

**Sexual Assault Victims' Rights Amendment Act  
Task Force  
Juvenile Survivor Workgroup**

*Issue: Whether a juvenile victim of sexual assault has the right to an independent advocate*

**Meeting Minutes**

**July 23, 2015**

**ATTENDEES:**

Elisabeth Olds (Chair), Independent Expert Consultant  
Cortney Fisher, Office of Victim Services and Justice Grants  
Jabeen Adwai, Network for Victim Recovery of DC  
Kelly Higashi, US Attorney's Office  
Nikki Charles, Network for Victim Recovery of DC  
Laila Leigh, Break the Cycle  
Lorraine Chase, US Attorneys' Office  
Amanda Lindamood, DC Rape Crisis Center  
Tonya Turner, Office of the Attorney General  
Daniel Rappapaort, Office of Victim Services and Justice Grants  
Geoffrey Middleberg, Office of Victim Services and Justice Grants  
Michelle Palmer, Wendt Center for Loss and Healing  
Smitty Smith, Office of Victim Services and Justice Grants  
Heather DeVore, DC Forensic Nurse Examiners

**Via Phone:**

Allison Jackson, Children's National Medical Center  
Sarah Colorne, Break the Cycle

**DOCUMENTS:**

Summary of Advocate Privilege and Mandatory Reporting Statutes nationally  
Agenda  
Motion of Task Force from July 8, 2015

Elisabeth Olds convened the meeting and facilitated introductions.

Elisabeth began the discussion by summarizing the substance of the Motion of the Task Force that passed on July 8, 2015. The Motion is attached by reference to these Minutes, but states:

*(1) Definitions:*

- (a) From this point forward, we make a clear distinction between youth ages 0-11 and youth ages 12-17.*

*(b) From this point forward, we make a clear distinction between peer-to-peer sexual assault and sexual abuse that is ongoing and perpetrated by a parent, caregiver, or individual in a position of authority to the child. I believe that Rose Gordy used the term "person with a significant relationship to the child". I have no problem using that definition provided that we are clear that the term applies only to those significant persons who are in the position of perceived, apparent, or actual authority.*

*(2) For youth who are 0-11, both where there is peer-to-peer sexual violence or violence perpetrated by a parent, caregiver, or individual in a position of authority to the child, the child shall have the right to an advocate in the same manner and method that the child (and the child's family) are provided advocacy through the current configuration of MDT and Safe Shores.*

*(3) For youth who are 12-17, and are the victim of sexual abuse perpetrated by a parent, caregiver, or individual in a position of authority to the child, the child shall have the right to an advocate in the same manner and method that the child (and the child's family) are provided advocacy through the current configuration of MDT and Safe Shores.*

*(4) For youth who are 12-17, and are the victim of peer-to-peer violence, sexual violence committed by a stranger, or sexual violence committed by someone who does not have a significant relationship to the victim, those youth shall be provided with **an independent, community-based advocate** using a model of vertical advocacy established by SAVRAA prior to any substantive, investigatory conversation with hospital-based personnel, law enforcement, CFSA, or prosecutorial authority. This provision shall not be construed to limit hospital-based personnel or law enforcement from gathering information for the purpose of providing time-sensitive, emergency, or triage care to the victim. The purpose of the advocate includes the following:*

*(a) Information to the youth about their rights under VAWA 2013 to receive a medical forensic exam free of charge and without reporting to law enforcement;*

*(b) The mandatory reporting requirements of each actor in the system;*

*(c) Their right to refuse to participate or engage with law enforcement should the case be reported by a mandatory reporter;*

*(d) Coordination with other actors in the system to help the youth and their family navigate the system regardless of whether it becomes a criminal or civil matter;*

*(e) Access to resources such as counseling, appropriate follow up medical care, housing, economic supports, family intervention and independent living support as needed; and*

*(f) Advocacy with various institutions and people in their lives to ensure that their safety plan is implemented regardless of whether they reported to law enforcement.*

The Work Group was instructed that the Motion passed as stated, which was revised from the original language. The Work Group was also informed that the Work Group was specifically directed by the Task Force to address mandatory reporting and CFSA's role in screening reported cases. The Work Group was also instructed that the Task Force has requested that the Work Group address entry points. From a practical standpoint, it will be nearly impossible for younger teens to exercise their rights because any person they currently speak to will deem themselves to be a mandatory reporter. The Work Group was

also instructed that the Task Force has directed the Work Group to ensure that the District is in compliance with the Violence Against Women Act with regard to the victim's right not to participate in a law enforcement interview.

The Work Group recommended that the 7<sup>th</sup> line of Section (4) be amended to include the term "minimal facts interview" since that is the terminology that the Multidisciplinary Team uses when gathering information from the victim in the beginning of the investigatory process.

Elisabeth Olds introduced that the purpose of this meeting of the Work Group was going to be focused on entry points available to youth who are seeking help and/or a medical forensic exam. Even though the Task Force is granting youth rights in this process, it is setting up an expectation that isn't going to happen if we as a group aren't able to develop youth-oriented entry points where a youth can get information about their rights and the system without triggering a mandatory report.

- Younger teens are going to have difficulty getting to the hospital as an entry point.
- Currently, Children's National Medical Center doesn't stock the physical PERKs so they rely on law enforcement to bring the PERK and the victim when a PERK is requested. This piece has to change, at a minimum, for VAWA compliance.

OVS has discussed the possibility of Safe Shores establishing a youth-oriented hotline and/or Safe Shores working collaboratively with the soon-to-be launched Victim Services hotline. This hotline would be anonymous.

- Amanda Lindamood stated that youth are already using the DCRCC hotline for information and resources. DCRCC discloses to the youth calling that they are mandatory reporters. Since doing that, they've never had someone provide enough information to provide a mandatory report to anyone.
  - Amanda indicated that the youth want to "think out loud" through their options, manage panic and anxiety
  - DCRCC engages in "harm reduction" safety planning, i.e. allowing the youth to manage those factors that are in their control
- The Work Group expressed a distinct interest in expanding the services provided by DCRCC so that the youth is connected with a professional advocate that will follow-up with the youth caller and help them walk through their decisions. The Work Group agreed that when the youth gets routed to an advocate, it's important that the advocate can have an honest conversation with the youth that is not disclosed to any authority.
- Nikki Charles suggested the possibility of amending the script for the current DC SANE Call Center so that a question is asked of the caller about their age, e.g. "Are you between the ages of 12-17?" If the caller replies yes, the Call Center can route that caller to an advocate from Safe Shores. This could be one additional entry point for youth who know they want an exam.
- The Work Group reiterated concern with CFSA being the point of entry for all mandatory report calls. There is some evidence raised by the Children's Law Center that CFSA isn't screening cases

appropriately either in or out of the system. This issue further raises the concern for and need for reform to the mandatory reporting laws in the District.

- The Work Group discussed the possibility of parents as an entry point. All members of the Work Group agreed that parents are an important entry point, but that a parent's involvement cannot supersede the child's right to an advocate since a parent's interests are often different than the interests of the child.
  - Courtney Fisher and Elisabeth Olds briefly summarized their meeting with the TAPP program through MedStar Washington Hospital Center. Lorel Patchen, the ED of that program, made very clear that when she is treating pregnant or parenting teens, their needs are very different from those of the teen's parent and she is very careful to carve out a space that she can share with the teen alone, without parental involvement.
  - It was discussed that pregnant or parenting teens may be inherently more mature than teens who aren't pregnant or parenting.
- Allison Jackson made clear that Children's National Medical Center cannot report something that they don't have information or details about. If the teen doesn't disclose details about the crime, CNMC won't coerce anyone to make a report.
- The Work Group recommended that any hotline that is established for the purpose of serving youth have a text and chat component that the youth can access from a phone or a computer.
- Members of the Work Group stated that adults need to acknowledge youth decision making as valid before designing a system to assist youth. There has been a lot of conversation in the current system that doesn't recognize any of the decisions that youth are making as valid decisions. To help these youth, this system has to acknowledge that youth are making valid decisions, even if they are decisions that we (as adults) wouldn't make ourselves.
  - Work Group again asserted that the hotline has to have a "warm hand-off" component to an advocate that has confidentiality (exempted from any mandatory reporting) that permits the youth to work through their options, e.g. "I know you talked to Jenny last night. I'm your advocate...let's work through your questions and concerns." The "help" cannot stop at a volunteer-run hotline.
- Members of the Work Group suggested a "Know Your Options" Public Awareness Campaign that provides information and awareness to the public using the networks that youth already participate in, e.g. schools, Kick, walk-in clinics for health care

Elisabeth introduced the need and will to reform the District's mandatory reporting laws and presented a brief chart compiled by interns at OVSJG and Georgetown University. This will be the topic at the next meeting.

- Cortney and Elisabeth introduced the issue as it relates to VAWA Compliance, i.e. ALL sexual assault victims (regardless of age or relationship to perpetrator) have a right under federal law to refuse cooperation with law enforcement and still receive a medical forensic exam. Cortney, Elisabeth, and Smitty had a conference call with Caroline Palmer, Law and Policy Manager at the Minnesota Coalition Against Sexual Assault's Sexual Violence Justice Institute. MNCASA SVJI provides technical assistance to VAWA grantees around the issue of mandatory reporting and compliance with the Violence Against Women Act.
  - Law enforcement should not be notified of an exam unless the victim wants to report to law enforcement. If a state has a mandatory reporting requirement for any particular sexual offense, that is fine, but the mandatory report should not be to law enforcement and the victim should be made aware that they do NOT have to cooperate with, i.e. talk to, law enforcement at the point of the exam.
  - Ms. Palmer made clear that mandatory reporting laws are not necessarily in contradiction to federal VAWA if the mandatory reporting is done to an entity not law enforcement, the victim is fully apprised of their rights not to cooperate, and law enforcement does not interfere in any capacity until the exam is complete.
  - Obviously, law enforcement is able to begin an investigation prior to an exam if the victim discloses (willingly) to law enforcement first. However, law enforcement must make clear to the person that they do not have to talk to them (regardless of what their parent wants) and may still access exam services.

The issue of mandatory reporting, and the Work Group's recommendations regarding mandatory reporting, will be the topic for the next Work Group meeting, which is scheduled for **Wednesday, August 26 at 1:00 pm at One Judiciary Square, 441 4<sup>th</sup> Street, NW, on the 11<sup>th</sup> Floor.**

**SAVRAA Task Force Juvenile Sexual Assault Work Group**

**Wednesday, July 23, 2015**

**1:00-3:00**

**441 4<sup>th</sup> Street, NW**

**11<sup>th</sup> Floor**

**Agenda**

- I. Introductions
- II. Summary of Task Force Vote
- III. Entry Points
- IV. Advocate Privilege and Mandatory Reporting
- V. Next Meeting Date and Topic

**Sexual Assault Victims' Rights Amendment Act**  
**Task Force**  
**Juvenile Survivor Workgroup**

*Issue: Whether a juvenile victim of sexual assault has the right to an independent advocate*

**Motion from Juvenile WorkGroup to SAVRAA Task Force (as revised and passed)**

**July 8, 2015**

**Chair: Elisabeth Olds**

- (1) Definitions:
  - (a) From this point forward, we make a clear distinction between youth ages 0-11 and youth ages 12-17.
  - (b) From this point forward, we make a clear distinction between peer-to-peer sexual assault and sexual abuse that is ongoing and perpetrated by a parent, caregiver, or individual in a position of authority to the child. I believe that Rose Gordy used the term "person with a significant relationship to the child". I have no problem using that definition provided that we are clear that the term applies only to those significant persons who are in the position of perceived, apparent, or actual authority.
- (2) For youth who are 0-11, both where there is peer-to-peer sexual violence or violence perpetrated by a parent, caregiver, or individual in a position of authority to the child, the child shall have the right to an advocate in the same manner and method that the child (and the child's family) are provided advocacy through the current configuration of MDT and Safe Shores.
- (3) For youth who are 12-17, and are the victim of sexual abuse perpetrated by a parent, caregiver, or individual in a position of authority to the child, the child shall have the right to an advocate in the same manner and method that the child (and the child's family) are provided advocacy through the current configuration of MDT and Safe Shores.
- (4) For youth who are 12-17, and are the victim of peer-to-peer violence, *sexual violence committed by a stranger, or sexual violence committed by someone who does not have a significant relationship to the victim*, those youth shall be provided with *an independent, community-based advocate* using a model of vertical advocacy established by SAVRAA *prior to any substantive, investigatory conversation* with hospital-based personnel, law enforcement, CFSA, or prosecutorial authority. *This provision shall not be construed to limit hospital-based personnel or law enforcement from gathering information for the purpose of providing time-sensitive, emergency or triage care to the victim.* The purpose of the advocate includes the following:
  - (a) Information to the youth about their rights under VAWA 2013 to receive a medical forensic exam free of charge and without reporting to law enforcement;
  - (b) The mandatory reporting requirements of each actor in the system;
  - (c) Their right to refuse to participate or engage with law enforcement should the case be reported by a mandatory reporter;
  - (d) Coordination with other actors in the system to help the youth and their family navigate the system regardless of whether it becomes a criminal or civil matter;

State	Advocate Privilege	Mandatory Reporter	Notes
Arizona	<p>A "crime victim advocate shall not disclose as a witness or otherwise any communication made by or with the victim, including any communication made to or in the presence of others." A.R.S. § 13-4430 (2012).</p> <p>"a crime victim advocate shall not disclose records, notes, documents, correspondence, reports or memoranda that contain opinions, theories or other information made while advising, counseling or assisting the victim or that are based on communications made by or with the victim, including communications made to or in the presence of others" unless the victim consents in writing to disclosure. A.R.S. § 13-4430 (2012).</p> <p>Exceptions: If the evidence is exculpatory, if the victim is perjuring. A.R.S. § 13-4430 (2012).</p> <p>A crime victim advocate is "a person who is employed or authorized by a public or private entity to provide counseling, treatment or other supportive assistance to crime victims." A.R.S. § 13-4401 (2012)</p> <p>"Victim" means a person against whom the criminal offense has been committed, including a minor" A.R.S. § 13-4401(2012).</p>	<p>"Any person who reasonably believes that a minor is or has been the victim of physical injury, abuse, child abuse, a reportable offense or neglect that appears to have been inflicted on the minor by other than accidental means or that is not explained by the available medical history as being accidental in nature or who reasonably believes there has been a denial or deprivation of necessary medical treatment or surgical care or nourishment with the intent to cause or allow the death of an infant who is protected under section 36 2281 shall immediately report or cause reports to be made of this information to a peace officer or to the department of child safety, except if the report concerns a person who does not have care, custody or control of the minor, the report shall be made to a peace officer only." (A.R.S. 13-3620).</p> <p>A person is:</p> <ol style="list-style-type: none"> <li>1. ...School personnel or domestic violence victim advocates who develop the reasonable belief in the course of their employment.</li> <li>2. <u>Any other person who has responsibility for the care or treatment of the minor.</u></li> </ol> <p>Clergy are exempt (A.R.S. 13-3620(A)) but only for communications, not physical issues not communicated.</p>	
California	<p>There is an advocate privilege in California. If a victim meets with a counselor, then, that communication is privileged unless the</p>	<p>The advocates are not a mandatory reporter. Cal. Penal Code § 11165.7 (2015).</p>	

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	<p>"probative value of the communication outweighs the effect on the victim, the treatment relationship, and the treatment services if disclosure is compelled." Cal. Evid. Code § 1035.4 (1983).</p> <p>A sexual assault counselor is trained in helping victims of sexual assault. In California this person must either be a psychotherapist, an individual with a masters in counseling or an individual must be under the supervision of a psychotherapist or counselor with a masters and have training in specified field. Cal Evid. Code § 1035.2 (2007).</p> <p>According to <i>People v. Gilbert</i>, in defense of a sexual assault crime, a lawyer may ask a counselor testifying as a witness if the witness remembers the victim attending the counseling, but, the lawyer may not ask how the witness remembers the victim attending the counseling. <i>People v. Gilbert</i>, 5 Cal. App. 4<sup>th</sup> 1372 (Cal. Ct. App. 6<sup>th</sup> Dist) (1992).</p> <p>A victim is an individual who consults a sexual assault counselor on the effects of a sexual assault. Cal. Evid. Code § 1035 (2007).</p> <p>A sexual assault is "rape . . . ; unlawful sexual intercourse . . . ; rape in concert with force and violence . . . ; rape of a spouse . . . ; sodomy . . . ; [sex with a minor under 14]; oral copulation. . . ; sexual penetration . . . ; annoying or</p>		

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Colorado	<p>molesing a child under 18 . . . ; any attempt to commit any of the above acts." Cal. Evid. Code § 1036.2 (2002).</p> <p>A sexual assault victim's advocate may not testify to any communications between the victim and the advocate without consent. C.R.S. 13-90-107(1)(k)(i) (2014).</p> <p>A victim's advocate must work at "a battered women's shelter", "rape crisis organization", "or a comparable community-based advocacy program for victims of . . . sexual assault". C.R.S. 13-90-107(i)(k)(ii) (2014). In addition, the advocate must have completed thirty hours of training. The privilege extends to those who are under the supervision of someone who runs the program if they have completed the training. <i>Id.</i></p>	<p>The victim's advocate is a mandated reporter. C.R.S. § 19-3-304(2)(w) (2014).</p> <p>The report has to be made to local law enforcement, the county agency, or to the hotline. C.R.S. § 19-3-304(1)(a) (2014).</p> <p>The report does not have to be made if no other child is being victimized or the child is in child care or institutional care. C.R.S. § 19-3-304(1)(b)(i)-(ii) (2014).</p>	
Florida	<p>The privilege includes records. <i>People v. Turner</i>, 109 P.3d 639 (Colo. 2005).</p> <p>Recognized advocates with privilege work at rape crisis centers. Fla. Stat. § 90.5035 (2002)</p> <p>The statute says that an advocate may not disclose a communication with a victim, without consent. Fla. Stat. § 90.5035(2) (2002).</p> <p>"The authority of a sexual assault counselor or trained volunteer to claim the privilege is presumed in the absence of evidence to the contrary." Fla. Stat. § 90.5035(3) (2002).</p>	<p>The mandatory law does not explicitly exclude advocates.</p> <p>"Any person who knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare . . . shall report such knowledge or suspicion to the department in the manner prescribed in subsection (2)." Fla. Stat. § 39.201(1)(a) (2014) (emphasis added).</p> <p>In addition, "Any person who knows, or who has</p>	

State	Advocate Privilege	Mandatory Reporter	Notes
	<p>"A 'rape crisis center' is any public or private agency that offers assistance to victims of sexual assault or sexual battery and their families." Fla. Stat. § 90.5035(1)(a) (2002).</p> <p>Sexual Assault Counselors work for rape crisis centers and provide assistance to victims of sexual assault. Fla. Stat. § 90.5035(1)(b) (2002).</p> <p>Rape Crisis Centers may hire unpaid volunteers, train them for 30 hours and supervise them. At that point, they become advocates. Fla. Stat. § 90.5035(1)(c) (2002).</p> <p>A victim, for the purposes of this specific section of the code, is one who seeks advice from an advocate. Fla. Stat. § 90.5035(1)(d) (2002).</p> <p>In order to get an in-camera review of privileged material, "a defendant must first establish a reasonable probability that the privileged matters contain material information necessary to [their] defense".</p> <p><i>State v. Pinter</i>, 678 So. 2d 410, 417 (Fl. Ct. App. 4<sup>th</sup> Dist. 1996) (<i>c.f.</i> <i>State v. Famigletti</i>, 817 So. 2d 901, 907-8 (Fl. Ct. App. 3d Dist. 2002) (says case law on which <i>Pinter</i> was decided, a Pennsylvania Supreme Court case, was misinterpreted by the <i>Pinter</i> court based on its reading of the relevant Pennsylvania statute)).</p> <p>Having a sheriff's deputy in the room when a</p>	<p>reasonable cause to suspect, that a child is abused by an adult other than a parent, legal custodian, caregiver, or other person responsible for the child's welfare, as defined in this chapter, shall report such knowledge or suspicion to the department in the manner prescribed in subsection (2)." Fla. Stat. § 39.201(1)(b) (2014) (emphasis added).</p> <p>"Any person who knows, or has reasonable cause to suspect, that a child is the victim of childhood sexual abuse or the victim of a known or suspected juvenile sexual offender, as defined in this chapter, shall report such knowledge or suspicion to the department in the manner prescribed in subsection (2)." Fla. Stat. § 39.201(1)(c) (2014) (emphasis added).</p>	

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	<p>privilege conversation occurs does not waive the privilege. <i>State v. Topps</i>, 142 So. 3d 978 (Fl. Ct. App. 4<sup>th</sup> Dist 2014).</p>		
Illinois	<p>No sexual assault advocate privilege but, DV advocate privilege.</p>	N/A	
Massachusetts	<p>The sexual assault advocate has to work at a rape crisis center, have 35 hours of training, be supervised by a licensed clinician, and help sexual assault victims. Mass. A.L.M. ch. 233, § 20J (1998).</p> <p>The information discussed between the advocate and victim may only be released with written consent. Mass. A.L.M. ch. 233, § 20J (1998).</p>	<p>Advocate exempt from mandatory reporter law. ALM GL ch. 119, § 51A (2011).</p>	
	<p>To obtain an in-camera review of records: In <i>Commonwealth v. Dwyer</i>, the court incorporated the federal rules of criminal procedure to say, “the party moving to subpoena documents to be produced before trial must establish good cause, satisfied by a showing ‘(1) that the documents are evidentiary and relevant; (2) they are not otherwise procurable reasonably in advance of trial by exercise of due diligence; (3) that the party cannot properly prepare for trial without such production and inspection in advance of trial and that the failure to obtain such inspection may tend unreasonably to delay the trial; and (4) that the application is made in good faith and in not intended as a general ‘fishing expedition’”. <i>Commonwealth v. Dwyer</i>,</p>		

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Maryland	<p>859 N.E.2d 400, 415 (Mass. 2006). Counsel has to sign a protective order that they will not disclose the privileged material. <i>Dwyer</i> at 419.</p> <p>Social Worker privilege does not apply in child abuse cases or suspected child abuse cases. Md. Courts and Judicial Proceedings Code Ann. § 9-121(e) (2014).</p> <p>In non-child abuse cases, the privilege extends to communications between the counselor and the client. Md. Courts and Judicial Proceedings Code Ann. § 9-121(b) (2014).</p> <p>The client can waive the privilege by consenting to protected information being disclosed. Md. Courts and Judicial Proceedings Code Ann. § 9-121(d)(5) (2014).</p> <p>Privileged information may be disclosed in-court after an in-camera review if there "[is] a reasonable likelihood that the privileged records contain exculpatory information necessary for a proper defense." <i>State v. Johnson</i>, 102 A.3d 295, 307 (Md. Ct. App. 2014). It is a higher standard than a "fishing expedition." <i>Johnson</i> at 309.</p> <p>Licensing boards can subpoena privileged records to investigate malpractice by social workers. <i>Doe v. Md. Board of Soc. Work Exam'rs</i>, 862 A.2d 996, 1007 (Md. Ct. App. 2004)</p>	<p>Social workers from whom the privilege applies are not exempt from the mandatory reporter law. Md. Family Law Code Ann. § 5-704(a) (2013).</p>	
New Jersey	<p>Victim counselor may not be called to testify</p>	<p>The victim counselor is not exempted from the</p>	

State	Advocate Privilege	Mandatory Reporter	Notes
	<p>regarding confidential communications. The privilege may only be waived with the written consent of the victim. A juvenile can waive the privilege, unless there is a court order that the juvenile is incapable of giving consent. Victim counselors and victims cannot be compelled to give the contact information of emergency housing given for the purposes of helping a victim. N.J. Stat. § 2A:84A-22.15 (2013).</p> <p>Sexual assault is one of the covered crimes. N.J. Stat. § 2A:84A-22.14(a) (2001).</p> <p>Victim Counseling Center – “any office, institution, or center offering assistance to victims and their families through crisis intervention, medical and legal accompaniment and follow-up counseling”. N.J. Stat. § 2A:84A-22.14(d) (2001).</p> <p>Victim Counselor – works for a Victim Counseling Center and has 40 hours of training. N.J. Stat. § 2A:84A-22.14(e) (2001).</p> <p>The privilege includes “secondary victims of violence”. For example, the parent of a victim. <i>State v. J.G.</i>, 619 A.2d 232, 234 (N.J. Sup. Ct., App. Div. 1993).</p>	<p>mandatory reporter law (“Any person having reasonable cause to believe that a child has been subjected to child abuse or acts of child abuse shall report the same immediately to the Division of Child Protection and Permanency by telephone or otherwise.”) N.J. Stat. § 9:6-8.10 (2012).</p> <p>Psychiatrists are mandatory reporters even though their communications are privileged. <i>State v. Snell</i>, 717 A.2d 977, 978 (N.J. Sup. Ct., App. Div. 1998).</p>	
New York	<p>Rape Crisis Counselor privilege</p> <p>Full privilege except if authorized by the client; if the client is about to commit a crime; starting legal action against the counselor or the</p>	<p>Rape Crisis Counselors are not exempt from the mandatory reporter law. N.Y. SOS, Art. 6, Title 6, § 413(1)(a) (2015).</p> <p>“Notwithstanding the privileges set forth in article</p>	

State	Advocate Privilege	Mandatory Reporter	Notes
	<p>center. N.Y. C.L.S. C.P.L.R. § 4510(b)(1)-(3) (2010).</p>	<p>forty-five of the civil practice law and rules, and any other provision of law to the contrary, mandated reporters who make a report which initiates an investigation of an allegation of child abuse or maltreatment are required to comply with all requests for records made by a child protective service relating to such report, including records relating to diagnosis, prognosis or treatment, and clinical records, of any patient or client that are essential for a full investigation of allegations of child abuse or maltreatment pursuant to this title; provided, however, that disclosure of substance abuse treatment records shall be made pursuant to the standards and procedures for disclosure of such records delineated in federal law.” NY CLS Soc Serv § 415</p>	
Oregon	<p>There is a Counselor-Client Privilege.</p> <p>The counselor has to be licensed by the Oregon Board of Licensed Professional Counselors and Therapists. The counselor cannot be called to testify in a civil or criminal trial. ORS § 40.262 Rule 507 (1989).</p> <p>Exceptions: (1) with consent to disclose; (2) if there is legal action against the counselor or where they work; (3) if the communications indicates a crime could be committed; (4) if a minor could be a victim of crime. ORS § 40.262 Rule 507(1)-(4) (1989).</p> <p>The privilege does not apply to exculpatory evidence. State v. Hansen, 743 P.2d 157,</p>	<p>Only psychiatrists and psychologists are exempt from the mandatory reporter law – no other counselors are exempt. ORS § 419B.010(1) (2013).</p>	

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Pennsylvania	<p>161-62 (Ore. 1987).</p> <p>Domestic Violence Advocate but not sexual assault advocate 23 Pa. Cons. Stat. Ann. § 6111 (1994)</p>	<p>Advocates are exempt from mandatory reporting. 23 Pa.C.S. § 6311.1 (2014).</p>	
Texas	<p>There are sexual assault advocates in Texas. The requirements are: (1) the advocate has to finish a training program approved by the Attorney General of Texas and (2) they must be an employee or volunteer of a sexual assault assistance program. Tex. Gov't Code § 420.051 (2013).</p> <p>The advocate may attend the forensic medical examination and provide counseling. Tex. Code Crim. Proc. Art. 56.045 (2013).</p> <p>Note: The victim is not required to "participate in the investigation or prosecution of an offense as a condition of receiving a forensic medical examination" Tex. Code Crim. Proc. art. 56.065 (2011).</p>	<p>The advocate only helps with the forensic medical exam after the crime has been reported so the mandatory reporter law is not relevant to this type of advocate.</p>	
Virginia	<p>A public or non-profit agency that helps survivors of sexual assault may not reveal information that identifies a client or any information about their treatment <i>unless</i> law enforcement requests it or it is needed for a prosecution. If it is requested as part of an investigation or for a court case, then, the agency should inform the victim and take action to protect the safety of the victim. Va. Code. Ann. § 63-2-104.1 (2006).</p>	<p>Not exempt from mandatory reporter law.</p>	

It is worth noting that there have been several attempts to say that the privileges advocate or not, are unconstitutional under the Confrontation Clause of the U.S. Constitution. It is worth keeping that in mind as the Task Force makes recommendations.

## SAVRAA Task Force Meeting

7/8/2015

### **In Attendance:**

Cortney Fisher  
Barbra Chikowore  
Jennifer Schweer  
Nikki Charles  
Elisabeth Olds  
Sherelle Hessell-Gordon  
Michelle Palmer  
Rose Gordy  
Cmdr. Alder  
Tonya Turner  
Nelly Montenegro  
Kelley Dillon  
Jennifer Pollitt-Hill

### **Absent:**

Laurel Wemhoff  
Heather DeVore  
Amy Loudermilk

### **Summary**

- Members of the task force reviewed minutes from the June task force meeting and approved.
- Juvenile Work Group report-outs were distributed.
- Elisabeth Olds is conducting more interviews next week. Juvenile working groups are meeting the 4<sup>th</sup> Wednesday of every month. The working groups are bigger than the named SAVRAA Task Force. There are more agencies involved.
- There was a motion from the Juvenile working group to divide age groups in to two different groups (0-11 and 12-17). For the purpose of the recommendation we are speaking about the 12-17 age group.
- In instances where the caregiver is the offender all ages would be treated the same as the 0-11 age group. In instances of peer to peer assault 12-17 would be treated the same as adults.

DISCUSSION:

*JPH – HIPPA concerns and VAWA concerns would still exist in the category that is still required to report to law enforcement*

*MP – Does this change the method of reporting?*

*CF- No*

*RG – We need to change the 4<sup>th</sup> group (refer to report-out document) to non-familial ie- coach, teacher, etc.*

### **Motion passed with changes by unanimous vote**

#### **Next Steps:**

Elisabeth Olds: Looking at National models how is mandatory reporting affected? The motion will be taken back to the working group, they will pick a question to start with and will start to peel back the layers from there.

#### **Main points from discussion:**

NM noted that they will need to take into consideration immigration status concerns.

MP – changes should be made to the CFSA process – remove the requirement to call

RG – DC child abuse hotline sends to CFSA for screening, it is more of a training issue

BC - The MPD youth division should not have to bring the kits to the hospital, the hospital should provide the kits **\*this would be a funding issue**

RG – Advocates dealing with youth should have special training/credentialing for working with youth/ should adapt the conversation to appropriate youth development stage

TT – There will be conflicts between youth and parents and getting an advocate in the middle. Where do the parents come in?

NC – Entry points – What are they likely to be? How would you know about services without engaging a mandatory reporter?

Messaging and an ad campaign would be needed to get the word out.

JPH – If legislation is passed and the process doesn't work because of hospital regulations or hospital staff independent decisions, this will fail.

CF - Historically hospitals in DC have not wanted the SANE programs housed in their hospital for financial reasons

- At the time Medstar WHC adopted the SANE program it was the only hospital in DC willing to house the SANE program
- OVS has funded the program to be VAWA compliant

SHG – Would OVS fund the adolescent SANE program?

CF – Absolutely if it brought DC in to compliance with VAWA

A discussion with Children's Hospital staff revealed that some staff will not treat minors without ID.

NM – It would be illegal for a hospital to not care for a trafficked minor due to them not having identification.

Hospital staffs need more training if some doctors have the perception that they should not treat minors without ID. If the law and their perceptions do not match up the programs would fail.

RG – SAVRAA rights attach at a strange time for this population. They won't be going to the hospital first. Almost everyone they would go to for help would be a mandatory reporter.

JS – Maybe this should be more of a hotline-based system like RAIN to get around mandatory reporting. For this population the hospital is not the most appropriate place to attached an advocate.

- **VOTE:**

A motion to add no more new members to the Task Force, barring replacement of current Task Force member who must vacate their position on the Task Force.

Motion passed with 9 votes in favor, 2 members abstaining, 4 members absent.

**Sexual Assault Victims' Rights Amendment Act  
Task Force  
Juvenile Survivor Workgroup**

*Issue: How to establish a juvenile victim's right to an independent advocate*

**Lorel Patchen, Certified Nurse Midwife  
Executive Director, MedStar Washington Hospital Center TAPP Program  
July 10, 2015**

**Present:** Cortney Fisher, Elisabeth Olds, Lorel Patchen

On Friday, July 10, Cortney Fisher and Elisabeth Olds met with Lorel Patchen, Certified Nurse Midwife and Executive Director of MedStar's Teen Alliance for Prepared Parenting program (TAPP). The TAPP program is a program that has been operational since 1999 and is the longest running program in the District of Columbia that provides prenatal and post-natal care to teenage girls. The program targets Wards 1, 5, 7, and 8 but serves participants throughout the District. Since 1999, more than 2,000 teenagers under 18 have benefited from TAPP services. Teen mothers are eligible to receive services until their child is 2 years old.

The program integrates medical services with intensive youth development coaching, and helps teen parents to complete their high school work or a GED program during the course of the program. Teens enrolled in the TAPP program receive obstetric and gynecologic services, prenatal and parenting education, family planning and contraceptive services, individual and group counseling, workshops in communication, conflict resolution, and life management, and ongoing support. 94% of TAPP participants are successful. TAPP received honors from the DC Council in 2015 for its work with this population.

Elisabeth Olds opened the conversation by introducing Lorel to the work of the Task Force and the Juvenile Survivors WorkGroup. Elisabeth indicated that the Work Group was interested in her perspective on the use of advocates for teen and adolescent victims of sexual assault, and her particular experiences working with teens who have been sexually assaulted. Lorel responded "Glad to see advocacy happen because her midwives have done examinations in the past and the experience with the medical forensic system for teens has been disturbing." She further indicated that there was "not much support" for teen and adolescent victims.

Lorel went on to clarify that the recognition among young people of what assault is isn't there. They don't see the sexual experience as the exchange that it is. They identify with the power piece of it, but don't connect with the intimacy of it. Therefore, there are typically many instances of assault that aren't identified by the teen as assault, but rather as a typical sexual experience. They are often "trading" sex for a safe place to sleep or for other material needs.

In TAPP's experience, the younger the teen is that is pregnant, the higher the likelihood that the teen has a sexual assault experience in their history. However, there is a lot more about the situation that you need to be aware of before you make judgments.

- In adult hospitals, the providers aren't necessarily equipped to care for adolescents.
- There is a lot of discomfort for pediatricians who are working with adolescents that are making adult decisions. They often have a very difficult time accepting the adult decision making that

the teens and adolescents are engaged in. Adolescents get caught in the middle because the adult providers aren't trained, and the pediatricians want them to be kids. There are layers of discomfort and judgment on both ends of the spectrum.

- Health care providers are a barrier in themselves because of the range of discomfort. Children's hospitals used to dealing with children aren't prepared for the adult decision making and as such, don't honor the decision making as valid.

The program that she runs is the only program in this hospital system with a pediatric or youth focus. The program is necessary because pediatricians aren't trained to do OB/GYN. Only within the last five years have pediatricians at CNMC developed skill sets around contraception and IUD insertions. Some hospitals do both, e.g. Howard and Georgetown. Teens are often going to UMC.

Elisabeth asked Lorel how teens are getting to the TAPP program—

- Referrals from all over the city, e.g. schools, Whitman-Walker Health, community-based providers, former patients, CFSA, DYRS.
- Presenting because they are pregnant or want birth control
- Fewer adolescents coming here for birth control alone. Most are pregnant.
- Can call and make an appointment on their own. When they go into registration, take their DOB. When their DOB flags them as 21 and under, they are flagged into the teen clinic. Both CNMC and WHC have teen clinics. WHC teen program is known as the TAPP program.

Elisabeth Olds indicated that there has been a lot of conversation about the brain development of the teens and their ability to take in and process the information that an advocate is telling them. We asked Lorel for her opinion on this.

- She indicated that this is not a problem for her, following up with asking us "What is the alternative?"
- "Gimme a break. Think about what they are already making a decision about." In Lorel's opinion, the teens are already making decisions about things that are not the perfect reality but she said that "the vast majority will make the decisions that adults will agree with"
- Lorel did say that any program will need to have folks who are trained to work with adolescents, making sure that you have folks who understand working with teens, understand their issues, and have the ability to grant them autonomy.
- Lorel indicated that the teen is already empowered to make choices about whether they are going to use birth control, already making decisions about screening for HIV. This is the same type of decision. We've already decided that they can make these decisions.

Lorel stated that "we need to be really clear that these teens need an advocate that are not their family." This adolescent needs support on their own. Their family is sometimes wrapped up in the complexities and competing priorities. "What is the alternative? The family advocate is talking to the mom who is brokering for the child? That's not appropriate"

"As a mother, I want my child to be looking to me for advice, guidance. But I still want someone looking out for only my daughter's interest. She deserves that"

Elisabeth asked her to describe the interactions when a teen comes into the clinic with a guardian or parent or aunt—

- Things always go better if there is relationship with the family. If they are present in the room, we start together. Everyone gets to know her. Gets a sense of why they are there: whether they are trying to supervise what is happening or whether they care about what is happening with their kid
- Tries to get some sense of a consent to start the visit – but does ask the parent/guardian/support person to step out because some part of the visit has to occur just between the two of them. If the teen initiates not wanting the mom to leave, she works with that but always gets alone time with the individual patient at the end. The patient directs the exam to a large extent.
- “Is there anything I need to know that you don’t want your mom to know about” “You should know that coming to your health care provider is always as a time that you can have to talk about things that you don’t want to tell a parent.”
- Sometimes the phone stays on, so that whoever is monitoring the visit can hear. It takes time. Doesn’t happen all in one visit. Has to establish a framework for follow up. Don’t want to alienate the companion.

We asked her about mandatory reporting – about what that looks like for her?

- Teens are never aware of the law. Doesn’t seem aware that there is a concern about having a partner of a different age. 14, 15 tend to see an older partner as a victory; 16, 17 year olds tend to be more savvy about the law and what they can tell people to not get caught.
- She always tells them what it may mean to talk about the age of the partner. It becomes very easy to tell if there is a problem, but tells them to revisit the conversation.
- Parents are often unaware that the issue becomes one of neglect, particularly when it’s a young child with a much older partners. Parents never think the issue is going to come back to them because the child has been unsupervised.
- Rarely, very rarely willing to tell her that the pregnancy was the result of a sexual assault. Most perceive the issue to be one of a relationship. Youth are willing to report this as a result of an assault when it is a stranger rape.
- Much higher level of tolerance for violence and assault than she is comfortable with. Shoving and pushing and emotional abuse is never seen as violence. A lot of communication occurs in front of her that is very loud and abusive, threatening, name calling, physical aggression.
- Abuse victims tend to disappear from care for a bit.

The issue of adolescents not having their own advocate makes no sense to her. They are engaged in a lot of things that are not being mediated by the adults in their life. When the child is assaulted, why are we then deciding that those adults should be making the decisions for that child. “These adults probably already have a troubled relationship with their pre-teen”

She analogized this issue to one of pregnancy termination. In trainings, everyone would get really upset when she discussed the fact that adolescents can get a termination without the parent’s consent in DC. She would often try to move the conversation forward by telling the adult to “Stop thinking about your own child. I trust your vision of your relationship with your child. Why are we pretending that these kids have this kind of relationship with their parents?”

In terms of the child's ability to make these decisions, there are real challenges about how much adolescents can make decisions about their future lives, but they are usually pretty good about the here and now. They may make a decision that they regret, but adults do that too. We are doing a better job for children if you involve them in the decisions. These kids are making rational and logical decisions based on their options, all of the options are shit. What she really needs is someone to sit down with her and work through the options that she does have, about all of the shitty options that she has without the threat of reporting her. Approaching this stuff through a punitive lens is not helpful.

"The mandatory reporting system stinks and often has the potential to be disruptive to the relationship that I have with the patients." The reason that it is disruptive is because things happen without their consent. She needs to get that young person to buy in to the decisions that have to be made. The mandatory reporting system prevents the child from getting health care. If she has the options to not report, the kid will come back. And she has more ability to get the kids moving toward health.

In term of requirements to report to police—

Providers are typically not comfortable with being the police, so mandatory reporting prevents many providers from asking the full slate of questions. Many health care providers just avoid asking questions that will open pandora's box when they know they will have to report, when they have no time to deal with the fallout, particularly when there is no one that is going to come to be on their side that is going to deal with the fallout in a way that works for the patient.

We asked Lorel about exempting the advocate specifically from the system, but keeping the rest of the mandatory reporters the same. She indicates that the problem is getting to the advocate without going through someone who is going to treat these teens like a child. How does the teenager get to the advocate? This would not be helpful to her, because the kids aren't going to have an advocate walking through the door so she is still going to be a mandatory reporter. "Don't get me wrong; people have to be held accountable. But I don't think it results in the best outcomes for the young person."

We asked Lorel what happens after she makes the report –

- They (the providers) don't know about the report unless the young person comes back and tells them. She tells the young person that they have to make the report.
- Only one time did she not tell the patient that she has to make the report, because she was very concerned about the aggressive family unit.
- Most of the time it feels like nothing happens from the report. When they follow up with the patient, many times the patient says that nothing happens.