subpoenaed in court. Police and court records are generally public record, however survivors can petition to have their identifying information concealed. For more information about privacy laws/policies:

- Health Information Portability & Accountability Act (HIPPA): http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html
- Ohio Law regarding the availability of public records for viewing and copying: http://codes.ohio.gov/orc/149.43
- Request to redact personal information online: http://ohioattorneygeneral.gov/OhioAttorneyGeneral/files/23/2341cda3-e71e-487d-b51e-ebaa5b231952.pdf

Ongoing Safety

Some survivors of sexual violence have concerns regarding their ongoing safety from the perpetrator and/or acquaintances or associates of the perpetrator. In addition to making safety arrangements surrounding housing and employment, survivors can obtain a variety of court orders designed to protect them.

- For more information on the types of protection orders available to survivors: http://www.womenslaw.org/laws_state_type.php?statelaw_name=Restraining%20Orders&state_code=OH
- For information on safety planning: http://www.ncdsv.org/publications_safetyplans.html
- Stalking & Sexually Oriented Protection Order Forms: http://www.supremecourt.ohio.gov/JCS/domesticViolence/protection_forms/stalkingforms/

Employment

Due to the trauma of sexual violence, some survivors may have difficulty concentrating at work and interacting with colleagues and customers/clients. Survivors may also need to miss work due to stress, to attend court proceedings, or to attend medical or mental health appointments. Employers should work with survivors regarding time off, reasonable accommodations, and safety while at work. If the perpetrator is a colleague or supervisor of the survivor, the employer must make accommodations to protect the survivor.

- For information about the Family Medical Leave Act (FMLA): https://www.ohiobar.org/ForPublic/Resources/LawYouCanUse/Pages/LawYouCanUse-82.aspx
- For information about civil rights in the workplace, including discrimination: http://crc.ohio.gov/AboutUs/RegionalOffices.aspx

Violence Against Women Reauthorization Act of 2013

The 2013 reauthorization of the Violence Against Women Act expanded numerous legal protections for survivors of sexual violence, particularly those from underserved communities, including Native American survivors, immigrant survivors, and LGBTQ survivors.

For more information about new/expanded protections in VAWA:
http://www.ncdsv.org/images/NTFESDVAW_SummaryOfChangesFromVAWAreauthorization2013.pdf

Education

Schools and campuses throughout the U.S. must abide by laws and policies establishing student safety, and to respond appropriately when students are victimized in any way. Information about these laws:

- Ohio Department of Education school safety resources: http://education.ohio.gov/Topics/Other-Resources/School-Safety/School-Safety-Resources
- Title IX enforcement information: http://www2.ed.gov/documents/press-releases/title-ix-enforcement.pdf
- Family Educational Rights & Privacy Act: http://www.ed.gov/policy/gen/guid/fpco/ferpa/index.html
- Jeanne Clery Act (campuses): http://clerycenter.org/summary-jeanne-clery-act
- U.S. Dept. of Education Office for Civil Rights: https://www2.ed.gov/about/offices/list/ocr/know.html
- Dear Colleague Letter on campus safety: http://www2.ed.gov/about/offices/list/ocr/letters/colleague-201104.pdf

Housing

The availability of safe, affordable housing for survivors of sexual violence is critically important. Some survivors are unable to pay rent after their victimization, they want to move in order to facilitate healing from the trauma, or they need to move in order to feel safe. VAWA-2013 extended housing protection rights to survivors of non-intimate partner violence within nine categories of public housing assistance. For more information about housing protections for survivors: http://www.ncsha.org/blog/violence-against-women-act-includes-housing-provisions

Immigration

Immigrant women are frequently targeted for violence and abuse. Perpetrators often exploit language barriers and the legal status of immigrant women in order to harm them. Survivors of sexual violence have rights as crime victims, regardless of their documentation status. U-Visas and T-Visas are potential remedies for undocumented survivors of sexual violence.

- For information on VAWA protections for immigrant survivors: http://casadeesperanza.org/pdfs/VAWAImmigrationfactsheetS47.pdf
- For information about U-Visas and T-Visas: http://www.oaesv.org/wp-content/uploads/2013/02/U-and-T-Visa-Fact-Sheet.pdf

Financial Assistance

The ability to meet basic needs is often impacted by the experience of sexual violence. Additionally, some survivors face financial hardship in the aftermath of violence due to the inability to work. Still other survivors seek financial compensation to address the impact of the crime on their lives. For more information about financial assistance for survivors of sexual violence:

- Public benefits available in Ohio: http://www.benefits.gov/benefits/browse-by-state/state/OH
- Ohio unemployment compensation: https://unemployment.ohio.gov/PublicSelfServiceChoice.html
- Ohio disability benefits: http://www.disabilityrightsohio.org/topic-social-security
- Crime Victims Compensation Program: http://ohioattorneygeneral.gov/Individuals-and-Families/Victims
- Information and guidance about civil tort actions (i.e. lawsuits): http://www.vawnet.org/applied-research-papers/print-document.php?doc_id=2150

This publication was supported by Victims of Crime Act Grant Award #2013VASAVE915, administered by the Ohio Attorney General's Office.

Stalking and Sexually Oriented Offenses Protection Order Forms

Note: The stalking and sexually oriented offenses protection order forms are available in Adobe PDF and Microsoft Word. To view, print and search Adobe Acrobat PDFs, you must have the free Adobe Acrobat Reader (**Instructions to download Adobe Acrobat Reader**). To view, print and search Microsoft Word documents, you must have the free Word Viewer (**Instructions to download Microsoft Word Viewer**).

10-A: Protection Order Notice to National Crime Information Center (**PDF** | **Word**)

10-B: Instructions for Completing a Protection Order Notice to National Crime Information Center (**PDF** | **Word**)

10.03-A: Motion for Criminal Protection Order (CRPO) (R.C. 2903.213) (**PDF** | **Word**)

10.03-B: Criminal Protection Order (CRPO) (R.C. 2903.213) (**PDF** | **Word**)

10.03-D: Petition for Civil Stalking Protection Order or Sexually Oriented Offense Protection Order (SSOOPO) (R.C. 2903.214) (**PDF** | **Word**)

10.03-E: Civil Stalking Protection Order or Civil Sexually Oriented Offense Protection Order (SSOOPO) *EX PARTE* (R.C. 2903.214) (**PDF** | **Word**)

10.03-F: Civil Stalking Protection Order or Civil Sexually Oriented Offense Protection Order (SSOOPO) Full Hearing (R.C. 2903.214) (**PDF** | **Word**)

10.03-G: Instructions For Obtaining Civil Stalking Protection Order or Civil Sexually Oriented Offense Protection Order (SSOOPO) (**PDF** | **Word** | **Select Another Language**)

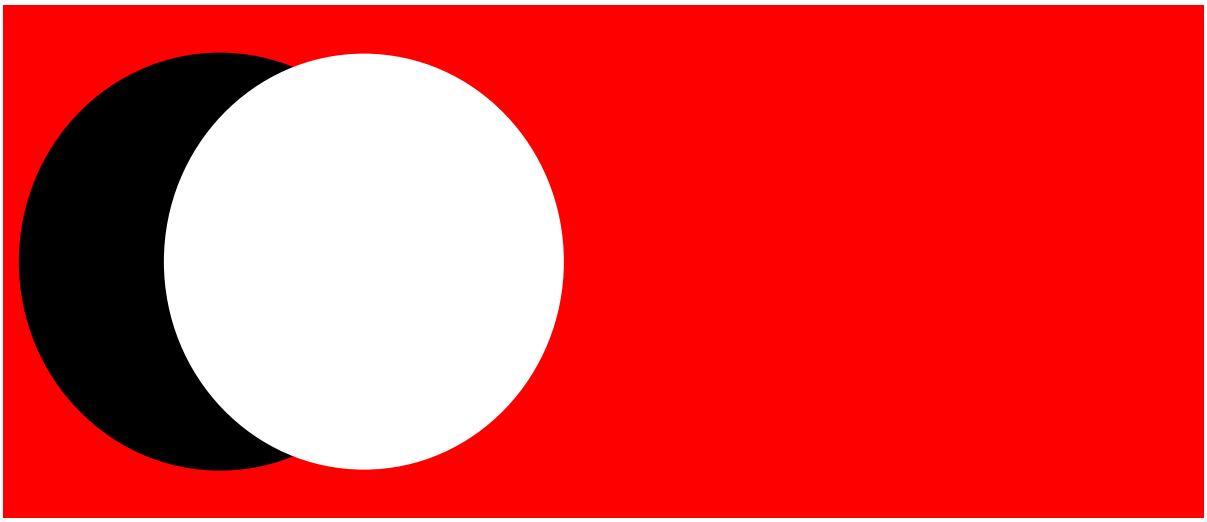
10.03-H: Warning Concerning Attached Protection Order (**PDF** | **Word** | **Select Another Language**)

Building Stronger Sexual Assault Survivor Services Through Collaboration

A Manual for Rape Crisis Programs and Communities in Texas for Developing Sexual Assault Coalitions

Developed by the Texas Association Against Sexual Assault

Contributions by Debbie Bressette, Linda Hunter, Eileen Gould and Victoria Hilton



Texas Association Against Sexual Assault
7701 North Lamar, Suite 104
Austin, Texas 78752
512.474.7190 phone ♦ 512.474.6190 fax
www.taasa.org

BUILDING STRONGER SEXUAL ASSAULT SURVIVOR SERVICES THROUGH COLLABORATION

INTRODUCTION

Serving the Survivors of Sexual Assault..... 1
Why Does My Organization Need To Collaborate With Others? 2
I'm Already Busy 3

UNDERSTANDING THE CONCEPT

What's The Definition of a Community Coalition?..... 4
Ten Functions of Community Coalitions 5
What a Community Coalition is Not..... 6
Nineteen Factors Influencing Successful Collaborations..... 7
Factors Which Inhibit Coalitions..... 8

LAYING THE FOUNDATION

Who Should Belong To The Coalition: Bringing People Together..... 9
Including Diversity..... 10
Learning About Each Other..... 11
Handling Conflict and Disagreements..... 12

DEVELOPING COALITION CAPACITY

Leadership (and Notes on Building Trust in Groups)..... 13
Knowing the Destination..... 15
How to Write a Mission Statement..... 16
Goal Setting..... 17
Establishing Objectives..... 18
Measuring Success..... 19

STARTING THE WORK PROCESS

Steps to Starting Your Own Community Coalition..... 20
Planning and Designing A Needs Assessment..... 21
Maintaining the Coalition..... 23
Group Training Workshop..... 24
Memorandum of Understanding (Sample)..... 25

ADDITIONAL READING

Basic Principles for Ethical Communication..... 30
Contrasting Communication Styles Among Various Ethnicities..... 33
Coalition Barriers and How to Overcome Them, Part I..... 35
Coalition Barriers and How to Overcome Them, Part II 37
Mission Statement Worksheet..... 40
Coalition Self-Evaluation Instrument..... 41
How Coalitions Can Enable Community Capacity Building..... 43
Managing Conflict in Groups- Ideas From the Business Sector..... 44
A Community Checklist:
Important Steps to End Violence Against Women..... 55

Serving the Survivors of Sexual Assault

When there is a sexual assault in your community, many different service agencies and organizations act to help the survivor in varying capacities and roles. Sometimes there is good communication between these providers; in many communities there is little or none. One common comment when working with survivors of sexual assault is that the various points of service are rarely coordinated and can be frustrating and even traumatizing to the victim.

Each group has a role to play. There can be many variations on a theme, since no two sexual assault scenarios are ever alike. However, it is a rare community where all of these different agents work together to provide comprehensive, coordinated services. This system can be a bewildering and complex system of agencies to negotiate for someone who has already been traumatized by the intimate crime of sexual assault. ***Creating a network between all of these groups can provide better services,*** and it can provide other positive results for the community as well.

Community sexual assault coalitions (or task forces) play key roles in many important ways. Two major functions of a sexual assault task force are:

1. bringing key people together to discuss and implement strategies for sexual assault prevention and
2. connecting agencies to provide improved service linkage for the survivors of this crime.

Imagination is the highest kite one can fly.

- Lauren Bacall

"The development of community coalitions can increase the ability of the members of a community to manage their shared environment through collective decision-making and action. A shared vision will increase the members ability to identify shared problems, develop policies and programs to address them, and mobilize appropriate resources effectively to fulfill these policies and programs"[1]

[1] Honadle, B. Defining and Doing Capacity Building. In B. Honadle & A. Howitt (eds.), *Perspectives on Management Capacity Building*. Albany; SUNY Press. 1986.

Why Does My Organization Need To Collaborate With Others?

The advantages of entering a collaborative effort may be immediate or long term, direct or indirect. Some partners may benefit more than others, but it is essential that each partner recognize that the benefits will outweigh the costs of participation.[2]

The advantages of collaborating most frequently are: more effective and efficient delivery of programs, professional development, improved communication, elimination of duplication, increased use of programs, improved public image, better needs assessment, consistency of information and increased availability of resources.[3]

Collaboration can open a vast complement of resources to the innovative administrator: new staff skills, knowledge, equipment, facilities and services, which may be available at other agencies. Combining the resources of two or more agencies can help to deliver more services for the same money or the same services for less money. The economics of scale, fewer duplicate programs and improved cost-benefit ratios, will make the delivery of programs more effective and efficient.[4]

It's easy to make a buck. It's a lot tougher to make a difference.

-Tom Brokaw

Staff members will grow professionally by meeting with colleagues from other agencies. They will be exposed to new methods and ideas that may benefit them. They may be made aware of new resources that are available and how to obtain them for their programs.

Improved communication between agencies will result in all partners providing more consistent and reliable information to the client, i.e. a better understanding of work done by others may help when directing clients who need critical information. Shared information can mean increased use of programs, more public support and more information about policy and legislative issues that effect their clientele groups. In addition, better communication between agencies will provide a more thorough evaluation of the total impact of programs.

And finally, coordinated needs assessment can be a benefit of collaboration. Service providers who work together can identify gaps in programs. They also can see critical widespread problems and rate issues for the most efficient use of available resources.

---

[2] Dluhy, Milan J. *Building Coalitions in the Human Services*. Newbury Park, California: Sage Publications, 1990.

[3] Jackson, Daney & Maddy, William. Ohio State University Fact Sheet. *Introduction: CDFS-1*. http://ohioline.ag.ohio-state.edu/~ohioline/bc-fact/0001.html

[4] Rossi, Robert J., et al. *Agencies Working Together, A Guide to Coordinating and Planning*. Beverly Hills, California: Sage Publications, 1982.

I'm Already Busy: Where Will I Find Time To Attend Another Meeting?

It is easy for employees at agencies that cope with daily crisis and busy schedules to become isolated and feel that they are unable to reach out to other community agencies who also work with the same clients at some point in the system.

However, by communicating across agencies, many service providers report that it not only makes their job easier, but it gives them more community visibility, support and access, and most importantly, helps create a web of accessibility for their clients, who must often move across unfamiliar ground in their search for both justice and healing

In order for this coalition to build a firm foundation, it is important for members and agencies to get to know each other, to spend the time needed to create trust, to set goals, to do strategic planning, and to creatively explore a shared vision of the desired changes. It is also helpful to have outcome measures and to be able to let the community know what you are doing to make their community safer and work more effectively.

With these goals in mind, each member will need to commit to giving the coalition at least a year of their time minimally, with monthly meetings of at least one hour.

The only thing necessary for the triumph of evil is for good men to do nothing.

- Edmund Burke

"At some time or another, most of us have been a member of a "great team." It might have been in sports, or the performing arts, or perhaps in our work. Regardless of the setting, we probably remember the trust, the relationships, the acceptance, the synergy—and the results that we achieved. But we often forget that great teams rarely start off as great. Usually, they start as a group of individuals. It takes time to develop the knowledge of working as a whole, just as it takes time to develop knowledge of walking or riding a bicycle. In other words, great teams are learning organizations— groups of people who, ***over time****, enhance their capacity to create what they truly desire to create."*[5]

[5] Ross, Rick. *Backing into a Vision*, The Fifth Discipline Fieldbook.

What's the Definition of a Community Coalition?

Starting and maintaining a coalition is no big mystery. It is similar to starting and maintaining a committee where there is a need and people interested in finding a solution. The United States started as a coalition of colonies with a need (problem) and people interested in finding a solution. Individually, you can't do everything, but collectively, something can be accomplished.

The coalition is essentially a mechanism for increasing the power or leverage of groups or individuals. **The object is to get more out of the coalition than is put into it.** Situations, although difficult or impossible for the individual to overcome alone, can be dealt with simply and rapidly by acquiring the right allies. This is coalition building.

You must be the change you wish to see.

- Mahatma Ghandi

Over the past ten years, community coalitions and task forces have been increasingly used to address a variety of complex and entrenched social and health problems, especially in poor and underserved communities. They are a wonderful way to pool resources, talent and creativity to solve community problems. Additionally, government and foundation prevention initiatives have embraced coalitions and partnerships as major components of their strategies.

Feighery and Rodgers offered a definition that probably reflects the most current use of the term: "an organization of individuals representing diverse organizations, factions, or constituencies who agree to work together in order to achieve a common goal."

Other authors have also emphasized that contemporary community coalitions are also formal, multipurpose, and long-term alliances. The term partnership also implies the shared and long-term commitment of effective community coalitions: everybody brings something to the table.

Dail Neugarten suggests that coalitions are "more like orchestras composed of autonomous and talented people linked together by a conductor and a score."[6]

The goal of community collaboration is to bring individuals and members of communities, agencies and organizations together in an atmosphere of support to systematically solve existing and emerging problems that could not be solved by one group alone. While this is easily "said," experience shows that it is not easily "done." In fact, at times it has been likened to "teaching dinosaurs to do ballet."

[6] Neugarten, Dail. *National Leadership Institute on Aging,* University of Colorado at Denver, 1445 Market Street, Suite 320, Denver, Co 80202.

Ten Functions of Community Coalitions

Community coalitions are capable of ten primary functions according to reviews of the literature. Here are some concrete ways that community coalitions can help.

1. Minimize duplication of services.
2. Increase the effectiveness and efficient delivery of programs/services.
3. Improve capacity to plan and evaluate.
4. Strengthen local organizations and institutions to respond better to the needs and aspirations of the constituents.
5. Develop wider public support for issues.
6. Increase the influence of individual community institutions over community policies and practice.
7. Increase accountability.
8. Exploit new resources in a changing economy.
9. Increase participation from diverse sectors and constituencies.
10. Broaden the mission of member organizations and develop more comprehensive strategies.

It has always seemed to me that the most difficult part of building a bridge would be the start.

- Robert Benchly

What a Community Coalition is Not[7]

There was a time when one of my adolescent daughters would respond to many a comment with the ubiquitous "NOT," popularized by Wayne and Garth of the movie "Wayne's World." Now, when I hear all sorts of people saying, "Our initiative is a coalition," often, my first instinct is to respond, "NOT."

While it is heartwarming for those of us who have been in the trenches doing coalition building for years to see that coalitions are now a hot new trend in program development, it is also disconcerting to see many initiatives using the term but stretching it beyond recognition. SO let's start bringing the term back into shape.

Coalitions are **not** externally run or externally driven organizations. They must have a strong base in the community. That base should have a strong citizen component; but even for a coalition of agencies, those agencies must have deep community roots.

Coalitions are **not** human service organizations. This is another common misconception. We see numerous coalitions that hire staff and run programs only to become the next mega-agency on the block. There certainly is a legitimate place for human service agencies, but they should not be confused with coalitions. Coalitions work best as catalyst to action, the more they become service delivery centers, the harder it is for them to focus on their role of catalyst for community change.

In the middle of difficulty lies opportunity.

- Albert Einstein

Coalitions are also **not** an automatic link to the grassroots and "real people." Too often people think that creating a coalition will naturally create links to the grassroots. But this is unlikely if coalitions are composed of institutional representatives rather than citizens. Coalitions must make special efforts (such as having outreach workers) if they are serious about reaching the grassroots.

And finally, coalition building is **not** a cure-all. Even the most successful coalitions are often limited by their focus on trying to solve the local community's problems; but this does not provide easy answers to dealing with the numerous issues impacting that community from outside.

Let's end on a positive note. Coalition building, collaborative problem solving and community development **are** some of the most effective interventions for change available to us today. Coalitions **are** partnerships of the many sectors of a community, which gather together collaboratively to solve the community's problems and guide the community's future. When coalitions are driven by citizen identified issues; citizens become involved in all steps of the problem solving process. Using this definition, coalition building becomes a powerful and enduring force for change.

[7] Wolff, Tom. *What Coalitions are Not.* Coalition Building Tips: AHEC Community Partners. http://www.ahecpartners.org/resources/cb/

Nineteen Factors Influencing Successful Collaborations

Listed below are nineteen factors which influence successful collaborations, as identified by Paul Mattesich and Barbara Monsey in *Collaborations: What Makes It Work?* Grouped into six categories, this review of the research literature describes:

Factors related to the ENVIRONMENT

1. History of collaboration in the community
2. Collaborative group seen as a leader in the community
3. Political/social climate favorable

Factors related to MEMBERSHIP CHARACTERISTICS

4. Mutual respect, understanding, and trust
5. Appropriate cross-section members
6. Members see collaboration in their self-interest
7. Ability to compromise

Factors related to PROCESS/STRUCTURE

8. Members share a stake in both process and outcome
9. Multiple layers of decision-making
10. Flexibility
11. Development of clear roles and policy guidelines
12. Adaptability

Factors related to COMMUNICATION

13. Open and frequent communication
14. Established formal and informal communication links

Factors related to PURPOSE

15. Concrete, obtainable goals and objectives
16. Shared vision
17. Unique purpose

Factors related to RESOURCES

18. Sufficient funds
19. Skilled convener

The true measure of a man is how he treats someone who can do him absolutely no good.

- Ann Landers

Factors Which Inhibit Coalitions

Building community coalitions has its challenges as well as rewards. Issues such as turf protection, mistrust, slow decision making, limited resources, an assumed position contrary to policy and decreased level of cooperation among collaborators during a crisis are all examples of the types of challenges you might face. The following is a list of factors which may inhibit the formation and growth of a coalition.

You have not converted a man because you have silenced him.

- John Morley

- Competitiveness, turf protection and mistrust. If a collaborator doesn't trust his or her partners he or she will not be as open and receptive to new ideas There will not be a willinginess to share resources and burdens.
- Dominating rather than shared leadership that discourages group decision making.
- Inflexibility in scheduling meetings and activities.
- Lack of understanding about how community agencies operate. Group members must understand the constraints and limitations of their partners.
- Hidden agenda for personal advancement.
- Cynicism about the advantage of information sharing.
- Time constraints and pressure to "push things through" without giving adequate time for discussion to work through conflicts .
- More emphasis on talking than listening.
- Preferring to do things alone rather than spending time negotiating.
- Prescribing actions for a partnership (coalition) from the top down.
- Lack of procedure for making decisions and solving disagreements when they emerge.
- Sometimes a coalition may take a position that is inconsistent with the policy of one of its partners. This may cause the partner to be uncooperative, ineffective or to withdraw from the coalition.
- If the group must reach a consensus to act on an issue, it may take time. Many partners may not be able to go forward without approval of a higher authority or more study. Depending on how well the group communicates or how often it meets, decision by consensus could make acting on a problem slow and ineffective.

Who Should Belong To The Coalition: Bringing People Together

Collaboration begins with the selection of resource people who have experience in dealing with the particular issue and understand the common goal. They have the authority and power to influence change and the energy and enthusiasm for keeping the momentum alive.

Initial contacts usually work best if they are between agency administrators. This follows protocol and allows the administrator to delegate the responsibility. It avoids the administrator hearing about the contact from someone lower in the agency, becoming suspicious and defensive, and scuttling the effort before it begins or initially putting it on bad footing.

Begin by determining all the natural allies, individuals or groups who share the concern and support a similar position. Continue by seeking all types of persons, groups and social structures likely to be affected by the issue or position taken both affirmatively or negatively. Do not forget to include all potentially interested and civic-minded groups who might stand to gain indirectly by supporting the issue or constituents.

The survivor of a sexual assault may have contact with the rape crisis center, law enforcement, a Sexual Assault Nurse Examiner or other medical professional, a mental health counselor or advocate, Child Protective Services (CPS), Child Advocacy Centers, CASA, Crime Victims Compensation, prosecutors, magistrates, the court, or other agents. Be as inclusive as possible when deciding who might want to join.

Anyone who works with sexual assault survivors or within agencies and organizations which impact them are important to consider. This can even include professionals such as forensic scientists who analyze the evidence collected from forensic/medical exams. Much can be learned about both the existing strengths as well as the weakness of the system by meeting with and getting to know these various individuals.

It may be helpful to sit down and create a flow chart of services, if none exists, to get a better picture of available service providers. Also, talk with others from organizations that you already know to see if they can think of anyone whom you may have inadvertently omitted.

Make a list of individuals and organizations to contact. Try to get as many individual names and phone numbers as possible. Set a date and time for the first meeting. If you want the prosecuting attorney in your county to come, (and you should!) it might be helpful to schedule the first (and possibly all successive) meetings on Fridays, as that is the day they are least likely to get tied up in court.

I am only one, but I am one. I cannot do everything, but I can do something. And I will not let what I cannot do interfere with what I can do.

- Edward Everett Hale

Steubenville rape trial: Case shows social media can be positive and negative

By Cliff Pinckard, The Plain Dealer
on March 14, 2013 at 3:15 PM, updated March 15, 2013 at 8:17 AM

STEUBENVILLE, Ohio -- As the Steubenville rape trial today has turned mostly on testimony and evidence regarding teen use of cellphones and social media, it has caused sexual assault experts on hand to consider the positive and negatives of the trend.

A June report by commonsensemedia.org said that 90 percent of teenagers use some form of social media. While that is not likely surprising for parents of any teen, it has become a definite frame of reference on the second day of the trial of two teen athletes accused of raping a 16-year-old girl.

Much of the testimony today has focused on how data from teens cellphones was retrieved and what it contained.

The trial began Wednesday morning in Steubenville in front of Judge Thomas Lipps. Portions of the **trial are being streamed live on cleveland.com,** courtesy of WKYC Channel 3.

A sergeant with the Steubenville Police Department testified this morning that he sifted through thousands of pages of data from one defendant's phone.

The data included texts, Tweets, and two photos of the teen girl lying on a couch and the floor, he said.

The current court case provides an inherent warning for teens and how social media can be abused, said Katie Hanna, executive director of the Ohio Alliance to End Sexual Violence.

"You're not talking to a person in front of you, you're talking to the whole world," Hanna said outside the Jefferson County Juvenile Justice Center this afternoon during a break in the trial.

The study by commonsensemedia.org shows most teens (52 percent) think social media has a positive impact. But 36 percent said they wish they could go back to a time before Facebook, and more than a third that want to "unplug" have endured racist, sexist and homophobic content.

Hanna said teens must be educated on how social media can impact relationships - and one way to do that is through the use of sites like Facebook and Twitter.

"It doesn't have to be used in a negative way," Hanna said. "Social media is a way you can do some good in real time."

A positive is how social media was used to bring attention to the case in Steubenville, said Tracy Cox, communications director for the National Sexual Violence Resource Center.

"There is a silver lining about it, because as horrible as it was, it was brought to life through social media," Cox said. "There are teachable moments in this as well on how to be an engaged bystander through social media."

Hanna and Cox are attending the trial. Their groups have been closely following the case for the past several months.

Testimony is continuing through this afternoon and could extend into evening, court officials have said.

A summary of arguments and testimony from the first day:

- An Ashland University student **said he asked the defendants to leave** when they arrived at his home with a 16-year-old girl the night the alleged rape occurred in August.

- Two teen witnesses **told the judge about what they remember** from the night of Aug. 11 and early morning of Aug. 12, one saying she asked her friend not to leave with several Steubenville athletes, including the defendants.
- Earlier in **opening statements, prosecutors said** the two teen boys knew the 16-year-old girl was too impaired by alcohol to consent to sex, and they took advantage by engaging in a pattern of degradation that continued through the night.
- But defense attorney Brian Duncan maintained his 17-year-old client's innocence, saying "[The defendant] did not rape the lady in question."
- Lawyer Walter Madison, who is representing the 16-year-old defendant, did not make an opening statement. Because the case is in Juvenile Court, the teens technically are charged with delinquency, a civil charge that is equivalent to an adult criminal charge. There is no jury, and the verdict will be decided by Lipps.
  If the two defendants who were released from detention in the fall are found guilty, they could be sent to a juvenile facility until they are 21 and be made to register as sex offenders.

Victim-Centered Stories:
How to Work with the Media to Convey the Complexities of Sexual Violence

FORGE RELATIONSHIPS

Meet with local media before a story is in the works.

- Offer to do a lunchtime brown bag for reporters and editors. Explain your job and your role in working with victims.
- Invite reporters and editors to *your* trainings -- especially SART trainings -- where they can meet people who work as part of a team to respond to sexual assaults.
- Provide locally relevant statistics on sexual assault reports, prosecutions, convictions and victim services. Try to do this annually and provide as much context as possible, such as how to figure the numbers of assaults not reported.
- Pass along important studies and news within your field to interested reporters.
- Use these contacts to talk about myths and misconceptions about sexual violence. Then when a story comes up, they will have a base of knowledge.
- When you see patterns or changes related to sexual violence in your community point them out to reporters. Share examples, even if they are anecdotal at first. If you think something is important but can't be an official source, point them in the right direction.
- If you see something wrong in print or on air say something. If it is a fact that need's correcting ask a reporter to correct it. If you feel a reporter misunderstood something have a follow-up conversation so they can do a better job next time. If they ignore you, call their editor or producer.

WHAT DO REPORTERS NEED? AND WHAT WILL THEY DO WITH IT?

Most reporters need a simple who, what, when, where for a daily story. For more in-depth or complex stories, they'll want a why and how.

- The more information you relay to a reporter in layman's terms the better. Try to avoid police or advocacy lingo. Reporters have to convey information to a very general audience. This is especially important for medical information related to sexual assaults.
- If reporters are dealing with a rape case and have accessed police reports and medical records, walk them through the documents so they understand what they are reading -- even if you can't be an official source.
- If there is information you cannot provide to a reporter, explain why. They

will have to explain it to an editor later.
- Many reporters in delicate situations will ask for information off-the-record. They will share the information with editors and they will use what you tell them to find that same information from somewhere else.
- In a delicate or complicated news situation that will likely involve multiple news outlets, put questions and answers in writing. Provide the basic facts to all outlets equally.

VICTIMS AND THE MEDIA

Victims will often have roles in stories whether they choose to or not. Prepare them.

- Know the law in your state as to whether victim names and address will be in public police and court records. Many victims are caught off guard when they find out reporters and others can get their phone number and address easily from public records.
- Police and advocates should inform victims that reporters could try and reach them. Talk about what to do if a reporter calls or shows up at their home.
- Most media will not name victims of sexual assault as a general rule. But some need to be reminded that familial, domestic, school or neighborhood-based sexual abuse victims can be easier to identify -- especially using social media.

LANGUAGE MATTERS

Just as language in police reports can affect the outcome of sexual assault cases, wording matters in media too.

- Media outlets have a responsibility to be fair. They cannot take sides in sexual assault cases.
- It's good to have a conversation about wording. Words like "claims" and "alleged" carry connotations of disbelief. But some media outlets, especially television stations and web sites, tend to use them. A more neutral but non-offensive or blaming word would be report, such as: "A woman reported Friday that she was attacked..."
- Police especially should remember that their initial report is can often be reviewed by media. If the report reads cynically, the reporter is likely to report on the case in that same manner.

INTERVIEWS. DECIDING WHETHER TO DO ONE.

Ultimately, it should be a victim's choice about whether to talk to the media. For some the idea is horrifying, for others it is empowering.

- Before making a decision, ask some basic questions about whether the story

is a short-term or daily story or if the victim's interview is part of a more in-depth or long term story or series.
- What purpose will the victim's point of view be serving? Is it to "tell their side of a story" as part of a case that is being covered? To add context and understanding in sexual assault cases? Or to point out flaws in the police, court or other systems in the community?

HOW TO HELP PREPARE A VICTIM FOR ITERVIEWS WITH THE MEDIA

Understanding the interview process and giving victims the choice will help them retain ownership of their story.

- Victims should also be given the choice whether to have their names withheld or whether to provide their name for publication. If a television interview, will their face be shielded or shown?
- Victims can ask that any agreement about the terms for an interview be in writing.
- Victims should know that a reporter will probably have already read any available police reports and likely done research on social media and searched public records.
- Victims should know where and when their story will appear. If it is going to appear online, they need to know that it will be in the digital realm basically *forever*.
- Media outlets also share their stories via wire services. That means a story that runs in one paper can appear in others across the country. The same is true with television and radio, which share pieces with affiliate station.
- Victims can have preconceived notions about what their story will look like in the newspaper, online or on television. Ask a reporter or keep on hand examples of other stories written about victims of sexual assault or domestic violence for a victim to review. Those pieces (whether print or video) can be helpful in a discussion about whether to do an interview and how much to share.
- Practice. If a victim thinks they want to do an interview with a media outlet, practice with them first. See if they feel comfortable or ready.
- Offer to accompany the victim to the interview as a support.
- Suggest that victim to write out their own story or make notes on points that are important for them to get across if they get nervous. A short chronological timeline is especially helpful.
- If doing a television interview, discuss ahead of time details a victim feels comfortable having a reporter describe and what the victim will talk about. Does a victim feel comfortable describing their attack on camera or would they prefer to talk about without the cameras rolling and then focus any on camera questions more on how an attack affected their life?
- If doing an on-camera interview, discuss whether a victim feels comfortable with their face being shown and their voice being heard.

- Ask ahead of time about the types of questions the interviewer plans on asking. Reporters will ask tough questions. Tell a victim they do not have to answer all questions. They can tell a reporter certain questions are inappropriate or make them feel uncomfortable.
- In some cases, especially involving younger victims, a reporter may agree to let that person write about details of what happened to them rather than describing it one-on-one.
- If a victim has participated in therapeutic art or writing, sharing those examples may be helpful for a reporter to understand what a victim is going through.
- Agree on a cue that a victim can use -- such as raising a palm in front of the face -- to signal that they need to stop the interview or to take a break.
- Do the interview where a victim is most comfortable; whether it is his or her own home, advocacy offices or the media outlet.
- Barring extraordinary circumstances, most reporters won't let you read or see their finished piece before publication. However, when working with victims many reporters will agree to read, send or show you how they are going to quote a victim or what portion of their interviews are going to air.

PREPARING A REPORTER

If you are the conduit setting up an interview between a reporter and a victim, you can prepare the reporter as well as the victim.

- Remind a reporter their physical reactions, cues and questions may be interpreted by a victim in a variety of ways. Simply nodding as a person talks helps.
- Explain to reporters that victims who have undergone the trauma of a sexual assault may have difficulties telling stories in a linear fashion, which is normal.
- Explain to the reporter that each victim reacts and copes differently to their trauma. Some may cry, others may seem unemotional; others may be nervous and giggle.
- Talk to the reporter about what types of questions could be considered victim blaming such as "Why didn't you fight?" or "How much were you drinking?"
- Advocates or officers may feel more comfortable if they can talk "off-the-record" to a reporter ahead of an interview to discuss information sensitive to an open or unsolved case.

ONLINE ISSUES

If the media outlet you are working with is web-based or has a presence on the Internet, discuss how they allow reader or viewer content and feedback.

- Some newspapers and television stations closely monitor online comments to assure their content isn't libelous or nasty. Others rely more on the community of commenters to regulate each other.
- If you feel that there is potential for nastiness or sexual or racial attacks in the comment section after a story, ask the media outlet if they would be willing to withhold or turn off comments.
- If that is against their policy, many sites have a "report this comment" section and will remove nasty comment. But that doesn't always happen quickly.
- Respond to myths, misconceptions and personal attacks online. State your profession and how you know the information. Insert links to factual information.
- More and more people are posting stories via Facebook and other media networks. Post stories on your organization's pages and facilitate a meaningful conversation.

AFTERMATH

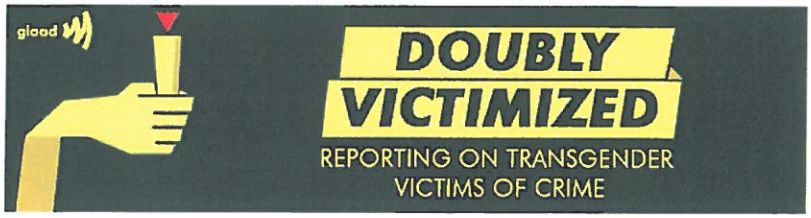
Touch base with a reporter after story has run with any relevant feedback. Encourage victims to give feedback as well.

- If there is a development in the story they did, let them know.
- Write letters or editorial commentary to be published in the aftermath breaking news story. Use the opportunity to broaden the topic and dispel myths.
- Offer yourself up as an expert for a television or online Q&A to add context to stories.

Like 25 Tweet 3 0

(http://www.glaad.org/printmail/publications/transgendervictimsofcrime)

DOUBLY VICTIMIZED: REPORTING ON TRANSGENDER VICTIMS OF CRIME | NOVEMBER 2012



Transgender people, and particularly transgender women of color, are disproportionately affected by hate violence in our communities. Sadly, the tragedy of these incidents is often compounded by reporting that does not respect (or, sometimes, even exploits) the victim's gender identity.

There is still a lot of education that needs to be done regarding the lives of transgender people. Often, reporters telling the stories of transgender victims of violent crimes will be given incorrect or incomplete information from police, from witnesses, or even from family/friends of the victim. The media also has a long history of sensationalizing stories that involve transgender people, although thankfully this is less common now than it once was.

The following guidelines will help you ensure that transgender victims of violent crimes are always treated respectfully and fairly. These guidelines apply to all stories that involve the transgender community, but are especially important when the person has been attacked or killed.

PLEASE NOTE:

All of the following illustrations are based on a *fictional* example of a person who was named John Smith and was classified as male at birth, but who lived as a woman named Justine Smith at the time she was killed.

What does transgender mean?

An umbrella term (adj.) for people whose gender identity and/or gender expression differs from the sex they were assigned at birth. Transgender people may or may not decide to alter their bodies hormonally and/or surgically. A person's medical history has no bearing whatsoever on whether or not they should be considered transgender.

For more information and terminology, check out our resources for covering transgender people in the media (http://www.glaad.org/reference/transgender).

Using the word "transgender"

A person classified as male at birth but living as a woman is a transgender woman. A person classified as female at birth but living as a man is a transgender man.

> **Incorrect:** Justine Smith, a transgender man, was 27 years old.
> **Correct:** Justine Smith, a transgender woman, was 27 years old.

The word *transgender* is an adjective, and should never be used as a noun or turned into an adverb.

> **Incorrect:** Justine Smith, a transgender*ed* woman, was 27 years old.
> **Incorrect:** Justine Smith, a transgender, was 27 years old.
> **Correct:** Justine Smith, a transgender woman, was 27 years old.

Gender and Pronouns

The only important piece of information in identifying a victim's gender is how they currently identify or, if they were killed, how they identified at the time of the incident. Always use the gender and pronoun that corresponds with the way the victim identifies/identified. If how the person identified is not known, use the pronoun consistent with how the individual lived publicly.

> **Incorrect:** A man was found on Friday morning in his Brooklyn neighborhood.
> **Correct:** A transgender woman was found on Friday morning in her Brooklyn neighborhood.

This holds true even if you have only been given the victim's birth name, and even if the only name you have for the victim does not match their self-identified gender. (also see NAMES section below)

> **Incorrect:** The victim, John Smith, was found on Friday morning in his Brooklyn neighborhood.

Correct: The victim, who was identified by police as John Smith, was found on Friday morning in her Brooklyn neighborhood.

Should pronouns be skipped?

The short answer is no.

It is possible to write a piece without using pronouns, instead referring to a subject only by last name, or with plural pronouns like "they" or "them." This is marginally preferable to using incorrect pronouns. But it creates very awkward sentences, and conveys a high level of uncomfortablily with referring to the victim as being the gender that he or she lived as. This is seen as disrespectful not just to the victim, but to the entire transgender community.

Incorrect: Smith was found Friday morning in the Brooklyn neighborhood he lived in.
Still Incorrect: Smith was found Friday morning in the Brooklyn neighborhood Smith lived in.
Correct: Smith was found Friday morning in the Brooklyn neighborhood she lived in.

Names

A transgender person's chosen name should be considered by reporters to be their *real name*, whether it has been legally changed or not. Often transgender people cannot afford a legal name change, or they live in a community where obtaining correct identification is difficult. All transgender people should be treated as though they have changed their name legally to their chosen name.

Incorrect: John Smith, who used the name Justine, was 27 years old.
Correct: Justine Smith was 27 years old.

Never put a person's chosen name in quotes. Treat their name the same way you would treat any other person's name.

Incorrect: "Justine" Smith was 27 years old.
Correct: Justine Smith was 27 years old.

If you do not know a transgender victim's chosen name, make the source for the name you are using clear.

Incorrect: The victim, John Smith, was found on Friday morning.
Correct: The victim, identified by police as John Smith, was found on Friday Morning.

If you get conflicting Information

Many transgender people are only able to live as their authentic gender some of the time. Some have only disclosed the fact that they are transgender to certain people. Often a victim's co-workers, neighbors, or even friends and family won't know that the person was transgender. In these cases, you should still default to the way a victim identified at the time of the incident.

If a source uses incorrect names or pronouns

Often, police or witnesses will use the wrong name or gender for the victim. When possible, paraphrase rather than quote directly, or quote elements of the statement that do not include this incorrect information. If this is not possible, leave the quote as-is but make sure that you, as the journalist, use the correct information.

Incorrect: "It looks like Smith was coming out of a local bar when he was attacked," said Officer Jones.
Correct: Officer Jones said it appeared as though Smith was coming out of a local bar when she was attacked.
Correct: According to Officer Jones, "It looks like Smith was coming out of a local bar" at the time she was attacked.

Things to avoid

Do not use language that implies the victim's identity was not "real," or that it was a costume, a disguise, or a false identity.

Incorrect: Justine Smith, whose real name was John Smith, was found on Friday morning.
Correct: Justine Smith, who was named John Smith at birth, was found on Friday morning.

Incorrect: The victim, John Smith, was dressed like a woman at the time of the attack.
Correct: The victim, identified by police as John Smith, was a transgender woman.

Incorrect: Police say the suspect attacked Smith after finding out he was actually a man.
Correct: Police say the suspect attacked Smith because she was transgender.

Do not mention or even hint at the victim's genitalia or history of surgical procedures under any circumstances.

Incorrect: Police say the suspect attacked the victim after discovering that Smith had a penis.
Incorrect: Police say the suspect attacked the victim after discovering that Smith was anatomically

male.
Correct: Police say the suspect attacked Smith because she was transgender.

Do not overemphasize or exploit the victim's transgender status. Treat the victim the way you would treat any other victim, and treat their transgender status the way you would treat any other identifying characteristic, even if police suspect it was the motive for the crime.

Incorrect: Justine Smith was dressed in high heels, a short miniskirt, a low-cut top and a wig at the time she was killed. Her purse contained makeup and a feather boa.
Correct: (There is no "correct" version of this sentence. These details are insignificant to the story and disrespectful to the victim, and should be skipped entirely.)

Providing Context

The transgender community is one of the most marginalized and discriminated against communities in our society. If a transgender victim was in a difficult or unfortunate life situation at the time of a violent crime, try to provide your audience with some context. It's also important to note that violence against transgender people disproportionately affects transgender women of color.

Example: Justine Smith was homeless at the time of her killing. Friends say she had been kicked out of her home for being transgender.

Example: Justine Smith was homeless at the time of her killing. Transgender advocates say that this is a problem faced by many transgender young people who are kicked out of their homes, and often end up on the street.

Example: Police say Justine Smith was working as a prostitute and suspect the attacker was one of her clients. According to transgender advocates, many transgender people, especially transgender women of color, face extreme discrimination in the workplace and might turn to illegal forms of employment as a last resort.

Example: The victim, Justine Smith, was found on Friday morning. She is believed to be the fourth transgender New Yorker to have been killed in the last year, all of them women of color.

Example: The victim was identified as Justine Smith by neighbors, but was identified as John Smith by police. Advocates say many transgender people are unable to legally change their names or obtain corrected identification documents.

More Information

GLAAD's Media Reference Guide (http://www.glaad.org/reference/transgender)

For additional information about discrimination and violence faced by the transgender community, please see "Injustice at Every Turn, (http://www.thetaskforce.org/reports_and_research/ntds)" a report issued by the National Gay and Lesbian Task Force and the National Center for Transgender Equality.

Ohio Alliance to End Sexual Violence

Developing Effective Responses to High-Profile Cases

A Factsheet for Rape Crisis Programs

High-profile cases, whether or not they occur in your community, offer both an opportunity and a challenge. Rape crisis programs are uniquely positioned to engage the broader community through factual, victim-centered messaging and action at a time when people are thinking about sexual violence. This factsheet provides tips for responding to high-profile cases.

In general, a response strategy from a rape crisis program should be focused on:

- Supporting survivors everywhere
- Educating the community about sexual violence, its impact, and prevention of it
- Advocating for systems change

Some things to expect during and after a high-profile case:

What to Expect	Response Ideas
More survivors may contact the program for services because the news coverage has triggered them, or it has inspired them to disclose for the first time	Ensure adequate hotline coverage and prepare all staff members and volunteers for the possibility that the need may increase for a while
Some survivors may contact the program wanting to speak out or "do something"	Prepare to help survivors work through actions that would be appropriate and healing for them; if possible, prepare small but meaningful activities survivors could participate in within your program
Concerned citizens may contact the program asking what you are doing, or plan to do, in response to the high-profile case	Discuss any specific, non-confidential responses you are providing, but emphasize the ongoing services you provide that support survivors, educate the community, and advocate for change
Professionals from inside or outside the victim services profession may contact the program to collaborate on a project or shared response	Be willing to have discussions/meetings, but only commit to projects that reflect your mission, allow for careful planning and meaningful contribution, are allowable by your funders, and are realistic for your program's staffing and resources
The media may contact your program for a quote or an interview; this may include newspapers, TV news stations or programs, radio stations, and/or web-based entities (e-magazines, blogs, etc.)	In addition to familiarizing yourself with media contacts in your area, prepare for interviews ahead of time (see below)

Preparing to Speak to the Media

- If possible, designate a single person to be the contact point for the media; this should be a Director or another staff member with considerable experience
- Develop general talking points for use in any interview
- Have materials available to give to reporters, including a business card, program brochure, etc.

Dos and Don'ts when Speaking to the Media

DO	DON'T
Investigate the media outlet and specific reporter seeking a quote/interview; if possible, review prior stories about sexual violence that this reporter has done	Assume that the media outlet/reporter is reputable or suitable for an interview about sexual violence
Agree to an interview at a mutually convenient time	Sacrifice your personal time, or time spent with survivors, in order to accommodate a reporter; at the same time, don't put off contacting the reporter, as he/she will quickly move on to someone else
Ask for the questions ahead of time, but be prepared for any question	Assume the reporter will ask predictable, comfortable, or easy-to-answer questions
Ask the reporter who else he/she has talked to or plans to interview	Assume you are the only one who will be heard on this issue
Stick to your main talking points	Comment on the specifics of the high-profile case or any individual survivor
Stick with positive messages that will inspire others to espouse your point of view	Make negative comments or focus on demonizing society
Say what you have to say during the interview	Make comments or statements "off the record"
Politely correct any myths or unsupportive statements made by the reporter	Argue with the reporter or suggest that he/she is part of the problem
Expect that your interview will likely be edited and that as a result, your statements may not come across as you would have liked	Be offended, take it personally or criticize yourself
Thank the reporter for contacting you and invite him/her to contact you in the future	Treat the reporter disdainfully or as a "necessary evil"
Ask for a copy of (or link to) the interview for record-keeping purposes, to share with others, and/or to learn from	Assume the interview will be published exactly as you hope, or pretend that others will not see/read/hear it

From the Front of the Room

A Survivor's Guide to Public Speaking



Developed by National Resource Center on Domestic Violence

Acknowledgements

Special thanks are due to Heidi Notario-Smull, NRCDV Training Specialist, Patty Branco, NRCDV TA Specialist, and Kenya Fairley, NRCDV Program Director for their diligent and thoughtful writing, organizing, and editing of this final edition of the speaker's guide. We also gratefully acknowledge Laurie Jorgensen, former NRCDV TA Specialist, for sparking the idea to create a guide of this nature and for its initial drafting. Thank you also to Casey Keene, VAWnet Project Manager and Rebecca Balog, WOCN Project Specialist for reviewing the guide and to Erica Keim, NRCDV Project Assistant for its layout, design, and styling.

The National Resource Center on Domestic Violence extends special thanks to the many advocates and organization staff who contributed and reviewed text for this guide.

Andrea Bible – Special Projects Coordinator, National Clearinghouse for the Defense of Battered Women

Nancy Durborow, Consultant

Maurice Hendrix – Violence Intervention Program Coordinator, Arlington County Department of Human Services

Brian Namey – Communications Advisor, National Resource Center on Domestic Violence

(Former Communications Director with the National Network to End Domestic Violence)

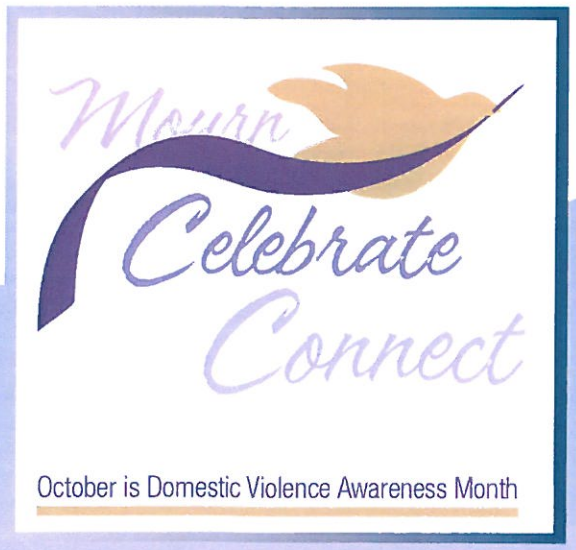
Denise Scotland – Technical Assistance Specialist, Pennsylvania Coalition Against Domestic Violence

Nancy Smith – Director, Center on Victimization and Safety, Vera Institute on Justice

Jackie Stutts – Training & Technical Assistance Specialist, Pennsylvania Coalition Against Domestic Violence.

Ann Turner – Elder Victim Services and Advocacy Coordinator, National Clearinghouse on Abuse in Later Life / Wisconsin Coalition Against Domestic Violence

Rob Valente – Legal Counsel, National Council of Juvenile and Family Court Judges



Introduction

Including the voices and real life experiences of survivors is crucial to our work to end intimate partner violence and abuse in later life[1] at the local, state and national level. Hearing directly from survivors about their experiences and the impact of domestic violence on their lives can inspire and energize others to act, as well as help reduce or remove barriers faced by survivors and their children. For survivors interested in sharing their story, public speaking can connect them in important ways to the larger domestic violence intervention and prevention efforts in their community and across the country. Opportunities for survivors to share their stories may include:

- Presenting to community groups at public awareness events
- Speaking before state and local government in support of legislation to enhance protections for victims of domestic violence
- Participating in magazine, television or newspaper interviews (anonymously if desired)
- Joining candlelight vigils, marches, rallies, or speaking at a memorial event for victims
- Being part of a domestic violence program's fund raising event
- Talking with a program's Board of Directors or agreeing to have their story included in the annual report of a local, state or national domestic violence organization
- Speaking at life skills development groups, parenting classes, asset building workshops or other types of empowerment groups for survivors
- Providing encouragement during a victim's support group
- Being featured as a keynote speaker at a conference or Domestic Violence Awareness Month event

[1] Domestic or Sexual Abuse in Later Life is abuse perpetrated on victims who are 50 years and older by someone with whom they have an ongoing relationship where there is an expectation of trust such as an intimate partner, adult child, other family member or a caregiver.

Purpose

From the Front of the Room (Guide) provides a basic overview of the issues that face survivors who desire to speak publicly about their experiences with intimate partner violence. It provides guidance for the survivor speaker to maximize their physical and emotional safety and ensure the overall success of the speaking engagement. This Guide is designed to explore the journey of sharing their story with the public.

While every situation is different, the guidelines, considerations, and ideas that follow can help ensure that your public speaking opportunity is as safe and informative as possible. The National Resource Center on Domestic Violence (NRCDV) welcomes any feedback readers have to enhance the guidance and resources provided here.

Tips for Survivor Speakers

As a survivor, are you considering if, how, and when to share your story with the public? Do you wonder what it would be like to step into the role of a public speaker? This section includes frequently asked questions and tangible steps that can help you make some of these decisions and develop a plan for sharing your story if you decide to do so.

Am I ready to start telling my story?

There are several considerations that can inform a Survivor Speaker's decision to tell her story publicly. Issues related to safety, physical and emotional well-being, and the overall impact on others of sharing a personal story all deserve attention. Questions such as, is it safe to share my story publicly? Do I really want to share my story or am I feeling that I SHOULD? Who could help me figure this out? These are some of the points we encourage you to consider as you decide whether or not to share your experiences with others in a public forum. Sorting through these questions can be challenging. However, victim advocates, other survivor speakers, and often family and friends can help inform your decision. Keep in mind that while others could provide you with support during this process, it is ultimately your personal decision to take this step.

How might telling my story impact my safety and well-being, my children and others I care about?

Impact on your emotional well-being

Speaking about traumatic events that you have experienced may produce strong emotional and physical reactions for you. While many survivors feel strong and empowered after telling their story, some survivor speakers also describe being exhausted and emotionally spent after public speaking events. Some have had flashbacks and nightmares or experience depression in the hours and days after sharing their story. Some have also experienced physical symptoms, such as headaches or stomachaches after presentations. Others have noted how helpful it was to have someone supportive at the presentation or later in the day when they

TIP If you have a pending legal case, such as child custody or divorce proceedings that involve the person who abused you, be mindful of how information that you might share as a survivor speaker could be used as evidence.



We recommend that survivors with an open court case not share their story publicly – the unintended consequences for you or your children could be too great.

Visualize a Positive Outcome

As you consider whether to become a survivor speaker, take time to visualize a speaking event unfolding in the way you want it to and the ways that it might make you feel strong and grounded. Remember all of the ways that you have been creative and resilient in your journey of survival, and imagine how inspired you and others will feel after you finish sharing your story. Many survivors have made use of a personal, encouraging mantra, a passage from a faith-based text, or motto as a form of positive self-talk throughout the day and prior to the event.

Another way to help you decide if you are ready to become a survivor speaker is to practice telling your story to a friend or trusted person who may not know too much about your survivor story. As you are telling your story, pay attention to any physical sensations that you may experience like muscle tension in the neck or headaches, pay attention to any emotional experiences you may have (e.g., sadness or anxiety). After you are done practicing, check in internally to see how the experience was for you. Pay attention to any feelings you may have afterwards or if you experience any flashbacks or nightmares. If it felt too overwhelming or intense then this can help you decide whether or not you'd like to become a survivor speaker at this time.

[2] The majority of domestic violence and sexual assault programs require specific training before someone is able to become a volunteer for their organization.

with the program can help you place your own individual experiences within a broader context of domestic violence as a public health and public safety issue. There may be opportunities to connect your story to a specific project, legislative effort, or event that is being planned in the community.

If you do not know how to contact the domestic violence program in your community, the state domestic violence coalition can help you. A complete list of contact information for all domestic and sexual violence coalitions across the United States and its Territories can be found at http://www.vawnet.org/links/state-coalitions.php. Some state coalitions coordinate a Speaker's Bureau and this might be a good way to find opportunities to talk with other survivors about their experiences as survivor speakers.

How do I prepare to tell my story?

Remember: It is your story

Tell about your experience with intimate partner violence – what happened and how it affected you and the people you care about. Perhaps you can describe how the violence and abuse affected your daily life and the factors that influenced the choices you made. If you are still in contact with the person who abused you, it may be helpful for the audience to hear about those dynamics and understand your motivation for remaining in contact. Share as much or as little as you feel comfortable. The audience wants to hear your story.

As you choose what to say, think about who helped you. What did they say or do that made a difference to you? What created obstacles for you? Find a way to describe how things could have been improved in the way others responded to you, without blaming or accusing the audience.

Don't feel that you need to include statistics, unless you are asked to do so. It is always appropriate to defer to or refer your audience to the local domestic violence program or state coalition for information that you do not feel prepared to address. If, however, you would like to be able to provide some statistics or general

It is generally better not to publicly identify the abuser or describe the abuser in a way that makes him/her easily identifiable unless that person has been convicted of domestic violence or a court has issued a protection order or other finding that the abuser committed violence against you. For example, if the abuser is the chief surgeon at the local hospital, it is better not to reference that position, because some people in the community could quickly identify them. If the abuser has not been found to have committed abuse by a court of law, and you name them publicly, an abuser might accuse you of libel or slander or claim intentional emotional harm. Again, it can be very helpful to have your comments reviewed by a legal advocate or attorney to be sure you are not exposed to retaliatory actions by the abuser who is still a threat to you.

HELPFUL CONTENT THAT EDUCATES LISTENERS

"What didn't help in my healing? It didn't help when people looked away and pretended that the abuse wasn't happening. One of my most painful memories was when my husband was beating me in front of some of his friends and they didn't do anything to help. They just sat there in my living room watching some game on TV while my husband assaulted me. That was an extreme example, but there were others. My family and friends knew what was going on, but they didn't ever say anything to me like, 'You don't deserve this.'" [4]

"What helped me most? The battered women's program helped me build up my self-esteem, and they helped me find what I needed to begin to think about my needs and well-being. I got into a support group, and I found out that other women have had the same experience and they have survived. I got back into school at the tribal college, and I'm studying to be a teacher." [5]

---

[4] North Dakota Council on Abused Women's Services/Coalition Against Sexual Assault, "Women are Sacred", booklet, p.12.

[5] Ibid.

[6] Women Helping Battered Women, Domestic Violence Program in Chittendon County, Vermont. http://www.whbw.org/a-survivors-story/

What do I need to know about the event?

Know your audience

Seek information about the audience to whom you will speak. How many people will be there? Will the audience include primarily other victims/survivors, only women, people from a particular age group, law enforcement, court or health care professionals, general community members, or be a mixed audience? For example, you may tell your story in a different way when speaking to youth than when telling your story to a group of experienced advocates or faith leaders, or when speaking to a particular cultural group.

Relationships that involve abuse are often complicated. In the course of identifying and addressing domestic violence issues and through the course of your experiences, you may have had contact with many different people and service providers such as community agencies, clergy or health care professionals. Including details about these interactions can be beneficial to audience members and can increase the impact of your story. The more you know about your audience, the better you will be able to choose which components of your experience to include.

TIP If you had negative interactions with individuals, community agencies, clergy or health care providers, be thoughtful about how you include these details. Share how these interactions made you feel and the effect it had on your decision-making, but do not use this public speaking opportunity to criticize or denounce the individual, community organizations or agencies, clergy or health care providers. That type of feedback is best presented in a private meeting between you, the individual, organization or agency in question and local advocates who can help identify and resolve a problem and improve response to future victims.

then plan a self-care activity (e.g., going for a walk, practicing to yoga, participating in a spiritual activity, etc.). It is important that you allow yourself some time to have a period after the presentation where you can reflect on the experience of presenting and care for yourself emotionally if necessary.

When you do meet with the advocate to debrief, be honest about what this experience was like for you, both positive and negative. Let the advocate know if you'd be interested in speaking again or if you need more time to process your thoughts and to consider whether you want to be on their list of speakers. Retelling your story many times over can be emotionally difficult. Sharing your experience with abuse once does not commit you to retelling your story every time an opportunity presents itself. You should also say no to public speaking requests unless you feel completely comfortable saying yes.

Should I expect to be compensated for sharing my story?

Asking for compensation is a reasonable request. However, be aware that local domestic violence programs and other non-profit organizations that typically organize these speaking engagements operate on small budgets and may not be able to afford to pay for speakers to come to their events. Where possible, domestic violence programs or other event sponsors will try to provide a small monetary stipend as compensation for survivor speakers. In the case of a national or statewide conference or other similar venues, the event sponsors may be able to provide an honorarium and pay for travel related expenses, including mileage reimbursement or transit fares, help with meals while you are there to speak, and accommodations.

Prior to agreeing to speak at the event, confirm with the event organizers whether you will be compensated and how, particularly if your ability to speak at the event is contingent upon financial assistance or compensation (that is, if you need help with gas money, transit fares, or other types of travel to/from the event). Often times, event organizers will do all they can to work out an arrangement that is agreeable and fits within their budget.

The Beginning.
Now, go forth and do good."

Teresa Ellis, *National Red Cross Volunteer*

For more information, please contact:

National Resource Center on Domestic Violence
3605 Vartan Way, Suite 101
Harrisburg, PA 17110

Phone: 800-537-2238

TTY: 800-553-2508

Fax: 717-545-9456

Email: nrcdv@nrcdv.org

NRCDV Website: www.nrcdv.org

DVAP Website: www.nrcdv.org/dvam

Checklist of Rape Crisis Advocacy Services

Ohio Alliance to End Sexual Violence
STATEWIDE ADVOCATE TRAINING
CHECKLIST OF RAPE CRISIS ADVOCACY SERVICES

In January 2013, OAESV published *Core Standards for Rape Crisis Programs in Ohio*, which defines rape crisis programs in Ohio based on the type of services provided to survivors and the manner in which those services are provided. "Rape Crisis Programs" are defined as "providing a full continuum of services, including hotlines, victim advocacy, and support services from the onset of the need for services through the completion of healing, to victims of sexual assault." *The Core Standards for Rape Crisis Programs in Ohio* are available in full on OAESV's website, and include a description of each Standard and a detailed checklist for each Standard. To access the full document, visit here: http://www.oaesv.org/ohio-core-rape-crisis-standards-2013/

Following is *general* (not exhaustive) checklist for rape crisis programs to use in assessing current service structure and services provided by advocates and administrative staff. A more detailed checklist is available by accessing the above-referenced link. It is understood that most Rape Crisis Programs will not be able to confirm compliance with each individual checklist component. Rape Crisis Programs are encouraged to contact OAESV with any questions, or to access training and technical assistance.

ADMINISTRATIVE SERVICE CAPACITY			
Item	***Description***	***Yes***	***No***
Accessibility	Staff are trained on barriers faced by survivors with varying abilities and LEP		
	Program has an equal employment opportunity policy & commitment to diversity/inclusion		
	Program facility is accessible to staff, survivors and visitors with physical disabilities		
	Program can readily access interpreters for ASL and languages other than English		
	Program materials are accessible to survivors with varying abilities		
	Program has collaborative partnerships with agencies serving those with varying abilities		
	Program's outreach/awareness activities are accessible to those with varying abilities		
Cultural Competency	Staff are trained on oppression of marginalized groups & assisting survivors in those groups		
	Cultural competency is part of ongoing staff development and continuing education		
	Program's services and materials are inclusive of individuals who identify as LGBTQI		
	Program's outreach/awareness activities are inclusive of individuals from diverse cultures		
	Program provides services to immigrant survivors regardless of documentation status		
ADMINSTRATIVE SERVICE CAPACITY (continued)			
Item	***Description***	***Yes***	***No***

Ethics/Accountability	Program has a policy about qualifications and acceptable criminal histories of staff		
	Program has a thorough personnel policy manual and orientation procedure for new hires		
	Program/agency is compliant with applicable federal nonprofit classification requirements		
	Program adheres to federal laws and regulations/conditions of funders, including finances		
	Program has publicized avenues for survivors to submit feedback/grievances about services		
	Program has clear anti-sexual harassment, discrimination and workplace violence policies		
	Program has a policy for documentation, confidentiality and retention of client information		
Training	Program has policy regarding the training of new staff members and volunteers		
	Training program includes components of OAESV's Statewide Advocate Training		
	Program supplements training of advocates based on local need and program policies		

CORE PROGRAM SERVICES			
Item	***Description***	***Yes***	***No***
24-Hour Hotline	Hotline is available toll-free 24 hours per day		
	Hotline is accessible to individuals who are Deaf or hard of hearing, or have LEP		
	Program has a policy regarding privacy and confidentiality of callers and their information		
	Program has a policy for responding to suicidal, threatening, and abusive callers		
	Program has an updated file with a wide variety of resources/referrals for callers		
	Hotline workers receive thorough training on responding to variety of crisis calls		
	Program has a policy for supporting and supervising hotline workers		
Criminal Justice/	Program is appropriately connected with local victim/witness advocates		
Advocacy	Program has a protocol detailing specific legal advocacy services provided		
	Legal advocates provide support and education only, not legal advice, to survivors		
	Program has a policy regarding staff testimony and release of client records		
Hospital/Medical	Advocacy is provided to survivors in the hospital 24 hours/day at no cost		
Advocacy	Program has a clear protocol for hospitals and survivors to access advocacy services		
	Program has a clear protocol for the role of advocates in the hospital setting		
	Advocates do not dispense medical advice or opinions about medical treatments		
CORE PROGRAM SERVICES (continued)			
Item	***Description***	***Yes***	***No***

Community Outreach	Staff is qualified to present developmentally and culturally-appropriate information		
	Program provides outreach programming that is responsive to community need		
	Presentations and materials are developed that are current, factual, and appropriate		
	Activities are developed and implemented with regard to diverse populations/needs		
Crisis Intervention	Crisis intervention is limited to short-term needs related to trauma (i.e. not counseling)		
	Face-to-face crisis intervention is provided to survivors free of charge		
	Program has a publicized policy on the availability of walk-in/face-to-face services		
	Program has a current listing of counseling referrals for survivors, as appropriate		
Collaboration/System	Program makes consistent efforts to collaborate with agencies who serve survivors		
Collaboration	Program is part of a formal collaborative group (i.e. SART, advisory board, etc.)		
	Program has memoranda of understanding with collaborative partners, as appropriate		
	Program has a confidentiality policy for sharing client information with outside agencies		

OPTIONAL/ANCILLARY SERVICES			
Item	***Description***	***Yes***	***No***
Prevention Education	Staff is committed to implementing activities that reflect the Spectrum of Prevention		
	Staff is qualified to present developmentally- and culturally-appropriate information		
	Presentations and materials are developed that are current, factual, and appropriate		
	Activities are developed and implemented with regard to diverse populations/needs		
Therapy/Professional	Clinicians possess required education, insurance, and licensure in good standing		
Counseling	Clinicians have training regarding trauma-informed service modalities for SA survivors		
	Clinicians abide by ethical guidelines as dictated by law, licensure boards, and agency policy		
	Program has a policy for documentation, confidentiality and retention of client information		
Support Groups	Groups should be limited in scope to crisis intervention/support, not counseling		
	Program has a policy regarding recruitment, screening, and support for group members		
	Facilitators are skilled at group discussion and facilitating group activities/exercises		
	Facilitators are qualified to present developmentally and culturally-appropriate information		

Training Evaluation

Ohio Alliance to End Sexual Violence
STATEWIDE ADVOCATE TRAINING EVALUATION

Please complete the following evaluation of the training you've received. Your feedback will assist OAESV in providing the most effective and relevant training and technical assistance to advocates and allied professionals throughout Ohio. Thank you!

Please place an "X" in the box that best reflects your opinion about each item.

As a result of this training…	**Strongly Agree**	**Agree**	**Somewhat/ Neutral**	**Disagree**	**Strongly Disagree**
I gained greater understanding of sexual violence and the role of rape crisis programs in responding to it.					
I am better informed about the role, expectations and limitations of a rape crisis advocate.					
I feel better equipped to successfully perform my duties as an advocate in my agency.					
Regarding the training format…	**Strongly Agree**	**Agree**	**Somewhat/ Neutral**	**Disagree**	**Strongly Disagree**
The training methods were effective (lecture, reading, activities, role play, etc.)					
The length and pace of the training was comfortable and conducive to learning.					
The training facility and accommodations met my needs and expectations.					
Regarding the presenters…	**Strongly Agree**	**Agree**	**Somewhat/ Neutral**	**Disagree**	**Strongly Disagree**
They were knowledgeable about the topics on which they were presenting.					
Their presentation style was effective and conducive to learning.					
They allowed, and were responsive to, questions and comments from trainees.					

FOR DAY 1: The training, reading and activities provided on these topics were beneficial:	**Strongly Agree**	**Agree**	**Somewhat/ Neutral**	**Disagree**	**Strongly Disagree**
Definitions and statistics about sexual violence.					
Rape culture (oppression, continuum of sexual violence, victim-blaming)					
Impact of sexual violence (physical, psychological, short-/long-term, impact on loved ones)					
The role of the rape crisis advocate in various service settings (hospital, court, hotline, etc.)					
Cultural competency (appropriate responses, accessibility, knowing your local community)					
Empathy and listening skills					
Hotline/Crisis Intervention (policies and effective responses)					
Special/Ancillary Issues (providing effective advocacy to specific survivor populations)					
Self-Care (vicarious trauma, burnout, strategies for monitoring and maintaining self-care)					
Impact of Advocacy (survivor testimony, effectiveness of rape crisis advocates)					

Please use the space below to comment on any aspect of the training you received on DAY 1:

FOR DAY 2: The training, reading and activities provided on these topics were beneficial:	**Strongly Agree**	**Agree**	**Somewhat/ Neutral**	**Disagree**	**Strongly Disagree**
Hospital/Medical Advocacy (hospital procedures, SANEs, rape kit exams, etc.)					
Criminal Justice/Legal Advocacy (criminal justice process, victim rights, civil legal issues)					
Role Play Scenarios (hotline calls and in-person advocacy)					
Advanced Advocacy (resource/referral networks, systems coordination, SART)					
Social Media (victimization/re-victimization issues, using social media for outreach/awareness)					
Media Advocacy (working with the media, ethics, survivor rights, empowering survivors)					
Appropriate Legislative Advocacy (legal restrictions, grassroots organizing for policy change)					
Question & Answer Session					

Please use the space below to comment on any aspect of the training you received on DAY 2:

OVERALL regarding the training…	**Strongly Agree**	**Agree**	**Somewhat/ Neutral**	Disagree	**Strongly Disagree**
I am happy with the training I've received and I'm glad I participated.					
I would recommend this training to other rape crisis advocates.					

Please use the space below to comment on any aspect of the training you found to be especially effective, useful, or helpful:

Please use the space below to comment on any aspect of the training that could be improved or eliminated, or any topic you feel was missing from the training that should be included:

Please use the space below for any additional comments about the training, presenters, format, etc.:

Follow-up Assignments and Certification

Follow-Up Assignments In-person Training:

- Journal exercise. Find an example of rape culture that really bothers you. Write a page describing the example, how it makes you feel, and how it could be addressed.

- Journal Exercise. Write a page about a time when you were in crisis. What did you need? Did you get it? Why or why not?

- Think about the cultural populations in your agency's service area. Visit www.oaesv.org/advocates/ and see the section on "Working with Underserved or Special Populations." Review two resources that would be useful to you where you work.

- Self-Care Assessment Worksheet http://www.ecu.edu/cs-dhs/rehb/upload/Wellness_Assessment.pdf (recommended monthly)

- "In Your Community" Checklist for Advocates [OAESV] http://www.oaesv.org/wp-content/uploads/2013/05/In-Your-Community-Sheet1.pdf

"In Your Community"
Checklist for Advocates

The following is a list of agencies/organizations you should be familiar with in your own community. If possible, create personal relationships with the people who work at these agencies in order to help provide a coordinated response to sexual violence in your community.

	AGENCY NAME	CONTACT NAME/TITLE	PHONE NUMBER	ADDRESS	EMAIL	WEBSITE	NOTES
EMERGENCY RESPONSE							
SART							
POLICE UNITS							
HOSPITALS WITH SANE UNITS/NURSES							
HIV/STI/PREGNANCY TESTING							
JUSTICE SYSTEM							
PROSECUTOR'S OFFICE/VICTIM WITNESS							
COURT PERSONNEL							
LEGAL AID							
SOCIAL SERVICES							
CHILD PROTECTIVE SERVICES							
DOMESTIC VIOLENCE							
FOOD PANTRIES							
HOUSING ASSISTANCE							
EMPLOYMENT ASSISTANCE							

MENTAL HEALTH & RECOVERY							
SUICIDE HOTLINE							
COUNTY MENTAL HEALTH SERVICES							
COUNSELORS/THERAPISTS							
SCHOOL AND CAMPUS BASED MENTAL HEALTH SERVICES							
SELF DEFENSE PROGRAMS							
RESOURCES FOR SPECIFIC POPULATIONS:							
CHILDREN/TEENS							
OLDER ADULTS							
MALE SURVIVORS							
LGBTQI							
INTERPRETING SERVICES							
PEOPLE WITH VARYING ABILITIES							
HUMAN TRAFFICKING							
PREA							
IMMIGRANT COMMUNITIES							
HOMELESS							
CULTURAL ORGANIZATIONS							
RELIGIOUS INSTITUTIONS							
OUTREACH							
MEDIA CONTACTS							
COMMUNITY LEADERS							

Post-Training Needs Assessment

Ohio Alliance to End Sexual Violence
STATEWIDE ADVOCATE TRAINING
POST-TRAINING NEEDS ASSESSMENT

The Statewide Advocate Training recently offered by OAESV was intended to be a thorough foundation of knowledge and skills necessary to provide effective advocacy and support to survivors of sexual violence. OAESV understands that additional time, learning, and experience within local agencies is needed in order to feel fully prepared and equipped to work as an advocate.

Please complete the following needs assessment, sign and return to OAESV. The information you supply here will help OAESV to provide you the additional training, technical assistance and resources needed to be an effective advocate in your local community.

Please provide the following information about you and your agency:

Program Name: _____

Mailing Address: _____

County/counties served by your Program: _____

Program Director/Manager Name: _____ **Email:** _____

How many advocates from your Program attended the Statewide Advocate Training? _____

Please list the name(s) of the advocate(s) who attended the training: _____

_____

Please list any topics NOT addressed in the Statewide Advocate Training for which you/your agency needs training: _____

_____

PART A: VICTIM ADVOCACY TRAINING NEEDS

Please indicate which of the following best describes your *current situation* based on each topic listed:

Topic	***The Statewide Advocate Training covered this topic sufficiently***	***My/our agency is able to provide our own additional training on this topic***		***I/we need someone to provide additional training on this topic (in-person or online)***	***I/we would like additional material resources/info on this topic***	***This topic is not relevant to my/our work at this time***
Impact of Sexual Violence (physical, psychological)		To be done	Completed			
Rape Culture (oppression, victim-blaming)		To be done	Completed			
Rape Crisis Advocacy (role, limitations)		To be done	Completed			
Empathy, active listening skills when working w/survivors		To be done	Completed			
24-hour crisis hotline advocacy & policies		To be done	Completed			
Criminal justice/legal advocacy		To be done	Completed			
Hospital/medical advocacy		To be done	Completed			
Cultural competency issues		To be done	Completed			
Self-Care, vicarious traumatization		To be done	Completed			

Topic	***The Statewide Advocate Training covered this topic sufficiently***	***My/our agency is able to provide our own additional training on this topic***		***I/we need someone to provide additional training on this topic (in-person or online)***	***I/we would like additional material resources/info on this topic***	***This topic is not relevant to my/our work at this time***
Ethics and Confidentiality		To be done	Completed			
Developing referrals and resource networks		To be done	Completed			
Working with professional partners (SART)		To be done	Completed			
Social media (victimization, awareness)		To be done	Completed			
Media Advocacy (working with media, supporting survivors)		To be done	Completed			
Grant & Administrative Policies & Procedures		To be done	Completed			

Certification & Signature

The above information, to the best of my knowledge, accurately reflects the current needs of my agency regarding the training of Rape Crisis Advocates. I am committed to following up with OAESV as needed to provide the most complete training possible for advocates in my agency, as appropriate.

_____ _____

Signature of Rape Crisis Program Director/Manager Date

Please mail the completed form to OAESV at 526 Superior Ave. #1400, Cleveland, OH 44114 or email completed form to info@oaesv.org.

Follow-up Assignment Checklist

- Journal exercise on Rape Culture
- Journal exercise on Crisis
- Review 2 resources on working with underserved special populations
- Self-Care Assessment Worksheet
- In Your Community checklist for advocates

Certification & Signature

The above information, to the best of my knowledge, certifies that I have completed the follow-up activities to become a certified Ohio Rape Crisis Advocate.

_____ _____

Signature of Rape Crisis Advocate Date

_____ _____

Signature of Rape Crisis Program Director/Manager Date

Please mail the completed form to OAESV at 526 Superior Ave. #1400, Cleveland, OH 44114 or email completed form to info@oaesv.org.

Core Standards for Rape Crisis Programs in Ohio

Distributed by the Ohio Alliance to End Sexual Violence

January 2013



Standards Committee:

Chaired by: Becky Perkins, Statewide Outreach Manager, Ohio Alliance to End Sexual Violence

Committee Members (alphabetical by last name):
Julie Broadwell, Program Manager, SAAFE Center (Bowling Green)
Karin Ho, Administrator, Office of Victim Services, Ohio Dept. of Rehabilitation & Corrections
Kimberly Kroh, Rape Crisis Director, American Red Cross Stark County Chapter
Sandra Lyons, Victim Advocate, Sexual Assault Help Center, Inc. (Steubenville)
Kirsti Mouncey, Vice President of Client & Clinical Services, Cleveland Rape Crisis Center

Publication Information:

Office on Violence Against Women (Coalition):
This publication was supported in part by Grant No. 2012-X1404-OH-SW awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication/program/exhibition are those of the authors and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

Office on Violence Against Women, Sexual Assault Services Program:
This project was supported by contract No. PREV-31048 awarded by the Ohio Department of Health, the state administering office for the SASP Formula Grant Program. The opinions, findings, conclusions and recommendations expressed in the publication are those of the authors and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

Ohio Attorney General's Office, Victims of Crime Act:
This document in its entirety was published by the Ohio Alliance to End Sexual Violence in part by Victims of Crime Act State Grant Awards # 2012VASAVE915 and # 2013VASAVE915, administered by the Ohio Attorney General's Office.

Executive Summary

Defining Sexual Violence

According to the Centers for Disease Control and Prevention, "Sexual violence (SV) is any sexual act that is perpetrated against someone's will. SV encompasses a range of offenses, including a completed nonconsensual sex act (i.e., rape), an attempted nonconsensual sex act, abusive sexual contact (i.e., unwanted touching), and non-contact sexual abuse (e.g., threatened sexual violence, exhibitionism, verbal sexual harassment). All types involve victims who do not consent, or who are unable to consent or refuse to allow the act."[1]

Defining Rape Crisis Programs

According to the National Sexual Assault Coalition Resource Sharing Project, "**Rape crisis centers are agencies whose major purpose is providing victim advocacy and support services to sexual violence survivors.** They may be attached to a domestic violence shelter or other social service agency, and they may provide more services than the core, but their focus is on supporting survivors and eradicating sexual violence. RCCs have different names or descriptors ("sexual assault services" as one example)...Services based in law enforcement, courts or hospitals are not included as RCCs as their goals and methods differ considerably from the work of centers."[2]

Why Standardized Rape Crisis Services are Important:

- The CDC's National Intimate Partner and Sexual Violence Survey indicates that nearly 1 in 5 women and 1 in 71 men have been raped in their lifetime.[3]
- Rape crisis services decrease the negative effects of a sexual assault.
- With more than half of Ohio's counties lacking rape crisis programs, survivors in all regions of the state are in need of rape crisis services.

Defining Core Rape Crisis Services in Ohio

As defined by the Standards Committee and more than 65 members/member programs of

[1] Basile KC, Saltzman LE. *Sexual violence surveillance: uniform definitions and recommended data elements* version

[2] Bein, K. National Sexual Assault Coalition Resource Sharing Project, 2010. *Core Services and Characteristics of Rape Crisis Centers: A Review of State Service Standards*, Available from: http://www.resourcesharingproject.org/attachments/349_Core%20Services%20and%20Characteristics%20of%20RCCs.pdf.

[3] Centers for Disease Control and Prevention, 2010. *The National Intimate Partner and Sexual Violence Survey*.

OAESV that voted to approve the Standards, rape crisis programs are defined in Ohio as *providing a full continuum of services, including hotlines, victim advocacy, and support services from the onset of the need for services through the completion of healing, to victims of sexual assault*. Rape crisis programs in Ohio provide the following core services:

- 24-hour Crisis Hotline
- Advocacy
    - Hospital/Medical Advocacy
    - Criminal Justice/Legal Advocacy
- Community Awareness/Outreach
- Crisis Intervention
- Information and Referral
- Systems Coordination/Collaboration

Service administration standards include:

- Accessibility
- Cultural Competency
- Ethics & Accountability
- Evaluation
- Staff/Volunteer Training

Ancillary Services offered by some rape crisis programs (but not all, due to limited funding) include:

- Prevention Education
- Professional Counseling/Therapy
- Support Groups

For additional information on rape crisis programs in Ohio, training and technical assistance and with any questions, please contact the Ohio Alliance to End Sexual Violence.

Ohio Alliance to End Sexual Violence
526 Superior Avenue, #1400
Cleveland, Ohio 44114

www.oaesv.org
216.658.1381
info@oaesv.org

Statement of Purpose

In many states across the country the characteristics and core services of rape crisis programs are defined by law, by funders, or by state coalitions. Until now, Ohio did not have a specific definition for rape crisis programs. Programs exist in many different forms throughout Ohio, offering varying types of services to survivors. The intent of developing and distributing standards for rape crisis programs is threefold:

1. To ensure that every survivor in the state of Ohio has access to consistent services regardless of personal or demographic characteristics, or location in the state;
2. To provide a formalized framework for identifying and describing specific services and characteristics that define a rape crisis program in Ohio; and
3. To serve as a resource for rape crisis programs in terms of training for staff and volunteers, continuing education, and best practices.

Development of the Standards

In January 2012, the Ohio Alliance to End Sexual Violence (OAESV) formed a Standards Committee, comprised of individuals from OAESV member organizations throughout Ohio. The Committee reviewed numerous documents and made recommendations for updates. These documents included the Ohio Department of Health Rape Prevention Program Standards (2001), *Model for Sexual Assault Community Protocol,* from the Ohio Sexual Assault Task Force (2005), and the *Core Services and Characteristics of Rape Crisis Centers: A Review of State Service Standards*, from the National Sexual Assault Coalition Resource Sharing Project (2010).

Acknowledgements

This document was made possible by the work of the Standards Committee, along with the support and contributions of the following individuals: Katie Hanna, OAESV Statewide Director; Jasmine Finnie, OAESV Statewide Prevention Coordinator; Ginnette Simko, OAESV Resource Specialist; Kara Porter, former OAESV Statewide Outreach Manager; Sarah Osmer, OAESV Consultant; and Debra Seltzer and Beth Malchus of the Ohio Department of Health Sexual Assault and Domestic Violence Prevention Program. Finally, the Standards Committee wishes to acknowledge the coalitions from the following states, which shared their standards for review: Kentucky, West Virginia, Indiana, Washington, New Mexico, Florida, and Vermont.

The Standards Committee and the Ohio Alliance to End Sexual Violence acknowledge that the *Core Standards for Rape Crisis Programs in Ohio* will require future revisions as necessitated by emerging best practices, as well as the requirements and expectations of governing institutions and funders. This document is intended to be a thorough starting point from which to define effective rape crisis services in the state of Ohio, in the best interests of survivors.

Document Organization

This document is organized as follows:

- **Core Rape Crisis Direct Service Standards**: These are core components that are considered to be essential to all rape crisis programs. They include basic services that are critical to providing consistent, effective services to survivors of sexual violence.
- **Service Administration Standards:** These include administrative practices necessary to ensure that all survivors have access to rape crisis services, and that agency/program policies exist and are followed.
- **Ancillary Services Standards**: These are services that many rape crisis programs offer, but are not required or possible for all programs due to funding or other restrictions.
- **Program Checklists**: These are step-by-step, detailed checklists that describe each Standard more fully and provide an assessment tool for programs to use.
- **Additional Resources**: These include links to state and national resources that provide additional information of relevance to rape crisis programs.

Table of Contents

TITLE	STANDARD PAGE	CHECKLIST PAGE
Core Rape Crisis Direct Service Standards	***PAGE 7***	
24-hour Crisis Hotline	8	27
Advocacy	9	--
Criminal Justice/Legal Advocacy	10	30
Hospital/Medical Advocacy	11	31
Community Awareness/Outreach	12	32
Crisis Intervention Services	13	34
Information & Referral	14	--
Systems Coordination/Collaboration	15	35
Service Administration Standards	***PAGE 16***	
Accessibility	17	37
Cultural Competency	18	38
Ethics & Accountability	19	40
Evaluation	20	--
Staff/Volunteer Training	21	42
Ancillary Services Standards	***PAGE 22***	
Prevention Education	23	44
Professional Counseling/Therapy	24	47
Support Groups	25	49
Additional Resources	***PAGE 50***	

Core Rape Crisis Direct Service Standards

24-hour Crisis Hotline	
Definition	A telephone service available on a 24-hour basis to connect survivors/co-survivors of sexual violence with a trained advocate
Goal	To provide the survivor/co-survivor with the appropriate telephone-based crisis intervention, support, information, referrals and options to help effectively address her/his needs
Duration	As needed and as defined by program's hotline usage policy
Qualifications	At a minimum, a 24-hour Crisis Hotline includes: • While crisis lines may serve dual purposes, the service must connect survivors of sexual violence to a trained advocate in a timely manner, within 30 minutes of the call • All crisis lines should be RAINN registered and thus accessible via toll-free number • Advocates answering a hotline should undergo at least 40 hours of training • Crisis line providers are encouraged to have a language line available as well as utilize Sorenson or Relay service or to equip their crisis line with text telephone capacity or assistive technology for clients who may be Deaf or hard of hearing

The Program Checklist for 24-hour Crisis Hotline can be found on page 27.

Advocacy	
Definition	An advocate is a trained individual whose role is to help survivors/co-survivors be aware of their options and support their decisions. Advocates provide emotional support and crisis intervention at any stage in the survivor's recovery process. Advocates provide information, make suggestions, and help ensure that survivors have the services they need
Goal	To ensure that needed services and adequate support to enhance recovery from sexual violence are available
Duration	Varies depending on individual survivor needs
Qualifications	At a minimum, Advocacy includes: • Providing confidential, nonjudgmental, victim-centered support • Providing accurate, timely information regarding unique needs presented by the survivor • Providing specific and appropriate program services to address the survivor's needs (may include hospital accompaniment, legal advocacy, etc.) • Providing service planning and referrals for follow-up services, as needed and requested by the survivor

There is no Program Checklist for Advocacy, as it is a generalized term, the application of which is inherent in all other Core Standards.

Criminal Justice/Legal Advocacy	
Definition	Acting on behalf of and in support of survivors/co-survivors navigating the legal system by ensuring that the survivor's questions are answered, interests are represented, and rights are upheld
Goal	To ensure that the survivor/co-survivor has the information and support s/he needs to effectively participate in the criminal justice and/or civil legal systems, or to make decisions about participation
Duration	May be long-term and episodic
Qualifications	At a minimum, Criminal Justice/Legal Advocacy includes: • Advocating for the rights, needs and wishes of the survivor within the legal system • Providing basic information about the criminal justice and civil legal systems, including victim rights • Providing information and referrals for assistance regarding administrative legal processes that may exist within other contexts, such as academic, immigration, housing, medical, and employment • Connecting survivors to court advocacy services provided in the community (such as Victim/Witness), if court accompaniment is not offered by the Program • Ensuring advocates do not dispense legal advice to survivors, even if they licensed to do so

The Program Checklist for Criminal Justice/Legal Advocacy can be found on page 30.

Hospital/Medical Advocacy	
Definition	Acting on behalf of and in support of survivors/co-survivors navigating the medical/healthcare system by ensuring that the survivor has the appropriate information and resources to make decisions about her/his healthcare needs, and to assist her/him in obtaining the desired care
Goal	To ensure that the survivor has access to competent, victim-centered medical care, treatment and/or evidence-collection, as desired
Duration	Generally short-term
Qualifications	At a minimum, Hospital/Medical Advocacy includes: • Providing the survivor/co-survivor with accurate information about the physical impact of sexual violence and about the resources and options available to the survivor to address healthcare needs • Accompanying the survivor, if s/he desires, to a local hospital or healthcare facility for forensic evidence collection, testing, and/or treatment for injury and/or exposure to STIs • Providing service planning and referrals for follow-up care related to medical/healthcare needs as the survivor recovers • Ensuring advocates do not diagnose medical conditions or recommend treatment regimens for survivors/co-survivors, even if they are licensed to do so

The Program Checklist for Hospital/Medical Advocacy can be found on page 31.

Community Awareness/Outreach	
Definition	Providing accurate information about sexual violence, and individual, organizational, and societal strategies that promote the elimination of sexual violence in the community; and ensuring the community is aware of the Program, its services, and how to access those services
Goal	To effectively engage the larger community in efforts to support survivors/co-survivors and to eliminate sexual violence
Duration	As dictated by community need and program capacity
Qualifications	At a minimum, Community Awareness/Outreach includes: • Ensuring that the community at large is aware of the Program, the services it provides, and how and when to access the Program; includes disseminating program brochures/cards, as appropriate • Disseminating messages and materials in the community that support survivors and advocate for the elimination of sexual violence • Implementing, hosting and/or participating in awareness activities/ events that expose the community to accurate information about sexual violence • Developing/utilizing materials and activities that are culturally and developmentally appropriate for the populations targeted • Being deliberately inclusive of underserved and marginalized populations when planning and implementing awareness/outreach activities (i.e. culturally-specific groups, those with varying abilities, economically disadvantaged, etc.) • Utilizing best practice/research-based curricula or presentation methods, when possible • Conducting evaluation of activities and adjusting approaches to awareness/outreach as needed to best meet the needs of survivors and the community

The Program Checklist for Community Awareness/Outreach can be found on page 32.

Crisis Intervention Services	
Definition	An immediately available 24-hour personal response provided by a trained advocate in a variety of settings to an individual presenting a crisis related to sexual violence. The goal is reducing the level of trauma experienced by assisting survivors in strengthening coping skills through an empathic response. May include information about the effects of sexual violence and possible reactions, general information about medical and legal resources, information about other services in the community, survivor options, and referral to the 24-hour Crisis Hotline
Goal	To alleviate acute distress of sexual violence, to begin stabilization, and assist in determining the next steps
Duration	Short-term and may be episodic in nature
Qualifications	At a minimum, Crisis Intervention Services include: • Providing confidential, nonjudgmental support, available 24-hours/day via 24-hour Crisis Hotline, and in-person at appropriate times and locations per program or agency policy • Assessing for the unique and core needs of the survivor/co-survivor, and providing an appropriate response to those needs, which may include referrals

The Program Checklist for Crisis Intervention Services can be found on page 34.

Information & Referral	
Definition	Providing timely, relevant contact information to survivors/co-survivors for community resources that address a need or needs of the survivor that the Program is not equipped to effectively address, which may include professional counseling or services indirectly related to sexual violence
Goal	To ensure the survivor/co-survivor has access to relevant and appropriate resources that will meet her/his unique and varying needs
Duration	Generally short-term, but as needed
Qualifications	At a minimum, Information & Referral includes: • Assisting the survivor/co-survivor in determining what needs exist and what types of resources would be of help • Providing the survivor/co-survivor with contact information, in writing when possible, for appropriate and relevant resources that can address her/his stated needs • Maintaining up-to-date contact information for all available resources in and surrounding the community, including resources that are not directly related to victimization (i.e. housing, employment assistance, immigration issues, etc.)

There is no Program Checklist for Information & Referral.

Systems Coordination/Collaboration	
Definition	Developing and maintaining professional partnerships with programs, agencies, organizations, and groups in the community that serve or otherwise impact survivors; such partnerships may be formal (such as a Sexual Assault Response Team), or informal
Goal	To promote consistent, comprehensive, victim-centered services for survivors/co-survivors of sexual violence in the community
Duration	Ongoing
Qualifications	At a minimum, Systems Coordination/Collaboration includes: • Awareness/understanding of the various organizations in and surrounding the community that serve or otherwise impact survivors • Sharing information and resources, as appropriate, with other programs and organizations in order to provide the most effective services to survivors/co-survivors • Meeting/speaking with collaborative partners on a regular basis to discuss best practices, barriers to service implementation, and strategies for effective collaboration; includes documentation of meetings (i.e. minutes) • When possible, memoranda of understanding should be developed with collaborative partners to formally define each partner's responsibilities in responding to survivors in the community

The Program Checklist for Systems Coordination/Collaboration can be found on page 35.

Service Administration Standards

Accessibility	
Definition	The ability of the program to effectively provide services to all survivors/co-survivors of sexual violence, including survivors that face barriers to access due to physical, mental, economic, limited English proficiency, or other barriers, including individuals who are Deaf or hard of hearing
Goal	To ensure that all program services are equally available to all survivors/co-survivors who seek services
Duration	Ongoing
Qualifications	At a minimum, Accessibility includes: • Adherence to all applicable laws and regulations set forth by the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act • Creating a physical environment that is welcoming of all individuals, and that promotes ease of access to, and independence within, the Program's facility • Flexibility of staff members and volunteers in accommodating unique survivor needs, such as utilizing assistive communication methods, allowing for the presence of service animals, etc. • Understanding of, and partnerships with, community resources to meet unique needs of individual survivors that the Program is not equipped to meet (i.e. case management, housing, transportation, psychiatric/medication services, etc.)

The Program Checklist for Accessibility can be found on page 37.

Cultural Competency	
Definition	The ability of the Program to provide effective services within the context of the unique and varying cultural beliefs, attitudes, behaviors, and needs of individual survivors/co-survivors who access services
Goal	To effectively meet the needs of individual survivors/co-survivors in ways that both honor and incorporate their cultural identity and experience
Duration	Ongoing
Qualifications	At a minimum, Cultural Competency includes: • Maintaining a service delivery structure that is sensitive and responsive to the diversity of the community in which the Program operates; this may include the utilization of messaging and materials in specific languages • Cultivating respect for all cultural beliefs and customs, and how those beliefs and customs impact the survivor's response to/recovery from violence; this may include training of staff members and volunteers • Accommodating, to every extent possible, the unique needs of the survivor that are hindered by institutional or physical barriers • Empowering the survivor/co-survivor by incorporating her/his specific beliefs and customs into the response process and service delivery • Connecting the survivor to resources in the community that can best meet her/his specific needs, whether directly or indirectly related to sexual violence

The Program Checklist for Cultural Competency can be found on page 38.

Ethics & Accountability	
Definition	The consistent, deliberate application of defined practices and procedures that promote the health and safety of individuals, the institutional integrity and legality of the Program and its services, and transparency of the Program within the community
Goal	To ensure the health and safety of survivors/co-survivors while receiving program services, and to ensure the health, safety, and integrity of staff members, volunteers, and the Program itself
Duration	Ongoing
Qualifications	At a minimum, Ethics & Accountability includes: • Adherence to all federal statutes regarding nonprofit organizations (if the Program is its own nonprofit), or adherence to agency policies (if the Program is part of a nonprofit organization) • Adherence to applicable laws and regulations as set forth by the Health Information Portability & Accountability Act (HIPAA), state and federal statutes, and requirements of program funders • Existence of and adherence to a policy regarding confidentiality of services provided to survivors/co-survivors • Adherence to expectations for personal and professional conduct of staff members and volunteers, as dictated by program and agency policy, and authoritative bodies such as licensing agencies (i.e. the Ohio Counselor, Social Worker, Marriage & Family Therapist Board) • Existence of and adherence to policies and statutes related to non-discrimination, sexual harassment, and violence in the workplace • Existence of and adherence to policies regarding financial transparency and accountability for all monies that fund program staffing and services • Existence of and adherence to a defined grievance process for survivors/co-survivors, staff members, and volunteers • To every extent possible, utilizing best practices/evidence-based approaches when providing services to survivors

The Program Checklist for Ethics & Accountability can be found on page 40.

Evaluation	
Definition	The systematic, deliberate assessment of the Program, its services and methods of service delivery
Goal	To assess the extent to which the Program's services are effectively meeting the needs of survivors/co-survivors and the community, with the purpose of altering or improving those services to become more effective
Duration	Ongoing; specific evaluation methods may be scheduled/activity-specific
Qualifications	At a minimum, Evaluation includes: • Consistent, regular documentation and reporting of the number of clients served and type of services provided by the Program • Consistent distribution of client satisfaction surveys, when possible, to all clients receiving face-to-face services • Consistent attempts to gauge client satisfaction from clients receiving telephone-based services • Inclusion of both qualitative and quantitative measures of services provided and clients served • Utilization of research-based evaluation tools, when possible • Surveys (formal or informal) of partner agencies/referral agencies in the community regarding the Program's effectiveness • A policy defining: ○ who conducts evaluation, as well as when and how assessments are conducted; may be service-specific ○ who reviews information obtained from assessments, as well as when and how such reviews are conducted ○ how information obtained from assessments will be utilized to alter/improve program services or service delivery • A policy defining the method and frequency of staff evaluations, and how those evaluations inform personnel decisions • A policy outlining opportunities for program staff to safely express job satisfaction, including questions/concerns and ideas for improvement

There is no Program Checklist for Evaluation; rather, each individual Checklist includes specific recommendations for evaluation.

Staff/Volunteer Training	
Definition	Educating staff and volunteers about the dynamics of sexual violence and equipping them with the skills to provide appropriate, client-centered, empathic support for survivors/co-survivors. Basic training topics include: discussion of myths v. facts; types of sexual violence; crisis intervention; law enforcement/criminal justice system overview; sexual assault exam information; meeting the needs of diverse populations; and supporting survivors with varying abilities
Goal	To equip staff and volunteers with the knowledge and skills necessary to become effective advocates for survivors/co-survivors of sexual violence
Duration	40 hours for volunteers; duration for new staff members may vary

Qualifications	At a minimum, Staff/Volunteer Training includes:
	• Volunteers must receive a minimum of 40 hours of sexual assault/abuse training following the Ohio Standards
	• Volunteers must complete an application, be interviewed by staff using a standardized list of questions, pass a background check, and possess the necessary auto insurance coverage, as well as other program or agency-specific requirements (e.g., TB test)
	• The Program must have written guidelines, policies, and procedures for staff and volunteers, including:
	  ○ Protocols for documentation of crisis contacts
	  ○ Protocols for when and how volunteers should contact a volunteer coordinator/staff member
	  ○ Protocols for referring clients elsewhere (e.g., suicidal ideation)
	  ○ Protocols for ensuring survivors receive information and referrals (e.g., Victims Compensation, VINE)
	• The Program should establish record-keeping protocols, including:
	  ○ Protocols for how to track the number of client contacts (phone and in-person) and how to dispose of confidential information
	  ○ A roster of all volunteer names/contact information on file
	  ○ Number of volunteer hours and types of assistance provided per volunteer
	• Volunteers do not need to be licensed mental health providers; if an advocate is a licensed mental health provider, they do not serve in their professional capacity when acting as an advocate
	  ○ All staff and volunteers must sign a confidentiality statement and the Program must keep it on file

The Program Checklist for Staff/Volunteer Training can be found on page 42.

Ancillary Services Standards

Prevention Education	
Definition	Culturally appropriate, structured activities/strategies implemented in a variety of settings and to a universal population that promote the primary prevention of sexual violence
Goal	To equip individuals, groups, institutions, and society at large with the knowledge and skills to prevent sexual violence before it occurs
Duration	As dictated by community need and program capacity; ideally, prevention programming should be sustained and expanded to increase exposure of prevention messages over time
Qualifications	At a minimum, Prevention Education includes: • Development and utilization of comprehensive, evidence-based strategies through a continuum of activities addressing all levels of the social ecological model or Spectrum of Prevention • Activities are based on promoting protective factors that reduce the likelihood of sexual violence occurring, instead of risk reduction • Activities are culturally appropriate for the selected population(s) • Activities are developmentally appropriate for the selected population(s) • Activities strive to address individuals/populations at various stages throughout the lifespan • Ideally, prevention strategies should include educational sessions/ seminars, professional training, coalition-building within the community, and changing social norms • Development and utilization of comprehensive evaluation methods/ tools that demonstrate knowledge, behavior change, and commitment to quality improvement • Institutional support for prevention programming should be a priority for agencies implementing primary prevention strategies

Developed by the Virginia Sexual and Domestic Violence Action Alliance. The *Guidelines for the Primary Prevention of Sexual and Intimate Partner Violence* can be downloaded from http://vsdvalliance.org/primary_prevention/. Please contact info@vsdvalliance.org for more information.

The Program Checklist for Prevention Education can be found on page 44.

Professional Counseling/Therapy	
Definition	A professional relationship between a qualified, licensed professional and a client (individual, family, or group) that utilizes therapeutic modalities to address one or more issues presented by the client
Goal	To empower the client to accomplish mental health, wellness, interpersonal, relational, educational, and/or vocational goals
Duration	Scheduled appointments for a defined period of time
Qualifications	At a minimum, Professional Counseling/Therapy includes: • Assessment, individual service planning, and therapeutic counseling provided by a qualified, licensed professional • Interventions utilizing best practices/evidence-based practices regarding sexual violence and trauma • Incorporation of all elements of a Trauma Sensitive and Trauma Informed Care System • Recognition that coercive interventions cause re-traumatization • All counselors/therapists should be aware and trained in co-occurring disorders such as mental health and substance abuse disorders, eating disorders, self-harming behaviors, and PTSD • Knowledge about the stages of trauma recovery • Knowledge about vicarious traumatization and self-care strategies, including adequate supervision • Knowledge of Ohio's Core Competencies of Sexual Violence for Helping Professions • Following Legal and Ethical Guidelines according to professional licensure requirements in Ohio

The Program Checklist for Professional Counseling/Therapy can be found on page 47.

Support Groups	
Definition	Survivors/co-survivors meeting in a safe, supportive, non-judgmental environment on a regular, scheduled basis to share information, share techniques for problem-solving, and to explore feelings resulting from sexual victimization and the recovery process
Goal	To foster a sense of empowerment, promote an understanding of the effects of sexual violence, support the recovery process, and assist with finding resolution concerning the sexual victimization
Duration	Periodic, as scheduled
Qualifications	At a minimum, Support Groups include: • Support group(s) should be offered by the Program when it determines that support groups are an appropriate peer support strategy in their service area and there are a sufficient number of survivors/co-survivors to form a group • Group facilitators should be trained staff or volunteers. A therapeutic group, which is different from a peer support group, should be facilitated by a master's level professional • Written curricula and guidelines for each type of group offered by the Program (female survivors, male survivors, co-survivors, etc.) • Support group attendees should be provided with access to crisis intervention services after/between meetings

The Program Checklist for Support Groups can be found on page 49.

Program Checklists for Standards

Program Checklist for 24-hour Crisis Hotline

1. Access

- ☐ Crisis hotline is available 24 hours/day and is RAINN registered
- ☐ Services are free through the use of toll free numbers, acceptance of collect calls from callers within the region, and the RAINN hotline
- ☐ Crisis line providers are encouraged to have a language line service available as well as utilize Sorenson or Relay service or text telephone capacity or assistive technology for clients who are Deaf or hard of hearing. If utilized, staff members receive training on the use of any technology or services
- ☐ Callers are not required to identify themselves to phone workers

2. Written protocol for the operation of the crisis line

- ☐ The Program provides clear guidelines on confidentiality
- ☐ The Program has a policy regarding the privacy of callers' phone numbers, and the privacy of advocates' phone numbers, if calling the client from a personal phone (i.e. caller I.D. blocking)
- ☐ The Program specifies how phone workers should respond to unique calls, such as:
  - Cases in which the caller appears to present a danger to self or others or appears to present a serious risk to the phone worker
  - Calls which are difficult, complex, or upsetting to the phone worker
- ☐ The Program has an established policy for dealing with difficult callers, including training for new phone workers and updating phone workers about current persistent callers
- ☐ The Program protocol identifies when phone workers must contact a supervisor and any situations in which law enforcement should be contacted
- ☐ The Program outlines a model for responding to calls, including safety assessment, emotional support, problem solving, provision of information/referral, and conclusion/evaluation

3. Referrals

- ☐ The Program maintains an updated resource manual or file with financial, medical, mental health, social service, and other referral resources
- ☐ The Program updates the manual/file annually to:
  - Confirm that listings are current and accurate
  - Distribute information about the crisis hotline through the dissemination of materials, in accordance with the "Community Awareness/Outreach" standard
  - Provide an opportunity to solicit feedback from the referral agencies regarding the appropriateness of referrals that have been made

4. Staffing

- ☐ Phone workers receive a minimum of 40 hours of training, which should ideally include role-plays, observation of experienced workers, and observation of new volunteers answering calls
- ☐ If the Program/agency's crisis line serves dual purposes, the service connects survivors of sexual violence to a trained advocate as soon as possible, but within 30 minutes
- ☐ If an answering service is used at any time, the Program/agency:
  - Will connect survivors with a trained advocate within 30 minutes at most
  - Has a written protocol for the answering service staff detailing their instructions in responding to a crisis call
  - Has a detailed confidentiality policy
  - Ensures that answering service staff have the appropriate knowledge about sexual violence and victimization to properly assist survivors who call
  - An opportunity for the answering service staff to meet with and ask questions of the crisis line coordinator/staff member at least quarterly
- ☐ If calls are forwarded to the phone worker's home, there is a protocol stating:
  - Only the phone worker will respond to calls while calls are forwarded
  - The phone worker must respond to calls in a private area where the conversation will not be overheard by others or interrupted by noise/intrusions
  - Phone systems that would interfere with calls or compromise confidentiality will not be used
- ☐ At all times, at least one staff member or volunteer has primary responsibility to answer the crisis line; at least one staff member or volunteer is assigned as back-up
- ☐ Phone workers are supervised by a coordinator/staff member with at least one year experience working with survivors
- ☐ Phone workers have access to their supervisor or another experienced phone worker for the support they may need while answering calls

5. Other Policies

- ☐ All phone workers report to staff the following day with information on the nature of the calls received. The Program has a policy regarding the documentation of referrals, actions recommended by the phone worker, and any caller feedback/evaluation
- ☐ All phone workers are made aware of their status as a mandated reporter and follow program/agency guidelines regarding mandated reporting requirements
- ☐ The hotline may refuse to provide crisis telephone service to persons who are harassing or offensive. Additionally, the crisis line may be restricted for persons who place repeat calls which impede the availability of the line for other callers. These callers are referred to other appropriate agencies as needed. Calls outside the scope of program/agency services are referred
- ☐ Calls for appointments or business matters are referred to the program/agency business line

- ☐ If possible, the duration of individual crisis calls are limited to 60 minutes; if a caller requests or appears to be in need of further clinical intervention, referrals are made to licensed counseling staff or to other mental health agencies

6. Evaluation

- ☐ The Program tallies the number of calls and hours of service on a regular basis, per program or agency policy
- ☐ The Program reviews call reports for accuracy and appropriateness of responses and referrals
- ☐ The Program has a protocol for additional evaluation through any combination of the following:
    - Permission for follow-up phone calls to survivors to assist/support the survivor and document their assessment of the value/results the of the original call
    - Supervision of phone workers, such as review of caller responses to specific calls and/or observation by supervisor of phone workers
    - Written evaluation from callers/survivors who later receive other direct services
- ☐ Phone workers are surveyed periodically as to training/continuing education needs
- ☐ Annual surveys are sent to agencies listed as referrals requesting feedback about appropriateness of referrals made
- ☐ The hotline coordinator/staff person gathers information from evaluations and makes/suggests recommended changes as needed

Program Checklist for Criminal Justice/Legal Advocacy

1. Staffing

- ☐ If advocacy within the court is not offered by the Program itself, the Program connects survivors to legal advocacy services provided in the community (such as Victim/Witness)
- ☐ All legal advocates are supervised by a coordinator/staff member who has at least one year experience working with survivors of sexual assault
- ☐ Legal advocates have access to their supervisor or another experienced legal advocate who would be available within a reasonable time period after any call for support or assistance

2. Policies

- ☐ Legal advocacy services are provided at no cost
- ☐ If the services are advertised as available 24 hours/day, the Program responds to all requests, including those that come through the crisis hotline
- ☐ Legal advocates limit their role to support and education, and do not provide legal advice or engage in the practice of law (even if licensed to do so)
- ☐ The Program has a protocol documenting specific legal advocacy services provided
- ☐ No staff or volunteers are dispatched to the home of a survivor without the specific prior approval of the Program/Agency Director
- ☐ Expert witness or case-specific testimony in court proceedings are provided by the Program staff upon written consent for release of information from the client or a court order. Case records are not taken to any court proceedings unless required by the court. Staff members make every attempt possible to review the record with the client prior to its release to the court
- ☐ The Program may refuse to provide legal advocacy services to persons who are harassing or offensive. These clients will be referred to other agencies as appropriate

3. Evaluation

- ☐ The Program provides a report of the numbers served on a regular basis, per program/agency policy
- ☐ Client satisfaction surveys are provided to all clients, when possible
- ☐ Advocates document the services provided, including clients' verbal feedback about services. The Program Director/staff member reviews to ensure compliance with the protocol and to review outcomes
- ☐ The Program conducts annual request for feedback from other professionals within the legal system regarding the efficacy/quality of the Program's legal advocacy services
- ☐ The Program reviews evaluations on a regular basis and makes adjustments as needed

Program Checklist for Hospital/Medical Advocacy

1. Staffing

- ☐ Hospital/medical advocates receive supervision from a coordinator/staff member who has at least one year experience working with survivors of sexual assault
- ☐ Hospital/medical advocates have access to a staff member or another experienced advocate who is available for any support needed following a hospital visit

2. Policies

- ☐ Hospital/medical advocates are available on a 24-hour basis at no cost
- ☐ The Program has a protocol for responding to requests for hospital/medical advocacy services, including through the crisis hotline
- ☐ The Program has a protocol with local hospitals which specifies when and how to contact the Program and the role of advocates responding to a call
- ☐ The Program has a policy forbidding advocates to dispense medical advice or diagnoses, even if the advocate is licensed to do so
- ☐ The Program has a policy forbidding advocates from dispensing unsolicited personal opinions about medical care, or coercing survivors into any medical treatment or protocol
- ☐ Services provided are documented according to an established protocol
- ☐ Staff or volunteers are not dispatched to the home of a survivor without the specific prior approval of the Program/Agency Director
- ☐ The Program may refuse to provide medical advocacy services to persons who are harassing or offensive. These clients will be referred to other appropriate agencies as needed

3. Evaluation

- ☐ The Program provides a report of the numbers served on a regular basis
- ☐ Client satisfaction surveys are provided to all clients, when possible
- ☐ Advocates document services provided, including client's verbal feedback about services. A program supervisor reviews documentation to ensure compliance with the protocol and to review outcomes
- ☐ The Program Director/coordinator reviews evaluations regularly and makes adjustments as needed
- ☐ Annual request for feedback from medical professionals, law enforcement, and other professionals involved in the medical advocacy program is conducted

Program Checklist for Community Awareness/Outreach

1. Staffing/Competencies

- ☐ Presenters must have completed the 40 hours of required training for rape crisis advocates, and should have at least one year experience working with survivors
- ☐ Presenters are competent in skills related to working with culturally and linguistically diverse communities
- ☐ Presenters recognize the differences in adult and pedagogy learning:
  - Problem center vs. subject learning
  - Readiness to learn vs. have to learn
  - Experiences
  - Self-directive vs. dependency

2. Development/Use of Materials

- ☐ The Program clearly defines awareness material's intended audience
- ☐ Materials have a defined key concept or message – single most important fact for the reader/participant to understand and remember
- ☐ Material has defined behavioral objectives – actions the reader/participant is to perform as a result of reading the material
- ☐ Materials contain key informational points the reader/participant needs to grasp to be able to achieve the behavioral objective
- ☐ The Program considers age, attitudes, beliefs, values, culture, and language of the individuals, groups, and community using the resource
- ☐ Materials demonstrate accurate and complete information, including biological, psychological, social and moral value aspects, and different viewpoints of an issue
- ☐ Materials convey information free from gender and racial bias, stereotype, and rigid assumptions or labels
- ☐ Materials are reviewed for age level and reading level of intended audience, grammar, type and style of print, font, layout, etc.

3. Planning and Implementing Awareness/Outreach Programming

- ☐ Presenters assess the audience's needs and goals
- ☐ Presenters formulate appropriate, measurable, and written objectives
- ☐ Presenters identify a variety of learning activities based on the Program's objectives
- ☐ Presenters select strategies best suited for the audience
- ☐ Presenters plan sequence of learning building upon and reinforcing mastery of the preceding objectives

4. Policy

- ☐ Information delivered is factual, current, and accurate
- ☐ Personal opinions and philosophies of presenters are kept to a minimum and if used are identified as such by the presenter
- ☐ Presenters only provide information within their level of expertise, experience, and training
- ☐ At their request, survivors may be a valued addition to awareness/outreach activities presented by the Program. Whether or not an individual is a survivor is not the determining factor in participation in such activities; rather, her/his appropriateness and comfort level for participation in the activity should be the determining factor
- ☐ All curriculum and written materials distributed are prepared and presented in a manner respectful of race, gender, culture, ability, age, and sexual orientation
- ☐ Awareness/Outreach curricula may include:
    - Facts about sexual violence based on up-to-date research/data/statistics
    - Legal definitions
    - Continuum of violence/power and control issues
    - Rape culture
    - Oppression
    - Crisis intervention information
    - Non victim-blaming
    - Local referrals
    - Confidentiality and disclosure laws
    - Awareness of issues related to alcohol/drugs
    - Healthy relationships – equality, traditional gender roles
    - Warning signs of abuse
    - Identify options
- ☐ The Program may refuse to provide awareness/outreach activities to inappropriate persons, including persons who are harassing or offensive. These clients will be referred to other appropriate agencies as needed

5. Evaluation of Awareness/Outreach Activities

- ☐ The Program develops/selects and implements effective evaluation tools to assess achievement of activity's objectives
- ☐ When possible, the Program conducts follow-up studies on impact of activities
- ☐ The Program reviews evaluation results and adjusts presentations/activities as appropriate
- ☐ The Program provides a report of numbers served and types of activities conducted on a regular basis, per program/agency policy

Program Checklist for Crisis Intervention Services

1. **Description of Services**
   - ☐ The Program limits face-to-face crisis intervention services to the management of emotional trauma related to sexual violence, or to the management of problems in daily living resulting from the recent sexual violence experience. Services may include problem solving, support, advocacy, or education regarding involvement with the legal or medical systems
   - ☐ The Program provides appropriate referrals

2. **Contacts**
   - ☐ Face-to-face crisis intervention services are available at no cost to survivors and co-survivors of sexual violence
   - ☐ The Program has a clear and publicized policy regarding whether face-to-face crisis intervention sessions must be pre-scheduled, and the hours for walk-in services
   - ☐ Referrals are made to an on-going counseling program, as needed

3. **Staffing**
   - ☐ Volunteers or new staff members providing face-to-face intervention services have access to a supervisor or experienced crisis intervention provider who is available within a reasonable time period after any intervention, either by phone or in person, for support they may need following the intervention

4. **Policy**
   - ☐ Non-licensed crisis workers or those not operating under an agency's confidentiality regulations are notified that they may not be protected by Ohio law from disclosing information that is shared during face-to-face crisis interventions if this information is required by a court order. Survivors are notified of this fact as is appropriate.
   - ☐ The Program maintains confidential client records containing only the nature of the trauma which precipitated the program contact, any referrals or action recommended, and any client feedback/evaluation comments

5. **Evaluation**
   - ☐ Client satisfaction surveys are provided to all clients, when possible
   - ☐ The Program provides a report of numbers served on a regular basis
   - ☐ The Program Director/staff member reviews crisis workers' documentation to ensure compliance with the protocol and to review outcomes

Program Checklist for Systems Coordination/Collaboration

1. Staffing

- ☐ Staff member(s) who participate in systems coordination should possess the following:
  - Demonstrated knowledge/expertise in dynamics of sexual victimization, and the needs, concerns, and rights of survivors
  - Extensive knowledge of the Program's mission, structure, and function
  - Extensive knowledge of agencies and entities in the community that provide services to/interact with survivors
  - Authority (bestowed by the Program) to make decisions and recommendations on behalf of the Program
  - Demonstrated ability to work effectively in a group/team setting, including excellent communication skills, meeting facilitation, and professionalism

2. Components of Systems Coordination/Collaboration

- ☐ Ideally, the community in which the Program operates should have, or develop, a formal Coordinated Community Response (may be titled Sexual Assault Response Team [SART], Sexual Assault Advisory Committee, etc.), including the following partners:
  - Rape Crisis
  - Law Enforcement
  - Prosecution
  - SANE/SAFE/forensic examiner
  - Social service/mental health providers
  - Campus representative (if applicable)
  - Survivor
  - Other entities, as appropriate for the specific community
- ☐ In addition to being representative of the groups listed above, collaborative groups should also reflect the cultural diversity of the community in which the group operates
- ☐ If a formal collaborative group has not yet been established in the community, the Program will actively pursue coordination/collaboration with professional partners through meetings or other forms of deliberate and direct communication
- ☐ The overarching purpose of collaboration should be to improve the system response to sexual violence survivors in the community; all activities of any collaborative group should work from this basic mission
- ☐ Basic tenets/principles of a collaborative group include:
  - Adherence to a shared vision
  - Trust and mutual respect
  - Continuity of membership/personnel
  - Open, honest, and professional communication
  - Commitment to problem-solving and compromise
  - Regular meetings

- ☐ Tasks of the collaborative group should ideally include:
  - Meeting regularly to discuss strengths and challenges to survivor response, and strategies for improving response; may include case review
  - Developing/revising protocol and guidelines for a standardized response to sexual violence survivors in the community
  - Providing interdisciplinary training/sharing of knowledge
  - Promoting/facilitating community education regarding sexual violence and the response to it
  - Promoting/facilitating fundraising for response services to survivors
  - Maintaining regular communication among members, including the distribution of meeting minutes and other communications as appropriate

3. Policy

- ☐ Memoranda of understanding (MOUs) should be developed and signed by members of the collaborative group, defining the role of each partner
- ☐ Protocol outlining the frequency of group meetings, composition and duration of membership, and goals/deliverables of the group
- ☐ A confidentiality policy describing the sharing of case information among the group, as appropriate, and the agreement not to share information outside the group
- ☐ Protocol for reviewing the work/accomplishments of the group; may include community surveys, focus groups, etc.
- ☐ If an individual is hired to coordinate the collaborative group, a protocol exists outlining specific duties and other personnel considerations

4. Evaluation

- ☐ The collaborative group maintains meeting minutes accessible to all group members
- ☐ The collaborative group seeks feedback from the community about response services for survivors and efficacy of the group through surveys, focus groups, or other methods; results inform future focus and activities of the group
- ☐ A report about group activities/deliverables is produced and made available to the public at least annually

Program Checklist for Accessibility

1. Staffing

- ☐ All staff members and volunteers receive training (as part of 40 hours of training for volunteers, as needed for staff) on the following:
  - Barriers faced by survivors with varying abilities
  - Barriers faced by survivors who are Deaf or hard of hearing
  - Barriers faced by survivors with limited English proficiency
- ☐ The Program has an equal opportunity employment policy that includes non-discriminatory practices regarding the hiring of persons with varying abilities, as well as the inclusion of board members and volunteers with varying abilities

2. Policies

- ☐ All program facilities are accessible, including:
  - Handicap-accessible parking
  - Ground-level entrance(s) with ramps (if stairs/steps are present)
  - Elevator access for offices above the ground floor, or full provision of services on the ground floor
  - Restrooms that are wheelchair-accessible
  - Adequate space in waiting areas and offices for wheelchairs, assistive devices, and service animals
  - Signage that clearly indicates emergency exists, restrooms, and other areas
  - Emergency alarm systems that are both visible and audible
- ☐ The Program provides interpreters for survivors in need of American Sign Language (ASL) and other language translation services to access program services, including:
  - Existing contracts with ASL interpreters and the Language Line
  - Adequate funding in the Program's budget to pay for interpreters
- ☐ The Program advocates for interpreting services paid for by hospitals and courts, when survivors receive services in those locations
- ☐ To every extent possible, the Program provides materials that are sensitive to visually impaired survivors, as well as to survivors with cognitive disabilities
- ☐ To every extent possible, the Program conducts community awareness/outreach activities and other program-related events in accessible areas/venues
- ☐ The Program has established collaborative partnerships with organizations in the community that provide services to individuals with varying abilities

3. Evaluation

- ☐ The Program provides a report of the numbers served on a regular basis, per program/agency and funding policy
- ☐ Client satisfaction surveys are completed with all clients, when possible
- ☐ The Program reviews evaluations on a regular basis and makes adjustments as needed
- ☐ The Program regularly assesses its accessibility and makes adjustments as needed; this may be accomplished by consulting with accessibility professionals/organizations

Program Checklist for Cultural Competency

1. Staffing

- ☐ As part of the standard 40 hours of training, all staff members and volunteers should receive training on the following (or, in the case of staff members, should be assessed for knowledge of the following):
  - Oppression of and barriers to service faced by individuals based on race, ethnicity, religion, language, socioeconomic status, sex, gender identity and expression, sexual orientation, and varying abilities
  - Strategies for assisting survivors from marginalized groups in overcoming barriers to service
- ☐ Staff members and volunteers must demonstrate consistent openness to alternative service modalities that are inclusive of the survivor's culture
- ☐ The Program has an equal opportunity employment policy that includes non-discriminatory practices regarding the recruitment, hiring, compensation, and promotion of persons from diverse cultures, as well as the inclusion of board members and volunteers from diverse cultures
- ☐ The Program's staffing should reflect, to every extent possible, the demographic and cultural characteristics of the community in which the Program operates

2. Policies

- ☐ The Program incorporates cultural competency into its service delivery by:
  - Involving all staff members in service planning and implementation
  - Developing an awareness of organizational and individual biases that may interfere with effective service delivery, and working to overcome those biases
  - Maintaining accurate demographic data about culturally diverse populations in the community served by the Program, and develop a protocol for learning about new/emerging and/or underserved populations in the community
  - Collaborating with individuals and organizations in the community who provide culturally competent services to populations served by the Program
  - Facilitating a training/in-service for staff on a topic related to cultural competency on a regular basis (at least annually)
- ☐ The Program provides for interpreting needs of survivors with limited English proficiency, or who are Deaf or hard of hearing
- ☐ To every extent possible, the Program provides materials translated into other languages in ways that are reflective of the understanding of/beliefs about how to address sexual violence within unique cultures
- ☐ The Program provides services, conducts activities, and utilizes language that does not alienate persons who identify as LGBTQI
- ☐ To every extent possible, the Program conducts community awareness/outreach activities and other program-related events in locations that are inclusive of individuals from diverse cultures

- ☐ Services provided to immigrant survivors are not denied on the basis of immigration/ documentation status; this is regularly communicated to immigrant survivors

3. Evaluation

- ☐ The Program provides a report of the numbers served on a regular basis, per program/agency and funding policy, including demographic information as appropriate
- ☐ Client satisfaction surveys are provided to all clients, when possible
- ☐ The Program reviews evaluations on a regular basis and makes adjustments as needed
- ☐ The Program regularly assesses its cultural competency and makes adjustments as needed; this may be accomplished by consulting with outside professionals/ organizations

Program Checklist for Ethics & Accountability

1. Staffing

- ☐ All staff members must pass a criminal background check prior to having contact with survivors/clients. The Program/its agency has a policy identifying the type(s) of background check(s) utilized, as well as acceptable/unacceptable criminal histories for staff members
- ☐ All staff positions should have a clear and concise job description listing core job duties, educational, experiential, and licensure requirements, and hours of work
- ☐ The Program/agency has an equal employment opportunity policy
- ☐ The Program/agency has a personnel policy manual including the personnel policies listed below, a copy of which is made accessible to each staff member upon hire
- ☐ All staff members receive orientation upon hire, which includes an explanation of all policies and procedures
- ☐ All staff members agree, in writing, to comply with all program/agency policies and procedures, and demonstrate consistent compliance with policies

2. Policies

- ☐ The Program/its agency demonstrates the following organizational components:
  - Appropriate status in good standing, i.e. 501 (c)(3)
  - Approved by-laws governing the structure and function of the Program/agency
  - Board of Directors that is active, engaged, and duly representative of the community and the interests of the Program/agency (i.e. culturally diverse, gender-inclusive, relevant and demonstrated expertise in given field)
  - A mission statement that is reflective of the Program's purpose and the need(s) it fulfills in the community
  - Adherence to applicable laws and regulations, including the Health Information Portability & Accountability Act, the Americans with Disabilities Act, Equal Employment Opportunity Commission, anti-terrorism statutes, and requirements of all applicable federal/state funders (VOCA/SVAA, VAWA, JAG, RPE, etc.)
- ☐ The Program/its agency demonstrates adherence to financial policies:
  - General accounting procedures, as dictated by the IRS, the State of Ohio, and funders of the program
  - Clearly delineated budget, including line item income and expense categories
  - Checks and balances system whereby at least two qualified individuals have access to the program/agency's financial information at all times
  - Understanding of all allowable and unallowable activities, as dictated by funders, and the ability to demonstrate adherence to those guidelines
  - Regular reporting procedure for all program/agency finances to the Board of Directors and funders

- Distribution of an annual report that demonstrates income and expenses; accessible to the general public
- Regular program/agency audit, per applicable funding and accreditation bodies

☐ The Program/agency has a personnel policy manual that includes:

- Hiring, firing, promotion, compensation, evaluation, grievance, and disciplinary processes
- Organizational chart listing all staff positions and to whom they report
- Description of benefits applicable to all program/agency staff, and benefits that are applicable to each specific program and/or staff position
- Policies regarding non-discrimination, sexual harassment/stalking, and violence in the workplace
- Detailed policy regarding confidentiality of clients and client information
- Clearly defined expectations regarding conduct, including professional boundaries with clients, colleagues and volunteers, dress code, etc., as dictated by the Program/agency, funders, and licensing agencies
- Emergency procedures for the facility

3. Evaluation

☐ The Program provides a report of the numbers served on a regular basis, per program/agency and funding policy
☐ Client satisfaction surveys are provided to all clients of all services, when possible
☐ The Program reviews evaluations on a regular basis and makes adjustments as needed
☐ The Board of Directors reviews evaluations and grievances on a regular basis, and makes recommendations as appropriate
☐ Licensure and CEU requirements of staff members are reviewed; staff maintain current licensure (if applicable)
☐ The Program has a policy regarding the content and frequency of staff evaluations, and how those evaluations inform personnel decisions

Program Checklist for Staff/Volunteer Training

1. About the Training

- ☐ All volunteers providing services to survivors will receive a minimum of 40 hours of specialized sexual assault training before being able to have client contact. Verification of the training will be placed in their personnel file
- ☐ New staff members will be evaluated on their knowledge/skill base and trained on the number of hours/topics needed prior to having contact with survivors
- ☐ Volunteers and staff members must pass a criminal background check prior to having contact with survivors/clients. The Program has a policy identifying the type(s) of background check(s) utilized, as well as acceptable/unacceptable criminal histories for staff members and volunteers

2. Training Content

All topics listed below are addressed to some extent during training. Time spent on each topic may vary depending on time available and local need

- ☐ Cultural diversity issues are covered throughout the training as a part of all topics. Time should be spent discussing the impact of racism/other "isms" on survivors, cultural sensitivity, and information about the issue of sexual assault within area communities
- ☐ Use a variety of training formats (lecture, discussion, role plays, activities, etc.)
- ☐ Topics to be addressed:
    - History of rape crisis, effects of socialization of women on the experience of sexual violence
    - Definition of rape/sexual assault and types of rape/sexual assault: child, marital or partner, acquaintance/stranger, adult male, etc.
    - Rape stereotypes and realities/statistics
    - Hospital/Medical – emergency department protocol, the rape kit, health issues including pregnancy, STI's, HIV and PEP, drug facilitated rape
    - The Legal System – reporting, relevant laws and definitions, victim rights, police, role of legal advocate, court information including the role of the prosecutor, the grand jury, trial, civil suits, victims of crime compensation, university procedures, other issues
    - Specific Populations – specific religious and ethnic groups, LGBTQI, elderly, children, developmentally disabled, chronically mentally ill, people with varying abilities, incarcerated individuals
    - Drug and alcohol addiction
    - Suicide prevention
    - Crisis intervention skills including listening and empathy skills
    - Prevention and safety skills for staff and volunteers
    - Overview of local agencies and how to make referrals
    - Program/agency procedures including record keeping

- Confidentiality
- Working with co-survivors (family and friends)
- Caring for the caregiver/vicarious trauma/setting appropriate boundaries

☐ A training manual is provided to all trainees

3. Additional Preparation

☐ In addition to basic training, all staff and volunteers receive additional supervised training for the service they will provide. This may include role playing, shadowing an experienced worker, and/or providing the service in conjunction with an experienced worker. Specific staff competencies are indicated in the Checklist for each Standard, as applicable, which may require additional training

☐ The Program has a policy stating the qualifications and requirements for volunteer service, which may include age, ability to travel, and minimum expected hours of service per a defined period of time (i.e. specified hours per month, for a minimum number of months)

4. Evaluation

☐ The Program indicates numbers/hours of training provided

☐ The Program provides demographics of those trained

☐ The Program conducts pre/post-tests to assess knowledge of trainees

☐ The Program conducts surveys and/or interviews of participants and trainers about the effectiveness and success of the training, including follow up at regular intervals

☐ The Program conducts surveys and/or interviews of dropouts, if possible, to obtain feedback about training

☐ The Program uses feedback from evaluation of services and from supervisors to determine if services are implemented effectively after the training

☐ The volunteer coordinator/staff member regularly monitors volunteers for emotional wellness/ vicarious trauma, and provides support accordingly

Program Checklist for Prevention Education

1. Staffing/Competencies

- ☐ Presenters must have demonstrated knowledge and competency in concepts of violence prevention, sexual assault dynamics, and social ecological theory or Spectrum of Prevention; ideally, all presenters will have completed the 40 hours of training for rape crisis advocates, and will have at least one year experience working with survivors
- ☐ Presenters are competent in skills related to working with culturally and linguistically diverse communities
- ☐ Presenters are committed to ongoing training in best practices related to sexual violence prevention
- ☐ Presenters recognize the differences in adult and pedagogy learning:
  - Problem center vs. subject learning
  - Readiness to learn vs. have to learn
  - Experiences
  - Self-directive vs. dependency

2. Development of Program Concepts/Materials

- ☐ Program clearly defines the prevention programming's selected audience
- ☐ Programming has a defined key concept or message – single most important fact for participant to understand and remember
- ☐ Programming has defined behavioral objectives – actions the individual is to perform as a result of participating in the prevention programming
- ☐ Programming contains key informational points the participant needs to grasp to be able to achieve the behavioral objective
- ☐ Program considers age, attitudes, beliefs, values, culture, and language of the individuals, groups, and community receiving the information
- ☐ Programming demonstrates accurate and complete information, including biological, psychological, social and moral value aspects, and different viewpoints of an issue
- ☐ Programming conveys information free from gender and racial bias, stereotype, and rigid assumptions or labels
- ☐ Programming materials are reviewed for age level and reading level of intended audience, grammar, type and style of print, font, layout, etc.

3. Planning and Implementing Prevention Education Programming

- ☐ Presenters assess the audience's needs and goals
- ☐ Presenters formulate appropriate, measurable, and written objectives
- ☐ Presenters identify a variety of evidence-based learning activities based on the program's objectives
- ☐ Presenters plan sequence of learning building upon and reinforcing mastery of the preceding objectives

- ☐ At minimum, prevention education methods should:*
  - Promote protective factors
  - Strive to be comprehensive
  - Be concentrated and capable of being sustained and expanded over time
  - Use varying teaching methods to address multiple learning processes
  - Be based on purposeful, logical rationale
  - Be developmentally appropriate
  - Be developed in collaboration with a representative cross-section of community members to incorporate diverse cultural beliefs, practices, and community norms
  - Include a systematic method to determine program effectiveness and promote continuous quality improvement
  - Become incorporated into the Program's overall mission to end sexual violence

4. Policy

- ☐ Information delivered is factual, current, and accurate
- ☐ Personal opinions and philosophies of presenters are kept to a minimum and if used are identified as such by the presenter
- ☐ Presenters only provide information within their level of expertise, experience, and training
- ☐ At their request, survivors may be a valued addition to prevention activities presented by the Program. Whether or not an individual is a survivor is not the determining factor in participation in such activities; rather, her/his appropriateness and comfort level for participation in the activity should be the determining factor
- ☐ All curriculum and written materials distributed are prepared and presented in a manner respectful of individual culture and self-identification
- ☐ The Program may refuse to provide prevention education programming to inappropriate persons, including persons who are harassing or offensive. These individuals will be referred to other appropriate agencies as needed
- ☐ Prevention education activities should only be conducted by programs and staff members who are specifically funded to do so; note that prevention education is an unallowable activity under many federal and state funding sources

5. Evaluation of Prevention Education Activities

- ☐ The Program develops/selects and implements effective evaluation tools to assess achievement of activity's objectives
- ☐ The Program carries out evaluation plans
- ☐ When possible, the Program conducts follow-up studies on impact of activities
- ☐ The Program reviews evaluation results and adjusts activities as appropriate
- ☐ The Program provides a report of numbers served, types of activities conducted, and results of pre- and post-tests on a regular basis, per program's and funders' policies

- ☐ The Program provides a summary of prevention activities, when requested, to program/agency Board of Directors, staff members, volunteers, and/or the community

*Developed by the Virginia Sexual and Domestic Violence Action Alliance. The *Guidelines for the Primary Prevention of Sexual and Intimate Partner Violence* can be downloaded from http://vsdvalliance.org/primary_prevention/. Please contact info@vsdvalliance.org for more information.

Program Checklist for Professional Counseling/Therapy

1. Staff Competencies

- ☐ Individuals providing professional counseling/therapy services must possess one of the following qualifications:
  - Licensed Professional Counselor (PC, PCC, or PCC-S)
  - Licensed Social Worker (LSW, LISW, or LISW-S)
  - Licensed Marriage & Family Therapist (MFT or IMFT)
  - Counselor or Social Worker Trainee, under the appropriate supervision
- ☐ All individuals meeting the above qualifications must complete 30 hours of continuing education every 2-year renewal period, including at least 3 hours in Ethics
- ☐ All individuals meeting the above qualifications must maintain licensure in good standing with the Ohio Counselor, Social Worker and Marriage & Family Therapist Board
- ☐ All individuals providing professional counseling/therapy must provide copies of licensure to employer
- ☐ All individuals providing professional counseling/therapy must maintain professional liability insurance coverage
- ☐ Those who do not possess supervisory status/independent licensure must comply with applicable regulations regarding supervision of contact with clients
- ☐ All individuals providing professional counseling/therapy to sexual assault survivors should possess knowledge of sexual violence, trauma resulting from sexual violence, co-occurring issues such as mental illness, PTSD and chemical dependency, and training/competency in Trauma Sensitive and Trauma Informed Care

2. Policy

- ☐ All professional counseling/therapy services must abide by ethical requirements as mandated by the Ohio Counselor, Social Worker and Marriage & Family Therapist Board and other authoritative bodies, which include:
  - Professional conduct regarding relationships/interactions between counselors/therapists and clients during and outside of sessions
  - Disclosure/informed consent regarding relevant program/agency policies, costs and billing procedures, and client rights/grievance process
  - Confidentiality of client information, in accordance with appropriate regulations as dictated by law and licensure requirements
  - Discontinuation of counseling/therapy services and referral to other agencies if the client is dissatisfied, uncomfortable or not benefitting from services
  - Termination and transfer of services when the clinician leaves the agency
- ☐ The Program reasonably accommodates the unique needs of individual clients, including accessibility and cultural needs
- ☐ The Program has a policy outlining the safe storage and removal of client files/case notes/documentation
- ☐ The Program has a policy regarding clients who miss appointments or show up late

- ☐ The Program may refuse to provide counseling/therapy services to clients who are harassing or offensive; instead, referrals to other agencies are made as appropriate
- ☐ Clinical group notes are stored properly with no identifiable client information of other survivors in the group listed in other client files (i.e. stored separately)
- ☐ Rape Crisis advocates must not coerce survivors/co-survivors into receiving professional counseling/therapy services at the program/agency
- ☐ The Program has a policy regarding mandated reporting of child abuse and neglect
- ☐ The Program has a policy and protocol regarding response to clients at risk of harming self and/or others, including active risk and involuntary hospitalization
- ☐ The Program has a policy regarding the self-care of counselors/therapists, including information about vicarious trauma, and protocol for supervision, time off, and caseload

3. Evaluation

- ☐ All counselors/therapists provide a report of the numbers served on a regular basis, per program/agency, funding, and licensing requirements
- ☐ Client feedback surveys are provided to clients upon discharge from services; surveys should be anonymous, unless the client chooses to self-identify
- ☐ The Counseling/Therapy Supervisor reviews surveys and other client input on a regular basis and provides constructive feedback to individual counselors/therapists
- ☐ Case notes/documentation are reviewed by the Counseling/Therapy Supervisor on a regular basis to ensure proper documentation
- ☐ The quality/efficacy of counseling/therapy services is evaluated on a regular basis by the Counseling/Therapy Supervisor, and adjustments are made to service structure and delivery as needed and feasible

Program Checklist for Support Groups

1. Staffing

- ☐ Support group facilitators must have completed the 40 hours of required training for rape crisis advocates, and should have at least one year experience working with survivors
- ☐ Facilitators receive additional training on group facilitation, as needed

2. Policy

- ☐ Support groups are limited in focus to the management of emotional trauma related to a recent or past sexual assault, or to the management of problems in daily living resulting from sexual violence. Counseling is not an appropriate component of a support group
- ☐ Support groups may be developed for distinct client populations served by the Program, including survivors of recent sexual offenses, adolescent survivors, adult survivors of child sexual abuse, secondary victims of sexual offenses, or others identified by the Program as appropriate
- ☐ Support groups may be time-limited or open, based on program discretion
- ☐ Group sessions, as a rule, do not exceed 90 minutes
- ☐ The Program documents services provided according to an established protocol
- ☐ The Program may refuse to provide support group services to persons who are harassing or offensive. These clients will be referred to other appropriate agencies as needed

3. Evaluation

- ☐ The Program provides a report of the numbers served on a regular basis, per program policy
- ☐ The Program provides data on requests for the group, number who attend the group, numbers who complete the group, and number of groups attended per person
- ☐ The Program makes follow up calls to participants who drop out of the group
- ☐ The Program collects satisfaction surveys from participants
- ☐ The Program logs/documents progress made by group participants
- ☐ The Program collects follow-up surveys of participants at a defined interval
- ☐ The Program's Director/lead staff person reviews all documentation/evaluations on a regular basis and makes recommendations accordingly

Additional Resources

State Resources

Ohio Alliance to End Sexual Violence	www.oaesv.org
Ohio Resources by County	www.oaesv.org/resources
Ohio Department of Health Sexual Assault Response & Recovery	www.odh.ohio.gov
Ohio Attorney General Victim Services	www.ohioattorneygeneral.gov/victim
Ohio Family Violence Prevention Center	www.fvpc.ohio.gov
Ohio Office of Criminal Justice Services	www.ocjs.ohio.gov
Ohio Domestic Violence Network	www.odvn.org
Action Ohio Coalition for Battered Women	www.actionohio.org
Prevent Child Abuse Ohio	www.preventchildabuse.org/chapters
Justice League of Ohio	www.tjlo.org
Ohio Department of Rehabilitation & Corrections Victim Services	www.drc.ohio.gov/web/victim
Ohio Counselor, Social Worker, and Marriage & Family Therapist Board	www.cswmft.ohio.gov

National Resources

Rape, Abuse & Incest National Network	www.rainn.org
The National Center for Victims of Crime	www.victimsofcrime.org
The National Sexual Violence Resource Center	www.nsvrc.org
The Resource Sharing Project	www.resourcesharingproject.org
MaleSurvivor	www.malesurvivor.org
Dept. of Justice Violence Against Women Office	www.ovw.usdoj.gov
Office for Victims of Crime	www.ojp.usdoj.gov/ovc
National Organization for Victim Assistance	www.trynova.org
Men Stopping Violence	www.menstoppingviolence.org
Sexual Assault Training & Investigations	www.mysati.com
The National Alliance to End Sexual Violence	www.naesv.org
National Coalition Against Domestic Violence	www.ncadv.org
National Network to End Domestic Violence	www.nnedv.org
Voices & Faces Project	www.voicesandfaces.org
The National Crime Victim Law Institute	www.ncvli.org
Victim Rights Law Center	www.victimrights.org
International Association of Forensic Nursing	www.iafn.org
SANE/SART Sexual Assault Resource Service	www.sane-sart.com
U.S. Department of Justice	www.usdoj.gov
Center for Disease Control, Injury Prevention	www.cdc.gov/violenceprevention
National Institute of Justice	www.nij.gov
National Judicial Education Program	www.legalmomentum.org/our-work/vaw/njep
Equitas	www.equitas.org
Office on Crimes Against Children	www.fbi.gov/about-us/investigate/vc_majorthefts/cac
National Center for Missing & Exploited Children	www.ncmec.org
National Center for Prosecution of Child Abuse	www.ndaa.org/ncpca_home.html

National Resources, continued

Coalition to Abolish Slavery and Trafficking	www.castla.org
National Center for Women & Policing	www.womenandpolicing.com
National Center on Domestic and Sexual Violence	www.ncdsv.org
Humantrafficking.org	www.humantrafficking.org
Polaris Project: For a World Without Slavery	www.polarisproject.org
Bureau of Justice Statistics	www.bjs.ojp.usdoj.gov
National Criminal Justice Reference Service	www.ncjrs.gov
National Violence Against Women Prevention Research	www.musc.edu/vawprevention
National Coalition of Anti-Violence Programs	www.ncavp.org
Amnesty International	www.amnestyusa.org
National PREA Resource Center	www.prearesourcecenter.org
Just Detention International	www.justdetention.org
Women of Color Network	www.womenofcolornetwork.org
Immigrant Women Network	www.immigrantwomennetwork.org
PreventConnect	www.preventconnect.org
The Clery Institute for Security on Campus	www.securityoncampus.org
Intermedia, Inc.	www.intermedia-inc.com
Internet Sexuality Information Services, Inc.	www.isis-inc.org
Volcano Press	www.volcanopress.com
Discover Films Video	www.discover-films.com
Cambridge Documentary Films	www.cambridgedocumentaryfilms.org
Asian & Pacific Islander Institute on Domestic Violence	www.apiidv.org
Asian/Pacific Islander Youth Violence Prevention Center	www.apiyvpc.org
Sister Song	www.sistersong.net
End Violence Against Women International	www.evawintl.org
Faith Trust Institute	www.faithtrustinstitute.org
Vera Institute of Justice	www.vera.org
Accessing Safety	www.accessingsafety.org
Office for Victims of Crime Training & Technical Assistance Center	www.ovcttac.gov
Americans with Disabilities Act	www.ada.gov
IRS compliance information for non-profits	www.irs.gov/Charities-&-Non-Profits

For additional resources, please contact info@oaesv.org



JUSTICE BEYOND 20 YEARS

Statute of Limitations for Rape in Ohio

What is the statute of limitations?

The statute of limitations is the maximum amount of time prescribed by law between when a crime is committed and when it can be prosecuted. The statute of limitations for all crimes is determined by each state. Currently in Ohio, the statute of limitations for rape, sexual battery, and gross sexual imposition is 20 years[1].

How does the statute of limitations impact survivors and communities in Ohio?

The ability to prosecute sex offenders for their crimes impacts the safety and well-being of all Ohioans. Following are some ways in which the current statute of limitations in Ohio complicates the pursuit of justice and public safety:

- **Stopping serial offenders**: The majority of rapists are serial offenders who rape multiple victims, as well as commit other types of crime[2]. Recent advances in DNA technology and increased efforts to test backlogged rape kits in Ohio[3] have demonstrated the importance of linking individual offenders to multiple offenses, including unknown offenders and crimes which were committed more than 20 years ago. The current statute of limitations in Ohio poses roadblocks in the ability to effectively prosecute serial offenders for all sex offenses.
- **Balancing victim and offender rights**: The presence or absence of a statute of limitations for rape does not alter the standard of proof required to prosecute an offender. DNA evidence gained from recent testing of rape kits, including DNA that has not yet been linked to a known offender ("John Doe" profiles), is evidence that meets the standard of proof. The current statute of limitations does, however, impact the ability of a survivor who was raped more than 20 years ago to obtain justice, even when a rape kit and DNA evidence were collected[4].
- **Barriers to reporting:** Many survivors of rape do not report the crime right away[5], due to psychological trauma, fear of the perpetrator, a sense of shame, and/or fear of not being believed or of being blamed for the assault. For some survivors, the statute of limitations may have passed by the time they feel capable of reporting the assault and participating in the criminal justice system.
- **Trauma impacts memory**: Sexual assault is a traumatic crime that impacts the physical, mental, and emotional health of survivors. Research on the brain's response to trauma[6] reveals that a survivor's ability to recall details about the assault may be impacted far beyond the immediate aftermath of the crime. The current statute of limitations hampers the ability of survivors who are unable to provide details about the assault when it happens to have the option of reporting it and criminally prosecuting their offender at a later time if they choose.

This publication was supported in part by Grant No. 2013-X1787-OH-SW awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in the publication are those of the authors and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

www.oaesv.org 526 Superior Avenue, #1400 • Cleveland, Ohio 44114 • Phone: (216) 658-1381 • Toll-Free: (888) 886-8388

[1] Ohio Revised Code 2901.13: Statute of limitations for criminal offenses, http://codes.ohio.gov/orc/2901.13
[2] Lisak, David (2011): *Understanding the Predatory Nature of Sexual Violence*, http://www.middlebury.edu/media/view/240951/original/
[3] Ohio Attorney General Mike DeWine (2014): Sexual Assault Kit Testing Initiative Update: http://www.ohioattorneygeneral.gov/Media/News-Releases/December-2014/Attorney-General-DeWine-Releases-December-Sexual-A
[4] National Center for Victims of Crime (2012): *Increasing Victims' Access to Justice: The Statute of Limitations and the Prosecution of Sexual Assault Cases*, http://victimsofcrime.org/docs/sak-backlog-laws/exceptions-to-sol.pdf?sfvrsn=2
[5] Rape, Abuse & Incest National Network (RAINN): https://rainn.org/get-information/statistics/reporting-rates
[6] Campbell, Rebecca (2012): *The Neurobiology of Sexual Assault*, http://www.nsvrc.org/elearning/20044

OHIO VICTIM RIGHTS REGARDING SEXUAL ASSAULT ON COLLEGE CAMPUSES

As a survivor of sexual assault on a college campus (though the options generally also apply to off-campus, college sponsored activities), you have three options:

- You may report the sexual assault off campus to the local police[1] and elect to participate in the criminal investigation and potential prosecution of the perpetrator; and/or
- You may report the sexual assault on campus to any responsible employee on campus to begin the campus process as outlined in your student handbook; or
- You may not report at all or through any official channels and just access support and services.

Report off campus – you can report off campus by calling local law enforcement or seeking medical treatment off campus. You are not required to make a report to the police by seeking medical attention, but be prepared for law enforcement to be called in and ask to interview you.

Report on campus – you can report on campus by disclosing the assault to any responsible employee on campus. Due to the increasing pressure on universities to address sexual assault, many are implementing policies to designate virtually every faculty and staff member[2] as mandatory reporters. Reports made will not be kept confidential. There may be a campus anonymous reporting line that you could call to make a report, but be advised to closely read the fine print as your anonymity may not be guaranteed by reporting in this way either. If you choose to call the "anonymous" hotline, and you wish to truly remain anonymous, be careful to not discuss any personally identifying information – which may include the exact time, place, and perpetrator of the assault.

After you report on campus, the process will vary depending on your institution. You can read your student handbook to figure out how things are handled at your school. Ultimately, your college is required to act to eliminate and remedy the harm of sexual violence on campus under Title IX.

Your rights include:

- The right to receive contact information about existing counseling, health, mental health, victim advocacy, legal assistance, and other services available both on-campus and in the community
- The right to reasonable accommodations to continue your education from sexual violence and harassment. This may include changes to your academic schedule, living arrangements, transportation, or working situations to avoid a hostile environment. It can also include a campus issued no contact directive against the perpetrator.

[1] Depending on your institution and exactly where the assault occurred, the campus police force may have jurisdiction over the crime. Usually local law enforcement handle felonies, but this will be campus specific depending on the agreements signed between the law enforcement agencies. If this is a concern for you, ask an advocate not affiliated with the university to find out for you.

[2] Mandatory reporting staff will likely include student staff, like Resident Advisors.

YOUR CRIME VICTIM RIGHTS: UNTESTED SEXUAL ASSAULT FORENSIC EVIDENCE (SAFE) KITS

In 2011, Ohio Attorney General Mike DeWine unveiled the Sexual Assault Kit Testing Initiative, encouraging law enforcement agencies across the state to submit any untested Sexual Assault Forensic Evidence (SAFE) Kits that sat untested for the last several decades.

Agencies are moving swiftly to submit kits for DNA testing, match results to offenders, and hold those offenders accountable. Thus, law enforcement officials may unexpectedly contact persons who survived a sexual assault within the last 20 years.

If this happens to you, you may be eager to assist law enforcement. Alternatively, you may be overwhelmed and wish to be left alone. Remember that no one can tell you how to feel, and no one should push you to participate in ways that make you feel uncomfortable or unsafe.

This document explores the evidence kits being tested, explains your legal rights at each stage of the investigation and prosecution, and highlights survivor-specific resources available if law enforcement or prosecutors decide to revisit your case.

The Forensic Evidence Collection Exam & SAFE Kits

Emergency rooms provide forensic evidence collection exams to sexual assault survivors. These exams are conducted to collect physical evidence of the assault, locate injuries, and treat medical concerns. Ohio forensic evidence collection exams are free,[1] though additional testing or procedures may be billed to the survivor. If you are billed for additional charges associated with the exam, you may be eligible for reimbursement through the Crime Victims Compensation fund, administered by the Ohio Attorney General's Office.[2]

Every hospital in Ohio is required to provide an exam. Many hospitals employ Sexual Assault Nurse Examiners (SANEs) and admit advocates to accompany survivors during the exam. Survivors have the right to refuse any part of the exam, though this may limit the amount of evidence ultimately collected. The hospital is also required to report to law enforcement that a crime occurred, but survivors are not obligated to speak with them.

After a medical professional completes the exam, the resulting evidence goes into a Sexual Assault Forensic Evidence (SAFE) Kit. The SAFE kit is picked up by law enforcement and submitted to the crime lab for testing. A survivor in Ohio has three reporting options: report to law enforcement; do not speak to law enforcement but allow the hospital to provide identifying

[1] Survivors may consider refusing to submit insurance information to avoid accidental charges.

[2] An advocate can assist you with applying. More information about Crime Victims Compensation is available here: http://www.ohioattorneygeneral.gov/victimscompensation.

information; or have an anonymous kit collected without identifiable information. A survivor that chooses the last two options can "convert" a report to law enforcement at any time.

When a crime lab opens a SAFE kit for testing, forensic scientists search the kit's contents for DNA. If these scientists successfully locate a DNA profile, they submit it for entry in the Combined DNA Index System (CODIS). CODIS is a national database containing DNA profiles for certain convicted offenders and arrestees. Agents enter the new DNA profile into CODIS and search for a matching profile. A match is called a "hit," and provides identifying information for the DNA's source (usually the perpetrator). If no "hit" is found, it means that perpetrator has not yet provided a DNA sample pursuant to a conviction or arrest.

Survivor Rights in a Delayed Criminal Investigation

In Ohio, the statute of limitations for a sexual assault is 20 years from the date of the incident. If the victim was a minor, the statute of limitations is 20 years from the date the victim turns 18. Thus, Ohio law enforcement agencies may seek to reopen an investigation after receiving DNA results from a SAFE kit obtained within the last 20 years.

No survivor has the same response to a reopened case, and you may find that you experience the same shared goals or disagreements with law enforcement that existed when you initially reported. As you decide whether further legal action is best for you, consider the following strategies and legal protections:

Communicating with Law Enforcement, Advocates, & Counselors

- Law Enforcement: Law enforcement agencies are working to produce as many successful convictions as possible. However, your personal goals may not match law enforcement strategies. You are not legally required to speak with law enforcement; however, you may receive a subpoena requiring you to appear in court or before a grand jury. If you fail to appear, you could be held in contempt of a court order and put in jail. This rarely occurs, but you should know all potential penalties for refusing a subpoena.

- Advocates: You can, and should strongly consider, getting a community-based rape crisis victim advocate to assist you through the process. Advocates explain the legal process and can help you if you do not understand or agree with law enforcement decisions. There are two types of advocates:

    a. Prosecutor-based Advocates: Prosecutors' offices often employ in-house advocates. Prosecutor-based advocates' primary jobs are to support survivors, work towards successful convictions, and promote community safety. Information you provide to a prosecutor-based advocate may be used to further any or all of these goals. Thus, communications between survivors and prosecutor-based advocates may not be confidential.

    b. Community-based Advocates: A community-based advocate's primary job is to support you and advocate for your wishes. In Ohio, communications between

survivors and community-based advocates are confidential but not privileged.[3] Your records could thus be shared in court and seen by your perpetrator. As such, you should ask your community-based advocate about their agency's privacy protection procedures.

- Therapists: If your case is reopened, you may experience long-buried memories and complications in new relationships or in daily functioning, as the trauma re-surfaces. A therapist can help you work through the impact your past assault has on your present life. Therapy records are privileged if your therapist is a licensed professional, though defense attorneys may try to gain access by serving your therapist with a subpoena.

  Ask your therapist to (1) explain their licensure and (2) notify you if they receive a subpoena, so that you can ask the Court for protection before the records are released.

Your Rights Under the Ohio Revised Code

Even if you reported your sexual assault years ago, your rights under the Ohio Constitution and Revised Code are still in place. Keep in mind that:

1. Law enforcement officers must provide you with information about your rights in the criminal and juvenile justice systems, local contacts for medical, counseling, housing, emergency services, and other types of assistance. *ORC 2930.04*

2. You may designate a representative to exercise your rights. *ORC 2930.02*

3. After a suspect is arrested or detained, a law enforcement officer must give you the suspect's name, the suspect's eligibility for pretrial release, the law enforcement agency's telephone number, and a number to call if you have questions about the suspect's bond and custody status. *ORC 2930.05*

4. A prosecutor must speak with you before granting a pretrial diversion, amending or dismissing a charge, negotiating a plea agreement, and beginning a trial or hearing. If the prosecutor fails to confer with you regarding the above legal actions, the court will note on the record the failure to confer and the reason after it receives notice that the failure occurred. The prosecutor's failure to afford you these rights does not affect the outcome of the case. *ORC 2930.06 (A)*

5. After a case begins, the prosecutor must provide you with the name of the defendant, the offense charged, the case number, an explanation of upcoming procedure, a summary of your victim rights, procedures if you are threatened, the name and number of a contact for more information about the case, notice of your right to representation, and notice of court proceedings or delays if you request this information. *ORC 2930.06(B)*

[3] When a communication or record is *privileged*, no one can see or access it without your permission or court order.

6. You have the right to attend the trial and any related hearings or proceedings (except for grand jury proceedings), unless the court finds that your exclusion is needed to protect the suspect's right to a fair trial. A support person may accompany you at your request. The court must make a reasonable effort to minimize contact between you, your family, and witnesses, and the defendant, defendant's family, or witnesses for the defense before, during, and immediately after court proceedings. *ORC 2930.09 and 2930.10*

7. At your request, you will be notified of the results of the case. If the suspect is found guilty, the prosecutor will provide you with the following information: crimes the defendant was convicted of, contact information of the probation office or person preparing a pre-sentence or disposition investigation, notice and explanation that you may make a victim impact statement to the pre-sentence investigator, which must be considered by the evaluator, when and where the sentencing or dispositional hearing will occur, any sentence imposed, including judicial release or modification after an offender's successful appeal. *ORC 2930.12*

8. You may provide a written or verbal victim impact statement that could include the following information: explanation of any physical, psychological, or emotional harm you suffered as a result of the offense, explanation of any property damage or other economic loss you suffered, an opinion regarding how much compensation is needed, other compensation you have received, what penalties you would like to see. Before sentence or disposition, the court must permit the victim to make an oral or written statement. Any written statement of the victim is confidential and is not a public record, though it can be shared with the offender and the defense attorney. The court must consider the statement, along with other factors, in imposing sentence or determining disposition. *ORC 2947.051; 2951.03; 2930.12; 2930.13; 2930.14*

9. Ohio law prohibits employers from firing employees who miss work to attend grand jury, delinquency, or criminal proceedings that they are subpoenaed to attend. However, they do not have to pay you for the time, unless the crime happened at work or if the suspect is the employer. In this case, the employer cannot decrease or withhold pay when the employee misses work to obey the subpoena. In addition, the employee cannot be discharged, disciplined, or retaliated against for participating, at the prosecutor's request, in the preparation of the criminal case against the suspect. An employer can be found in contempt of court for taking such action. *ORC 2151.211; 2939.121; 2945.451; 2930.18; 2151.211; 2939.121; 2945.451; 2930.18*

10. Upon request, the prosecutor must notify you about the offender's sentencing, any motions for early release, or modification of the offender's sentence or an appeal. When the court considers releasing the offender, you can make an additional statement about the effects of the crime and whether the suspect should be released. *ORC 2930.15; 2930.16; 2930.17*

11. Upon request, the Office of Victim Services in the Ohio Department of Rehabilitation and Correction (DRC) will notify you of the following regarding adult offenders who are

incarcerated or are under community control: parole board hearings, end of definite sentence, expiration of stated term, offender's release and conditions of that release, offender's death, when an offender leaves an institution for court proceedings, escape, and pending execution. *ORC 2930.16; 2949.25; 2967.12; 5120.60*

12. Upon proper written request, the hospital or clinic that administered your forensic evidence collection exam must provide you, your chosen representative, or other authorized party with a copy of all or part of your medical record, at no cost. The health care provider must follow your instructions to hold the record for pick-up or send the record to a specified address. If you do not wish to obtain a copy, the health care provider must allow you to examine your record during regular business hours. Note: if a treating licensed therapist, counselor, psychiatrist, social worker, or chiropractor determines that your treatment would be hindered by access to the record, the hospital or clinic shall provide the record to a licensed physician, therapist, counselor, psychiatrist, social worker, or chiropractor designated by the patient. If your hospital or clinic fails to fulfill your request, you may bring a civil action to enforce your right to access the record. *ORC 3701.74; 3701.741*

If You Feel Your Rights Are Not Being Upheld

If you feel that any law enforcement official, therapist, advocate, or prosecutor is not respecting your legal rights during this process, you may consider consulting a victims' rights attorney. Though you may work closely with the prosecutor, he or she is not your personal attorney. The prosecutor represents the state. Therefore, you may need your own private attorney to represent your interests, assert your rights in a criminal trial, and help protect your privacy and interests in the case.

This publication is designed to provide accurate and authoritative information regarding victim rights. Nothing in this publication is to be construed as the rendering of legal advice. Anyone reading this publication is responsible for obtaining such advice from their own legal counsel. This publication is intended for educational and informational purposes only. This publication was supported by Victims of Crime Act Grant Award #2014VASAVE915, administered by the Ohio Attorney General's Office. Victims of federal crimes will be served.

www.oaesv.org 526 Superior Avenue, #1400 • Cleveland, Ohio 44114 • Phone: (216) 658-1381 • Toll-Free: (888) 886-8388

- The right to a prompt, fair, and impartial investigation and resolution by trained officials. The school's disciplinary process and the range of possible sanctions must be established and clear. Read the policy carefully as it may identify gatekeepers that could prevent your case from proceeding to an actual disciplinary board.
- The right to have an advisor of your choice present during an institutional disciplinary proceeding. This advisor may be an attorney, but it is important to remember that the campus proceeding is not a legal proceeding and the lawyer will not be afforded the same ability to represent you or speak on your behalf as he or she would in court. Also, all of the legal training that an attorney receives regarding court rules will not apply during your hearing. The perpetrator's advisor will be similarly restrained.
- The right to receive a written decision of all disciplinary proceedings at the same time as the perpetrator.
- The right to be free from retaliation for filing a report with the institution. The school also has an obligation to take action to prevent retaliation for the perpetrator or third parties.

If you believe that your institution is not abiding by their requirement to provide you with a safe, educational environment free from sexual violence and sexual harassment, you can file a complaint with the U.S. Department of Education under the Campus SaVE Act, the Clery Act, and/or Title IX. You can file a formal complaint with the Clery Act Compliance Division by e-mailing clery@ed.gov. Your campus is required to have a Title IX compliance officer to receive your Title IX complaint. Check your student handbook or your school's website for that person's contact information and reporting options. Also, see NotAlone.gov's website for reporting information.

Not to report at all – you can choose to not report the assault at all or just not to any person with official responsibilities to law enforcement or the institution. There are a number of reasons that survivors choose this option and if you do so, it is important that you plan how to access support and services so that your choice will be respected. You always have the right to access services off campus from unaffiliated rape crisis centers and hotlines in your area or nationally. If you are concerned about a report being made, call in anonymously from a blocked number first to ask if a report will be made to law enforcement or the institution.

Whether you report or not, support is available. **Contact your local rape crisis center** for additional confidential advocacy in Ohio.

This publication is designed to provide accurate and authoritative information regarding victim rights. Nothing in this publication is to be construed as the rendering of legal advice. Anyone reading this publication is responsible for obtaining such advice from their own legal counsel. This publication is intended for educational and informational purposes only. This publication was supported by Victims of Crime Act Grant Award #2014VASAVE915, administered by the Ohio Attorney General's Office. Victims of federal crimes will be served.

www.oaesv.org 526 Superior Avenue, #1400 • Cleveland, Ohio 44114 • Phone: (216) 658-1381 • Toll-Free: (888) 886-8388