U.S. Department of Justice
National Institute of Justice
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Assisting Child Victims of Sexual Abuse:

The Sexual Assault Center
Seattle, Washington

The Child Protection Center—Special Unit
Washington, D.C.

a program of the **National Institute of Justice**

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EXEMPLARY PROJECTS

Assisting Child Victims of Sexual Abuse:

The Sexual Assault Center Seattle, Washington

The Child Protection Center—Special Unit Washington, D.C.

by

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CHAPTER 1: INTRODUCTION AND OVERVIEW

1.1 Scope of the Problem

Little is known with certainty about child sexual abuse--why it happens, how frequently it happens, or how to prevent it. But as more and more cases are reported and documented, an ugly picture begins to emerge:

- As many as[1] 100,000 to 500,000 children may be sexually abused each year. They range in age from infancy to adolescence.
- The sexual acts committed upon a child victim are no different than those committed upon an adult victim; their impact may be psychologically devastating for a child.

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[1] The National Center on Child Abuse and Neglect projects a lower bound of 60-100,000 cases annually, based upon intrafamily cases reported to child protection authorities in 1978. National Center on Child Abuse and Neglect, Child Sexual Abuse: Incest, Assault, and Sexual Exploitation (Washington, D.C.: U.S. Department of Health, Education, and Welfare, Agency for Children, Youth, and Families, 1978). This estimate considers only children who were sexually abused by members of the same household.

Based on the number of sexual offenses against children reported in a one-year period to law enforcement and child protection agencies in four locales, Sarafino projected a nationwide annual incidence of 336,200. Edward P. Sarafino, "An Estimate of Nationwide Incidence of Sexual Offenses Against Children," Child Welfare, Vol. 58 (February 1979): 127-134. In projecting actual incidence from reported incidence, the author assumed that unreported incidents were three to four times the number of reported incidents, an assumption which is open to question.

Based on retrospective interviews with adult women, Gagnon estimated that half a million girls under age 14 are sexually abused each year. J.H. Gagnon, "Female Child Victims of Sex Offenses," Social Problems, Vol. 13 (1965): 176-192. In this study, sexual abuse was very loosely defined to include victims of exhibitionism, voyeurism, or even obscene language.

In sum, each of the above estimates has serious drawbacks that preclude a conclusive statement about the actual incidence of child sexual abuse.

- Victims are predominantly girls, although boys are victimized too. Offenders are almost invariably male, both adults and juveniles. In most cases, the offender is someone known to the child and her family.[2]

- Intrafamily abuse, or incest, may continue for years. Sometimes more than one child in the family is victimized.

- Child sexual abuse is not restricted to any one social or economic class.

The magnitude of the impact that sexual abuse may have on a child depends on the child's relationship to the offender and the support she receives from her family. Experts agree that repeated sexual abuse by a family member carries a high potential of lasting damage to the child, especially if she becomes enmeshed in a volatile family situation.[3] While the mother may suspect or even know about the incest, she may wittingly or unwittingly act in collusion with the offender by not taking steps to protect her child. She may fear a family break-up, which would threaten her own emotional stability and, possibly, her only source of income. She may fear the intervention and humiliation that would follow disclosure to authorities. The mother may simply refuse to face the facts--at great cost to her child.

In some situations where the offender is someone known to the child, even a family member, the mother does reject the offender and support the child. Here, the trauma of being abused by a trusted individual may be tempered somewhat by the unquestioning support of another trusted person. Even so, the child may suffer guilt if her disclosure leads to the separation or divorce of her parents or to the public disgrace of the offender. Counselors have observed that anger and love co-exist uneasily when the abuser is a parent, close relative, or friend. These ambivalent feelings only sharpen the pain of revelation.

A different constellation of emotions typifies the situation where a child is sexually assaulted by a stranger. Because such incidents frequently involve violence, there is a greater danger of physical harm than in incestuous

[2] Throughout this manual, feminine pronouns are used to describe victims of sexual abuse and masculine pronouns are used to describe offenders. The decision to use these pronouns merely reflects the realities of child sexual abuse today as evidenced in available statistics. It is not meant to imply that all victims are girls, or that all offenders are men.

[3] From a counseling perspective, the term "incest" extends beyond the natural family to include sexual activity perpetrated by a step-parent or even a live-in boyfriend. This extended definition of incest will be used throughout the manual.

abuse. However, the psychological impact may be less severe in cases of stranger assault because parents almost invariably rally to the child's side and seek professional assistance to resolve the crisis. Effective crisis intervention and short-term therapy may suffice to help the child and family overcome their shock and resume their lives as before.

As startling as they are, cases like these are familiar to counselors of the Sexual Assault Center in Seattle, Washington, and the Child Protection Center-Special Unit in Washington, D.C. Both of these projects recognized that certain problems are unique to the treatment of child sexual abuse victims and have taken notable steps to resolve those problems. Both projects were named Exemplary by the National Institute of Justice on the strength of these accomplishments. This manual documents the achievements of these two projects in the hope that others will follow their lead.

1.2 Deficiencies in the Treatment of Child Victims

Regardless of the details of the abusive incident, professionals who work with the victims seem to agree that a major determinant of the child's response to her situation is the reactions of those around her, whether parents, counselors, police, or prosecutors. It is precisely the anticipation of these reactions that inhibits many victims from reporting the abuse to their parents, and parents from reporting to authorities.

What generally happens when a child does tell someone that she has been sexually abused? First, she may encounter disbelief. Unwilling to accept the reality that children are sexually abused by adults, many people are prone to attribute the child's complaint to her creative imagination. This reaction is perhaps most common when a child accuses a close family member or friend. A child who encounters disbelief or hostility upon her first disclosure may be unwilling to risk a similar reaction from other persons and may, instead, choose to live with her secret and suffer continuing abuse.

If the child has been physically injured, she may be taken to a hospital emergency room or doctor's office. She is subjected to an examination which may be as frightening as the incident itself. In addition, the examining physician is likely to question her about the details of the abuse, often using language the child does not understand.

The language barrier is exacerbated if the child's case enters the criminal justice system. Police and prosecutors often use language which is not easily understood even by adult laypersons. Moreover, children tend to perceive and relate events differently than adults do, and certain details of their stories may change from one telling to the next. The child's

inability to tell a cogent story may cause untrained police and prosecutors to doubt her truthfulness and dismiss the case as the child's fantasy. Similar problems may beset the older child or adolescent; while the language barriers are not as severe, an allegation of sexual abuse may still trigger doubt and disbelief among interviewers, particularly if the victim has a history of misbehavior or status offenses. She may be required to justify her actions much as though she herself were accused of misconduct.

Not all cases of child sexual abuse are reported to the criminal justice system. However, most jurisdictions do mandate that cases of intrafamily abuse be reported to the local child protection agency, which is usually responsible for investigating the veracity of complaints of child abuse and for protecting child victims from future threat. Pending the outcome of an investigation, which may take several weeks, the child may be removed from the home--regardless of whether the offender is being detained or is under a no-contact order. Social workers in child protection agencies often lack training specific to child sexual abuse, and, consequently, may be uncomfortable with sexual abuse cases and unsure of how to handle them.

In sum, the child may receive wholly inadequate treatment at every turn, even from those whose job it is to help her.

1.3 Development of Child Victim Assistance Programs

The child victim's plight has not escaped notice. In 1978, the Law Enforcement Assistance Administration (LEAA) awarded grants to both of the projects discussed in this manual. And, in fiscal year 1980, the U.S. Congress appropriated $4 million to the National Center on Child Abuse and Neglect (NCCAN) to support special programs to serve child victims of sexual abuse. NCCAN estimates that at least 250 such programs now exist.

Many of these programs are relatively new; some are less than two years old. They vary greatly in numerous respects. Underlying the variations in approach are two highly controversial issues: the etiology of incest and the manner in which the criminal justice system should be involved in child sexual abuse cases. The first issue, the cause of incest, falls within the realm of human psychology. Is a father's sexual misuse of his own child a symptom of some larger family dysfunction in which the mother and child play significant roles? Or is it the result of the father's sexual behavior disorder or his inability to find suitable outlets for his own anxieties and frustration? While these questions have been raised time and again in the literature, the answers are still very much in debate. The position adopted by a program will profoundly affect the course of treatment provided to incestuous families.

The second issue of controversy among professionals in this field is whether and how to involve the criminal justice system. Certainly child sexual abuse is a crime in all states, but many social workers and mental health counselors view the criminal justice system as disruptive of the family and threatening to the child. Others believe that child sex offenders must be held accountable for their actions, and hence that offenders should be reported and prosecuted. Still others believe that criminal conviction is the best available means of assuring that the offender begins and completes approved therapy.

The two projects that are the subject of this manual--the Sexual Assault Center in Seattle, Washington, and the Child Protection Center-Special Unit in Washington, D.C.--both believe that incidents of child sexual abuse should be reported to police and that offenders should be prosecuted for their crimes. Both projects support prosecution as a means of holding the offender accountable for his actions and deterring others from following a similar course; in Seattle, project counselors also see prosecution as a means of obtaining court-ordered therapy for the offenders. Staff in Seattle assert that child sexual abuse--even incest--is a behavioral disorder of the offender; they do not counsel offenders but refer them elsewhere so that project staff can concentrate their resources on the child. In D.C., the project recently received a grant to provide therapy for juvenile intrafamily sex offenders.

Four additional programs were identified by an official of the National Center on Child Abuse and Neglect as representative of current approaches to both incest treatment and criminal justice system involvement. The four programs are described briefly below.

(1) The Child Sexual Abuse Treatment Program (CSATP), Santa Clara County, California. Founded in 1971 by humanistic psychologist Dr. Henry Giarretto, CSATP is among the most extensively documented and best known programs in the field of incest treatment. Offenders, victims, and other family members are involved in individual, group, and family counseling with the goal of reducing the victims' and siblings' trauma and reuniting the families, if they so desire. Coordinated with the program are two self-help groups, Parents United and Daughters and Sons United, to which all CSATP clients are referred. CSATP is administratively located in the Juvenile Probation Department (the mandated child abuse reporting agency) and is closely linked to other criminal justice agencies in Santa Clara County. CSATP emphasizes that the adjudication process is important to coerce offenders into counseling. The Santa Clara program has been replicated with state funding in 30 locales in California; outside California, 35 additional programs have adopted elements of the CSATP approach.

(2) Child Abuse Unit for Studies, Education, and Sources (CAUSES), Chicago, Illinois. CAUSES provides individual therapy to sexually abused children, their families, and "significant others" (e.g., mother's boyfriend). CAUSES

tries to avoid involving their clients in the criminal justice system if at all possible, believing that coercion is not necessary to keep families in treatment and, in fact, could be counterproductive to rehabilitation. The program often prepares reports for the court regarding families whose situations become known to criminal justice officials, usually recommending therapy rather than prosecution. CAUSES receives its cases of child sexual abuse from the Department of Child and Family Services (DCFS) in Cook County and is required to report all cases of reincidence. Until recently, DCFS would not notify police until a second incident occurred, a policy consistent with Illinois law. However, in April 1981, the Department announced a new policy of reporting all substantiated incidents of child sexual abuse to police. It remains to be seen if this policy will affect the treatment approach taken by CAUSES.

(3) The Joseph J. Peters Institute, Philadelphia, Pennsylvania. Launched in 1955 as a psychiatric program for sex offenders, the Institute in 1970 began treating victims, too. Staffed primarily by social workers and psychiatrists, the Institute receives approximately 400 referrals of child victims per year, of whom about 150 are incest victims. The Institute provides individual and group therapy for incest daughters, fathers, and mothers, plus couples therapy and family therapy where appropriate. The average length of treatment for incest victims and families ranges from six months to one year. This program does not initiate contact with the criminal justice system, although they do provide psychiatric evaluations of offenders upon request of the Philadelphia Department of Adult Probation. The project's clinical services are supported almost entirely by the city's Office of Mental Health and Mental Retardation.

(4) Project Against Sexual Abuse of Appalachian Children (PASAAC), Knoxville, Tennessee. A special project of Child and Family Services of Knox County, Inc., PASAAC is a private nonprofit agency serving one urban and five rural counties. The project handles predominantly incest cases, but treats other sexual assault victims and their families when their caseload permits it; otherwise, these families are referred to other counselors in the community. PASAAC therapy is family-centered, utilizing crisis intervention, individual, group, and marital counseling, and play therapy for children. PASAAC only becomes involved in the criminal justice system after the state's Children's Protective Services agency has referred the case for prosecution. For example, staff work with the county district attorneys to prepare child victims for trial if their cases are being prosecuted. Occasionally, they write reports or recommendations for the court, but only upon request.

All six programs treat victims of nonfamily sexual abuse as well as incest victims. All but the Sexual Assault Center treat offenders in addition to victims and other family members. The projects are more evenly split on the issue of criminal justice system involvement: CSATP, the Sexual Assault Center, and the Child Protection Center-Special Unit favor involvement and work closely with criminal justice agencies; the other three projects only work with those agencies when it is necessary or requested. To

date, there is no comparative research to suggest that one treatment modality may be more effective than another.

In the spring of 1980, the Sexual Assault Center in Seattle and the Child Protection Center-Special Unit in Washington, D.C., submitted applications for the National Institute of Justice's Exemplary Projects Program. Based on the criteria of that program--that the candidate project demonstrate evidence of measurability, goal achievement, efficiency, accessibility, and replicability--both projects were identified as models worthy of consideration by those who are planning to initiate or expand services for child victims of sexual abuse.

1.4 The Exemplary Projects

Initially funded under the Law Enforcement Assistance Administration's Family Violence Program, the Sexual Assault Center and the Child Protection Center-Special Unit have much in common:

- Both are located in hospitals--Harborview Medical Center in Seattle, and Children's Hospital National Medical Center in Washington, D.C.
- Both provide medical care, crisis intervention, and counseling for victims and their families.
- Both believe strongly in criminal prosecution of child molesters, and both have found ways to make the legal system less threatening to the child victim.
- Both are committed to improving the community's response to child victims through specialized training and public awareness activities.

Most important, both projects have succeeded in focusing the community's attention on a problem of serious proportions.

1.4.1 Medical Care

Both projects have taken steps to ensure that child victims receive sensitive yet thorough medical attention. The initial medical exam serves three purposes: to treat physical injuries the child may have suffered as a result of the sexual abuse and to reassure the child and family that the child is "okay"; to test for venereal disease and pregnancy; and to collect medical evidence in support of investigation and prosecution. In both Harborview

Medical Center and Children's Hospital National Medical Center, physicians, nurses, and social workers have been trained to recognize and respond to the child victim's special needs.

In Washington, D.C., the law requires all children's testimony to be supported by corroborating evidence. Medical evidence of sexual abuse is the most frequent source of corroboration. A new Medical-Legal Sexual Assault Evidence Form designed by the project has greatly enhanced the quality of cases presented for prosecution. Detailed protocols guide all aspects of the examination and suggest techniques that are sensitive to the child's concerns. Because nearly 60 percent of the project's clients are referred through the emergency room or other divisions of the hospital, the medical protocols specifically instruct physicians to contact the project's on-call counselor.

Before interviewing the child, the project counselor confers with the examining physician and police officer (if present) to avoid asking questions the child has already answered. The initial interview with the family takes place within the emergency treatment area in a small room filled with books and toys for the child's comfort. This interview focuses on the family's reactions to the incident, since their behavior is critical to the child's recovery. Because project counselors have observed that families tend to keep their medical appointments, the first formal counseling session is often scheduled to coincide with the follow-up medical exam.

Project staff believe that childhood venereal disease is always transmitted sexually, and so they have instructed hospital physicians to refer all cases of childhood gonorrhea to them for counseling and follow-up to determine the source of contact. Also, the project successfully persuaded the city's Public Health Department to institute special sites where children can be tested for venereal disease.

In Seattle, fewer than 20 percent of the victims are referred through the emergency room. Many have no immediate medical trauma; others are treated by private physicians or clinics and referred to the project for counseling. Often, children who have no apparent injuries are nevertheless examined by a project pediatrician for venereal disease and pregnancy and to reassure them that, despite the abuse, they are "okay." A project counselor will stay with the child throughout the exam if the child wishes. The medical protocol developed by the project instructs all hospital physicians in child-oriented techniques of examination--for example, holding the child on the doctor's lap rather than examining her on the table. Emergency cases are briefly counseled by a trained social worker in the emergency room, who also schedules an appointment for the child and family with project staff within the next day or two.

1.4.2 Counseling and Therapy

In Seattle, all six project counselors are experienced, master's level social workers, who share a firm belief that the child's needs are of paramount importance. Because half of the children they see have been abused by someone in the same household, protection of the child from repeated abuse is critical.

Counselors work closely with caseworkers from the state's Children's Protective Services (CPS). CPS has three key responsibilities: (1) to substantiate reports of child abuse; (2) to develop a plan for dealing with the medical and emotional consequences suffered by the victim; and (3) to protect the child from further abuse, which might entail petitioning the court for a no-contact order or placing the child outside the home.

Individual counseling for victims and non-offending family members focuses primarily on ensuring the child's continuing protection, addressing the impact of the abuse on the child's life, and above all, making sure that the child understands that the abuse was not her fault. Project staff also lead counseling groups for adolescent victims and for mothers of incest victims.

Project counselors in Seattle do not treat offenders because, they say, to do so would interfere with their advocacy for the child. Instead, offenders are referred to other therapists identified by the project. Project counselors maintain close contact with offender therapists to coordinate the family's treatment and to support reconciliation if the family so desires.

In Washington, D.C., the project director is a registered nurse/public health administrator. Counseling staff include a clinical psychologist, a master's level psychiatric nurse, and three master's level social workers. Staff view the child victim as their principal client, although counseling usually includes other family members.

Play therapy is the key to communicating with children. Through dolls, stories, and art, victims are able to describe the abuse and express their feelings. Cases are reviewed at weekly staff meetings and each counselor receives clinical supervision from the appropriate disciplinary department in the hospital.

The project's orientation is primarily crisis intervention and therapy, although victims involved in legal proceedings are counseled until their cases reach final disposition. Because complex incest cases require more extensive therapy, they are frequently referred to the Psychiatry Department. The project recently received a grant from the National Center on

Child Abuse and Neglect to provide counseling to intrafamily juvenile sex offenders.

1.4.3 Support and Encouragement in Prosecution

The D.C. project is legally required to report cases of child sexual abuse to police. The staff willingly comply with this requirement, for three reasons: (1) victims or families may be unwilling to report the abuse themselves; (2) in the District of Columbia, only the police have the authority to remove a child or offender from the home; and (3) staff believe the offender should be held accountable to the victim and the community for his conduct. In Seattle, the project staff report cases of intrafamily abuse to Children's Protective Services, which, in turn, files a report with police. The Seattle counselors have observed that sex offenders tend to resist voluntary treatment and are likely to commit additional offenses. Thus, they encourage the victim and her family to prosecute with the goal of obtaining court-ordered treatment for the offender.

In Washington, D.C., victims and their families are guided through the complexities of the legal system by the project's full-time criminal justice specialist, an attorney. The specialist advises project staff on such issues as whether a certain child is legally competent to testify or whether a case is strong enough to be prosecuted. For cases that are prosecuted, the specialist accompanies the victim through every phase of the prosecution, preparing her in advance of each proceeding and explaining the outcome. By virtue of formal agreements with police and prosecutors and a special order from the Juvenile Court, the criminal justice specialist also tracks cases as they progress through the system. To ensure that child victims receive the utmost attention and understanding, the project has provided extensive training to police officers and prosecutors. All of the city's criminal justice and social service agencies are represented on the project's Community Advisory Council, which helped to develop the project's training curriculum.

In Seattle, project counselors accompany their child clients to all criminal justice proceedings. Project training has been incorporated into the curriculum of the State Police Academy; prosecutors, probation officers, and other criminal justice and social service personnel also receive training periodically. Project staff also have worked to introduce new techniques and attitudes to criminal justice and social service personnel. These innovations are all geared toward easing the victim's trauma:

- Police and prosecutors conduct joint interviews to relieve the child from the traditional burden of telling her story so many times to so many people. Written interview guidelines prepared by the project explain the several stages of child development, and outline approaches to questioning that are appropriate to each stage.

- All child sexual abuse cases are prosecuted by a single deputy prosecutor from beginning to end.

- The project has been credited with persuading the prosecutor's office and Children's Protective Services to establish special sexual abuse units.

The Seattle project's most valued accomplishment is the network it has created among agencies involved in treating and prosecuting cases of child sexual abuse. Representatives of the prosecutor's Special Assault Unit, the Sexual Abuse Unit of Children's Protective Services, the Seattle and King County Police Departments, and other service agencies meet weekly with Sexual Assault Center staff at the prosecutor's office to review and discuss individual cases currently being processed, to identify problems in case processing and suggest solutions, and, most important, to encourage and reinforce mutual understanding of what needs to be done for both victims and offenders in cases of child sexual abuse.

1.4.4 Community Outreach

Both projects do more than provide after-the-fact intervention and therapy. Project staff in both cities maintain a heavy schedule of public speaking engagements in which they describe the problem of child sexual abuse and the projects' approaches to treatment through lectures, brochures, and films. In Seattle, counselors take their program into the schools, where a special film and brochure are presented to children.

Both projects have extended their outreach to professionals in the medical, criminal justice, and social service fields. The D.C. project hosted the first national conference on the subject of child sexual abuse, attended by more than 200 professionals. The Seattle project has conducted workshops and community forums in many communities across the country and received a grant from the National Center on Child Abuse and Neglect to operate a regional Treatment-Training Institute.

1.4.5 Project Accomplishments

The achievements of both the Seattle and D.C. projects are noteworthy:

Washington, D.C.

- The number of victims referred to the project increased nearly 30 percent over the three years of project operations.

- A growing number of requests for information and case consultation suggests that the project is recognized as an expert resource among professionals in related fields.

- The project has developed a model curriculum for training criminal justice, social service, health care, and mental health personnel. Those who have participated in the project's extensive training say that it has improved their interviews and rapport with child victims and their families.

- The project's use of diagnosed gonorrhea as a possible indicator of abuse is an innovation in the field.

- The Medical-Legal Sexual Assault Evidence Form designed by the project was adopted by the D.C. police for adult sexual assault cases as well as child cases.

- The project has devised a system that allows, for the first time, careful tracking of cases through the criminal and juvenile justice systems.

- A full-time Director of Research is compiling a comprehensive data base on child sexual abuse victims. Numerous reports and papers based on the project's findings have been published and presented at professional conferences.

Seattle, Washington

- The project succeeded in forming a cohesive, supportive network among the key agencies involved in treating and prosecuting cases of child sexual abuse.

- The project is credited with the institution of several new investigative procedures that accommodate the special needs of the child victim.

- While conviction rates have remained uniformly high (80 to 90 percent) since project inception, the number of cases filed and disposed of in the King County courts has more than doubled, from 82 in 1978 to 193 in 1980.

- Families' increased willingness to prosecute can be attributed at least in part to the realistic prospect of treatment of the offender--not incarceration--as the final outcome. Recent figures show that only 14 percent of convicted adult offenders are imprisoned, 19 percent are committed to inpatient treatment, and the remainder are sentenced to probation or jail-based work release on condition of treatment from a community-based therapist.

- The availability of offender therapy resources in the Seattle community can be traced to the project's efforts to locate and develop qualified experts. The courts' acceptance of therapy as a sentencing option can be attributed to the project's successful advocacy.

Both projects have experienced increasing caseloads, a tribute to their success in informing the public of their services and in persuading reluctant families to seek help. Perhaps an even greater tribute, though, is the fact that both projects are continuing with local support. By the end of 1980, both projects had completed their terms of LEAA funding. In Seattle, the Sexual Assault Center is supported by a number of contributors: the State of Washington, the City of Seattle, Harborview Medical Center, a research grant from the National Institute of Mental Health, and most recently, a $170,000 award from the National Center on Child Abuse and Neglect to establish a regional Treatment-Training Institute.

The D.C. project has a similar array of funding sources: Children's Hospital National Medical Center, a $50,000 NCCAN grant to treat juvenile sex offenders, $40,000 in private foundation funds and, in fiscal year 1982, a $100,000 appropriation from the District of Columbia. The project has instituted a third party billing system which is expected to cover nearly one-third of its total costs.

1.5 Guide to the Manual

Each Exemplary Project is described fully in a separate section of the manual, but, as shown below, the chapters in the two sections correspond to one another to allow readers to contrast various features and draw their own conclusions as to which are most applicable in their communities.

The first section presents the approach taken by the Sexual Assault Center in Seattle. Chapter 2 traces the history of its special Child Victim/Witness Project, explains the project's philosophy toward treatment, and presents its funding history. Chapter 3 describes organizational structure and staff composition. Chapter 4 details the medical care and counseling services provided. Chapter 5 explains the project's relationship to child protection agencies and criminal and juvenile justice agencies in King County, focusing on the tight network that was created among them to serve the needs of child victims. Finally, Chapter 6 discusses the various strategies employed by the project to reach the general public and professionals in related fields.

The second section, which presents the approach of the D.C. Child Protection Center-Special Unit, is similarly structured. Chapter 7 describes its establishment as a special focus of the pre-existing Child Protection Center,

presents its philosophy and goals, and discusses its funding sources. Chapter 8 describes the project's organization, staffing, and internal training procedures. Chapter 9 presents the program's treatment approach, from initial medical examination to counseling, including decisions on case termination and referrals. Chapter 10 discusses the project's involvement with Child Protective Services and the criminal and juvenile justice systems in the District of Columbia. Chapter 11 describes the project's community outreach efforts and its professional training activities.

The manual then turns to a more general discussion of evaluation and monitoring practices (Chapter 12) and replication issues (Chapter 13).

Chapter 12 suggests a number of goals that are relevant to child sexual abuse victim assistance programs, offers ways of measuring a project's achievement of those goals, and presents the accomplishments of the Sexual Assault Center and Child Protection Center-Special Unit. The chapter also contains a brief discussion of routine data collection for purposes of monitoring caseloads and day-to-day activities.

Chapter 13 concludes the manual with a discussion of critical issues to be considered in replicating aspects of the Exemplary Projects. Topics that are covered include the legal environment, program affiliation, interagency coordination, professional training, and sources of funding.

No attempt is made in this manual to compare the Sexual Assault Center to the Child Protection Center-Special Unit (or to any other program of this genre) or to suggest that one approach is preferable over another. Indeed, the literature in this area is insufficient to support any such comparisons. The reader should recognize that the Sexual Assault Center and Child Protection Center-Special Unit are only two of many programs currently operating to serve child victims of sexual abuse. Other approaches may be equally valid.[4] By identifying and documenting the achievements of these two Exemplary Projects, this manual is intended to provoke serious thought about alternative strategies for assisting children who have been sexually abused.

[4] Additional information may be available from the National Center on Child Abuse and Neglect which is currently supporting many such programs. Write to: Children's Bureau, NCCAN, P.O. Box 1182, Washington, D.C. 20013.

THE SEXUAL ASSAULT CENTER, SEATTLE, WASHINGTON

CHAPTER 2: PROJECT DEVELOPMENT AND APPROACH TO TREATMENT

The Child Victim/Witness Project in Seattle developed out of the Sexual Assault Center, a rape victim assistance program that began operating in 1973. Over the years, the Sexual Assault Center treated a growing number of child victims. Staff became increasingly aware of problems unique to children and began to identify ways of resolving these problems. Putting these solutions to the test was the initial purpose of the special project. This chapter briefly traces the development of the Child Victim/Witness Project, describes its philosophy toward treating cases of child sexual abuse, and discusses the project's funding history.

2.1 Treatment of Child Victims Prior to Project Inception

Little is known about the official response to child victims of sexual abuse in Seattle--or anywhere--in years prior to the creation of a special project to treat them. However, a study conducted by a University of Washington law student in 1975 offered a view of case processing once an incident of child sexual abuse was reported to police in King County:[1]

A police officer visited the victim at the crime scene or at her home, interviewed her briefly, and prepared a report of the incident. By the next day, this report would be followed up by a detective from the department's morals unit, who again visited the child to interview her in greater depth. The detective would then prepare the case and file it with the Prosecuting Attorney's Office, where it would be assigned to one of seven or eight deputy prosecutors who specialized in morals cases. Again, the victim was interviewed. At any time the victim might be referred for medical treatment, counseling, or to Children's Protective Services; each such referral, of course, resulted in yet another telling of the incident. Case files did not indicate the frequency of such referrals.[2]

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[1] Christine McKenna, "A Study in King County of Child Victims of Sexual Assault." Unpublished manuscript, University of Washington, 1975.

[2] Pretrial release data were reported only for the 24 incest suspects in the sample. All were released on bond or personal recognizance, providing the defendant stay away from the victim. Case files did not indicate the extent of compliance with these no-contact orders.

Half the 94 cases studied[3] involved a preliminary hearing in which the child confronted her offender, testified, and was cross-examined. More than one-third of the offenders (37 percent) were charged with indecent liberties; less frequently charged were rape (20 percent), carnal knowledge (18 percent), sodomy (12 percent), soliciting a minor (eight percent), assault (one percent), and other offenses (unspecified, four percent). Seventeen, or 28 percent, of the cases went to trial, which, of course, entailed multiple interviews, a courtroom appearance, testimony, and cross-examination. Eighty-one of the 94 offenders (86 percent) were convicted either by guilty plea or trial (four defendants were acquitted and nine cases were dismissed). Of the 81 convicted offenders, 67 percent were convicted on a lesser charge.

Convicted offenders received the following sentences: 16 were sentenced to jail or prison, eight were committed to Western State Hospital's Sexual Psychopath Program, 48 received deferred sentences (in which sentencing is delayed pending the outcome of the defendant's adherence to certain conditions for a specified period), and 11 received suspended sentences.[4] Conditions were usually attached both to the deferred and suspended sentences; for example, the offender might be prohibited from seeing the victim, or he might be required to stay sober and employed or to report for outpatient therapy as recommended by a court-appointed psychiatrist. Case files did not record the offenders' compliance with these conditions.

The research report noted two problems in particular with the above proceedings: (1) child victims were required to repeat their stories anywhere from two to six or more times; and (2) while these cases were handled by members of morals units, police and prosecutors in those units lacked training in child development and behavior. These observations prompted the following recommendations:

- Police agencies should appoint a youth officer responsible for all investigations of child sexual abuse cases.
- This individual should receive specialized training in problems of child behavior through courses in counseling, social work, or child psychology.

[3]The King County Prosecutor's Office actually handled far more than 94 child victims and sexual offenses. The study was based on the prosecutor's files of sexual assault cases in which the victim was 18 years old or younger. Frequently, case files included more than one victim, defendant, offense, or charge; in these instances, information was recorded only on the first victim listed and on the offense which gave rise to the final count filed by the prosecutor.

[4]The study reports 81 convictions and 83 sentences but does not explain the cause of this discrepancy.

- The first interview with the child should be taped to obviate the need for additional interviews.
- The child should be referred for counseling within 24 hours of the report; in incest cases, the entire family should be referred.
- A Family Counseling Center should be created to treat incest cases, to serve as an advocate for child victims in criminal justice proceedings, and to monitor the defendant's behavior on pretrial release.
- The youth officer should also serve as an advocate and accompany the child during all prosecutor interviews.

In advancing these proposals, the report cautioned that the police and child protection agencies could in many cases be working at cross-purposes: "The coordination necessary to effectuate both investigation and child welfare would be difficult."[5]

As that report was being prepared, the Sexual Assault Center, located in the Harborview Medical Center, was handling increasing numbers of child victims. Created primarily to serve adult rape victims, the Sexual Assault Center had never publicized a special interest in treating children under age 16. Still, the Center treated eight children in its first three months of operation (September-December 1973), 79 in 1974, 110 in 1975, and 156 in 1976--a 97 percent increase over three years.

Early in 1977, the Director of Social Services in Harborview Medical Center learned of the Law Enforcement Assistance Administration's Family Violence Program, which was to include two demonstration projects explicitly for child victims of sexual abuse. In January 1977, Sexual Assault Center staff submitted a proposal, citing their own experience with child victims as well as the findings of the 1975 study just reviewed. In this proposal, they observed that while most child victims and their families are interested in prosecution, many decline to press charges because of the damage that they feel might result from pursuing the case through the criminal justice system. To increase reporting of child sexual abuse and improve conviction rates, it was argued, steps must be taken to relieve the victims' trauma and to ease their way through legal proceedings.

[5]McKenna, "A Study in King County," p. 45.

2.2 Philosophy and Goal Statement

Sexual Assault Center staff maintain that victim treatment and criminal prosecution are both important components of their program, regardless of the relationship between the victim and offender. To them, the child's needs are paramount. Counseling should be provided for an indefinite period. Also, a victim's family may be unable to recognize and articulate the child's needs, and may be unaware of available resources to help. In such cases, the support of an experienced social services advocate is critical.

Protection of the child from future abuse is vital in cases of intrafamily abuse, or incest. Unlike many mental health professionals, Center staff conceptualize incest as an outlet for the offender's sexual behavior disorder, not as a symptom of family dysfunction, and argue that the offender must assume full responsibility for his behavior. But the Center's primary motivation for supporting criminal prosecution is not the prospect of punishment for the offender, but of treatment. Center staff maintain that only the courts wield the clout necessary to keep a sex offender in treatment. The Sexual Assault Center does not itself provide services to offenders because, they say, to do so would interfere with their advocacy for the children. Instead, offenders are referred to local therapists identified by the Center and recommended to the court.

The Center's initial grant proposal to LEAA was ambitious. Much of what they proposed to accomplish was predicated on their past experience with both adult and child victims. Indeed, some of the suggested activities were already in place for adult victims and needed only to be extended to child victims. The goals, related objectives, and suggested activities were enunciated in the initial proposal as follows:

Goal A: To increase the rate of reporting incidents of sexual abuse of children

Objectives:

- to increase community awareness of the problem; and
- to increase community awareness of the resources to cope with the problem.

The activities proposed to meet these objectives included: reaching a general audience through pamphlets, media appearances, and speaking engagements; providing information on child sexual abuse to educators and personnel from medical and social service agencies; and creating a community network to facilitate the referral of appropriate cases to the Sexual Assault Center. The extent to which the Center has undertaken these activities, and the degree of the Center's success in achieving Goal A and its related objectives, are addressed in Chapter 6.

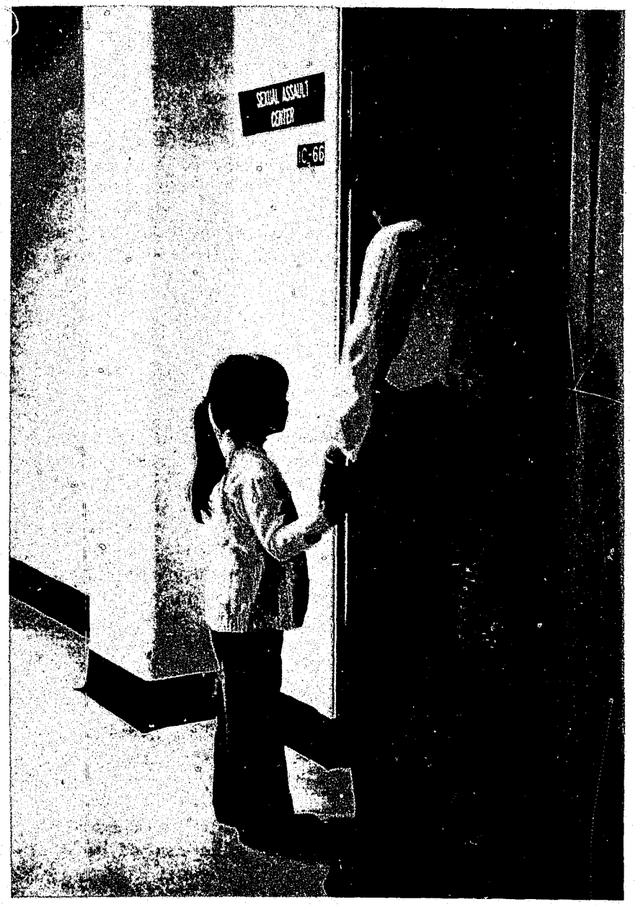
Goal B: To maintain the cooperation of the victims and their families throughout criminal justice system prosecution efforts

Objectives:

- to provide sensitive medical care for sexually assaulted children and obtain forensic evidence;
- to provide crisis intervention and supportive counseling services to sexually abused children and their families;
- to provide criminal justice system personnel with training in child development and in the social and psychological nature of the crime of child molestation; and
- to research and develop new procedures for accommodating child victim/witnesses within the criminal justice system.

The activities proposed to meet the objectives listed under Goal B included: employment of a staff pediatrician to examine child victims, monitor their continuing medical needs, and train other physicians at the hospital and in the community; development of counseling protocols for Center staff that incorporate advocacy for the child in any criminal justice proceedings; and provision of training for police and prosecutors in the medical, social, and psychological ramifications of child sexual abuse. Finally, a team composed of Center staff, police, and prosecutor representatives would be created to consider the following proposed innovations:

- instituting special protocols for handling child victims in the hospital, police department, and King County Prosecuting Attorney's Office;
- minimizing the length of time between initial reporting of sexual abuse and interviews with police and prosecutor;
- providing a less intimidating physical setting for interviewing the child victim;
- minimizing the number of interviews for purposes of investigation and prosecution and the number of different persons who interview the child witness;
- videotaping the initial interview with the child for use by criminal justice system personnel who need to evaluate the child's ability to testify;
- having a special "child courtroom" for preliminary hearings and trials; and



Child victims and their families receive a broad range of services from the Sexual Assault Center in Harborview Medical Center. Photo by Charlie Kirry, Harborview Medical Center

- appointing a child advocate to represent and protect the child victim/witness throughout the prosecution process.

These suggestions closely parallel the recommendations made in the 1975 report on case processing in King County. And, as Chapters 4, 5, and 6 will demonstrate, many have since been implemented.

2.3 Funding History

In October 1977, the Sexual Assault Center launched its Child Victim/Witness Project with a $90,000 award from LEAA. The level of funding requested had been predicated on the expectation that 100 children would be treated by the project in its first year. However, by the end of February 1978--halfway through the grant year--the project had already treated 133 children and projected that a total of 300 would be seen before the grant year ended.

In March 1978, the project requested supplemental funding in the amount of $80,115. This award allowed the Center to hire additional counselors and supported occasional use of legal, law enforcement, and psychiatric consultants. The greatest proportion of the supplemental funds ($54,000) supported the production of the project's film, Double Jeopardy, described in Chapter 6. In the project's second and third years, its LEAA funding increased to $166,081 and $193,657, respectively. These increases partially reflected the project's commitment to provide technical assistance to 21 demonstration sites of LEAA's Family Violence initiative.

While LEAA provided substantial support, the project had access to additional financial resources as well. The Child Victim/Witness Project has always been viewed as a fully integrated subgroup of the Sexual Assault Center, and LEAA monies were pooled with funds from other contributors. At the time this manual was written, the Center received funding from federal, state, and local sources, as follows:

The National Institute of Mental Health awarded the Center a two-year grant to examine the post-rape experiences of adult victims in situations where drugs or alcohol had been used either by the victim or her assailant. This grant provided $130,034 in its first year (July 1979 through June 1980) and $152,462 in its second (through June 1981).

In July 1980, the National Center on Child Abuse and Neglect, a division of the U.S. Department of Health and Human Services, awarded $170,000 to the Sexual Assault Center to establish a regional Treatment-Training Institute to provide periodic training to selected individuals from ten states.

The state of Washington's Department of Social and Health Services awarded two separate contracts to the Center in 1981. The first, in the amount of $54,414, allows the Center to provide training and consultation to seven communities outside King County. A one-day workshop in each community focuses on the Center's approach to "networking" (described in Chapter 5) and counseling for child victims and their families; a two-day workshop will be held for persons who provide substitute care for children (e.g., foster parents). A $28,542 contract from the same Department supports the preparation of an educational packet, including a 20-minute videotape, for medical personnel that explains how to care for sexual assault victims, collect medical evidence, and utilize the packet for their own training of other medical staff.

The City of Seattle has partially funded the Center since its inception in 1973. Under this contract, the Center provides direct counseling and advocacy services to adult and child rape victims and their families, training to medical professionals in Harborview Medical Center, and educational programs for various community groups and agencies. In calendar year 1980, the city provided $156,600 to the Center, and $180,550 is budgeted for 1981. These awards include funds for subcontracting to the local rape crisis center, which operates a telephone hotline and provides victim accompaniment services.

In the last half of 1980, the Center was awarded $17,000 from King County to assist the county's Youth Service Bureaus in forming support groups for adolescent sexual assault victims.

Finally, Harborview Medical Center itself supports some of the Center's administrative and counseling activities. Its support amounted to $31,835 in fiscal 1980 (July 1979-June 1980) and $47,578 in fiscal 1981.

The bulk of the Center's revenues are used to pay staff salaries. The Center pays no rent for its space in Harborview Medical Center. Other expenses, such as consultant fees or travel, are incurred in executing the work supported by particular grants; for example, travel costs were incurred in performing the technical assistance required during the second and third years of the LEAA grant.

The diversity of the Center's funding sources provides the Center with greater stability as some sources constrict and others expand. Many grants are of short duration, but because they overlap considerably, and because the Center has had some assurance of stable support from the city and the medical center, the Center has never been financially hard-pressed. Moreover, each grant has allowed the Center to expand its own scope of activities and enhance its value to the community.

However, the complexity of the Sexual Assault Center's finances makes it extremely difficult to isolate the costs of providing direct services--counseling and advocacy--to sexual assault victims. All counseling staff are involved in public education, professional training, technical assistance, and research activities in addition to their counseling caseload, and they do not record the fraction of time spent on such indirect services. Nor is it possible to isolate the cost of treating child vs. adult victims, because, as noted above, the Child Victim/Witness Project has always been fully integrated with the Sexual Assault Center, not only in terms of finances, but in practice as well. All counseling staff work with adults and children alike and do not record the proportion of their time spent with each.

LEAA funding of the Child Victim/Witness Project expired in September 1980, but the services for child victims initiated under the grant have become routine for Sexual Assault Center staff. While the Sexual Assault Center continues to treat both adults and children, it has gained national prominence recently for its child victim program. The remainder of this manual refers to the project as the Sexual Assault Center, as it is known in the field, but focuses solely on the Center's activities regarding child victims.

CHAPTER 3: STAFFING AND CLIENT PROFILE

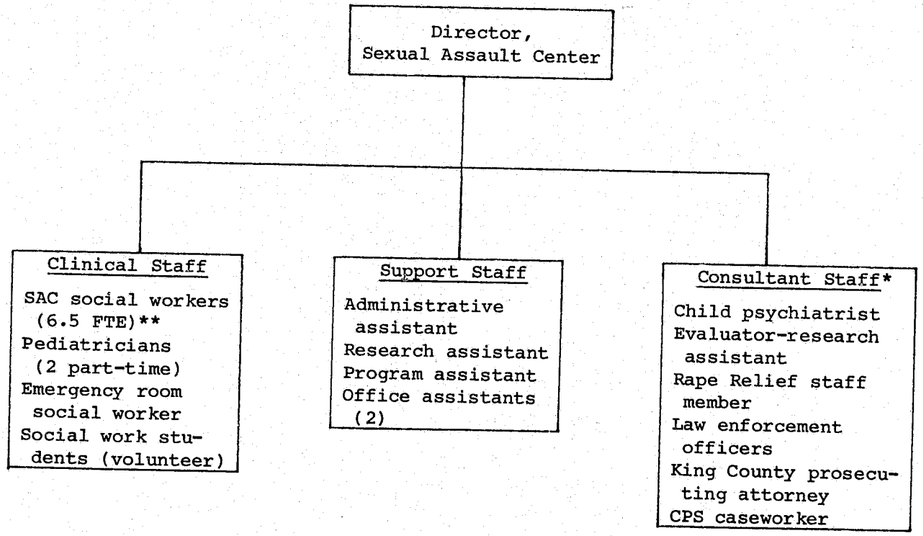
3.1 Staff Composition

As depicted in the organization chart in Figure 3.1, the Sexual Assault Center operates with a relatively small core staff. Its 6.5 (full-time equivalent) counselors are all experienced, master's level social workers. The director is also a social worker (MSW) with considerable clinical and administrative experience. Center funds also support an emergency room social worker who is specially trained to provide crisis intervention counseling to emergency victims of sexual abuse. The Center's counseling staff is occasionally supplemented by second-year graduate students from the University of Washington's School of Social Work. Also on the Center's payroll are two part-time pediatricians who are members of the hospital's Pediatrics Department, but work exclusively with the Sexual Assault Center. Six administrative/clerical positions complete the Center's staffing arrangement.

All counseling staff provide crisis intervention, short- and long-term therapy to adult and child sexual assault victims and their families. In addition, they often intercede in behalf of their clients with various criminal justice and social service agencies in the Seattle area. All are involved to some extent in planning and conducting community education and professional training programs. Some may pursue individual interests as well. For example, one staff social worker was primarily responsible for the Center's NIMH grant to study the role of alcohol or drug use in rape incidents and how substance abuse affects the victim's subsequent recovery. She took the lead in writing the grant proposal and continues to play a major role in performing the research.

The two pediatricians on the Center staff supervise resident physicians who provide direct patient care to many of the child victims. They are also responsible for training medical personnel, pediatric residents, and medical students at Harborview Medical Center, at other local hospitals, and in private practice to recognize symptoms or indicators of sexual abuse, to conduct thorough and sensitive examinations of child victims, and to gather the necessary evidence for legal purposes. One of the pediatricians had worked with the Center to develop the Child Victim/Witness Project and developed the medical protocol now being used by physicians in numerous locales. This individual is often called upon in court as an expert witness

Figure 3.1
Sexual Assault Center Organization Chart



*Not listed are additional consultants retained for purposes relating only to adult clients.
**Full-time equivalent.

on medical issues pertaining to child sexual abuse and has been an integral member of the project's technical assistance team.

As shown in Figure 3.1 above, the Center augments its core staff with several consultants. Some have fairly explicit, well-defined roles:

- the psychiatric consultants evaluate certain child clients as ordered by the court or requested by Center counselors;
- the evaluators were retained under the LEAA grant to assess the Child Victim/Witness Project's achievements; and
- the "rape relief" consultant is a paid employee of Seattle Rape Relief, an organization that provides a hotline and peer support primarily for adult sexual assault victims; however, the Sexual Assault Center occasionally calls on this group for assistance in community outreach programs, victim transportation, and court accompaniment of child victims.

The consultant positions from the Seattle and King County Police Departments, Children's Protective Services, and the King County Prosecuting Attorney's Office were retained under the LEAA grant for a more general purpose: to meet as a team with the Sexual Assault Center staff to develop and institute new techniques to make criminal justice proceedings less threatening to the child victim, and to participate in technical assistance presentations around the country. Because team members' work with the new project would not be part of their routine job requirements and they would have to meet on their own time, the Center staff felt that the best way to ensure continuing participation was to develop a contract and pay each team member a consultant fee. Now that the LEAA grant has expired, the Sexual Assault Center can no longer compensate these people for their participation in the weekly meetings. Over the years, however, the team members have formed a friendly alliance among themselves, and the rewards they receive from each other as a voluntary "support group" will sustain their continuing involvement. The various methods used by the Sexual Assault Center to achieve interagency coordination are described more fully in Chapter 13.

3.2 Staff Recruitment and Training

Because the Sexual Assault Center is located in Harborview Medical Center, which is a teaching hospital of the University of Washington, all Center staff are recruited through the University. Job listings are formally posted, and the hospital's personnel department conducts the initial screening of all applicants. At a minimum, project counselors must be master's

The child's home may be a more comfortable setting for a counseling session. Photo by Charlie Kirry, Harborview Medical Center

level social workers with some related experience. Interviews with job applicants focus on clinical skills, attitudes and beliefs about sexual assault, and whether they are comfortable working both with child and adult victims. Applicants are told they must be able to deal with the crisis atmosphere that pervades the Center's day-to-day activities. They are also forewarned that conflicts may arise in their attempts to advocate for clients within other agencies, but that they must be persistent.

The Sexual Assault Center has experienced relatively little turnover among its counseling staff. Consequently, when a new counselor is hired--typically, upon award of a new grant or contract--training is provided on a highly personalized level. Initial orientation to the Center and its activities consists of assigned readings on topics of child development, sexual abuse, and the criminal justice system; observation of veteran Center staff during counseling sessions; and an introduction to the other agencies with which the Center works. This orientation period continues for about one month.

The new counselor then assumes a limited caseload under close supervision from a senior counselor for another six months. Case charts, on which the counselor records the actions taken in the course of therapy, are used to monitor the counselor's performance. Weekly staff meetings provide a forum for advice, consultation, and ongoing training for the counseling staff, as well as discussion of more general issues pertaining to the Center, such as the need for more physical space or the Center's approach to upcoming funding opportunities.

3.3 Client Profile

The Sexual Assault Center serves anyone alleged to have been sexually assaulted or abused. While the Center technically serves only King County, approximately ten percent of its clients reside elsewhere.

Child sexual assault or abuse is defined by the Center as "overt sexual contact between an adult and a child, or between a child and a person who is significantly older or larger, or where force is used." For the purposes of case management and statistics, a child is defined as being age 16 or younger. Since 1978, the first full year in which the Center received funding for the Child Victim/Witness Project, child victims have accounted for more than half of the Center's total caseload, 53 percent in 1980.

Table 3.1 on the following page presents descriptive data for the child victims treated by the Sexual Assault Center. Eighty-three percent of the victims are girls, and 17 percent are boys. Thirty-eight percent of the victims are 13 to 16 years old, 62 percent are under age 13; 17 percent

Table 3.1
Child Victim Characteristics, 1980:
Sexual Assault Center

Victim Characteristics	Number	Percent		
Total Victims	730			
Sex:				
Males	124	(17%)		
Females	606	(83%)		
Age:				
0-4 years	127	(17%)		
5-8 years	172	(24%)		
9-12 years	155	(21%)		
13-16 years	275	(38%)		
Unknown	1	(<1%)		
Race:				
Caucasian	551	(76%)		
Black	60	(8%)		
Spanish American	10	(1%)		
Native American	16	(2%)		
Asian	5	(1%)		
Other	18	(2%)		
Unknown	70	(10%)		
Relationship to Offender:				
Intrafamily	373	(51%)		
Natural parent			129	(18%)
Step-parent			103	(14%)
Other parental figure*			78	(11%)
Other relative**			63	(9%)
Non-family	326	(46%)		
Acquaintance			229	(31%)
Stranger			97	(13%)
Unknown	31	(4%)		

*Adoptive or foster parent, parent's partner, grandparent.
**Uncle, sibling, cousin, other relative.

Source: Sexual Assault Center Statistics, January-December 1980.

are not yet five years old. Child sexual abuse occurs among all ethnic groups, in proportions that resemble the ethnic breakdown of Seattle generally[1]: 87 percent white, seven percent black, one percent Native American, four percent Asian, and one percent "other." Table 3.1 also indicates that approximately half of the Center's child clients are victims of intrafamily abuse, where the perpetrator is a parental figure or relative. Only 13 percent were abused by strangers.

Center staff collected data on the nature of the coercion and abuse suffered by 677 child victims treated by the Center between October 1977 and July 1979 (see Table 3.2). These data show that a significant proportion of these children were subjected to actual or threatened physical force, and that the nature of abuse spanned the full range of sexual behaviors.

Table 3.2
Nature of Coercion and Abuse
Inflicted Upon Child Victims:
Sexual Assault Center

Nature of Abusive Incident	Number	Percent
Total Victims	677	
Nature of Coercion		
Used force	180	27%
Force threatened	99	15%
Adult coercion	280	41%
Tangible enticements	34	5%
Other	21	3%
Unknown	63	9%
Nature of Abuse (totals more than 100%)		
Genital fondling	353	57%
Vaginal intercourse	203	33%
Oral-genital contact	169	27%
Attempted intercourse	120	19%
Forced masturbation	72	12%
Digital penetration	61	10%
Anal intercourse	49	8%

Source: Sexual Assault Center Statistics, October 1977-June 1979.

[1] U.S. Department of Commerce, Social and Economic Statistics Administration, Bureau of the Census, 1970 Census of Population, Vol. 1: Characteristics of the Population, part 49, Washington, p. 49-55.

The Center also has found that child clients are likely to suffer repeated incidents of abuse, especially if the offender is a family member. Table 3.3 below shows that, in 1980, 82 percent of incest victims suffered repeated incidents of abuse, compared to 29 percent of non-incest victims treated by the Center. Conversely, fully half of the non-incest victims suffered a single incident by a single assailant, compared to only 10 percent of incest victims.

Table 3.3
Number of Assailants and Number of Incidents
Reported by Child Victims, 1980:
Sexual Assault Center

	All Child Victims		Incest Victims		Non-Incest Victims	
Multiple Incidents						
Single assailant	353	(48%)	276	(74%)	77	(22%)
Multiple assailants	54	(7%)	30	(8%)	24	(7%)
	407	(56%)*	306	(82%)	101	(28%)*
Single Incident						
Single assailant	216	(30%)	37	(10%)	179	(50%)
Multiple assailants	27	(4%)	5	(1%)	22	(6%)
	243	(33%)*	42	(11%)	201	(56%)
Unreported	80	(11%)	25	(7%)	55	(15%)
TOTAL	730		373		357	

*Errors due to rounding.

Source: Sexual Assault Center Statistics, January-December 1980.

In sum, the Sexual Assault Center treats a large number of children who have suffered various forms of sexual abuse, often at the hands of a family member. Victims are both male and female and come from all ethnic groups. Most children seen at the Center are pre-adolescent; some are mere infants. Like adult rape victims, children are often subjected to a range of sexual acts, often committed by force or the threat of force. The victims are likely to have suffered repeated incidents. Chapter 4 describes the clinical services provided to these children by Sexual Assault Center staff.

CHAPTER 4: CLINICAL SERVICES

This chapter focuses on the Sexual Assault Center's approach to clinical treatment for child victims of sexual abuse. It describes the medical examination and continuing care provided by Center pediatricians and presents the counseling techniques employed by the Center's social workers. The Center's intervention with offender therapists and social service and criminal justice agencies is discussed in Chapter 5.

4.1 Referral Sources

Child victims of sexual abuse are referred to the Sexual Assault Center from a number of sources. Table 4.1 lists referral sources for 1980, distinguishing between incest and non-incest victims. Overall, most child victims were referred by law enforcement agencies (18 percent) and Children's Protective Services (34 percent). Incest cases were more likely than non-incest cases to come from Children's Protective Services (CPS), which is consistent with that agency's mandate to receive reports of intrafamily abuse and neglect. Conversely, non-incest victims were more likely than incest victims to be referred by police.

Virtually all cases of child sexual abuse occurring in the Seattle vicinity and reported to police or CPS are referred to the Sexual Assault Center for treatment. The director of CPS' Sexual Abuse Unit estimates that 95 percent of her Unit's cases are shared with the Center. Officers in the Seattle and King County Police Departments routinely refer and transport victims to the Sexual Assault Center. Officers of the Bellevue Police Department, the third major law enforcement agency in the area, do not typically transport victims to the Center since there is a closer emergency room in their jurisdiction, but they do inform victims and families of the Center's services.

4.2 Overview of Client Services

Once a child sexual abuse victim is referred to the Sexual Assault Center, whether by telephone or in person, a full range of treatment services becomes available. These services fall into three general categories: medical care,

Table 4.1
Referral Sources for Child Victims, 1980:
Sexual Assault Center

	Total Victims		Incest Victims		Non-Incest Victims	
Children's Protective Services (CPS)	251	(34%)	192	(52%)	59	(17%)
Police	129	(18%)	24	(6%)	105	(29%)
Family of client	72	(10%)	34	(9%)	38	(11%)
Social service agency	54	(7%)	30	(8%)	24	(7%)
Other medical facility	53	(7%)	31	(8%)	22	(6%)
Friend or neighbor	33	(5%)	13	(4%)	20	(6%)
Self	34	(5%)	10	(3%)	24	(7%)
Prosecutor	27	(4%)	8	(2%)	19	(5%)
Rape Relief (volunteer organization)	23	(3%)	3	(1%)	20	(6%)
Other	25	(3%)	15	(4%)	10	(3%)
Unknown	29	(4%)	13	(4%)	16	(4%)
TOTAL	730		373		357	

Source: Sexual Assault Center Statistics, January-December 1980.

counseling, and legal advocacy. A child victim may receive any or all of the Center's services, depending on what is needed. Table 4.2 below shows the various combinations of services provided by the Sexual Assault Center to child victims in 1980. Virtually all received at least some form of counseling, 41 percent received medical care, and 31 percent received legal advocacy assistance. More detail on each of these services is provided in the sections which follow.

4.2.1 Medical Care

The initial medical examination of a child sexual abuse victim serves three purposes. From a medical standpoint, the primary purpose is to detect injuries, pregnancy, or venereal disease that may have resulted from the abuse. From a law enforcement standpoint, the initial exam is critical for collecting forensic evidence if the abuse occurred within 48 hours of the exam. (In 1980, only 18 percent of the child victims contacted the Center within 48 hours of the incident.) From a counseling standpoint, it provides an opportunity for the physician to reassure the child and her family that she is not physically "different" from other children because of the sexual abuse.

Table 4.2
Direct Child Client Services, 1980*:
Sexual Assault Center

	Total Child Victims		Incest Victims		Non-Incest Victims	
Counseling only	306	(42%)	173	(46%)	133	(37%)
Counseling and legal advocacy	128	(18%)	68	(18%)	60	(17%)
Medical only	18	(3%)	8	(2%)	10	(3%)
Medical and counseling	185	(25%)	67	(18%)	118	(33%)
Medical, counseling, and legal advocacy	93	(13%)	57	(15%)	36	(10%)
TOTAL	730		373		357	

*The figures in this table refer only to services provided in the calendar month of the client's initial direct contact with the Center.

Source: Sexual Assault Center Statistics, January-December 1980

Only persons whose lives are in danger take priority over child sexual abuse victims who are brought to the emergency room. Social workers are in the emergency room around-the-clock and have been trained by Center staff to respond appropriately to child sexual abuse victims. Typically, the social worker briefly interviews the child and family (or accompanying adult) to assess the nature of the abuse or assault and to determine whether immediate medical treatment is required. If so, the social worker will contact a pediatric resident in the hospital and apprise him or her of the incident so that the child will not need to be questioned again. All hospital residents are trained periodically and supervised by the Sexual Assault Center's pediatricians (see Chapter 6), making them sensitive to the child's medical and emotional needs and fully aware of the evidentiary requirements for criminal investigation.

Emergency room procedures apply only to 17 percent of the Center's child victims. The remainder have no immediate medical trauma and go directly to the Sexual Assault Center for counseling. Still, unless the child has been examined by a private physician or clinic, the Center schedules a routine medical exam through the hospital's outpatient Pediatrics Clinic. An examining room designated for sexual assault victims (adult and child) is equipped for collecting the necessary medical evidence and conducting a gynecological exam. A medical protocol designed by the Center's staff pediatrician (see Appendix A-1) guides the examination and instructs the physician to use the least intrusive techniques possible. For example, if external signs and the child's report show no apparent evidence of attempted vaginal penetration, there is no need to subject the child to a complete vaginal examination. The

physician may hold a small child on his or her lap rather than making the child lie down on the table. If the child desires, the emergency room social worker will remain with her throughout the exam. If injuries are present, they are photographed as legal evidence of abuse.

According to the Center's protocol, the child is routinely scheduled for a follow-up exam after one week to test for gonorrhea, and again after eight weeks to test for syphilis. The emergency room social worker arranges for the child to meet with a counselor from the Sexual Assault Center, usually within a day or two, and the Center counselor is responsible for monitoring the child's compliance with the follow-up examinations.

Forty-one percent of the children treated by the Center in 1980 received medical care at Harborview Medical Center (see Table 4.2 above). Non-incest victims were more likely than incest victims to receive medical care at Harborview (46 percent vs. 35 percent respectively). This is because nonfamily cases tend to involve single, violent assaults, compared to the prolonged abuse which typifies an incestuous situation. Also, Center staff have observed that increasing numbers of child sexual abuse victims are being treated by private physicians or community clinics. Staff pediatricians have done extensive outreach to these groups to ensure that these children are properly diagnosed and treated and to encourage physicians to collect medical evidence where possible before referring the victims to the Sexual Assault Center for counseling.

4.2.2 Counseling

Regardless of how closely the disclosure of sexual abuse follows the actual event, Sexual Assault Center counselors consider the victims to be in a crisis situation. They provide crisis intervention services, short-term counseling, and long-term therapy in some cases. Individual counseling sessions may be held at the Center or at the victim's home. Centrally located in downtown Seattle, Harborview Medical Center is easily accessible by public transportation.

Center counselors name three major goals of victim therapy: (1) to see that the child is no longer in a potentially dangerous environment; (2) to assist the child in addressing the impact of the incident on her life (this may be impractical for very young children); and (3) to ensure that the victim understands and believes that she was in no way responsible for the abuse and that there is nothing wrong with her. The victim's parents must plan how they will protect the child in the future; they must come to grips with the impact the abuse has had on their own lives; and, in incest cases, they must decide whether they will continue to share a household.

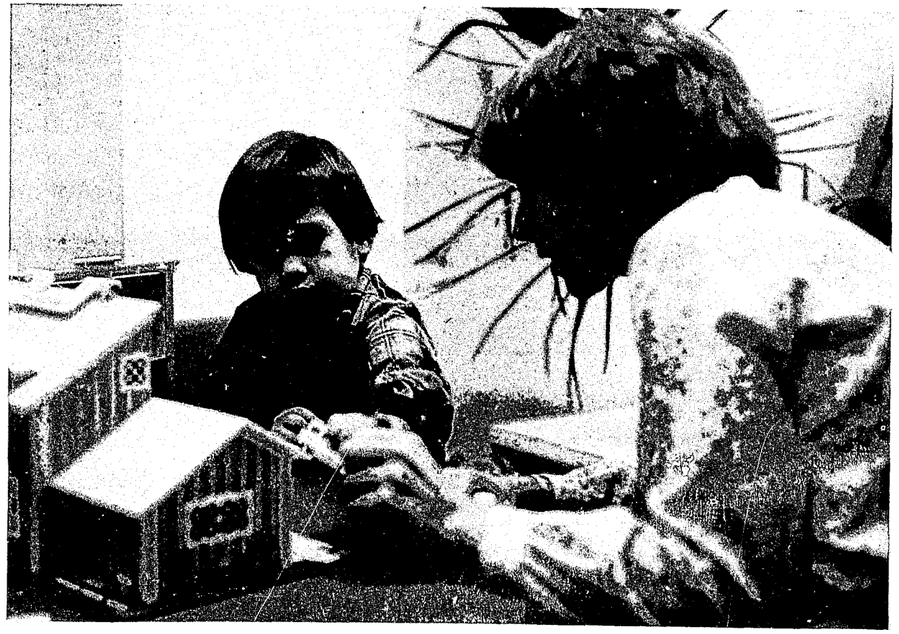
The parents' response to the child's initial disclosure of sexual abuse is usually a critical factor in determining the child's own response. For example, a three-year-old who tells her mother that her babysitter was playing "doctor" with her probably has no awareness of the sexual nature of their "game." If the parents' reaction to this report is strongly negative, the child may begin to blame herself for doing something wrong. The mother's reaction in incest cases is especially critical, for if she chooses to believe that the offender, usually her husband, is not at fault, her daughter is likely to feel confused, guilty, and alone. Consequently, in the initial counseling session, the Center social worker assesses the parents' ability to cope with the situation and to protect the child from further abuse.

The frequency and intensity of counseling depend on several factors. Cases requiring the most immediate and urgent treatment include children in danger of being remolested, children who have no support system other than the Center (i.e., whose parents or guardians do not believe them), and children (or families) who have especially severe reactions to the abusive incident. If the offender shares the household, the first order of business is to separate the child from the offender. State law requires the Sexual Assault Center to report such cases to Children's Protective Services, which then initiates proceedings to assure the child's continued safety. Although Center counselors strongly encourage a report to police in all cases, the decision is reserved for the child and family. (The frequency of reports to CPS and police are discussed in Chapter 5.)

The child's parent or guardian is asked to sign a release of confidentiality form, a request that is only rarely refused. This guarantees that the Center can coordinate with CPS, police, and prosecutors to arrive at a treatment plan that is most advantageous to the child and family. It also means that the Center can discuss the case with offender therapists, compare the offender's version of the incident against the victim's version, and work toward integrating counseling plans for various family members (see Chapter 5).

The Center describes its approach to therapy as "an eclectic one which attempts to meet the victim at her level in respect to her feelings about the abuse."[1] Of course, the techniques are modified according to the victim's age and the nature of the abuse. Although incest victims typically require the most intensive intervention, Center staff also recognize the medical and emotional concerns of the non-incest victim and counsel them accordingly. In all cases, the counselor provides a forum for the victim to express her emotions and to receive encouragement and support, ultimately helping the victim to expiate feelings of guilt, responsibility, and blame. The counselor also introduces and models assertive skills, emphasizing "the victim's right and ability to make decisions for herself about her body and other areas of her life."

[1] University of Washington/Sexual Assault Center, Grant application to the National Center on Child Abuse and Neglect: "Regional Child Sexual Abuse Treatment Training Institute," May 1980.



Small children often use dolls to describe what happened to them.
Photo by Charlie Kirry, Harborview Medical Center

In incest cases, victims often feel that they were to blame for the offender's actions and the subsequent upheaval of the family. The critical goal of therapy is for the victim to understand that she was exploited and that the offender was solely responsible. Therapy with the mother and siblings follows much the same pattern. Early counseling sessions may focus on the logistics of finding food and shelter if the mother and children are leaving home. Once the family's living arrangements are settled, the counselor helps them deal with their feelings of isolation and the effects of the abuse on their lives. Important issues include the family's victimization and the mother's feelings of guilt and responsibility. The counselor helps the mother to understand that her primary role is to protect her children, and that the offender must accept full responsibility for the incest. The counselor then explains the mother's role in encouraging the offender to seek treatment and helps her to assess her options with regard to her marriage or her partner. Center staff have developed several handouts which are given to families to explain the Center's view of sexual abuse as the offender's behavioral problem.

To help victims and families overcome feelings of isolation and "being different," the Center also leads support groups for adolescent victims and for wives or partners of sexual offenders. These groups are conducted by social workers from the Center and an offender therapist is involved in the mothers' group. The Center also helped to plan for additional support groups with the Youth Service Bureaus under a special "mini-grant" from King County: two groups for pre-adolescent victims, two groups for early adolescent victims, two groups for older teens, one group for sexually abused boys, and one for siblings of victims. Finally, a highly structured, six-week support group is offered for adult women who were molested as children.

Individual and group therapy will continue for as long as the client desires or as required by the court or Children's Protective Services. The Center makes it a firm policy to allow the victim to guide the course of therapy in terms of length of treatment, although staff will sometimes encourage clients to continue their therapy. The average length of treatment depends on the type of case, and can range from several weeks to over a year.

Occasionally, the Center will refer victims who appear to be severely disturbed to a psychologist or psychiatrist for evaluation, diagnosis, and treatment. Sometimes the court or the child's attorney will request such an evaluation. For some cases, the distance between a child's home and the Sexual Assault Center may preclude frequent visits, either at the Center or at the child's home, so Center counselors will refer the family to therapists who are more conveniently located. Through the Center's outreach and training activities, they have identified therapists and counselors throughout Washington state whose approach to treatment is consonant with that of the Center, and feel comfortable referring families when it is necessary. Still, Center counselors often maintain contact with these counselors, particularly if the child or other family members attend group sessions at the Center or if the offender is in treatment and the family intends to reunite.

4.3 Summary of Clinical Approach

To a certain extent, the Sexual Assault Center has adopted a fairly traditional social work approach to victim treatment that emphasizes individual and group counseling, identification of social service needs and the resources to fill them, and intervention with appropriate agencies and bureaucracies on behalf of their clients. But a major point of departure from many victim treatment programs, particularly those treating incest cases, is the Center's decision not to treat offenders as part of the family unit. Instead, the Center has actively sought to identify, develop, and coordinate with experienced sex offender therapists. Reconstitution of the family, if desired, is not attempted until all are assured that the offender is sufficiently rehabilitated, the victim fully understands that she was not to blame, and the mother understands the significance of her role in protecting the child. A second major point of departure in the Sexual Assault Center's approach is the degree of its involvement with the criminal justice system, as described in the following chapter.

CHAPTER 5: COORDINATION WITH OTHER AGENCIES

In many communities, child protection agencies and law enforcement agencies appear to work at cross-purposes: the child protection workers attempt to keep families intact wherever possible, and law enforcement officers attempt to apprehend offenders and bring them to justice. These goals tend to conflict when the offender is a family member. Through effective advocacy, the Sexual Assault Center has succeeded in convincing child protection and criminal justice personnel that they do, indeed, share a common goal: namely, to protect the child victim and other potential victims from future abuse. Center staff believe strongly that the criminal justice system's clout is vital in ensuring that offenders receive treatment and that children are protected. Also described in this chapter are the ways in which victim and offender treatment plans are coordinated for incestuous families wishing to reunite. Together, the Sexual Assault Center, Children's Protective Services, key criminal justice agencies, and offender therapists have developed a system of case processing that benefits everyone--especially the child.

5.1 Coordination with Children's Protective Services

Under Washington state's child abuse and neglect statutes, Children's Protective Services (CPS) is the agency mandated to receive all reports of child abuse perpetrated by a caretaker or parental figure, including intra-family sexual abuse. CPS is then responsible for investigating the report to determine whether abuse did, in fact, occur and whether the child is in a threatening environment. This investigation is typically completed within four weeks. If CPS finds that the child was sexually abused, they may petition the Juvenile Court for a no-contact order on the offender. If the victim's mother appears unable to protect her child from continuing abuse, or if the offender does not comply with the no-contact order, CPS can petition the Juvenile Court for an order removing the child from the home, temporarily or permanently. This latter action is taken only as a last resort, for two reasons. First, separating the victim from the family in this way may suggest to the child that she is to blame for the abuse. Second, Center staff cite incidents where the father, left in the home after the victim was placed elsewhere, molests other children in the family.

Upon finding that abuse or neglect has occurred, the Juvenile Court may impose orders requiring the offender, victim, or other family members to undergo treatment. CPS is responsible for monitoring the family's compliance with the court's orders and for seeing that the family receives the necessary mental health and social services. While CPS does provide some counseling services directly, most families are referred to other agencies for specialized care, housing assistance, income supplements, and other emergency support. CPS intervention terminates when the caseworker believes there is no further danger to the child.

King County is served by five CPS units, each responsible for a certain geographical jurisdiction. However, in November 1979, the CPS Sexual Abuse Unit, consisting of five social workers, was established exclusively to handle cases of sexual abuse in Seattle. (Sexual abuse victims residing elsewhere in King County are still treated by the appropriate geographic unit.) This new unit owes its existence largely to advocacy efforts of the Sexual Assault Center and the unit's supervisor, who has worked closely with the Center over the years and shares its philosophy and approach to treatment.

The referrals between the Sexual Assault Center and CPS are reciprocal. As mandated by law, cases that come first to the attention of the Sexual Assault Center are reported to CPS for investigation, necessary protective actions, and development of a treatment plan, which may include assistance with temporary shelter or income in addition to various forms of counseling.[1] In 1980, 82 percent of the Center's incest cases were reported to CPS. In turn, cases that are reported first to CPS are almost invariably referred to the Sexual Assault Center for medical care, counseling, and legal advocacy services. The supervisor of the CPS Sexual Abuse Unit estimates that her unit sees approximately 45 new cases per month, and that nearly all of them are also clients of the Sexual Assault Center.

Together, the CPS Sexual Abuse Unit supervisor and Center staff developed a standard protocol (see Appendix A-2) which instructs the CPS caseworker to notify police after a report of intrafamily sexual abuse has been substantiated to the caseworker's satisfaction. A special form ensures that police receive standard information on each referral. The protocol also delineates the respective responsibilities of CPS and police investigations: the CPS caseworker focuses solely on the child victim and other non-offending family members; the assigned police detective is responsible for interviewing the alleged offender and for investigating any criminal activity.

[1] Included in the 18 percent of incest cases not reported to CPS are cases involving a relative not residing in the child's home (such as an uncle or cousin) where Center staff have determined that the abuse is not likely to recur, and cases involving an older sibling, which do not mandate a report to CPS or police under Washington law. Still, nearly one-fifth of the incest cases not reported to CPS were reported to police for investigation.

5.2 Coordination with the Criminal Justice System

5.2.1 Law Enforcement Agencies

Washington law mandates that incidents of child sexual abuse be reported to either law enforcement authorities or CPS. While the Sexual Assault Center routinely reports to CPS all cases involving a caretaker or parental figure, its policy regarding reports to police in any case, regardless of the relationship between victim and offender, is to leave the decision to the victim and family. In 1980, 56 percent of the Center's child cases were reported to police.

Of the 26 law enforcement agencies in King County, three are significant to the Sexual Assault Center in terms of the volume of child sexual abuse cases reported: the King County, Seattle, and Bellevue Police Departments.[2] The Center has developed comfortable relationships with each, and each department has adopted many of the Center's suggestions for improving their response to child victims.

Center staff had long enjoyed a friendly rapport with detectives in the King County Police Department's Sex Crimes Unit, by virtue of their earlier work to improve services for adult rape victims. Consequently, these detectives were receptive to the suggestions offered by project staff to limit the number of interviews required of the child victim. The result was the joint police/prosecutor interview, described in Section 5.2.3 below.

Recently, the King County Sheriff centralized his department, a move opposed by the Sexual Assault Center because it dissolved the Sex Crimes Unit. The Center met with the Sheriff and later with County officials in an attempt to reinstate the Unit. Shortly thereafter, the three detectives who had comprised the Sex Crimes Unit were assigned to a new unit which, although it is not called a Sex Crimes Unit, continues to handle sexual assault cases in King County.

In its early years, the Sexual Assault Center experienced considerable difficulty in formulating a rapport with the Seattle Police Department. Various commanding officers within the department had not been receptive to the suggestions of Center staff or other community agencies. The Center persisted in efforts to reach the Police Department by documenting the problem in

[2] The Seattle and Bellevue Police Departments are responsible for law enforcement within their respective city limits; the King County Department is responsible for enforcement in unincorporated areas and municipalities that do not have their own departments.

reports to local, state, and federal agencies. Soon, the Center was asked to meet with top officials in the Police Department. A new sergeant was assigned to the Sex Crimes Unit, and he has since become a key member of the child sexual abuse treatment network in Seattle. This sergeant assisted in developing a guide for interviewing child victims of sexual abuse (see Appendix A-3 and discussion below) and has instituted joint police/prosecutor interviews for cases originating in Seattle.

The third large law enforcement agency in King County is the Bellevue Police Department. Bellevue officers routinely inform child victims and their families of the services available from the Sexual Assault Center, but distance prevents them from transporting the families to the Center directly. Through frequent contacts on individual cases, Center staff have developed a comfortable rapport with officers from this department.

5.2.2 King County Prosecuting Attorney's Office

If the family chooses to press charges, the King County Prosecuting Attorney's Office, Special Assault Unit, handles the case. The Chief of this unit credits the Sexual Assault Center with instigating its creation in November 1979. Some time previously, the Prosecuting Attorney's Office had instituted a sexual assault screening unit. Because such cases often resulted in guilty pleas and rarely went to trial, assignment to this unit was perceived as good "training" for new attorneys with little trial experience and low caseloads. Counselors from the Sexual Assault Center and Seattle Rape Relief sponsored training sessions for the prosecutors and recommended instituting special procedures especially for child victims. With the strong internal support of several newly hired female attorneys, the Prosecuting Attorney's Office implemented prosecution for sexual assault victims age 12 and under.

Soon the Office saw a large surge of these cases. It became evident that in order to implement vertical prosecution on a large scale, and to apply the procedures to all sexual assault cases, a separate Special Assault Unit would be needed. Today, the Unit is staffed by eight deputy prosecutors who handle all adult and child sexual abuse cases (and other child abuse cases) in King County.

5.2.3 Case Processing

The point at which case processing "begins" depends on which agency receives the initial report of child sexual abuse. If it is the Sexual Assault Center, the case might never be reported to a law enforcement agency because, although Center staff strongly encourage a report to police, the decision is

left with the family. However, if the case involves intrafamily abuse, the Center is mandated by law to report the case to CPS, which in turn notifies police according to their protocol. If CPS receives the initial report, the sequence of events is as described above in Section 5.1. If Seattle or King County Police are the first to receive a report of child sexual abuse, the officer responding to the call briefly interviews the child or parent at the scene (usually their home) and informs them of the services available from the Sexual Assault Center.

If the facts warrant and the family is cooperative with continuing investigation, a detective will arrange for a meeting in which the child and parent will be interviewed by the detective and prosecuting attorney. (In intrafamily cases, the detective notifies CPS as well.) A Center counselor usually accompanies the child to the joint police/prosecutor interview and to any subsequent proceedings.

This interview is conducted in a special room at the prosecutor's office which has child-sized furniture, toys, and books. A one-way mirror allows others (CPS or parents, for example) to observe the interview without intruding. The prosecutor usually leads the questioning, assisted by the interview guide designed by the project, which suggests questions that are appropriate to children at different developmental stages. This attorney will handle the case until final disposition. Like the joint interview and use of the one-way mirror, this innovation reduces the need for repeated questioning. Indeed, because most cases result in guilty pleas and there is no trial, the initial interview of the child is often the only one required.

For the small fraction of cases that go to trial, the Sexual Assault Center provides additional support services. A counselor accompanies the child and family to all court proceedings, preparing them in advance and debriefing them afterwards. Although the "hearsay" rule precludes them from testifying on behalf of the child, Center counselors and pediatricians frequently serve as expert witnesses. Several information packets have been developed to supplement the expert testimony, including research on: the life span of sperm, anal assault, characteristics of sexual abuse victims, and Rape Trauma Syndrome. The Special Assault Unit Chief gives enormous credit to the Center for maintaining the family's interest and willingness to pursue prosecution, supporting them throughout the process and even beyond final disposition. Center staff are frequently asked to contribute their suggestions for treatment or incarceration to the prosecutor's sentencing recommendation to the court, and the Special Assault Unit Chief notes a relatively high degree of concurrence with the Center's recommendations among judges.

The Sexual Assault Center also takes the lead in generating and maintaining high levels of enthusiasm among the social service and criminal justice professionals involved with these cases. Each week, representatives of the prosecutor's Special Assault Unit, Seattle and King County Police Departments, Children's Protective Services, Seattle Rape Relief, and the Sexual

Artwork can be used to assess the child's progress in therapy. Photo by Charlie Kirry, Harborview Medical Center

Assault Center meet at the prosecutor's office. While these meetings are guided by no formal agenda, they are central to the Center's success in introducing innovations to agencies that are traditionally reluctant to accept change. During a typical meeting, for example, the ten or twelve persons present discussed a case of child sexual abuse reported on a nearby military base; the prosecutor had contacted the Special Assault Unit of the King County Prosecuting Attorney's Office for advice. Another topic at that meeting was the recent sentence imposed on a juvenile who had been convicted of sexually assaulting several women and girls. Sexual Assault Center staff were disappointed that this offender, whom they believed needed residential treatment, had been returned to the community on probation, and the entire team discussed ways of enhancing their involvement in Juvenile Court decisions.

To summarize, the Sexual Assault Center can be credited with helping to develop and implement several innovations in the handling of child victims of sexual abuse:

- joint interviews by police and prosecutors;
- a children's interviewing room at the prosecutor's office equipped with a one-way mirror;
- vertical prosecution;
- the Special Assault Unit in the prosecutor's office;
- the Sexual Abuse Unit in Children's Protective Services;
- standard protocols for reciprocal referrals among police, CPS, and the Sexual Assault Center;
- an interview guide that suggests appropriate questions for children at different developmental levels; and
- weekly meetings of all personnel who are involved in handling these cases.

The Center's approach has created a team of professionals from agencies that historically have been isolated, joining them in a common effort to help child victims and offenders.

5.3 Coordination with the Juvenile Justice System

The Sexual Assault Center to date has had less success in instituting change within the juvenile justice system. Child sexual abuse cases in which the alleged offender is a juvenile are investigated by the juvenile divisions of

the respective police departments. Center staff report that officers in these divisions remain unconvinced of the Center's approach--particularly the need for offenders to receive treatment--and, therefore, are less cooperative in referring these cases to the Sexual Assault Center. In the Seattle Police Department, the Chief of the Sex Crimes Unit has proposed that all sexual abuse cases involving a child victim be assigned to his unit, regardless of the alleged offender's age. Center staff are also attempting to resolve the problem by working more closely with individual officers in these divisions.

Similar difficulties characterize the Center's interaction with attorneys in the Juvenile Division of the King County Prosecuting Attorney's Office. This division has not yet implemented the joint interviews and vertical prosecution that characterize the Special Assault Unit's approach. However, office policy requires attorneys to rotate through the various divisions every six months. To date, three attorneys who had worked with the Special Assault Unit have since been transferred into the Juvenile Division. They have high expectations of bringing the innovations of the Special Assault Unit along with them.

5.4 Outcomes of Prosecution

The charges that most frequently apply to child sexual abuse cases are statutory rape, forcible rape, indecent liberties, and incest. All are felonies. Conviction on the more serious charges of statutory and forcible rape carries a mandatory sentence of up to 10 years either in prison or in Western State Hospital's inpatient sex offender program. Victims and families in incest cases are often reluctant to pursue these charges, for two reasons: (1) many do not want the offender to be incarcerated, and (2) such cases are more likely to go to trial, thus increasing the tension for the child. Incest is rarely charged because it requires proof of a blood relationship and carries the minimum penalty of the sex offenses. Consequently, particularly in intrafamily cases, an initial rape charge is often reduced to the lesser offense of indecent liberties. Because conviction on a charge of indecent liberties is more likely to carry a sentence of probation on condition of treatment, this outcome supports the Sexual Assault Center's goal of obtaining treatment for offenders. Cases that are not reduced to lesser charges are typically violent stranger assaults. Center staff clearly recognize that such offenders often are inappropriate for treatment in the community and require some form of incarceration.

Table 5.1 displays the outcomes of 215 child sexual abuse cases filed in the King County criminal court in 1980, as of April 1981. Of the 193 cases that had reached final disposition, 72 percent were disposed by guilty plea and 11 percent were convicted at trial, for an overall conviction rate of 83 percent. Six percent of the cases resulted in acquittals and two percent in a hung jury. Nine percent were dismissed before trial, for reasons including death of the defendant, parent noncooperation, and failure of the child to

Table 5.1
Disposition of Child Sexual Abuse Cases
Filed in 1980, as of April 1981
King County, Washington

	Intrafamily Abuse	Nonfamily Abuse	Total
TOTAL CASES FILED	120	95	215
Cases Pending	12	10	22
Total Cases Disposed	108	85	193
Hung jury, not retried	2 (2%)	1 (1%)	3 (2%)
Acquittals	7 (6%)	5 (6%)	12 (6%)
Dismissals before trial	12 (11%)	5 (6%)	17 (9%)
Guilty Pleas	79 (73%)	61 (72%)	140 (72%)
Felony	75	57	132
Misdemeanor as charged*	2	1	3
Reduced misdemeanor	2	3	5
Insanity plea	0	0	0
Convictions at trial	8 (7%)	13 (15%)	21 (11%)
Felony	8	12	20
Lesser misdemeanor	0	1	1
Total Conviction Rate	81%	87%	83%
Trial Rate	16%	22%	19%

*The applicable misdemeanor offense is communication with a minor for immoral purposes.

Source: Special Assault Unit Statistics, King County Prosecuting Attorney's Office.

satisfy tests of competency as a witness. The Special Assault Unit Chief points out that the nine percent dismissal rate for child sexual abuse cases is lower than the rate for adult sexual assault cases, which is 14 percent.

The table also identifies some variations in outcome between intrafamily and nonfamily cases. Nonfamily cases were more likely to go to trial, and the outcome of trial was more often conviction than it was for intrafamily cases. It is important to recall, though, that even though an intrafamily case may be acquitted in criminal court, the family may still fall under the auspices of the Juvenile Court which can order therapy upon risk of having the child removed from the home. The Special Assault Unit Chief observed that intrafamily cases experience lesser success at trial because juries and some judges are reluctant either to believe a child who accuses a parent of sexual abuse, or to intervene in a family by finding the parent guilty. To counteract this problem, prosecutors are relying more heavily on expert witnesses to educate juries about the facts of child sexual abuse, and are lobbying for legislative changes to the hearsay rule whereby the victim's counselor could testify regarding the facts of the case as related by the child.

Before sentencing a convicted sex offender, the court frequently will order a psychiatric or psychological evaluation to determine whether the offender is a sexual psychopath under Washington law.[3] The law defines a sexual psychopath as a person whose sexual behavior or proclivities render him (or her) a "menace to the health or safety of others" and sets forth explicit criteria for assessing whether an offender should be so classified. Those who are ruled "sexual psychopaths" by the court may be committed to Western State Hospital, an inpatient mental health facility, for a 90-day evaluation. If this assessment concludes that the offenders do not present a risk to the community, they are generally sentenced to probation or jail work-release on condition of treatment; sexual psychopaths who are found to be too dangerous to be in the community, yet amenable to treatment, will be sentenced to inpatient treatment at Western State for two to three years. Those who resist treatment are sentenced to prison. Generally, offenders who do not present a risk to the community are evaluated locally and receive treatment as part of a probation or work-release plan without undergoing the Western State evaluation.

As shown in Table 5.2 below, only 14 percent of adults convicted of charges relating to child sexual abuse in 1980 were sentenced to jail or prison. Nineteen percent were committed to Western State Hospital for inpatient treatment. By far the majority of convicted adult offenders (67 percent) were sentenced to probation or a jail work-release program on condition of treatment in the community. Intrafamily offenders were more likely than nonfamily offenders to receive a sentence that incorporates treatment (74 percent and 59 percent, respectively). The King County Probation Department

[3] R.C.W. Chapter 71.06.

Table 5.2
Sentencing Outcomes of Child Sexual Abuse Cases
Filed in 1980 and Sentenced as of April 1981
King County, Washington*

	Intrafamily Abuse	Nonfamily Abuse	Total
Total Sentences	80	75	155
Treatment only	18 (23%)	11 (15%)	29 (19%)
Treatment + jail time (work-release)	41 (51%)	33 (44%)	74 (48%)
Straight jail (< 1 year)	0 (--)	4 (5%)	4 (2%)
Inpatient treatment (Western State)	13 (16%)	17 (23%)	30 (19%)
Prison (> 1 year)	8 (10%)	10 (13%)	18 (12%)

*Initial sentence only. Does not reflect offenders who fail to comply with community treatment requirements and are later sentenced to imprisonment or residential care.

Source: Special Assault Unit Statistics, King County Prosecuting Attorney's Office.

monitors the offenders' compliance with community-based sentences and can recommend that the court reconsider the sentence if the offender fails to comply. The Special Assault Unit does not keep data on the frequency of such recommendations.

While statistics are not available for juveniles prosecuted for child sexual abuse, the sentencing options resemble those available for adult offenders: incarceration, probation on condition of treatment in the community, and commitment to a residential treatment facility. The Adolescent Clinic, run by the University of Washington, was the first treatment program in the country exclusively for juvenile sex offenders. The Clinic treats a mixed outpatient population of voluntary clients and those under court order. Directors of the Adolescent Clinic recently developed an inpatient program for juvenile sex offenders at a residential facility; a second juvenile residential program is in the planning stages.

The Sexual Assault Center played a key role in expanding the use of treatment programs as a sentencing option for sex offenders. Center staff worked to identify mental health counselors and therapists who shared their philosophy of child sexual abuse and to develop their treatment programs through

educational support and referrals. The Center's suggested referrals for convicted offenders are often incorporated into the prosecutor's sentencing recommendation to the court, which usually concurs. As a result of the Center's developmental efforts, there are a number of specialized, experienced community-based programs and private therapists to whom sex offenders may be referred in the King County area.

All offender treatment resources recommended by the Sexual Assault Center require their clients to sign a blanket release of confidentiality. It is absolutely critical for the offender therapist to know the victim's perspective in order to deal effectively with the offender. Conversely, victims and families are often quite concerned about the offender, and information about his progress in therapy can help to enhance their own progress. Center counselors maintain regular contact with offender therapists, sharing information with them and with family members, monitoring the progress of therapy, determining when the offender and family are ready for visits and when they are ready to reunite, if that is their goal.

5.5 Summary of Coordination Activities

The Sexual Assault Center has assumed a "catalyst" role in working with and mediating between criminal justice and social service agencies--agencies which traditionally have worked independently of each other and, at times, at cross-purposes. The level of interagency coordination achieved in Seattle is exemplified by the supportive weekly meetings among police officers, prosecutors, CPS caseworkers, and Center counselors. Moreover, the Center has succeeded in identifying a range of offender treatment facilities in the Seattle area, and has worked with them towards common criteria for offender placement and treatment decisions. As a result of the Center's extensive advocacy efforts on behalf of sexually abused children, professionals who work with child sexual abuse cases in Seattle now share a philosophy and approach to treatment that benefits victims and offenders alike.

CHAPTER 6: COMMUNITY OUTREACH ACTIVITIES

Outreach to the general public and the professional community has always been an integral part of the Sexual Assault Center's efforts to help child victims of sexual abuse or assault. If the public at-large remains unaware of special services offered by the project, many children in need will go unaided and project resources will be underutilized. Outreach to professionals is equally critical, because they may be the first to see victims and their families. They must learn to recognize signs of abuse and to empathize with child victims and families if their intervention is to be helpful. Moreover, professionals in related fields are likely to be referral sources for the project, and their support is vital to the project's operations.

6.1 Community Awareness

From the Sexual Assault Center's perspective, the ultimate goal of community awareness activities is to increase reporting rates, thereby funnelling a greater number of child victims, family members, and offenders into treatment. In its initial proposal to LEAA, the Sexual Assault Center described a two-pronged approach that still applies today. The first element is directed toward the lay population to explain the scope of the problem, how to recognize indicators of child sexual abuse, and what to do if abuse is suspected. The second component is designed for professionals--teachers, school nurses, physicians, and mental health personnel. It focuses largely on how to identify victims and encourages the audience to refer suspected cases to the Center for treatment.

Community outreach is accomplished in various ways, including radio and television appearances, newspaper features, and distribution of Center-developed brochures and handouts. The brochures are designed for different audiences, but all serve to introduce the Sexual Assault Center and its approach to treatment. To date, four brochures have been produced:

- "What if your child has been sexually molested . . ." (for parents of victims);
- "The sexually abused child and the law" (for families considering prosecution);

- "The hardest crisis a woman may ever face" (for mothers/ wives); and
- "This pamphlet is for you" (for child victims).

The brochure for child victims is reproduced in Appendix A-4. The Center also distributes several handouts which explain in greater detail the Center's philosophy and approach to treatment, e.g., "Sexual Abuse Within the Family" and "Sexual Abuse of Children--The Offender."

All counseling staff accept speaking engagements with community groups throughout the Seattle/King County area and sometimes beyond. These presentations typically involve a general discussion, distribution of Center brochures and other reading materials, and the screening of several short films that graphically illustrate the many problems associated with child sexual abuse and its treatment. At one recent presentation for school counselors, three films were shown (all were commercially produced):

The first film demonstrated the absurdity of cross-examinations in rape trials[1] that force the victim to justify her actions as though she were on trial. The second film documented a "rap" session of four young women who had been incest victims as children[2]; each woman described her feelings then and now and explored how the experience has affected her adult life.

The third film is intended for potential child victims themselves.[3] Its theme is simply that the child has the right to say "no," even to an adult, even to a parent. This concept is foreign to many children who are taught to obey their elders without question. Because the film is shown to children as young as four or five, it is instructive to describe its approach to this very sensitive topic.

The film shows three scenarios of attempted sexual abuse. The first is a stranger in the playground, offering money to a small boy if he will go for a ride in the man's car. Fortunately, the boy calls to his older brother, who tells the man to go away and later calls the police. The message is clear and familiar to most children: never accept anything from a stranger.

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[1] Rape: A New Perspective. Produced by Summerhill Productions, Inc., available through Motorola Teleprograms Inc., 7 min., color.

[2] Incest: The Victim Nobody Believes. Produced by the J. Gary Mitchell Film Company, San Anselmo, CA, 20 min., color.

[3] Child Molestation: When to Say No. Aims Instructional Media Services, Inc., Glendale, CA, 20 min., color.

In the second scenario, a friendly neighbor invites a ten-year-old girl to his apartment. Even though she is acquainted with the man, the girl is immediately suspicious. She says that her mother would disapprove, and after some verbal interchange she runs home, frightened. She tells her mother, who reports the man to a local child abuse hotline. In the postscript, we learn that a police check revealed the man to be a known child molester in other communities, and that he is eventually hospitalized for treatment.

The third scenario is a case of intrafamily abuse perpetrated by a stepfather. He and the young girl are home alone watching television when he reaches out and pulls her toward him. The little girl tries to fend him off, and he twists her arm. There are no blatant sexual advances. When the mother returns, she takes her daughter to a hospital to have her arm examined and explains to her that the stepfather is a sick man.

Film presentations are followed by group discussion and a question-answer period. The counselor describes the services provided by the Sexual Assault Center and provides a list of names and telephone numbers for other local contacts--child abuse and rape hotlines, Children's Protective Services, and nearby therapists and clinics.

The schools have always been a primary target of the Center's public awareness campaigns. Center staff believe that this may ultimately be the most effective strategy for preventing child sexual abuse. Only by alerting the children themselves to their rights, the nature of the threat, and the resources available to help them can such a hidden offense be prevented. To ensure that parents and faculty understand the need to broach this discomforting topic with children, and that they are prepared to answer some difficult questions the children may raise, the Center's school program is conducted in a sequence of three presentations. The first is for the parents (Parent-Teacher-Student Association), the second is for teachers and counselors, and the third presentation is for the children themselves. The Center reports that its school presentations reached approximately 6,000 persons over the three years of LEAA funding, and the program is continuing on a limited basis.

6.2 Professional Training

Professional training activities have always occupied a high priority position within the Sexual Assault Center's victim assistance program. Through their work with individual cases and the associated daily contacts with social workers, mental health counselors, medical personnel, and professionals in criminal justice agencies, Center staff are closely attuned to problems that may arise in the treatment of child victims. And, because the Center's interdisciplinary training program is ongoing and routine for most agencies that are directly concerned with cases of child sexual abuse, the

Center can tailor its training efforts to resolve these problems quickly. Although the Center does not formally evaluate its training program, staff counselors believe that victims and families are receiving better treatment from these agencies than they had in the past. This section describes the Center's approach to professional training.

6.2.1 Criminal Justice Training

> [T]he narrative account of a four-year-old tends to be rambling and disjointed, containing both relevant and irrelevant details. S/he entertains one thought at any given moment and cannot conceive of multiple thoughts as an integrated whole. For the four-year-old, concepts of time, space, and distance are personalized and not logical and orderly. It is apparent that the abilities of the pre-school child fall far short of the traditional requirements which the legal system has for witness performance, and there is nothing that can be done to make a four-year-old participate like an adult witness would.[4]

This excerpt from the Sexual Assault Center's initial grant proposal to LEAA fully captures the need for training among criminal justice personnel. Learning to tailor questions to a child's developmental stage is critical, because the child's statement is frequently the strongest--if not the only--evidence to support a criminal prosecution. Cases of child sexual abuse rarely have witness testimony or physical evidence to corroborate the child's testimony. Furthermore, intrafamily cases are typically exacerbated by internal strife that may inhibit the child and foster a lack of cooperation. Thus, in order to make the most of a child's testimony, and to fashion the best case possible, police and prosecutors alike must learn to deal effectively with troubled children and sometimes with equally troubled families. Presentations for criminal justice personnel generally cover the following topics:

- nature, incidence, prevalence, causes, and consequences of child sexual assault;
- identification, diagnosis, and treatment of child victims;
- crisis intervention;
- interviewing the child victim and the family;

[4] Sexual Assault Center, "The Sexually Abused Child as a Victim/Witness," grant proposal to the Law Enforcement Assistance Administration, 1977, p. 10.

- family dynamics of child sexual assault;
- child development;
- criminal and juvenile justice systems as they relate to child sexual assault; and
- medical examination.

In the first year of LEAA funding (October 1977-September 1978), the Center made 11 presentations to 141 personnel, including police sergeants, juvenile detectives, and guardian ad litems for the Juvenile Court (individuals named to represent the child in abuse/neglect proceedings). In the project's second year, Sexual Assault Center training became a formal part of the training program for all new police recruits at the Washington Police Academy. In both years, Center staff were key speakers at overnight retreats for deputy prosecutors and police detectives that were co-sponsored by Seattle Rape Relief and the King County Prosecuting Attorney's Office. In the third year, the Center added the King County Probation and Parole Department to its list of target agencies for training. Over the three years of LEAA support, the Sexual Assault Center reached nearly 2,800 criminal justice personnel in the State of Washington. Still, counselors point to the daily dialogue between themselves and various agency members as perhaps the most effective means of enhancing their knowledge of child sexual abuse.

To accompany its professional training efforts, the Sexual Assault Center developed and produced two films. Child Abuse: Police Intervention[5] is specifically designed for training police in effective techniques of interviewing abused children. The other film, Double Jeopardy,[6] is broader in scope and is used in virtually all professional training and technical assistance provided by the Center. It is generally not screened at community presentations because its approach assumes that the audience is knowledgeable of the criminal justice system.

Double Jeopardy presents the Center's approach to victim treatment and its emphasis on prosecution of the offender. The film portrays several scenarios of a child victim's experience in the criminal justice system:

- The police detective who interviews the child demands an accurate, to-the-minute chronology of events, not realizing that young children are incapable of providing such an account.

[5] Child Abuse: Police Intervention. Available through Motorola Teleprograms Inc., color.

[6] Double Jeopardy. Produced by Cavalcade Productions Inc., available through Motorola Teleprograms Inc., 40 minutes, color.

- The detective's manner is brusque and disinterested. He is repeatedly interrupted by telephone calls and cannot follow the child's story.

- The prosecutor uses language that is incomprehensible to the child. He is insensitive to the child's intellectual abilities and, like the detective, appears uncomfortable with the subject matter.

While these examples may be exaggerated in the film, they amply demonstrate why many families are reluctant to subject their children to the ordeal of criminal prosecution.

Double Jeopardy also provides examples of cases processed with Sexual Assault Center intervention. One victim whose case goes to trial is counseled and accompanied at every stage by a supportive Center staff member. A little boy is interviewed at his home by a police detective and CPS caseworker who talk at the child's level. A pediatrician talks comfortingly to a little girl and allows her to select the gown she will wear during her exam. Throughout the film, the narrator explains the Center's strong emphasis on prosecution and the need for medical, social service, and criminal justice personnel to adapt traditional procedures to the child victim.

The film is accompanied by a discussion guide which poses questions to be considered and discussed by trainees after the presentation. These questions address critical issues raised in the film, for example:

- In one scenario, the child's case is prosecuted by a female attorney. How important do you think this is in eliciting the necessary testimony from the child (and her mother)? Are there potential pitfalls in having a female prosecutor of a male sex offender?

- What reforms could be made in the handling of child sexual abuse cases without jeopardizing the defendant's right to a fair trial?

- After the police/prosecutor interview, there is a discussion with the child of the merits of proceeding with prosecution. Do you think the child is too young for such an experience? How can possible additional trauma to the child be weighed against the hazards of not prosecuting an accused sex offender?

- Is the defendant's presence likely to affect the testimony of a young child? In such cases, should an exception be made to the defendant's right to confront his accusers?

These questions are intended to provoke serious thought about a number of issues germane to the treatment of child sexual abuse victims. Double Jeopardy is highly acclaimed and received a prestigious film-maker's award. It is available commercially for purchase and rental and is also on loan from several child abuse resource centers around the country.

6.2.2 Medical and Social Service Training

Mental health counselors and all new Children's Protective Services caseworkers are routinely introduced to the Center's services and receive periodic training from Center staff. Also, the Center's pediatricians have been particularly active in training medical personnel. Because Harborview Medical Center is a teaching hospital, resident physicians are rotated frequently and training on the medical examination, legal evidence gathering, medical care, and counseling of child sexual abuse victims is provided to each new group. Most of these new physicians eventually set up practice in the Seattle/King County area so that the pool of Seattle physicians who have received specialized training in treating child victims continues to grow. The Center's pediatricians also work with community clinics and other child-serving medical facilities in the area, and most now refer victims to the Center for counseling and advocacy services.

In addition to these formal training sessions, the Sexual Assault Center has sponsored several conferences in the community to educate mental health professionals on the characteristics and treatment of sex offenders, counseling approaches with victims and families, and ways of coordinating with criminal justice agencies. In its second and third years of LEAA funding, the Center provided technical assistance to LEAA Family Violence Projects in 21 locations. At each site, the technical assistance team conducted community forums or workshops that focused primarily on interagency coordination. To present the perspective of each agency involved in the network created in Seattle, the technical assistance team usually consisted of a Sexual Assault Center counselor, a pediatrician, one or more criminal justice personnel, and occasionally a CPS caseworker.

The Center's pediatricians and counselors have also published a number of articles outlining their philosophy and techniques:

Anderson, S., and Kennelly, K., "Sexual abuse: The interface between treatment and the law," presented at the Fourth National Conference on Child Abuse and Neglect, Los Angeles, California, October 1979.

Bach, C., et al., "Adolescent sexual abuse and assault," Journal of Current Adolescent Medicine (January 1980).

Berliner, L., "Child sexual abuse: What happens next?" Victimology: An International Journal (Summer 1977).

Berliner, L., Conte, J., and Nolan, D., "Police and social work cooperation: A key in child sexual assault cases," FBI Law Enforcement Bulletin (March 1980).

Berliner, L., and Stevens, D., "Special techniques for child witnesses," in L. Schultz (ed.), The Sexual Victimology of Youth. Springfield, Ill.: Charles C. Thomas, 1980.

Conte, J., and Berliner, L., "Prosecution of the offender in cases of sexual assault against children," Victimology (1980).

Conte, J., and Berliner, L., "Child sexual abuse: Implications for practice," accepted for publication in Social Casework, 1981.

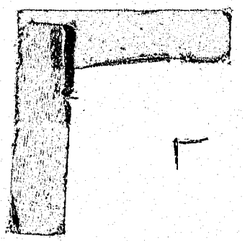
As their titles suggest, these publications address all aspects of the treatment of child sexual abuse victims: medical care, counseling techniques, criminal prosecution of the offender, as well as the coordination that is required among physicians, counselors, and criminal justice personnel.

Based on the Center's demonstrated success in handling child sexual abuse cases and the quality of training it has provided in Washington state, the National Center on Child Abuse and Neglect awarded the Sexual Assault Center a grant to establish one of five Regional Treatment-Training Institutes in the country. Every six weeks, approximately 25 trainees receive instruction and clinical observation at appropriate sites in the Seattle area. Much of the training is provided by representatives of the various agencies tied into the Sexual Assault Center's network, including police agencies, CPS, offender therapists, Seattle Rape Relief, and the King County Prosecuting Attorney's Office. The schedule for the first session of the training institute held in January 1981 is attached in Appendix A-5.

6.3 Summary of Community Outreach Activities

The Sexual Assault Center regards its outreach activities as a critical element of child victim assistance. Community awareness presentations are ongoing in a continuing effort to increase reporting levels so that more victims will seek and receive medical care and counseling. The Center's school program is a preventive measure, designed to alert young children to potential threats and to advise them of where they can get help. Finally, extensive training has ensured that professionals in related fields will recognize indicators of child sexual abuse, know how to interview affected children and their families, and work cooperatively with Center counselors towards a common goal of improved treatment for child victims.

THE CHILD PROTECTION CENTER – SPECIAL UNIT, WASHINGTON, D.C.



CHAPTER 7: PROJECT DEVELOPMENT AND APPROACH TO TREATMENT

As its name suggests, the Child Protection Center-Special Unit emerged from an existing program that treated abused children in need of protection. Over the years, however, the Special Unit has established its own reputation among professionals in Washington, D.C., and beyond who are knowledgeable in the field of child sexual abuse. This chapter summarizes the three-year history of the project, presents its stated philosophy and approach, and discusses its funding sources.

7.1 Treatment of Victims Prior to Project Inception

In 1975, a Child Protection Center was established in Children's Hospital National Medical Center as a demonstration project of the National Center on Child Abuse and Neglect (NCCAN), an agency of the U.S. Department of Health and Human Services (formerly the Department of Health, Education and Welfare). Its purpose was to coordinate medical, counseling, and advocacy services for children who are abused by parents or legal caretakers. As the Child Protection Center became known within the hospital, physicians began referring children who were sexually abused in addition to those who were physically abused, without regard to the relationship between the child and the offender. While the Child Protection Center did accept many children who had been sexually abused by someone outside the immediate family, the terms of its grant did not provide for their treatment. Consequently, the services that could be provided to these children were somewhat constrained by a lack of funds.

A retrospective study conducted in 1978 found that the Child Protection Center treated 151 child victims of sexual abuse in the two and one-half years from October 1975 to March 1978 (when the Special Unit began full operations).[1] Only 21 percent of the offenders in these cases were members

[1] Neil K. Makstein, Ann Marie McLaughlin, and Carl M. Rogers, "Sexual Abuse and the Pediatric Setting: Treatment and Research Implications," paper presented at the annual convention of the American Psychological Association, New York, New York, September 1979.

of the victim's immediate family; the remaining 79 percent were outside the family (27 percent were other relatives, 35 percent were friends and acquaintances, and 18 percent were strangers). Thus, the majority of sexual abuse victims referred to the Center were technically ineligible for treatment.

The study also found that in the period examined, older children tended to receive more services than younger children. While the victims ranged in age from 11 months to 16 years, the teenagers were more likely to be referred for ongoing psychotherapy, and the number of crisis counseling sessions they had with staff of the Child Protection Center was considerably greater. Finally, the study reported that formal criminal proceedings were undertaken in 36 percent of the cases, but no outcome data were available.

The Child Protection Center staff soon learned that handling cases of sexual abuse required different procedures and linkages with different agencies than did cases of physical abuse and neglect. This was particularly evident for cases of nonfamily abuse as opposed to intrafamily abuse. Project staff began to develop a grant proposal for a special unit exclusively to treat children who had been sexually abused, regardless of their relationship to the offender. After exploring several funding possibilities--the National Center on Child Abuse and Neglect, the National Institute of Mental Health, the Department of Justice--they learned of LEAA's Family Violence Initiative. The Special Unit began to take shape in October 1977 with an award of $127,480.

7.2 Philosophy, Approach, and Early Effort

The Special Unit states as its primary goal, "to assure improved responses to the needs of victims of child sexual abuse and their families in the District of Columbia by the legal, medical, and social service systems." It is important to note that the child is perceived as the principal client, for the Unit recognized early in its development that cases of child sexual abuse typically pose a choice between three client targets: the child victim, the parent-child relationship, or the family as an entity. In its written philosophical statement,[2] the Special Unit explains its reasons for selecting the child as its focus:

1) The child is the direct victim. Family members develop needs in reaction to the incident itself and to its effect on the child, but these may lack the intensity and immediacy of those of the child.

[2]Child Protection Center-Special Unit, "The Philosophical Bases for Policies of the Child Sexual Abuse Victim Assistance Project," pp. 7-8.

2) The interests of the child victim may not coincide with the interests of other family members (for example, when the offender is a close friend or relative of a parent).

3) In incest cases there may not be a set of needs common to any of the family members. In fact, some needs may be inimical to those of other family members. For example, the mother may be forced to choose between her child and her husband. To prosecute the offender would likely entail a family split, and some mothers may elect to accept an incestuous situation rather than lose their husband's company and financial support. Such a decision is obviously detrimental to the child, who either will continue to be victimized or be removed from her home.

4) Some family members may require individual mental health services as a precondition to participation in conjoint family therapy.

In sum, Unit staff believe that to select a relationship or group as the client could mean that the child victim's needs would be ineffectively addressed. In some incest cases, providing family therapy in an attempt to keep the family intact might risk further abuse to the child. Indeed, other children in the family may also be in danger. Moreover, focusing on the parents' relationship may detract from the attention given to the child as the ultimate victim of aberrant family dynamics.

The initial grant proposal set forth five explicit objectives which have guided the Unit's operations ever since:

- to document the special needs of victims of child sexual abuse and their families and identify methods of addressing those needs;
- to improve the knowledge and skills of law enforcement personnel in the sensitive management of victims, witnesses, and families;
- to improve the knowledge, skills, and mutual cooperation of medical and social services personnel in the collection and transmission of evidence and information to the legal system;
- to improve interaction, coordination, and cooperative case management among the legal, medical, and social service systems; and

- to increase public knowledge about methods of preventing child sexual abuse and public confidence in and knowledge about legal, medical, and social supports available to victims and their families.

The activities associated with these objectives fall into three categories: (1) direct clinical services (medical examination and treatment, crisis intervention and counseling, and guidance regarding ancillary services and criminal justice involvement); (2) education and training for professionals and the general community; and (3) research on the nature of child sexual abuse and its effects on the victim and family.

In designing the Special Unit, the Child Protection Center wished to avoid transferring expert counselors from the existing program, and so the new Unit was to be staffed by new hires. For the month of February 1978, Child Protection Center staff helped the Special Unit staff acclimate to their new positions, providing a general introduction and orientation to the hospital and its procedures, plus some in-service training on the topic of child sexual abuse. They also worked with the Special Unit to develop case management and review procedures and associated forms and to establish referral arrangements within the hospital and with community service agencies. The Special Unit began providing direct clinical services in March 1978 with a ready supply of clients.

The Special Unit also moved quickly to achieve its educational and training objectives. The first contact was the sergeant in charge of the Metropolitan Police Department's Sex Offenses Branch. Discussion centered around two topics: collection of medical evidence, and police attitudes toward hospital procedures. Through these meetings and observations in several early cases, Unit staff learned that police had been misinterpreting one of the key laboratory findings concerning the presence of sperm. A finding of "non-motile sperm" was being construed as an absence of sperm, when the sperm were indeed present but no longer viable. This problem was especially critical because District of Columbia law requires corroborating evidence for all children's testimony; in sexual abuse cases, which typically lack witnesses, medical evidence is often the only source of corroboration. The need for training police officers was obvious, not only to familiarize them with relevant medical language, but to educate them on more general issues: how to discriminate abuse from normal sexual activity, how to identify when parental neglect is a contributing factor, and how to work with hospital personnel and understand their procedures.

Because the criminal and juvenile justice systems in the District of Columbia are complex (as described in Chapter 10), the Special Unit commissioned a local attorney to prepare a detailed study of how a case is handled when an incident of child sexual abuse is reported to authorities. This document has been extremely valuable to Unit staff in their dealings with law enforcement officers and prosecutors, and its author was later hired as the Unit's criminal justice specialist.

Another step taken in the Unit's early stages was to convene its Community Advisory Council. Its membership was diverse, including representatives of Children's Hospital, D.C. General Hospital (a public facility), police, prosecutors, child advocates, and others. Most of these individuals had worked with the Child Protection Center and thus were familiar with the issues and problems of child sexual abuse. The Council's primary purposes have been to assist in the Special Unit's public education efforts, to enhance interagency collaboration, and to identify ways of improving the treatment of child victims and their families. The Council's composition and functions are discussed in Chapter 11.

In sum, the first three months of the Special Unit's operations were focused on laying the groundwork for expanding and improving the services available for child victims of sexual abuse. Agreements were made with hospital staff to ensure that all victims coming to their attention would be referred to the Unit. Contacts were made with key personnel of medical, social service, and criminal justice agencies. Specific training needs were identified--both among police and among Unit staff--and steps were taken to address those needs. The concrete results of these early activities are described in subsequent chapters.

7.3 Funding: Past, Present, and Future

The Child Protection Center-Special Unit completed its third and final year of LEAA discretionary funding in January 1981. Table 7.1 shows the project's funding history since 1978. Initially funded at $127,480, the Unit soon found that the staffing level was inadequate to handle the full scope of project activities, and requested additional funding to support an increase in clinical and administrative staff. The Unit also requested a three-month extension of the grant year (without additional funds) to compensate for the late start-up date resulting from delays in hiring. Total first-year funding thus amounted to $179,398. In its second year, the Unit's total budget was $260,324, and third-year funding was $265,857. Children's Hospital National Medical Center supplied the required matching funds each year.

As is true of most human service programs, the bulk of the Special Unit's budget pays staff salaries. Attempts to compute an average cost per client are futile, however, for several reasons:

- The Unit does not differentiate its costs by type of service provided (direct client services vs. professional training and community education).
- Unit staff do not record the number of hours they devote to clinical services.

Table 7.1
Funding History
Child Protection Center-Special Unit

	Year 1 Total 10/77-12/78 (includes supplement)	Year 2 1/79-12/79	Year 3 1/80-12/80
Personnel	$114,003	$161,631	$165,198
Fringe	9,690	13,738	14,041
Travel	3,975	2,222	1,862
Equipment		700	1,300
Supplies	2,400	2,496	1,000
Consultants	13,350*	4,100	3,950
Other**	6,950	9,330	10,940***
Indirect	29,030	66,107	67,566
TOTAL	$179,398	$260,324	$265,857
(LEAA funds)	($161,176)	($206,628)	($188,423)
(Children's Hospital)	($18,222)	($53,696)	($77,434)

*First year consultants included curriculum specialists, a film producer, and an independent evaluator. The URSA Institute assumed the evaluation function in year 2 as part of an LEAA-funded evaluation of family violence projects.

**"Other" includes computer services, emergency room laboratory services for clients unable to pay, mental health referrals to the Psychiatry Department, and printing charges.

***Includes a $9,715 special award to host an LEAA "cluster" conference on the subject of child sexual abuse.

Source: Child Protection Center-Special Unit documentation.

- Direct services may also be provided to members of a victim's family, but the exact number and extent of such services are unknown.

In anticipation of the expiration of LEAA funding in January 1981, the Special Unit worked to adapt a third-party billing procedure already in use by the Child Protection Center. As of December 1980, when this procedure became effective, clients are charged for the Unit's services if they are covered by private medical insurance or by Medicaid, which includes all child victims of intrafamily abuse. The Unit's services covered under third-party billing include all medical examinations, crisis intervention, mental health screenings, public health evaluations, counseling, and family therapy. A trial application of the third-party billing system indicated that perhaps 30 percent of the Unit's total costs (approximately $80,000) could be covered this way.

Children's Hospital continues to support the Unit with a commitment of $77,000. Also, the Unit was recently awarded a grant from the National Center on Child Abuse and Neglect to treat juvenile intrafamily sex offenders (see Chapter 9 for discussion); this grant amounts to $50,000 for each of three years. Two private foundations (the Children's Hospital Board of Lady Visitors and the Child Health Center Board) awarded a total of $15,000 to the Unit. Finally, the District of Columbia Mayor and City Council authorized $100,000 for the Unit to be available October 1981. Several additional applications with various funding sources are still pending.

Certainly the primary thrust of the Unit's funding initiatives has been the maintenance of its direct clinical services to child victims. Hospital funds and third-party billing should suffice to cover most treatment needs. Still, the Unit places a high priority on its community education, professional training, and research commitments, and continues to seek additional funding sources.

CHAPTER 8: STAFFING AND CLIENT PROFILE

8.1 Staff Composition

Located in Children's Hospital National Medical Center, the Child Protection Center-Special Unit is administratively responsible to its "parent" project, the Child Protection Center (CPC). However, the Special Unit functions independently of the CPC.

As the organization chart in Figure 8.1 shows, both CPC and the Special Unit fall within the hospital's Office of Child Health Advocacy. This Office was established in 1973 to coordinate hospital services with existing services in the community, to identify unmet service needs, and to develop new programs to meet those needs. In addition to CPC and the Special Unit, the Office of Child Health Advocacy also administers a screening and treatment program for lead poisoning, a Comprehensive Health Care Program of satellite clinics throughout the city, and a research division.

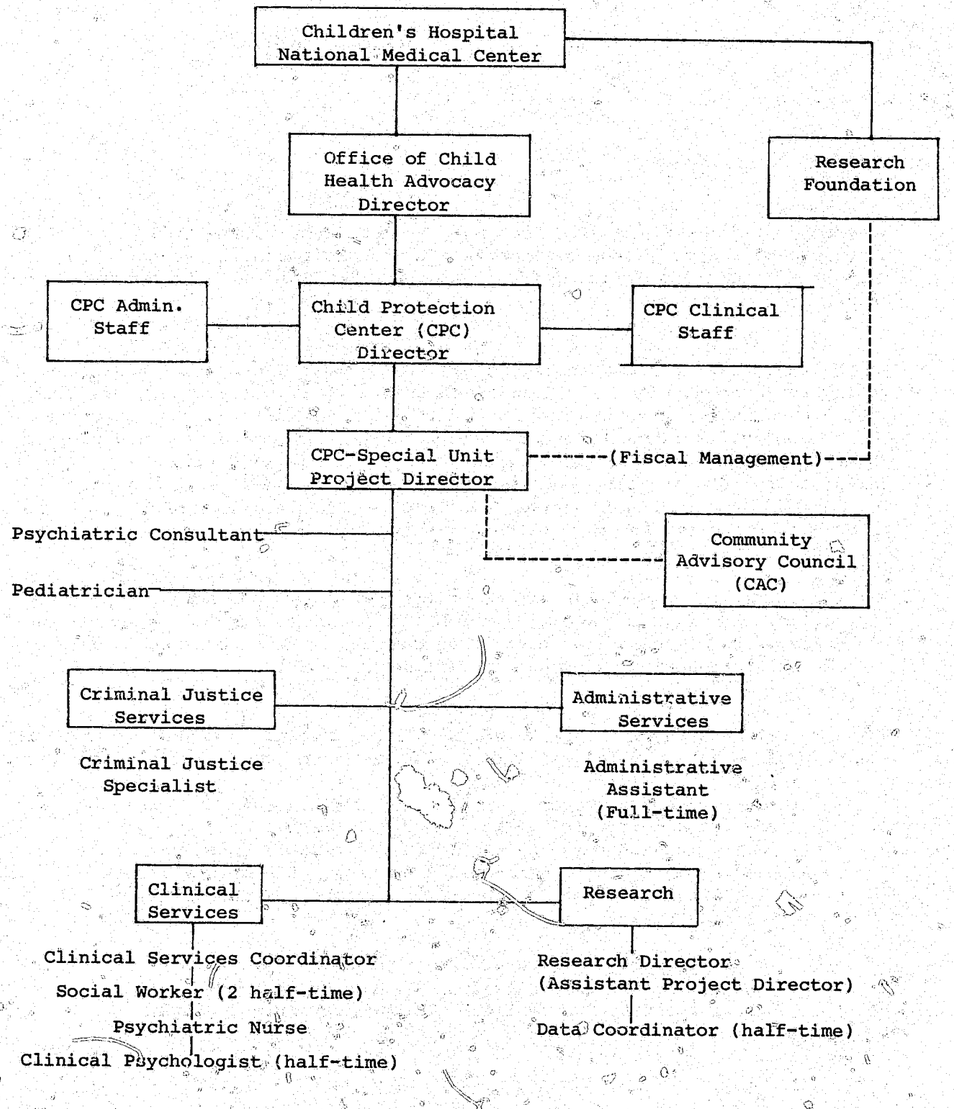
The organization chart illustrates the Special Unit's current staffing configuration. It is instructive, however, to recount the Unit's growth over the three years of operation, since the addition of new staff tends to parallel the Unit's changing needs and expanding interests.

When it began operations in March 1978, the Special Unit had only seven staff, four of whom were part-time. The original staff were as follows:

- The project director, a registered nurse holding a master's degree in Public Health Administration. While much of the project director's time is spent on administrative and managerial functions, she maintains a small caseload and is considered a member of the Unit's clinical team.

- A social worker, primarily responsible for providing counseling and criminal justice advocacy to child victims and their families. Through her prior position

Figure 8.1
Current Organizational Chart*
Child Protection Center-Special Unit



*Adapted from Child Protection Center-Special Unit Program Status Report, 1980, p. 4.

with a Child Protection Unit in Virginia, the social worker had first-hand experience with the treatment needs of abused children.

- A half-time pediatrician whose role included establishing liaison and referral arrangements with various departments of the hospital, training medical personnel, and revising hospital protocols for examining and treating child victims of sexual abuse.

These three individuals comprised the Unit's clinical staff. All participated heavily in the Unit's community and professional outreach activities as well. The remaining staff comprised the Special Unit's research component:

- A director of research with a Ph.D. in social psychology and considerable research background. His role was to develop and implement appropriate data collection forms and research instruments toward the establishment of a comprehensive data base on child victims and their response to treatment. This individual has since been named assistant project director.

- A half-time data coordinator responsible for data collection and recordkeeping.

- Two part-time (10 percent each) research associate consultants, both already employed by the hospital, to provide guidance and technical assistance to the director of research in developing instruments and preparing evaluation reports.

Within one month after they began providing direct services to child victims and their families, Special Unit staff realized that they had underestimated the need for clinical services personnel. Today, the clinical staff alone numbers 4.5 (full-time equivalent): the project director, the original social worker (now coordinator for clinical services), plus two half-time social workers, a psychiatric nurse, and a half-time clinical psychologist. The psychologist joined the Special Unit in its third year, when the pediatrician moved from half-time to consultant status. This change in the pediatrician's role reflected a reduced need for his assistance in developing medical protocols and contributing to medical sections of the Unit's training curriculum. Also contributing to the Special Unit's clinical staff is a child psychiatrist who has a private practice and consults with the Unit on difficult cases.

As discussed in the preceding chapter, the Special Unit had commissioned a local attorney to research the progress of child sexual abuse cases through the criminal justice system in the District of Columbia. This individual soon joined the Special Unit as its full-time criminal justice specialist.

He serves both as an advocate for the victims and as counsel for Unit staff. When necessary, the criminal justice specialist prepares clinical staff to provide expert testimony and interprets statutes and regulations. Occasionally, he has filed motions to quash defense subpoenas for project case records. Recently, he testified before the U.S. Congress regarding proposed changes to the D.C. Criminal Code. Finally, the specialist is involved in all training and public awareness activities and has published articles on the legal aspects of case handling. More detail on his victim advocacy functions is provided in Chapter 10.

The interdisciplinary mix of project staff was intentional. Each staff member specializes in a particular skill or subject area; for example, one counselor might specialize in home visits, another in prepubertal venereal disease. With their varied academic training and professional experience, clinical staff members often bring different perspectives to case management which, they feel, broaden their understanding both of individual cases and of child sexual abuse generally. Of course, differences in approach and terminology sometimes lead to disputes which are resolved through group discussion (see Chapter 9).

Written job descriptions for each staff position are contained in the Special Unit's "Policies and Guidelines" manual (described in the following section).

8.2 Staff Training

Although the Special Unit has experienced little turnover among its professional staff in the last three years, an orientation program and schedule were developed for new staff. A written outline provides a complete overview of the Unit's administrative, clinical, research, and training activities. Instructional sessions are scheduled over a 2-1/2 week period and involve most of the staff as instructors. The project director gives the initial overview and discusses the Unit's public education film (see Chapter 11) and their training program for social service, mental health, and criminal justice personnel. She also explains the Unit's approach to detecting sexual abuse through cases of childhood venereal disease. The staff pediatrician provides a brief outline of the medical aspects of child sexual abuse; the criminal justice specialist discusses the legal aspects. The clinical coordinator covers the Unit's counseling services, mental health aspects of treatment, and the Unit's supervisory practices. Other Unit counselors describe intake procedures and the project's approach to incest treatment. Finally, the research director describes the research program and the forms and records that are maintained.

The orientation schedule and outline are contained in the Unit's "Policies and Guidelines" manual which is a useful training reference in itself. This manual includes a written job description for each staff position; memoranda

from the criminal justice specialist concerning disclosure of data and procedures for obtaining informed consent from parents to provide clinical services; documentation of various Unit procedures and hospital policies; copies of all case management protocols and data collection forms, along with instructions for their use; and a directory of referral sources in the Washington metropolitan area.

Another reference document available to new staff is the curriculum developed by the Unit for training personnel of other agencies. This volume should answer any questions a new hire may have concerning the etiology of child sexual abuse and its treatment in the medical, criminal justice, and social services arenas. Both the "Policies and Guidelines" manual and the training curriculum illustrate the broad range of topics that are important for professionals who work with child sexual abuse victims. The tables of contents are included in Appendix B-1.

All clinical staff receive guidance and supervision from the Unit's coordinator for clinical services. In addition, each is assigned a supervisor from the specialized department of the hospital that represents the staff member's academic training; for example, the psychiatric nurse receives supervision from the nursing department, the clinical psychologist from the psychology department. The Special Unit believes that departmental supervision is especially important for an interdisciplinary team such as theirs. While each staff member certainly benefits from the diversity of experience represented on the team, input from someone with a similar academic background and perspective on treatment is equally valuable.

8.3 Client Profile

When staff of the Child Protection Center first conceived of the Special Unit, they noted that existing legal definitions of child sexual abuse were not adequate to describe the full range of cases that had been referred for treatment. The D.C. child abuse law was too narrow because it refers only to abuse perpetrated by a parent or caretaker, thereby excluding all nonfamily assaults. Conversely, criminal statutes were too broad because they include sexual activity among consenting children (under age 16). Center staff generally believe that sex play between children or adolescents is normal explorative behavior unless there is an element of coercion. The Special Unit has since developed its own operating definition of child sexual abuse:[1]

1. incidents of sexual assault involving physical force in which a child (younger than 16 years) is the victim; and/or

[1] Child Protection Center-Special Unit, "The Philosophical Bases for Policies of the Child Sexual Abuse Victim Assistance Project," p. 5.

2. sexual contact or interaction (such as intercourse, fondling of genitalia, exhibitionism, sodomy, etc.) between a child and another person of any age in which the child's participation has been obtained through undue means such as threats, bribery, coercion, misrepresentation of moral standards, or similar tactics; and/or

3. sexual conduct or interaction between a child and an adult or other person, even with the free cooperation of the child, when such activity is inappropriate to the age and level of maturity of the other person.

While most of the children treated by the Special Unit fall into one of these categories, the Unit also engages in case-finding through diagnosed cases of childhood gonorrhea. Like venereal disease in adults, diagnosed gonorrhea in pre-pubertal children is always transmitted sexually. Some medical professionals, however, are reluctant to believe that young children are involved in sexual activity; consequently, they prefer to treat the symptoms without exploring the underlying cause. Until the source of infection (i.e., the sexual contact) is removed, unfortunately, the symptoms will recur. The Child Protection Center-Special Unit has instructed all hospital physicians to refer childhood gonorrhea cases to the Unit for follow-up of the source of contact and any necessary counseling. This method of case-finding is a unique aspect of the Special Unit and accounts for approximately 11 percent of new cases each year.

Initially, the Special Unit treated only victims age 12 and under. In general, adolescents are less likely than children to come to Children's Hospital for emergency care, and in its early stages, the Unit felt a need to specialize. Still, in 1979 the Unit began accepting teenagers up to age 18, for three reasons: (1) 18 is the upper age limit for patients at Children's Hospital, which maintains a separate division for Adolescent Medicine; (2) 18 is the legal age of consent in the District of Columbia; and (3) staff perceived the treatment needs of adolescents to be similar to those of younger children. Based on all 1978, 1979, and 1980 sex abuse cases, the Unit reports the mean client age to be 9 years, 1 month.

Table 8.1 below summarizes other descriptive data from project statistics. To date, more than one-fourth of their clients have been male. Forty-two percent of the cases have been intrafamily cases, and 58 percent have been nonfamily cases. Only six percent of the victims were 15 years of age or older; the Unit suggests that many teenaged victims go to D.C. General Hospital (where there is a Sexual Assault Follow-Up Unit) for treatment rather than to a pediatric hospital.

Table 8.1
Victim Characteristics
Child Protection Center-Special Unit

Victim Characteristics		Number	Percent
Total Intakes*		518	
Age Distribution			
0-3 yrs.		39	(8%)
3-6		116	(22%)
6-9		129	(25%)
9-12		110	(21%)
12-15		91	(18%)
15-18		33	(6%)
		518	(100%)
Sex Distribution			
Male		137	(26%)
Female		381	(74%)
		518	(100%)
Relationship to Offender			
Nonfamily		236	(58%)
Stranger	62 (15%)		
Acquaintance/ neighbor/friend	158 (39%)		
Other	16 (4%)		
Intrafamily		170	(42%)
Parent/stepparent/ mother's boyfriend	97 (24%)		
Related by blood or marriage	73 (18%)		
		406	(100%)

*Only those intakes on which complete data were collected.

Source: Child Protection Center-Special Unit statistics, January 1, 1978-July 20, 1980.

Table 8.2 presents the nature of abuse and means of coercion inflicted upon child victims treated by the Special Unit in 1978, 1979, and 1980. Vaginal intercourse occurred in 40 percent of the cases, anal intercourse occurred in 21 percent, and oral sodomy occurred in 21 percent of the cases. Nearly half of the cases involved physical coercion. In 15 percent of the cases, the offender had deceived the child by misrepresenting moral standards--e.g., "This is how daddies help their daughters learn to relate to boys." Bribery and threats were also frequently used.

Table 8.2
Nature of Abuse and Means of Coercion
Child Protection Center-Special Unit

Nature of Incident	Percent
Nature of Abuse (non-exclusive categories)	
Vaginal intercourse	40%
Anal intercourse	21%
Oral sodomy	21%
Fondling	25%
Digital penetration	12%
Penetration by foreign object	3%
Means of Coercion (non-exclusive categories)	
Use of physical force	49%
Threat of physical harm	40%
Misrepresentation of moral standards	15%
Bribery	16%
Reliance on adult authority	18%
Non-physical threats	8%

Source: Child Protection Center-Special Unit statistics, 1978, 1979, and 1980.

CHAPTER 9: CLINICAL SERVICES

First and foremost, the Child Protection Center-Special Unit is designed to provide direct clinical care to child victims of sexual abuse: medical examination and treatment, crisis intervention and counseling, referrals for other needed services. The Unit is recognized throughout the D.C. metropolitan area as a unique source of specialized care. This chapter describes the procedures for referring appropriate clients to the Unit and for treating those children when they arrive.

9.1 Referral Sources

The Special Unit characterizes itself primarily as a crisis intervention project, and this orientation is reflected in the sources of the Unit's clientele: most clients (59 percent) are referred through the Children's Hospital Emergency Room or other divisions of the hospital. It is hospital policy for all staff to refer to the Unit all patients who allege to be victims of sexual abuse, as well as those who exhibit signs of "inordinate sexual behavior" because of the possibility that such children have been abused. Similarly, hospital staff refer all cases of prepubertal gonorrhea so that the Unit can assess the possibility of abuse and work with the Public Health Department to follow up the source of contact. (Coordination with the Public Health Department is discussed further in Section 10.2.) The Unit reports that 81 percent of its intakes are cases of sexual abuse; nine percent are cases of childhood venereal disease; six percent involve inappropriate sex play; and four percent involve physical injuries to genitals or unexplained vaginal bleeding, but no evidence or allegation of abuse.[1]

The second major source of referrals is the Metropolitan Police Department, which accounts for 33 percent of the Unit's active caseload. D.C. police are prohibited by statute from referring residents to the project because of its location within a private hospital, with two exceptions: (1) it is an emergency and Children's Hospital is the closest hospital, or (2) the person explicitly requests to be taken there. The city maintains a public hospital, D.C. General, and police are required to instruct victims and families that a

[1] Child Protection Center-Special Unit, Program Status Report, 1980.

medical examination is necessary and will be performed free of charge at D.C. General. There are no reliable data on the proportion of child sexual abuse victims who ask police to take them to Children's Hospital; the project estimates that they see approximately 70 percent of the child sexual abuse victims who report to the police.

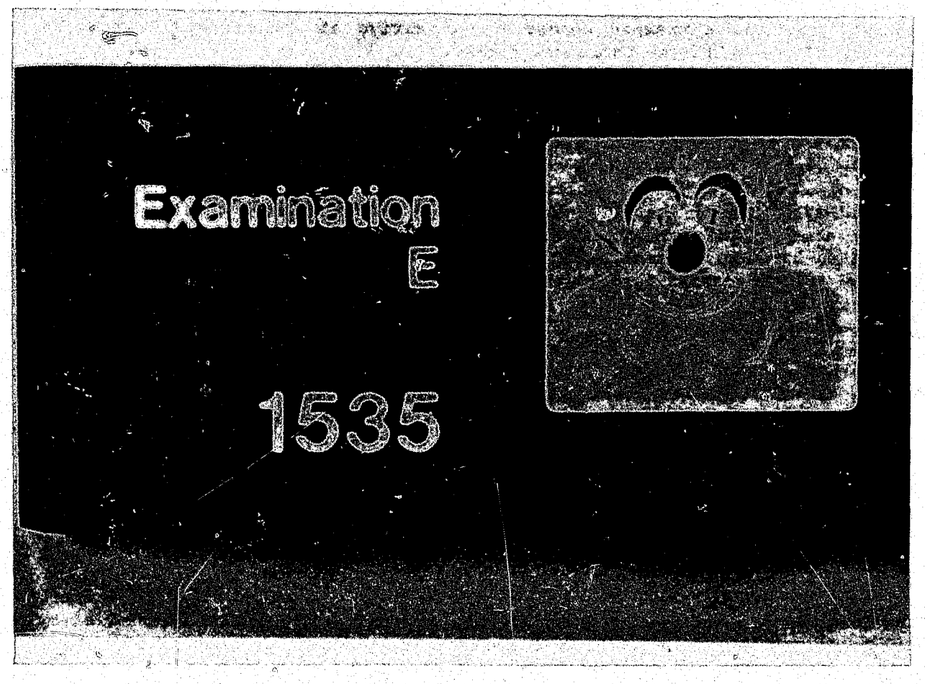
The remaining eight percent of the Unit's clients are referred by private physicians, other hospitals, and Child Protective Services. Some cases are referred by court personnel. In keeping with its crisis intervention orientation, the Special Unit requires that cases referred by these sources involve either a recent incident of sexual abuse or a recent disclosure, usually within several weeks. Victims reporting past incidents may be referred to therapy services in the community. The Unit will also refer victims who reside in neighboring counties of Maryland and Virginia. To assist themselves in making these referrals, Unit staff developed a directory of mental health services, both public and private, in the District and vicinity. To compile this directory, the Unit solicited recommendations from its Community Advisory Council, followed by telephone contacts to determine each service's eligibility criteria (if any), costs, and interest in treating child sexual abuse victims.

9.2 The Medical Examination

Child victims of sexual assault require medical attention for three reasons: (1) to treat injuries that may result from the assault; (2) to test for sexually transmitted diseases and pregnancy; and (3) to collect medical evidence of the assault--e.g., the presence of sperm, genital, or rectal trauma. The latter reason is quite critical because the District of Columbia requires that all children's testimony be supported by corroborating evidence.[2] Because child sexual abuse incidents rarely involve witnesses, medical evidence is often the only source of corroboration.

Most child sexual abuse victims treated by the Special Unit are referred through the Children's Hospital emergency room, where they are accorded high priority unless there are patients whose lives are in danger. A special waiting room directly within the emergency room entrance has been designated for these children and is furnished with toys and books for their comfort.

[2] Only Georgia, Nebraska, and New York have similar requirements. See Josephine Bulkley and Howard A. Davidson, "Child Sexual Abuse: Legal Issues and Approaches," American Bar Association, National Legal Resource Center for Child Advocacy and Protection, Washington, D.C., 1980, p. 16.



Hospital physicians are instructed to use examination techniques that are less frightening to the child.

Upon their arrival in the emergency room, the child and family (and police officer, if present) are first seen by a nurse, who in turn relates information to the attending physician. The doctor then contacts the Special Unit, which is on-call around-the-clock via a personal paging system. The Unit's counseling staff maintain a rotating on-call schedule, so that in an emergency situation, a trained counselor can arrive at the hospital within 30 minutes to talk with the child and family.

Emergency room staff, both physicians and nurses, receive periodic training from Unit staff on how to recognize signs of sexual abuse in children of varying ages, how to conduct the initial examination, and how to use the protocols designed by the Unit. Early in the Unit's history, the staff revised an existing emergency room protocol for examining victims of child sexual abuse. This protocol guides physicians through the initial examination step-by-step. It instructs them never to begin the exam until they feel assured that the child is calm and, above all, never to coerce the child. To comfort the child, the protocol recommends that the nurse or a trusted parent accompany her during the exam. It identifies for the doctor the tests and specimens that are necessary for evidentiary purposes, all of which can be completed with only one vaginal culture. Because medical evidence is so crucial to the prosecution, the protocol also instructs hospital personnel in recordkeeping practices that are necessary to preserve the chain of custody.

Early in the Unit's history, it was discovered that police had been misinterpreting some critical laboratory findings, submitted by several D.C. hospitals, regarding the presence of sperm in the vaginal specimens of sexual assault victims. As a result, many cases had been dropped mistakenly for lack of corroborating evidence. To ensure that this problem would not persist, Unit pediatricians provided training to D.C. police to improve their understanding of laboratory findings. The Special Unit also designed a new Medical-Legal Sexual Assault Evidence Form onto which all test results are transcribed. This form, reproduced in Appendix B-2, has been adopted by the Metropolitan Police for use in both child and adult sexual assault cases.

Victims are screened for venereal disease at the initial exam and again within two weeks. The Special Unit prepared a Gonorrhea Culture Protocol which instructs physicians to test for gonorrhea in every child with vaginal or urethral discharge. The protocol discusses the techniques of screening for gonorrhea, suggests a list of questions to ask of the child and parents to ascertain how the disease was transmitted, and lists the reports that must be made to the city's Epidemiological Services Office, DHS Public Health representative, and the Child Protection Center-Special Unit. The project's efforts to identify sexually abused children through diagnosed cases of venereal disease is a unique feature among programs of its kind.

9.3 Counseling

9.3.1 Initial Interviews and Case Scheduling

Counseling begins in the emergency room. The Child Protection Center-Special Unit staff rotate to maintain a 24-hour on-call schedule so that an experienced counselor can respond to calls from the emergency room within 30 minutes. To guide emergency room personnel and Unit counselors in managing the diverse types of cases seen at Children's Hospital, a set of protocols has been developed as new situations arise. Each protocol clearly spells out persons to notify and forms to complete in the given situation. Following are the protocols in use as of January 1981:

- Management of Cases in Which the Victim and/or Offender Lives Outside of the District of Columbia
- Management of Cases in Which the D.C. Police are Already Involved
- Management of Those Cases Where the Team Has Not Been Notified at the Time of the Incident
- Adolescent Rape Cases
- Cases Which are Transferred from Another Hospital
- Cases Involving Fondling, Exhibitionism, or Pornography
- Management of Cases Involving a Child Who is Two Years Old or Younger With no Evidence of Physical Injury
- Management Guidelines for Intrafamily Sexual Abuse Cases
- Situations Involving Extensive Sexual Play or Inappropriate Sexual Behavior

Obviously, any given case may fall into two or more of these categories. Likewise, the materials in the protocols overlap considerably. This duplication was intentional, so that when the counselor identifies the most salient feature of a given case, the corresponding protocol will provide all the necessary information. Selected examples of these protocols appear in Appendix B-3.

Upon arriving in the emergency room, the Unit counselor confers first with the attending physician and police officer (if present) so that the victim will not have to tell her story to yet another stranger. The counselor meets with the victim and family after the medical examination in the playroom located near the emergency room entrance. This interview often focuses more

CONTINUED

1 OF 3

on the family than on the victim, since the family's response to the incident may be critical to the child's recovery. The counselor assesses the parents' reaction and attempts to impress upon them the child's need for counseling assistance. This intake interview usually requires between 45 minutes and one and one-half hours.

The victim is then scheduled for her first counseling session within the following week or on the same day as the follow-up medical exam; Unit staff have found that parents are more likely to observe medical appointments than counseling sessions. This meeting is still considered part of the assessment phase. The counselor tries to determine if the crisis has passed, how the victim and family are adjusting to the fact of the incident and any ensuing criminal justice proceedings, and whether the parents can adequately protect the child.

Counselor and victim meet weekly during the initial crisis and about every other week thereafter, depending on the victim's needs. The counselor also meets with parents and siblings, both at the hospital and at home, to assess further the home environment, the child's emotional condition, and family relationships. The frequency of counseling sessions depends largely on the severity of the case. Those accorded highest priority are cases involving physical injury, incest, rectal sodomy, adolescent rape, and prepubertal gonorrhea. Victims who are prosecuting their cases also receive preparatory counseling for each proceeding, as described in the next chapter.

9.3.2 Counseling Techniques

Specific counseling techniques vary with the child's age and cognitive abilities. Older children may be asked directly why they are at the hospital; younger children are encouraged to describe the abuse and their feelings through creative play with dolls and crayons. The child may be asked to draw a person, a common therapeutic technique which allows the child to portray graphically incidents which she may not be able to describe verbally. For example, a drawing which overemphasizes the mouth could indicate that the child had experienced some form of oral sex. A drawing of the family may suggest the dominant characters and the child's perception of family relationships. Or the child may re-enact the incident using dolls. The counselor continues to question the child, using language and imagery that are familiar to her:

- What does a good/bad mommy (daddy) do?
- Who in your family is a pest? Who bothers you?
- What's your saddest time? Your happiest time?
- What three wishes would you make?

Some children find it easier to talk about sensitive issues when they whisper into the counselor's ear.

- Do you ever have scary dreams?

Children who are non-responsive or unduly anxious will be referred to the hospital's Psychiatry Department for evaluation. Some cases are referred to the Psychiatry Department for ongoing treatment, usually those considered by the Unit to be very complex, for example, a teenager who has run away from home because her mother blames her for an incestuous situation. Special Unit staff meet approximately every two weeks with a child psychiatrist to discuss these cases. In one meeting, for example, the discussion revolved around the relationships of a 17-year-old incest victim with her mother, sister, and stepfather (the counselor was also treating the mother and sister); the possible impact of the incest on her later life; and how much more the Unit counselor should do before referring the girl to the Psychiatry Department for continuing therapy.

9.3.3 Case Planning and Decisionmaking

Early in the course of therapy the counselor identifies treatment goals that are appropriate to each child. For example, a victim who feels responsible for the incident must understand that the offender, not she, is responsible. School reports, behavioral checklists completed by the parents (in Appendix B-6), and the judgment of the Special Unit clinical staff are used to measure the victim's progress in therapy.

All case management and planning decisions are made jointly by the Special Unit clinical team at weekly staff meetings. Each new intake is scheduled for a team review within one week of the initial interview and is reviewed again every five to six weeks thereafter. The Unit's clinical coordinator sets up an agenda in advance of each meeting, listing cases initiated since the last meeting, those scheduled for regular review, and problem cases of which she is aware. She then chairs the ensuing discussion. Each counselor presents new cases and the treatment steps already taken, and the clinical team develops a tentative treatment or intervention plan. These plans are intended to address the full range of the victim's needs--criminal justice, social service, medical, and mental health services--and are updated whenever the case comes up for its scheduled review.

Victims typically remain in treatment until all problems relating directly to the abuse have been resolved as assessed by the clinical team; victims exhibiting problems not related to the sexual abuse may be referred elsewhere for continuing treatment. Decisions to close cases or refer them are also made by the clinical staff as a group. The Unit considers a number of factors in case termination: (1) medical examination reveals no further problems; (2) social service referrals have been made; (3) the case is disposed in the criminal justice system; and (4) the short-term crisis is resolved. Of course, therapy is never terminated against the wishes of the victim and family.

Table 9.1 below illustrates the outcomes for 399 victims treated by the Special Unit between January 1978 and March 1980. Approximately one-third of the cases were terminated because the Special Unit staff had determined that their crises were resolved; 44 percent were referred elsewhere for continuing treatment; and 21 percent could not be located or refused treatment. Cases may also be terminated if the medical/psychological evaluation reveals no indication of sexual abuse, or if the Special Unit is unable to identify a venereal disease contact.

Table 9.1
Reasons for Case Termination
Child Protection Center-Special Unit

Reason Specified	Percent of Cases
Crisis Resolved	34%
Referred to Another Agency for Follow-up Care Other than Mental Health	27%
Referred for Long-Term Mental Health Care	17%
Terminated by Client (Client Refuses Treatment)	12%
Project Unable to Locate Client	9%
	99% (rounding error)

Source: Child Protection Center-Special Unit, Program Status Report, 1980, p. 12.

The Unit reports the average length of treatment to be 14 to 16 weeks, with some cases extending for six months or more.[3] Victims who are prosecuting their cases will be counseled until their cases are closed. The Unit is proscribed from following up on referrals made to other agencies by the terms of the D.C. Mental Health Information Act, which requires the client's written consent prior to each interagency discussion of diagnosis and treatment of mental health problems.

9.3.4 Juvenile Intrafamily Sex Offender Treatment Program

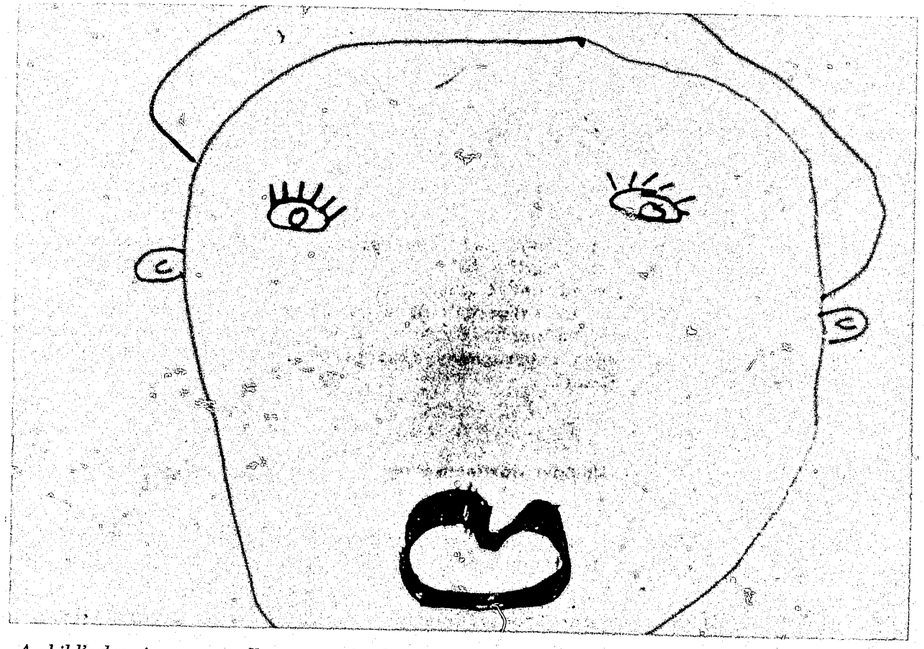
In October 1980, the Child Protection Center-Special Unit was awarded a grant from the National Center on Child Abuse and Neglect to develop

[3] Child Protection Center-Special Unit, Program Status Report, 1980, p. 14.

a specialized treatment program for juvenile intrafamily sex offenders. Offender, victim, and parents (and sometimes other family members) will be enrolled in therapy at the Special Unit, both individually and as a family, if appropriate. Offenders become eligible for treatment only after their juvenile justice status has been resolved (e.g., their cases were adjudicated, they agreed to a pretrial diversion program, or they were sentenced to probation). This policy assures that Special Unit counselors will not encounter any conflict of interest as they treat both victims and offenders concurrently.

Staff for the Juvenile Treatment Program includes 1.5 (full-time equivalent) social workers, a consulting psychologist, and part-time services from the Special Unit director, assistant director, and criminal justice specialist. A maximum of 30 juveniles and their families will be treated at any given time.

As of September 1, 1981, the program had received 30 referrals. Ten cases were in active treatment, three had been closed, and the remaining 20 cases never entered treatment, for several reasons: (1) the referral came from a suburban area and treatment was sought elsewhere; (2) staff were unable to locate the family; (3) the referral proved to be ineligible for services; and (4) no charges had been petitioned and the family denied that sexual molestation had occurred. The Unit has since decided to broaden the program to nonfamily juvenile sex offenders as well as intrafamily offenders.



A child's drawing can vividly portray the details of sexual abuse.

CHAPTER 10: COORDINATION WITH OTHER AGENCIES

Since its inception, the Special Unit has firmly adhered to a policy of reporting all incidents of child sexual abuse to the appropriate agencies. D.C. law requires that all cases of intrafamily child abuse be reported either to the Metropolitan Police Department or to Child Protective Services to ensure the child's protection from future threats. On the other hand, reports to police are voluntary for incidents that are not perpetrated by a family member. Still, the Special Unit reports these cases routinely, citing three reasons:[1]

- as a private non-profit facility, Children's Hospital has no authority to protect the child from future danger;
- staff believe that offenders should be held accountable to the community for their conduct; and
- in some instances the child's parents/guardians may be unwilling to report the incidents themselves.

To ensure that reports to authorities are made in a routine fashion, the Special Unit has developed protocols and formal agreements with the relevant agencies. These and other cooperative arrangements are discussed in the following sections.

10.1 Coordination with Criminal and Juvenile Justice Systems

10.1.1 Reporting Procedures

The District of Columbia's child abuse and neglect reporting statute provides that incidents of intrafamily child abuse must be reported either to the Metropolitan Police Department or to Child Protective Services (CPS). In

[1] Child Protection Center-Special Unit, "The Philosophical Bases for Policies of the Child Sexual Abuse Victim Assistance Project," pp. 8-9.

practice, however, incidents of child abuse (in which injuries are perpetrated by a family member) are reported to police. Incidents of neglect (in which the injuries are attributed to the parent's or guardian's failure to meet the child's normal physical, intellectual, and psychological needs) are typically reported to CPS. The law does not explicitly address the need for reports between police and CPS in many of these cases.

In 1979, the Special Unit and its Community Advisory Council developed a procedure whereby all concerned agencies would be promptly notified of child sexual abuse incidents. Under this strategy, the Special Unit reports all known cases of child sexual abuse directly to the Metropolitan Police Department, Sex Offenses Branch. This Branch is responsible for investigating all sex offenses involving an adult suspect, regardless of the relationship between the victim and offender. The Sex Offenses Branch, in turn, notifies the Police Department's Youth Division, which investigates cases involving juvenile suspects as well as cases of intrafamily abuse and neglect. If the reported incident does involve intrafamily abuse, the Youth Division conducts an investigation and forwards a report to CPS.

The Special Unit observes this policy in virtually all cases. Project data indicate that of 529 cases known to the project between February 1978 and December 1980, only 72 were not reported to D.C. Police: 37 did not involve sexual abuse, 18 were cases of gonorrhea where sexual abuse was not substantiated, three were incidents that occurred outside the District of Columbia,[2] and 14 were cases where the victim was not treated at Children's Hospital.

10.1.2 Investigation and Prosecution

A male/female team of plainclothes detectives from the Metropolitan Police Department's Sex Offenses Branch responds to all reports from the Special Unit. The Youth Division, with support from the Sex Offenses Branch, investigates cases involving juvenile suspects and cases of intrafamily abuse and neglect. When interviewing a child victim, the detectives prefer to be isolated from an "audience" situation in order to develop a close, personal rapport with the child. Typically, the same team is assigned throughout the life of the case, from initial report to final disposition. This "vertical investigation" procedure has been utilized by the Sex Offenses Branch for many years.

Criminal prosecution of adult offenders in the District of Columbia is handled by the U.S. Attorney's Office; juvenile offenders are prosecuted by the Office of the Corporation Counsel which also handles child abuse and neglect

[2] Fifty incidents that occurred outside the District were reported to appropriate authorities.

proceedings. Neither agency has adopted a vertical mode of prosecution, so that child victims may be interviewed by as many as six or eight attorneys as their cases progress through the criminal justice system. To help alleviate the stress that accompanies these interviews, the Special Unit has placed a heavy emphasis on training for prosecutors and law enforcement officers, focusing on interviewing techniques and ways of helping the child feel more comfortable (see Section 11.3.3 for additional information on the Unit's criminal justice training efforts).

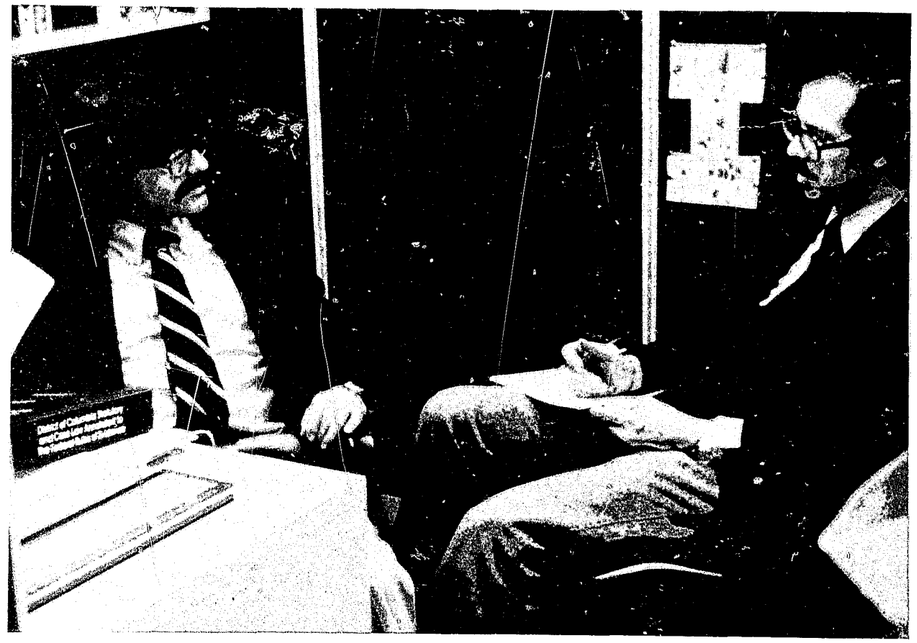
10.1.3 The Criminal Justice Specialist

The Special Unit's link to the criminal/juvenile justice system is through its criminal justice specialist, who serves as general counsel, victim advocate, and researcher for the project.

As general counsel, the criminal justice specialist prepares memoranda and consults with Unit staff about legal issues such as confidentiality of mental health information, assessing a child's ability to testify, the use of expert witnesses, and the disclosure of data for research purposes. Prior to his employment with the Unit, he prepared a detailed description of how child sexual abuse cases progress through the criminal justice system. Recently, he represented the Unit in testimony responding to proposed changes in the D.C. Criminal Code.

As a victim advocate, the criminal justice specialist's primary function is to encourage the cooperation of child victims and their families with law enforcement and prosecution. First, he explains to them the need to apprehend and prosecute the offender. Then, if the family chooses to pursue their case, the specialist prepares them in advance of each proceeding, defining terms, giving a tour of the courtroom, and rehearsing the child's testimony. He also accompanies the child to scheduled appointments and debriefs the family afterwards.

As a researcher, the criminal justice specialist developed a system for tracking all known child sexual abuse cases throughout the criminal and juvenile justice systems, from the initial report to police to final disposition of the offender. Files of the Metropolitan Police Department Sex Offenses Branch, U.S. Attorney's Office, and D.C. Corporation Counsel are all open to the criminal justice specialist. Through special court order, he also obtained access to the files of the Juvenile Court which are highly confidential and heavily protected. This latter achievement allows the criminal justice specialist to track information on juvenile offenders and intrafamily abuse cases and to accompany victims in Juvenile Court proceedings. This case tracking system is exceptionally comprehensive and provides a summary overview of case processing in the D.C. criminal and juvenile justice systems. The data collection form used by the criminal justice specialist and the cumulative report for February 1978-December 1980 are contained in Appendix B-4.



In Washington, D.C., the project's criminal justice specialist maintains close contact with prosecutors.

An important side effect of the case tracking activities is the opportunity for the criminal justice specialist to meet police, prosecutors, and judges on a personal level. Through informal discussions and casual conversation, the criminal justice specialist can gradually work to sensitize these persons to the special needs of child victims. In turn, the specialist can learn about issues and problems from the court's perspective and relate this knowledge to Unit counselors who may be able to work with the victims to improve the strength of their legal cases. In sum, the data collection responsibilities of the criminal justice specialist have enhanced his relationships with prosecutors and court officials, thereby setting the stage for a meaningful dialogue between the project and the criminal justice system.

10.2 Coordination with Child Protective Services

Historically, the Child Protection Center (the Special Unit's parent project) had experienced strained relations with Child Protective Services, due to some competitive interest in handling similar cases. By including the CPS director in the Unit's Community Advisory Council, however, this problem was avoided and cooperative referral systems were developed. The system for reporting suspected child sexual abuse cases to CPS was described above: the Special Unit reports indirectly to CPS via the Police Department's Sex Offenses Branch and Youth Division. Occasionally, the Special Unit refers cases requiring neglect investigations directly to CPS; such referrals constitute about four percent of all referrals made by the Unit. Conversely, CPS refers cases to the Special Unit for medical evaluation when the caseworker suspects sexual abuse; these referrals are relatively rare because medical examinations are most effective within 48 hours after the abuse has occurred.

10.3 Coordination with the Public Health Department

Consistent with its unique focus on identifying incidents of sexual abuse through diagnosed cases of childhood venereal disease, the Special Unit has pursued a formal, collaborative link with the city's Public Health Department. Special Unit staff met with public health officials to discuss several important issues: the need for a designated testing center for children, the need to conduct contact investigations of childhood gonorrhea cases, and the need to establish policies governing the investigation of cases and reports to other agencies (i.e., police and CPS).

With the assistance of its Community Advisory Council, the Special Unit drew up a formal Interagency Agreement with the Public Health Department, Venereal Disease Control Division (VDCD). Under the terms of this agreement, VDCD designated a liaison person to provide epidemiologic follow-up of all children age 15 or younger who are diagnosed with syphilis or gonorrhea and

reported to the liaison representative within 24 hours of diagnosis. The official request for follow-up investigation is made by a Special Unit staff member through the Children's Hospital laboratory manager. The agreement further stipulates that the VDCD liaison will not become involved in legal proceedings, except perhaps as an expert witness.

The Special Unit also succeeded in persuading the Public Health Department to set up two venereal disease screening sites specially designated for testing children. Finally, the Special Unit has provided considerable training for public health nurses, as described in Chapter 11.

CHAPTER 11: COMMUNITY OUTREACH ACTIVITIES

Outreach to the general public and professional audiences has always ranked high on the Special Unit's list of priorities. The Unit employs an array of techniques to enhance general awareness of the problem of child sexual abuse and to assist professionals in dealing with the victims. This chapter presents the many outreach activities of the Child Protection Center-Special Unit: sponsoring task groups, conducting a community awareness program, developing and providing specialized professional training, and reaching a national audience through conferences and publications.

11.1 Task Groups

11.1.1 The Community Advisory Council

Among the first steps taken by the newly created Special Unit was to convene a Community Advisory Council. Council members are professionals and administrators in agencies concerned with child sexual abuse: D.C. public schools, other crisis assistance programs, law enforcement (Sex Offenses Branch and Youth Division), prosecutors (U.S. Attorney's Office and Corporation Counsel), probation, Child Protective Services, other medical facilities, and the general community. Total membership has varied in size from 21 to 32.

The Community Advisory Council was particularly instrumental in developing the scope and activities of the Special Unit. Its primary purposes were to enhance public education and awareness of the new project; to help set goals, objectives, and priorities; to provide a vehicle for exchanging information about procedures for handling child sexual abuse cases; and to improve coordination between Children's Hospital and other agencies.

In the first two years of project operations, the Council was divided into three subcommittees: Public Education, Case Management, and Medical-Legal Education and Mental Health. Each subcommittee can claim credit for several accomplishments.

Medical-Legal Education and Mental Health. This subcommittee was most heavily involved in developing and reviewing the Special Unit's extensive training curricula, discussed in Section 11.3 below. Members helped develop

the new Medical-Legal Sexual Assault Evidence form which was ultimately adopted by the Metropolitan Police Department for both adult and child sex offense investigations. They also contributed to the development of the Special Unit's protocols for examining victims and reporting cases to the appropriate authorities.

Public Education. Among the first activities of this subcommittee was to formulate an education and public relations plan so that the general public would quickly become aware of both the problem of child sexual abuse and the Special Unit's services for victims and families. As a result, the Special Unit has received extensive media coverage and staff are much in demand as speakers for various community groups. Members of the subcommittee reviewed and revised the project's two brochures (discussed in Section 11.2). Their recommendations of other counselors, therapists, and mental health centers in the D.C. area formed the basis for the Community Resource Directory now used by Unit counselors in referring clients for additional services. Members of this subcommittee also constituted the core of a Speakers Bureau which addressed community groups on behalf of the Special Unit.

Case Management and Review. This group was primarily concerned with identifying avenues of interagency cooperation in handling cases of child sexual abuse. They succeeded in establishing a cooperative reporting system whereby the Special Unit reports all cases to the Police Department's Sex Offenses Branch, which in turn notifies the Youth Division; if the case involves intrafamily abuse, the Youth Division investigates and forwards a report to Child Protective Services. This system ensures that all concerned agencies are properly and punctually notified of all child sexual abuse cases treated by the Unit. The Case Review subcommittee also helped to fashion an agreement between the Special Unit and the D.C. Public Health Department whereby the two agencies work together to ensure that all cases of prepubertal gonorrhea are followed up both to identify the source of contact and to determine whether abuse had occurred.

All Advisory Council members have arranged for the Special Unit to provide training to their agencies. More recently, they reviewed the project's testimony regarding proposed revisions to the D.C. Criminal Code. Finally, as the years of LEAA funding drew to a close, the Community Advisory Council turned its attention to securing funding for the Special Unit. The Council no longer meets on a regular basis, but is still available to advise the Unit upon request.

11.1.2 The Cross-Jurisdictional Council

The proximity of Children's Hospital to surrounding communities in Maryland and Virginia, coupled with the hospital's prestige in the Washington metropolitan area, have given rise to a number of cases referred to Children's

Hospital with complex jurisdictional problems. For example, a child who lives in Maryland may have been abducted from her home and assaulted in the District. Should the child be treated by the Special Unit or should she be referred to a therapist closer to home? Which law enforcement agency is responsible for the investigation, and how can they work together?

To answer questions like these and to ensure that victims will be treated competently, the Special Unit periodically convenes a Cross-Jurisdictional Forum. Invited to these meetings are mental health and criminal justice professionals from Montgomery, Prince Georges, and Baltimore Counties in Maryland; Arlington, Alexandria, and Fairfax Counties in Virginia; and the District of Columbia. A different set of persons has attended each meeting, but the participants typically represent rape victim assistance programs, protective services agencies, and law enforcement agencies. The agenda centers on sharing information about procedures used in each jurisdiction and resources available to treat child victims. More recently, the meetings have focused on formalizing lines of authority when complex cases occur, providing in-service education, and encouraging networking.

11.2 Community Awareness

The Special Unit has devoted considerable energy toward enhancing public awareness of both the problem of child sexual abuse and the Unit's availability to counsel victims and families. Two factors are especially critical to the prevention and treatment of child sexual abuse: (1) the ability of parents and teachers to recognize physical and behavioral signs of sexual abuse, and (2) their willingness to report the incident and seek help for the victims. All Unit staff are involved in public awareness activities, although the Unit's director, clinical coordinator, and criminal justice specialist are perhaps the most active.

Unit staff have appeared on numerous radio and television talk shows. Between September 1979 and June 1980, for example, they appeared on five television shows, including "The Baxters," a nationally syndicated issues program, and six radio shows, including the nationally syndicated "Parenting Plus." News articles highlighting the project have been published in the New York Times, Washington Post, Washington Star, and the CBS Editorial Service. A brochure developed by the Unit is distributed in local libraries, hospitals, day care centers, and by agencies represented on the Unit's Community Advisory Council. In addition, a parent information booklet is given to parents of all children seen by the Special Unit.

Early in the Unit's history, the staff developed a slide-tape show, later converted to film, for making presentations to large audiences. (Several of the photographs in this manual were taken from the original slide show.) Entitled Child Sexual Abuse: Trauma and Treatment, the film provides facts

about child sexual abuse and explains the approach to treatment offered by the Special Unit. The film discusses the hidden nature of the crime and explains the difference between normal sexual activity and abuse, noting that children are deemed incapable of giving informed consent to sexual activity.

The film then describes the Unit's approach to treatment, beginning in the emergency room. It explains the need for the physician to develop a rapport with the child before the examination and suggests a few techniques to help the child relax, e.g., letting the child play with the medical instruments or whisper into the doctor's ear. The scene then shifts to the playroom and shows how the child relates the incident through drawings, stories, and active play. Finally, the film introduces the criminal justice system and the role of the criminal justice specialist. The audience is reminded that relatively few cases of child sexual abuse ever go to trial, so that most victims are spared the interviews and appearances. For the minority who do go to court, the film shows the specialist and child as they tour the courtroom and talk to prosecutors. The film concludes with a meeting of Unit staff as they review their current caseload.

This 23-minute film is a standard feature of virtually all of the Unit's appearances with community groups and professional organizations. Speaking engagements are perhaps the Unit's most effective means of outreach, for they allow Unit staff to contact various groups representing a cross-section of the community. For example, in the first six months of 1980, the Unit gave presentations to the Arlington, Virginia, chapter of the National Organization for Women, faculty and staff of the D.C. public schools, the Action Federal Women's Program, the D.C. Rape Crisis Center, a group of foster grandparents, and students from the University of Maryland and George Washington University. The Unit also conducts more extensive training with members of medical, counseling, and criminal justice professions, described in the following section.

11.3 Professional Training

Professional training is a key component of the Special Unit's efforts to assist child victims of sexual abuse. There are three broad goals of the training effort:[1]

(1) to increase the capacity of other agencies to cooperate and communicate with each other around common case management problems;

[1] Child Protection Center-Special Unit, Fourth Quarterly Report submitted to LEAA, 1979, p. 5.

(2) to increase knowledge and skills in specific case management in other settings; and

(3) to encourage the development of new and more effective treatment methods.

The Unit's director estimates that one-half of the Unit's total resources are expended on training presentations and workshops.[2]

Training sessions range in length from one hour to three days, depending on the audience and the material to be conveyed. Typically, the Special Unit initiates the training effort. For example, a needs assessment questionnaire was mailed to supervisory personnel in adult, juvenile, and intrafamily branches of the D.C. Superior Court Probation Office prior to launching a training program. In addition, Community Advisory Council members were approached to supply the necessary impetus for Special Unit presentations in their respective agencies. Some agencies have since requested and received "refresher" training from Special Unit Staff. All clinical staff participate in the professional training activities.

As noted above, the Special Unit's staff have prepared a multidisciplinary curriculum which is cross-indexed so that sections most appropriate to medical, social services, or criminal justice personnel can be easily identified. For example, instruction on interviewing techniques for young children is relevant to virtually every audience, but instruction on the mechanics of collecting forensic evidence has a more limited audience of medical personnel and law enforcement officers. The index to this curriculum is included in Appendix B-1.

The Unit periodically evaluates the effectiveness of its training sessions. (The pre-test and post-training participant evaluation forms used in a recent seminar for public health nurses are included in Appendix B-5.) Evaluations of training sessions for pediatric nurse practitioners and personnel of the D.C. public schools concluded that the format, content, and usefulness of the training were rated excellent by the respondents, and that participants were able to enhance their skills in interviewing, case finding, and crisis counseling.[3]

[2] Joyce N. Thomas, Testimony to the D.C. City Council Committee on Human Services, November 1980, p. 16.

[3] Child Protection Center-Special Unit, First Quarterly Report to LEAA, 1980, p. 5.

11.3.1 Medical Training

The Special Unit gives presentations to the staff of Children's Hospital as part of the biannual Grand Rounds for all staff physicians and interns and as part of an ongoing lecture series for the Outpatient Division. Unit staff have also provided training in the Grand Rounds for the Psychiatry Department and for nurses. This training focuses on the collection and transfer of medical and laboratory evidence, techniques for interviewing the child victim, reporting requirements, hospital treatment procedures, and childhood venereal disease. The Unit routinely invites local pediatricians to the Grand Rounds and has held seminars for physicians in private practice.

The Special Unit has also provided medical training to staff of other hospitals as distant as Children's Hospital in Oakland, California, and as close as Baltimore City Hospital. Unit staff have been asked to speak at conferences of medical associations such as the National Black Nurses Association and the National Association of Nurse Practitioners and Nurse Associates. Training for public health nurses and other public health specialists focuses primarily on the investigation of childhood venereal disease cases, legal reporting requirements, methods of collecting medical evidence, and strategies for conducting contact investigations.

11.3.2 Social Service and Mental Health Worker Training

The Special Unit is also committed to providing training for social service and mental health personnel. This category includes social workers in the hospital as well as those in Child Protective Services and counselors in community mental health centers. The Unit has conducted a joint training session for probation officers in the D.C. Superior Court and caseworkers in Child Protective Services. They also gave an all-day presentation for school nurses, counselors, protective service workers, and social workers at the Family Planning Institute in Baltimore. In one recent three-month period, Unit staff visited two community mental health centers in the Washington, D.C., vicinity to train counselors in identifying and treating child victims of sexual abuse.

11.3.3 Criminal Justice Training

A large proportion of the Special Unit's training commitments are with agencies of the Washington, D.C., criminal justice system. Detectives in the Sex Offenses Branch and Youth Division of the Metropolitan Police Department received training in evidentiary issues, interviewing techniques, and concepts of child development. Recently, officers in the Sex Offenses Branch received additional training in techniques of interviewing adolescent victims.

Prosecutors from the U.S. Attorney's Office and the Office of the D.C. Corporation Counsel received training in techniques for interviewing and minimizing trauma to the child victim, methods of obtaining medical and forensic corroboration, factors related to child witness credibility, and issues in interagency collaboration in incest cases. Volunteer attorneys, who represent the children's interests in abuse and neglect proceedings, received similar training, with special emphasis on the psychodynamics of incest and alternatives to removing the child from the home.

11.4 Conferences and Publications

In November 1979, the Child Protection Center-Special Unit hosted the first national conference on the subject of child sexual abuse, attended by approximately 260 professionals from across the country. Agenda topics included federal funding patterns, human sexuality, and incest treatment. Topics for small group discussion included, among many others:

- emergency medical management;
- crisis intervention--theory and practice;
- childhood gonorrhea;
- interviewing the child victim;
- clinical assessment and treatment goals;
- the child victim--short-term and long-term reactions; and
- promoting professional collaboration in case management.

Several months later, in April 1980, the Law Enforcement Assistance Administration asked the Special Unit to host a colloquium entitled, "Child Victims of Sex Offenses and the Criminal Justice System." Approximately 25 representatives of child sexual abuse victim assistance programs, criminal justice agencies, and LEAA offices attended. Discussions centered around the benefits of invoking the criminal justice system in cases of child sexual abuse, aspects of the system that are detrimental to the child, and strategies for implementing change. As a result of these two conferences, the Special Unit has acquired a national reputation in the field of child sexual abuse treatment. The Unit will sponsor its second national conference in May 1982.

Also contributing to the Unit's visibility are the staff's publications in academic journals and presentations at national meetings of professional organizations. Following is a partial list of papers presented or published by the Special Unit staff:

- Horstmann, N.M., and Berg, R.F. Problems of sexually abused children: Clinical implications. Paper presented at the annual meeting of the American Psychological Association, Los Angeles, August 1981.
- Lloyd, D.W. An Overview of the Statutory, Police Investigative, and District of Columbia Superior Court Procedures Relating to Children Who Are Victims of Sexual Abuse. Unpublished manuscript, 1978, copyright pending.
- Lloyd, D. Medical-legal aspects of sexual abuse. Pediatric Annals, March 1979.
- Lloyd, D.W. Unequal protection: The criminal defendant and the child victim. Paper presented at the annual meeting of the American Psychological Association, Montreal, September 1980.
- Makstein, N.K., McLaughlin, A.M., and Rogers, C.R. Sexual abuse and the pediatric setting: Treatment and research implications. Paper presented at the annual meeting of the American Psychological Association, New York City, September 1979.
- Rogers, C.M. Sexual abuse and the courts: Empirical findings and implications. Paper presented at the annual meeting of the American Psychological Association, Montreal, September 1980.
- Rogers, C.M. Child sexual victimization and the prevention problem. Paper presented at the annual meeting of the American Psychological Association, Los Angeles, August 1981.
- Simrel, K., Berg, R., and Thomas, J. Crisis management of child sexual abuse cases. Pediatric Annals, March 1979.
- Thomas, J. Venereal diseases in children: A case of sexual abuse. Response, 1979, 2 (6).
- Thomas, J. Multi-professional management of child sexual abuse in an urban/hospital base setting. Paper presented at the American Public Health Association, 107th National Conference, New York City, November 1979.
- Thomas, J. Nursing management of child sexual abuse. RN Magazine, in press.
- Thomas, J. Early identification and intervention as a prevention method. Paper presented at the annual meeting of the American Psychological Association, Los Angeles, August 1981.
- Thomas, J., and Simrel, K. Childhood venereal diseases: An indication to initiate an investigation into the possibility of sexual abuse. Paper presented at the American Public Health Association, 107th National Conference, New York City, November 1979.

In addition, the Unit's procedures and policy manual, while not written for general dissemination, could be useful to practitioners seeking to replicate aspects of the Special Unit's approach. The prolific documentation of the Child Protection Center-Special Unit should be most valuable to others seeking to enhance services for child victims of sexual abuse.

EVALUATION AND REPLICATION ISSUES

CHAPTER 12: EVALUATION OF CHILD SEXUAL ABUSE PROGRAMS

Specialized treatment programs for child victims of sexual abuse are an emergent phenomenon. There is little precedent to guide them in developing treatment approaches, nor are there standards against which to gauge their performance. Indeed, it may be argued that any treatment for these children is preferable to none, and thus, merely by virtue of their existence, these programs are performing a valuable service for society. The Sexual Assault Center in Seattle and the Child Protection Center-Special Unit in Washington, D.C., however, are not satisfied with such a claim. Both projects have formulated explicit goals and objectives and have taken steps to measure their achievements. In doing so, their efforts have contributed to a field that is gaining increasing recognition. Moreover, routine data analysis has enabled the projects to identify problems and trends so that steps can be taken to address them.

Formal assessment of program effectiveness generally follows a standard, five-step approach: formulating the question, designing instruments, designing the study, collecting the data, and utilizing the results.[1] Although neither of the Exemplary Projects has undertaken such a formal approach to evaluation, the methodology is a useful device for discussing the tasks of program assessment. Consequently, this chapter is organized into six corresponding sections:

12.1 Articulation of Goals: why this step is important and how the projects have stated their goals

12.2 Instrument Design and Data Collection: forms used by the projects, routine analyses that are performed, and examples of how the findings contribute to program improvements

12.3 Approaches to Evaluation: distinctions between process and impact evaluations and techniques used by the Exemplary Projects

[1] U.S. Department of Justice, Law Enforcement Assistance Administration, Office of Juvenile Justice and Delinquency Prevention, Evaluation Issues (Washington, D.C.: Government Printing Office, June 1978), pp. 10-14.

12.4 Demonstration of Goal Achievement: enumeration of the projects' stated goals and supportive evidence of their achievement

12.5 Impact Assessment: An Example: brief description of a published study of the effectiveness of an incest treatment program

12.6 Summary: purposes and outcomes of routine assessment of project performance

12.1 Articulation of Goals

The importance of developing explicit program goals cannot be understated. Written goals serve to shape a program's operations and to ensure that all staff members share a common perception of purpose and priority. However, merely stating a general program mission will not suffice for purposes of assessing goal achievement. Rather, the program's goals and objectives must be stated in measurable terms, for example, "to reduce recidivism" or "to increase project caseloads." Once the project's goals have been properly articulated, the stage is set for the subsequent steps of evaluation.

The goals presented below are a composite of the goals and objectives set forth by the two Exemplary Projects. They are stated in general terms so that they should apply to most child sexual abuse victim assistance projects. To clarify this presentation, project goals are grouped into three categories: victim support goals, community awareness goals, and training goals.

Victim Support Goals

- to provide crisis intervention and supportive counseling services to victims and their families;
- to provide protection from sexual abuse to actual and potential child victims;
- to improve the response of the medical care system to victims;
- to improve the response of the criminal justice system to victims; and
- to improve interaction, coordination, and cooperative case management among legal, medical, and social service systems.

Community Awareness Goals

- to increase community awareness of the problem of child sexual abuse; and
- to increase community awareness of the resources available to deal with the problem.

Training Goal

- to provide training to professionals in related fields.

The following sections of this chapter discuss the techniques employed by the Exemplary Projects to assess their achievement of these goals. Section 12.4 presents the evidence supporting each project's accomplishments.

12.2 Instrument Design and Data Collection

Measuring the achievement of long-term goals is only one component of a program's self-assessment efforts. Sound management of a child sexual abuse victim assistance program, as with any human services program, also requires a periodic analysis of client characteristics, project caseloads, and services rendered. Such an analysis can identify, for example, whether certain population groups are underrepresented in the project's clientele, whether the clients' treatment needs are changing, or whether a particular source of referrals appears to be waning. In other words, frequent monitoring of the project's activities can reveal problems or changing trends which require staff attention.

In order to develop a strong data base, both the Sexual Assault Center and the Child Protection Center-Special Unit have designed forms to capture important information on each client receiving treatment from the project. Data collection forms used by the Seattle Sexual Assault Center are reproduced as Exhibits 1 and 2. Staff social workers complete the patient profile form shortly after their initial interviews with the client and fill out the case checklist as each case progresses through the medical exam, is reported to police or Children's Protective Services, or enters prosecution. The statistics are collected monthly and reported annually by a staff research assistant. The annual report for clients seen by the Sexual Assault Center in 1980 is contained in Appendix A-6.

An annual review of these statistics over the life of the project has revealed important trends. For example, an increasing proportion of child victims are not receiving initial medical care at Harborview Medical Center, but rather from private physicians and community clinics. Based on this

EXHIBIT 1
S.A.C. Patient Profile

For Administrative Use Only

(1-6)- ☐☐☐☐☐☐ SAC ID#

(7-8)- ☐☐ Worker ID#

(9-14)- ☐☐/☐☐/☐☐ Date of initial HMC/SAC contact

(15-16)- ☐☐ Age (Child, teen, or adult if exact age is unknown): _____

(17)- ☐ Sex 1 = male, 2 = female

(18)- ☐ Race:
1 = Caucasian
2 = Black
3 = Spanish-American
4 = Native American
5 = Asian
6 = Other: _____
0 = Do not know

(19)- ☐ DPA/Medicaid (welfare):
1 = yes, 2 = no, 0 = Do not know

(20)- ☐ Developmentally disabled or handicapped
1 = yes, 2 = no, 0 = Do not know

(21-22)- ☐☐ Who referred client to HMC/SAC?
01 = Self-referred
02 = Friend/neighbor
03 = Family member
04 = CPS
05 = Police
06 = Rape Relief
07 = Social agency
08 = Doctor/medical
09 = Prosecutor
10 = Other: _____
11 = Media
00 = Do not know

(23)- ☐ Time lapse since last assault/incident:
1 = Less than 48 hours
2 = 2 days to 2 weeks
3 = 2 weeks to 6 months
4 = 6 months or longer
9 = No abuse found
0 = Do not know

(24)- ☐ Number of assailants and incidents:
1 = Single incident, single offender
2 = Single incident, multiple offenders (such as in gang rape)
3 = Multiple incidents, single offender
4 = Multiple incidents, multiple offenders (such as in incest cases with parent and uncle both offending over time)
9 = No abuse found
0 = Do not know

(25-26)- ☐☐ Relationship of assailant to victim: (If more than one, code most significant to victim.)
01 = Stranger
02 = Acquaintance
03 = Friend of family
04 = Neighbor
05 = Co-worker
06 = Babysitter
07 = Exhusband/lover (adult victim)
08 = Husband/lover (adult victim)
09 = Natural parent
10 = Adoptive parent
11 = Step-parent
12 = Foster parent
13 = Parent's live-in partner
14 = Parent's partner (not live in)
15 = Other relative: _____
16 = Grandparent
17 = Uncle
18 = Sibling
19 = Cousin
20 = DO NOT KNOW
21 = NO ABUSE FOUND

(27)- ☐ Type of Assault: (If more than one, code most significant to victim)
1 = Rape
2 = Attempted rape
3 = Child molestation (stranger/acquaintance)
4 = Child incest (adult living in home or relative in or out of home)
5 = Other: _____
7 = Adult, molested as child (stranger/acqu.
8 = Adult, incest as child
9 = No abuse found
0 = Do not know

(28)- ☐ Location of assault:
1 = Victim's home
2 = Assailant's home
3 = Other's home
4 = Victim's car
5 = Assailant's car
6 = Public place: _____
7 = Other
9 = No abuse found
0 = Do not know

_____ Neighborhood where assault occurred

(29)- ☐ Has the abuse been reported to CPS
(1 = yes, 2 = no, 9 = No abuse found, 0 = Do not know)

(30)- ☐ Has the abuse been reported to police?
1 = yes, Seattle PD
2 = Yes, King County Sheriff's Department
3 = Yes, other: _____
4 = No
9 = No abuse found
0 = Do not know

(31)- (Blank)

SERVICES PROVIDED TO VICTIM (intake month): (Code at least one service)

(32)- ☐ Medical exam
(33)- ☐ Counseling
(34)- ☐ CJS Advocacy
→ 1 = yes, 2 = no

(35)- ☐ **** Seattle Rape Relief involvement:
1 = yes, 2 = no, 0 = Do not know

**** (64)- ☐ Is victim member of female-headed household?
1 = Yes (woman financially responsible for self and/or others)
2 = No or Joint (spouse/partner households, include adult male victims)
0 = Do not know

(65-66)- ☐☐ Number of family members and friends of victim contacted.

For Administrative Use Only

(36)- ☐ POE: _____

(37)- ☐ Initial Medical: _____

(38-42)- ☐☐☐☐☐ Reside: _____

(43-47)- ☐☐☐☐☐ Assault: _____

(48-52)- ☐☐☐☐☐ **** DHR

6/81

EXHIBIT 2
Case Checklist

MEDICAL CARE

1. Date of initial exam: _____

Reason, if no exam: _____

	DATE	Positive	Negative
GC (EUROV)	____	____	____
VDRL	____	____	____
PAP	____	____	____
Gravindex	____	____	____
MAT (_____)	____	____(yes)	____(no)

2. Date of follow-up exam: _____

	DATE	Positive	Negative
GC (EUROV)	____	____	____
PERIOD	____	____(yes)	____(no)
3. 8-Week VDRL	____	____	____

CPS INTERACTION

1. __ Reported to CPS

Date _____

Caseworker (& ph. #) _____

2. __ Not reported to CPS

Reason: _____

NAMES AND PHONE NUMBERS OF SIGNIFICANT OTHERS INVOLVED WITH CLIENT

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

CJS INTERACTION

Reporting:

1. __ Not reported

Reason: _____

2. Police jurisdiction: _____

Date of report: _____

3. Detective: _____

Date of interview: _____

4. Prosecuting Attorney: _____

Date of interview: _____

Prosecution:

1. __ Declined: date: _____

Reason: _____

2. __ Charged: date: _____

With what: __ Indecent liberties

__ Incest

__ Rape: 1° 2° 3°

__ Statutory Rape: 1° 2° 3°

__ Misdemeanor (sex offense)

__ Other: _____

_____

Disposition:

1. __ Plead to original charge

Date: _____

2. __ Plea bargained: date: _____

What charges: _____

3. __ Dismissed by State

Date: _____

Reason: _____

4. __ Trial: date: _____

__ Convicted

What charges: _____

__ Mistrial
__ Acquitted
__ Dismissed by Court
Reason: _____

observation, the Sexual Assault Center has concentrated its training and outreach more heavily on doctors in the community, encouraging them to treat child sexual abuse victims sensitively and to collect the forensic evidence necessary for prosecution. In addition, the Center found that a large proportion of their clients are molested at a very early age; for example, 1980 data show that 41 percent of the child victims treated were under eight years old and that 62 percent were not yet 13 years old. This finding has prompted the Center to place greater emphasis on their awareness program for elementary schools.

Data collection and analysis have always been principal components of the Child Protection Center-Special Unit in Washington, D.C.; the project has had a full-time director of research since its inception. The Unit's counseling staff maintain detailed records for each case in order to build a comprehensive data base on the types of cases being handled by the program, the needs of the child and family, and the effectiveness of the Unit's services. The data collection instruments designed by the Special Unit are, in themselves, a significant contribution to the field, especially in their attempt to capture complex information such as parental and child responses to counseling. Several forms are filled out for each case (selected examples appear in Appendix B-6):

- Intake Note, filled out by the intake counselor to record identification information on both the child and her parent, scheduled laboratory work, the intake counselor's initial impressions from the parent and child interview, and the status of law enforcement activity, if any;
- Case Summary Form, on which is recorded demographic information on the victim, details of the incident, and preliminary observations of parental reactions;
- Child Behavioral Checklist, completed by parents to assess the physical, interpersonal, affect, and behavioral problems manifested by the child victim;
- Parental Response Follow-Up Form, completed by the counselor after each session with a parent to assess the parent's feelings along several dimensions;
- Clinical Services Summary Form, on which the staff log all events in the treatment of each case--for example, counseling appointments or referrals for other services;
- Medical Summary Form, a single page on which all laboratory results are compiled; and
- Directory of Involved Personnel, on which is recorded the names of both the Children's Hospital staff and the personnel of other agencies (e.g., criminal justice, CPS, school) contacted in each case.

The D.C. project staff caution that if the number of forms becomes too large, or if the structure of the forms is too complex, recordkeeping can become burdensome to the program's counselors. Thus, the possible value of each form must be weighed against the time that will be required to maintain records on each case and to compile that information.

In reporting its case summary statistics, the Special Unit distinguishes between three categories of clients: intakes, who are interviewed directly by a Unit counselor; incoming referrals, who are expected to become intakes but have not been interviewed at the time the report is prepared; and consults, who are known to the project only through telephone contact with the victim, a family member, or an outside agency or counselor. For research purposes, the Unit attempts to compile as much information as possible on all three categories, though the most extensive data are obtained on project intakes. The criminal justice specialist, for example, tracks the cases of incoming referrals as well as those of Unit intakes, thus providing a more complete picture of case processing (see Chapter 10).

The Unit's research director prepares both quarterly reports and cumulative reports which tabulate selected data from the time of project inception to the date of the report. Table 12.1 shows a sample quarterly statistical report. The Unit has purchased a limited amount of computer time from George Washington University, and the results of various analyses have been published in journal articles and presented at conferences. Unfortunately, financial constraints have so far precluded a thorough analysis of much of the data collected by the project.

12.3 Approaches to Evaluation

Performance assessments of human services programs can be described as either process evaluations, which are "accomplished through careful and systematic documentation of staff activities, project attributes, recipients, etc., and the conditions and changes in any of these;"[2] or impact evaluations, which are designed to demonstrate the extent to which project activities created some change in a target group.[3] In an optimal situation, both process and impact evaluations would be performed concurrently so that program administrators would learn not only whether their programs were having the desired effects (impact), but also which elements of the programs may have contributed to or detracted from the program's success.[4]

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[2] Evaluation Issues, op. cit., p. 4.

[3] Ibid., p. 4.

[4] Ibid., p. 5.

Table 12.1
Summary Intake Statistics 9/16/80 - 12/15/80
Child Protection Center-Special Unit

	MALE VICTIMS		FEMALE VICTIMS		TOTAL	
Case Type (Base N=62)*	N	(%Base N)	N	(%Base N)	N	(%Base N)
Alleged Sexual Abuse	13	21%	40	65%	53	86%
Childhood Gonorrhea	0	0	4	6	4	6
Other	1	2	4	6	5	8
Column Total	14	23%	48	77%	62	100%
Type of Offense (Base N=53)						
More serious**	12	23%	32	60%	44	83%
Less serious	1	2	8	15	9	17
Column Total	13	25%	40	75%	53	100%
Victim Age (Base N=62)						
Under 8 years	6	10%	20	32%	26	42%
8 years or older	8	13	28	45	36	58
Column Total	14	23%	48%	77%	62	100%
Offender Age (Base N=50)						
Under 18 years	7	14%	9	18%	16	32%
18 years or older	5	10	29	58	34	68
Column Total	12	24%	38	76%	50	100%
Offender Relationship (Base N=53)						
Parental Figures	0	0%	20	38%	20	38%
Other relatives	1	2	8	15	9	17
Others, known to victim	12	23	9	17	21	39
Strangers	0	0	3	6	3	6
Column Total	13	25%	40	75%	53	100%

*Base Ns vary because the Unit did not have complete information on all cases at the time the table was compiled.

**More serious offenses are those involving oral or anal sodomy or vaginal intercourse.

Source: Child Protection Center-Special Unit, Fourth Quarterly Report to LEAA, 1980.

While process evaluations often take the form of very detailed, qualitatively analytic case studies, impact evaluations require the imposition of experimental conditions and data collection techniques that may be beyond the resources of many programs. Many of the goals listed for the two Exemplary Projects in Section 12.1 can be assessed either through process or impact evaluation. Both the Sexual Assault Center and the Child Protection Center-Special Unit have opted for process evaluations, not only because of the complexity of impact evaluation, but because the outcomes of process evaluation more closely suited their immediate need to improve upon project operations as specified in their stated goals. As described in the publication, Evaluation Issues, cited above, a process evaluation:

> involves more than monitoring project activities and careful documentation of project characteristics. It also requires judging the quality, adequacy, or appropriateness of the procedures and making necessary adjustments.[5]

Using this definition of process evaluation, both qualitative and quantitative measures are integral to assessing goal achievement. This is the approach taken by the two Exemplary Projects, as described in the following section.

12.4 Demonstration of Goal Achievement

This section presents the outcomes of assessments undertaken by the Sexual Assault Center and the Child Protection Center-Special Unit in their efforts to demonstrate goal achievement. For readers interested in pursuing impact evaluations, an example is provided in Section 12.5 of an evaluation of counseling effectiveness in one well-known incest treatment program. Readers desiring greater detail in the methodology and techniques of impact evaluation are encouraged to consult a standard evaluation textbook.[6]

12.4.1 Victim Support Goals

Goal 1: To provide crisis intervention and supportive counseling services to victims and their families.

Neither the Sexual Assault Center nor the Child Protection Center-Special Unit can estimate the proportion of child sexual abuse victims in their

[5] Evaluation Issues, op. cit., p. 4.

[6] See, for example, Carol H. Weiss, Evaluation Research (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1972), or Emil J. Posavac and Raymond G. Carey, Program Evaluation: Methods and Case Studies (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1980).

respective jurisdictions that are receiving project services. The problem lies in the hidden nature of the crime. Many incidents are never reported to authorities, so that programs have no way of knowing how many children are treated by other medical or counseling agencies or how many are not treated at all. In Seattle, referral agreements with Children's Protective Services and the major police departments suggest that the Sexual Assault Center is treating virtually all victims known to those authorities. In D.C., the Special Unit certainly treats all victims referred to Children's Hospital, but because the police are prohibited by law from making direct referrals to a private hospital unless specifically requested by the victim or family, an unknown proportion of child victims are taken elsewhere. The project estimates that 70 percent of child sexual abuse victims in D.C. are treated at Children's Hospital.

Both projects compile data on the services they provide to children referred for treatment. Table 12.2 shows the services provided by the Child Protection Center-Special Unit to clients treated since 1979. The project does not routinely report these data in terms of what percentage of clients receive various combinations of services.

Table 12.2
Direct Services Provided
Child Protection Center-Special Unit

Type of Direct Service	Percentage of Services Provided
Psychological Assessment/Evaluation	26%
Crisis Intervention (Short-term Counseling/Therapy)*	46%
Medical Follow-Up Services**	11%
Case Tracking/Court Accompaniment	9%
Other***	8%

*All project intakes receive at least one counseling/crisis intervention session.
**Excludes intake exam provided to 98 percent of Special Unit clients.
***Includes interviews with client attorneys, consultation with other hospitals or physicians, and handling related problems with siblings.

Source: Child Protection Center-Special Unit statistics.

Table 12.3 shows the direct services provided by the Sexual Assault Center. The project reports the combinations of services provided to both incest victims and nonfamily assault victims.

In addition to documenting the services they now provide to child sexual abuse victims, both the Child Protection Center-Special Unit and the Sexual Assault Center have documentation of the relative dearth of services avail-

Table 12.3
Direct Services Provided
Sexual Assault Center

Type of Service Provided	Total Child Victims N	Total Child Victims % of Clients	Nonfamily Assault N	Nonfamily Assault % of Clients	Incest Victims N	Incest Victims % of Clients
Medical only	18	2%	10	3%	8	2%
Medical and counseling	185	25%	118	33%	67	18%
Counseling only	306	42%	133	37%	173	46%
Counseling and legal advocacy	128	18%	60	17%	68	18%
Medical, counseling, and legal advocacy	93	13%	36	10%	57	15%
TOTAL	730	100%	357	100%	373	99%

Source: Sexual Assault Center statistics, 1980.

able in years prior to project inception (see Chapters 7 and 2, respectively). In the District of Columbia, an analysis was performed on the characteristics of sexual abuse victims treated by the Child Protection Center before the Special Unit was created. In Seattle, a law student had independently conducted a study of the management of these cases within the criminal justice system. These studies found serious deficiencies in the services available to assist child victims, both in Seattle and Washington, D.C. Both projects have succeeded in developing specialized counseling programs where there had been none before.

Goal 2: To provide protection from sexual abuse to actual and potential child victims.

Protecting a particular child victim against reincidence is a problem largely confined to intrafamily cases or cases in which parental neglect contributed to an assault by a neighbor or friend. In Seattle, the Sexual Assault Center attempts to persuade most family offenders to leave the home immediately and to stay away until the crisis is resolved. Children's Protective Services (CPS) is responsible for monitoring the offenders' compliance with no-contact orders imposed by the Juvenile Court. Once the offender enters treatment, voluntarily or by court order, his therapist maintains contact with Center staff, and decisions on reuniting the family are dealt with jointly by the project, CPS, the offender therapist, and of course, the family.

The most drastic means of attempting to protect these children is to remove them from their homes or to remove the offender if he shares the household.[7] In the District of Columbia, as in most jurisdictions, when an arrest is made, the offender is frequently placed under a no-contact order by the criminal court as a condition of pretrial release. A similar order may be imposed by the juvenile (or family) courts as a means of protecting the child pending further investigation and disposition of the case. However, often there is some delay in obtaining these orders from the court. Removing the child from the home is usually considered to be the last resort. In fact, the Special Unit's statistics reveal that in nearly three years of project operations, from February 1978 to December 1980, only 18 child sexual abuse victims were committed to foster care.[8]

Protecting potential victims from sexual abuse is a matter of prevention. Because prevention is a long-term goal, however, it is difficult to measure the effects of a project's efforts to reduce the actual incidence of child sexual abuse. Through their many outreach and public awareness activities, both projects have taken steps to inform the community of the reality of child sexual abuse and ways to recognize and treat children who have been victimized. A major target of the projects' public awareness campaigns has been the schools--parents, teachers and counseling staff, and students. This effort probably constitutes the most effective strategy for preventing sexual abuse of children.

Goal 3: To improve the response of the medical care system to victims.

Both the Sexual Assault Center and the Child Protection Center-Special Unit have developed protocols to guide physicians in conducting thorough and sensitive examinations of child sexual abuse victims. Both projects provide extensive training in the use of their protocols and examination techniques to hospital physicians, interns, and nursing staffs, in emergency rooms and outpatient clinics not only in their own hospitals, but in other medical facilities and private offices. Police and prosecutors in both jurisdictions report that the projects' protocols for interviewing child victims have significantly improved the quality of cases presented for prosecution. Finally, in Washington, D.C., the Special Unit has persuaded the city's Public Health Department to establish two venereal disease screening sites that are designated for testing children. Further detail on improvements in the medical arena is provided in Chapters 4 and 9.

Goal 4: To improve the response of the criminal justice system to child victims and their families.

As was noted in Chapter 1 and will be discussed more fully in Chapter 13, there is considerable controversy among mental health, social service, medical, and even criminal justice professionals as to the appropriateness of criminal justice involvement in child sexual abuse cases. Some child victim assistance projects, like the Sexual Assault Center and the Child Protection Center-Special Unit, strongly endorse criminal prosecution; others make it a policy to keep their clients out of the system wherever possible. Regardless of their stance towards criminal justice system involvement, however, all programs should recognize that a certain proportion of their clients will be drawn into that system nevertheless. Thus, it becomes critical to take steps to make the experience of prosecution less traumatic for victims and their families and to make the system more responsive to their needs.

In Seattle, prior to the project's inception, the case management problems in the criminal justice system were severe, as described in Chapter 2. After one year under the LEAA grant, the Sexual Assault Center retained a consultant to evaluate the outcomes of project intervention in the criminal justice system. Based on personal interviews with police and prosecutors in King County, the evaluator reported the following results:[9]

- As a result of discussions between Center staff and law enforcement personnel, a joint detective/prosecuting attorney interview of the child victim was instituted to reduce the number of times the child had to recount the specifics of the abuse incident.
- Criminal justice respondents reported that they were more effective interviewers of children as a result of project training.
- Presence of a counselor during the interview was reported by law enforcement and criminal justice personnel to be helpful. It gave the child a sense of security and enabled the interviewers to obtain more details. In one particularly difficult case, the detective requested that the counselor conduct the interview while he took notes.

[7] It should be noted that the "home" may not have been intact at the time of the incident--e.g., a child may be abused by her biological father who is divorced from her mother, but abuses his daughter at visitations. In other circumstances, a mother may choose to leave the home with her children. Also, children placed in foster homes are not guaranteed immunity to sexual abuse; they may fall prey to unscrupulous foster parents or older children in the home.

[8] Child Protection Center-Special Unit, Fourth Quarterly Report to LEAA, 1980.

[9] Jon R. Conte, Memorandum to Lucy Berliner, December 30, 1978.

- Child sexual abuse cases are assigned to a prosecuting attorney who sees the case through the pretrial and trial process. Prosecutors who were interviewed felt that this vertical system resulted in more sensitive handling of the child victim as well as more effective prosecution of cases.

- The project identified a network of experts in the evaluation and treatment of juvenile and adult offenders and advocated with prosecutors and the courts for particular sentencing alternatives.

While Seattle project staff stress that they leave the decision to press charges up to families, both they and the prosecutor's staff report that few families drop charges once they decide to prosecute. Indeed, the Chief of the Prosecuting Attorney's Special Assault Unit credits the Sexual Assault Center with "keeping cases together" throughout the ordeal of criminal prosecution. Data collected in three separate studies appear to support this conclusion, although the actual impact of the Center's efforts has not been measured directly. In 1973 and 1974, prior to project start-up, 94 cases had been disposed of in King County Superior Court.[10] A later study found that 84 cases had been disposed of in 1978 alone, the first year of project operations.[11] The number of cases processed continues to increase. In 1980, the Special Assault Unit of the King County Prosecuting Attorney's Office filed 215 child sexual abuse cases, and 193 reached disposition (the remainder were still pending as of April 1981).[12] Only 17 cases were dismissed before trial, for reasons including noncooperative parents, death of the defendant, or a later determination that a child was incompetent to testify. The Special Assault Unit Chief noted that this eight percent dismissal rate was considerably lower than that of cases involving adult victims of sexual abuse, which was 14 percent for cases filed in 1980.

The Sexual Assault Center's emphasis on prosecution has been coupled with aggressive efforts to identify and utilize offender treatment programs and to have offenders referred for treatment as one of the outcomes of prosecution. This dual emphasis may account for the project's success, according to the Chief of the Prosecutor's Special Assault Unit. Prosecution of offenders without the possibility of treatment is unlikely to win the cooperation of victims and their families, especially if the offender is either a family member or known to the family.

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[10] Christine McKenna, "A Study in King County of Child Victims of Sexual Assault: Results and Recommendations for Police and Prosecutors," unpublished manuscript, Seattle, Washington, Summer 1975.

[11] Jon R. Conte and Lucy Berliner, "Prosecution of the Offender in Cases of Sexual Assault Against Children," forthcoming in Victimology.

[12] Special Assault Unit statistics, King County Prosecuting Attorney's Office, 1981.

Table 12.4 shows that the proportion of sentences explicitly requiring counseling appears to have increased over the three time periods for which sentencing data were compiled. In 1973-74, some proportion of the 48 deferred sentences incorporated counseling in the community; in 1978, the figure was 51 percent; and in 1980, approximately 66 percent of the sentences required outpatient counseling. At the same time, the proportion of sentences to inpatient treatment at Western State Hospital also increased, from 10 percent in 1973-74, to 14 percent in 1978, and 19 percent in 1980.

Table 12.4
Sentences Imposed on Defendants
Convicted of Crimes Involving Child Sexual Abuse,
1973-74, 1978, and 1980, King County, Washington

Sentence Imposed*	1973-74		1978**		1980	
	N	%	N	%	N	%
Jail or prison	16	19%	44	60%	22	14%
Western State Hospital	8	10	10	14	30	19
Counseling	-	-	38	51	103	67
Restitution	-	-	15	20	-	-
Deferred***	48	58	-	-	-	-
Suspended	11	13	-	-	-	-
Other (usually court costs)	-	-	55	74	-	-
TOTAL	83	100%	162	NA	155	100%

*Reporting categories differ among the three studies.

**The study reports patterns of multiple sentences for 74 convicted defendants, e.g., 21 defendants (28 percent) were sentenced both to jail/work-release and counseling. The column in the table reflects the percentage of total sentences that incorporate each alternative, and thus the total exceeds 100 percent.

***Reporting for outpatient therapy was a condition commonly attached to deferred sentences, although the study does not report the actual frequency.

Sources: Christine McKenna, "A Study in King County of Child Victims of Sexual Assault: Results and Recommendations for Police and Prosecutors," unpublished manuscript, Seattle, Washington, Summer 1975, p. 35;

Jon R. Conte and Lucy Berliner, "Prosecution of the Offender in Cases of Sexual Assault Against Children," forthcoming in Victimology, p. 13;

Special Assault Unit statistics, King County Prosecuting Attorney's Office, 1981.

The Child Protection Center-Special Unit in Washington, D.C., also has taken steps to improve the criminal justice system response to child victims. The Unit's criminal justice specialist works closely with the children and their families to ensure that they understand the need for prosecution and the procedures involved. He takes the children for a tour of the courtroom and rehearses their testimony so they will be better prepared for defense cross-examination. He also advises Unit counselors regarding their clients' apparent readiness for court so that counselors can focus their efforts on each client's individual needs. The criminal justice specialist's direct assistance is perhaps the most visible way in which the Special Unit supports victims in the legal proceedings.

Training seminars and presentations are another vehicle used by the project to press for change in the system. Prosecutors, both in the U.S. Attorney's Office and the D.C. Corporation Counsel, and police have been trained in interviewing techniques and basic principles of child development. (The project's training efforts are described more fully in Chapter 11.) Also, the criminal justice specialist testified at hearings regarding a proposal to reorganize sexual assault offenses into a new chapter of the D.C. Criminal Code. The Unit's recommendations pertained to: (1) eliminating the requirement for corroborative evidence; (2) eliminating cross-examination on the victim's sexual history, except under extraordinary circumstances; (3) voting down a proposal to allow voluntary intoxication as a defense; and (4) requiring harsher penalties for sexual offenses involving a child. Some of these recommendations were incorporated in the D.C. City Council's final proposal. However, the legislative process in the District of Columbia is unique in that all proposed revisions must be reviewed and approved in the U.S. Congress. Congress did not pass the City Council's proposal, and the laws pertaining to child sexual abuse remain unchanged.

Finally, as a result of the criminal justice specialist's diligence in tracking all known cases of child sexual abuse from the initial report to police to final case disposition, the Child Protection Center-Special Unit possesses perhaps the most comprehensive picture available of the processing and outcomes of child sexual abuse cases in a single jurisdiction. The criminal justice specialist's records reveal that only a small number of cases "fall out" of the D.C. criminal justice system because of victim or family noncooperation, and, although it is difficult to document, it may be surmised that the Special Unit's constant support and encouragement help to persuade families to pursue prosecution. Also, through the specialist's case tracking activities, he has cultivated informal contacts with prosecutors, and they have come to rely on him for advice regarding a child's ability to testify, the availability of evidence, or recommendations for expert witnesses. Finally, the project has taken concrete steps to address the single major cause of case attrition, the lack of corroborative evidence, by improving the evidence reporting form used by police and by advocating for the elimination of the corroborative evidence requirement from the D.C. Criminal Code.

Goal 5: To improve interaction, coordination, and cooperative case management among the legal, medical, and social service systems.

An incident of child sexual abuse may come to the attention of a number of professionals in both public and private agencies: physicians, caseworkers, therapists, police, and attorneys. If the incident is reported to authorities, two or more of these persons are likely to become involved in what should be a cohesive, complementary strategy for helping the child and family to overcome the immediate crisis and move forward with their lives. The agencies most frequently sharing responsibility for case management will depend largely on the types of cases that are reported in the community (i.e., intrafamily or nonfamily) and the attitudes of key personnel in those agencies. Unfortunately, however, in many communities the medical, mental health, social service, and legal professions are unaccustomed to working together and may view each other as adversaries. Both the Sexual Assault Center and the Child Protection Center-Special Unit have assumed a "catalyst" role, taking steps to bridge the gaps among these professions in order to achieve cooperative case management.

In Washington, D.C., the Special Unit's creation of the Community Advisory Council was its first attempt to persuade agency representatives of the need to adopt a common goal in managing child sexual abuse cases. As noted in Chapter 11, Council members include officials in law enforcement, prosecution, child protection services, probation, public health, and various community groups. Inclusion of CPS was a significant accomplishment because that agency had experienced conflicts with the Child Protection Center prior to the Special Unit's inception. The Cross-Jurisdictional Forum is another group of agency representatives convened by the Special Unit to encourage coordination of case handling. This group is attempting to define the lines of authority that apply when cases involve more than one jurisdiction, a situation that occurs frequently in Washington, D.C. Finally, the Special Unit attempts to foster interagency coordination in its extensive training sessions and professional conferences, where the need for cooperative case management is a featured topic.

In Seattle, the following accomplishments have been attributed to the initiative of Sexual Assault Center staff:

- institution of joint police/prosecutor interviews;
- creation of the Special Assault Unit of the King County Prosecutor's Office;
- creation of the Sexual Abuse Unit of Children's Protective Services;
- development of a CPS protocol for informing police of reported child sexual abuse; and

- institution of weekly meetings of Sexual Assault Center staff, police, prosecutors, and CPS.

These weekly meetings exemplify the Sexual Assault Center's approach to child victim assistance. The meetings take place in an atmosphere of mutual respect and common purpose. Questions both specific to individual cases and general to the subject of improved case management are raised, and everyone's voice is heard. It is important to note, too, that in recent years several sex offender therapists have become active members of the network of agencies involved in aspects of child sexual abuse, maintained by the Sexual Assault Center. Not yet represented in this network, however, are the juvenile divisions of the Seattle Police Department and King County Prosecuting Attorney's Office. Project staff have indicated that members of these divisions remain unconvinced of the Center's approach to case management (for reasons discussed in Chapter 5). The Sexual Assault Center has accelerated its outreach to these groups in hopes that they will eventually adopt the strategies used by agencies in the network.

12.4.2 Community Awareness Goals

Goal 1: To increase community awareness of the problem of child sexual abuse.

Chapters 6 and 11 described the outreach efforts of the Sexual Assault Center and the Special Unit, respectively. Both projects are heavily committed to speaking engagements and presentations for a wide range of community groups. Both have appeared on local television and radio talk shows and have contributed to newspaper articles discussing the problem of child sexual abuse. The Sexual Assault Center has additionally developed a special program for presentation to school-age children, their parents and teachers. Both projects estimate that they have reached several thousand people through their community awareness programs.

Goal 2: To increase community awareness of the resources available to deal with the problem.

One measure of achievement of this goal is increasing project caseload over time. If the general public comes to know that an effective resource is available to assist them, particularly when there were no resources before, then that resource should experience an increasing caseload.

Both projects have demonstrated increased caseloads in the years since their inception. In the District of Columbia, the predecessor Child Protection Center had treated 151 child victims of sexual abuse in the two and one-half years between October 1975 and March 1978, when the Special Unit began operations. In calendar year 1978, the Special Unit treated 150 child sexual

abuse victims. The number of project intakes increased in 1979 to 185, and again in 1980 to 194. Concurrent with the increase in client caseload, the Special Unit has recorded a substantial increase in requests for consultation: from 45 in 1978, to 107 in 1979, to 114 in 1980. Clearly, the Special Unit is recognized as a valuable source of advice and assistance in the Washington metropolitan area.

In Seattle, the Sexual Assault Center also has experienced an increase in caseload. The project has recorded the number of child victims treated by the Center since 1974, as shown in Table 12.5 below. The Law Enforcement Assistance Administration funded the Center's Child Victim/Witness Project in October 1977, and it was in that year that the Center saw its most dramatic increase in child clients. The caseload has continued to rise ever since.

Table 12.5
Annual Caseload of Child Victims
Sexual Assault Center

Year	N	Percent Increase Over Previous Years
1974	79	
1975	110	39%
1976	156	42%
1977*	251	61%
1978	359	43%
1979	525	46%
1980	730	39%

*Year in which the Child Victim/Witness Project was initiated.

Source: Sexual Assault Center annual statistics, 1974-1980.

12.4.3 Training Goals

Goal 1: To provide training to professionals in related fields.

Enumeration of the various professional training activities of the Sexual Assault Center and the Child Protection Center-Special Unit was provided in Chapters 6 and 11, respectively. Both have offered extensive training to members of the medical, social services, mental health, and criminal justice professions both locally and elsewhere in the country. In Seattle, the Center's training is a fully-incorporated component of the State Police Academy. In 1980, the Center was awarded a grant to develop a regional Treatment-Training Institute for agencies dealing with child sexual abuse victims in 10 states.

The Special Unit in Washington, D.C., has developed a multi-disciplinary curriculum which is cross-indexed for police, nurses, physicians, and social workers. The cross-index allows members of each discipline to identify quickly those topics that are most appropriate to their interests. Certain subjects, such as facts and myths about the incidence of child sexual abuse, case management procedures, and issues and problems of victim treatment, are germane to all four disciplines. Other topics are clearly audience-specific--for example, medical examination protocols are relevant only to nurses and physicians; the child's need for a "friend" during interviews and court proceedings has more meaning for police and prosecutors. The table of contents to the curriculum is contained in Appendix B-1.

The Special Unit has attempted to evaluate the effectiveness of its training in enhancing participants' knowledge of child sexual abuse and its treatment. The pretest and participant evaluation instruments used in a recent Special Unit training session for public health nurses are attached in Appendix B-5. The results of these evaluations have not been compiled, but the Unit's research director reports that they have been uniformly positive in terms of measures of increased understanding among training participants, and that findings have been used to refine the Unit's training approach.

The Sexual Assault Center also has developed an instrument to capture the reactions of participants in its Treatment-Training Institute. Unlike the pretest-posttest evaluation of the D.C. Special Unit, however, Seattle's form does not test increases in knowledge of specific items, but rather asks respondents to rate the usefulness of various components of the two-week training session. The results are currently being analyzed by an independent evaluator.

12.5 Impact Assessment: An Example

Although it may be impractical for a child victim assistance program to attempt a full-scale impact evaluation, such studies can provide the most reliable evidence of the effectiveness of project services. To date, there has been one published attempt to evaluate the counseling services provided by a child sexual abuse victim assistance program. This was a study of incestuous families in therapy at the Child Sexual Abuse Treatment Program (CSATP) in Santa Clara County, California.[13] This study is briefly summarized here as an example for readers who may wish to undertake similar research within their own programs.

[13] This summary is taken from Jerome A. Kroth, Child Sexual Abuse: Analysis of a Family Therapy Approach (Springfield, Ill.: Charles C. Thomas, 1979). A brief description of the CSATP approach to treatment appears in Chapter 1 of this manual.

For his sample, the evaluator selected three matched groups of 17 clients each, at varying stages of their therapy: intake (2-3 weeks into therapy), midterm (average 5.1 months of therapy), and near termination (average 14 months of treatment). By selecting a one-time cross-section of subjects at various stages in the course of treatment, this design simulates a traditional longitudinal study of a single sample, which typically requires a year or more of tracking subjects.

The clients participating in the evaluation were perpetrators (nine per group) and unrelated non-offending spouses (eight per group), involving a total of 70 child victims. The victims themselves, however, were not included in the study. The three groups were matched across ten criteria to ensure comparability of the results. These ten variables were: (1) age of perpetrator, (2) age of non-offending parent, (3) age of victim, (4) percent of pre-adolescent victims, (5) percent of homosexual relationships among victims and perpetrators, (6) duration of molestation, (7) educational level of perpetrator, (8) educational level of non-offending parent, (9) relationship of perpetrator to victim, and (10) total number of victims involved.

Clients in the three sample groups were asked to complete instruments that contained more than 40 measures of the effectiveness of the CSATP approach to therapy. While reincidence is certainly a critical measure of counseling effectiveness, particularly in incest cases, the child and other family members may suffer emotional and behavioral reactions that also should be addressed in therapy. Thus, in this study, respondents were asked to report on family relationships, victim's behavior, and their feelings about themselves and each other over the last two months. The 40 measures used in the study are briefly described in five categories, as follows:

(1) Crisis Resolution: e.g., nervous and psychosomatic symptoms of victims (nail biting, bedwetting, fainting); respondent's closeness to a "nervous breakdown."

(2) Data on Victims' Social Behaviors: e.g., instances of running away from home, changes in school grades, frequency of absence from school, use of drugs or alcohol.

(3) Data on the Family: e.g., likelihood of perpetrator and spouse staying together, frequency and adequacy of sexual relationships between perpetrator and spouse, feelings of guilt and responsibility for the molestation.

(4) Data on the Perpetrator: e.g., frequency of drunkenness or drug abuse, number of days missed from work, degree to which perpetrator feels he has a sexual problem.

(5) Recidivism: e.g., number of sexual contacts between perpetrator and victim; assessment of whether the victim, perpetrator, or spouse would report future incidents; and feelings that molestation would happen again.

The evaluator found almost uniformly positive effects of CSATP therapy when comparing the intake sample to the midterm and near termination groups, many of which were statistically significant. For example, at the beginning of therapy, 47 percent of the respondents reported that the child victims exhibited nervous or psychosomatic symptoms (e.g., nail biting, bedwetting). Only 30 percent of the midterm sample and six percent of the near termination sample reported such symptoms among the child victims.[14] None of the negative findings was statistically significant.

While the findings of this study appear to offer strong evidence that CSATP therapy is effective, there are four important caveats to the particular design that was used:

- information on child victims was gathered from perpetrators and non-offending spouses, not from the children themselves;
- because the study was cross-sectional in design, it did not account for clients who may "drop out" at various points between intake, midterm, and termination;
- although matching was used to ensure comparability among the three groups, there may have been some critical variables distinguishing the groups that were not considered in the matching process; and
- the evaluation only examined incestuous families, not the larger picture of child sexual abuse.[15]

To be sure, the measures employed in the evaluation of the CSATP approach to incest treatment are closely tied to the program's own goals and objectives and may not be applicable for other treatment programs. For example, many of the measures used here would not apply to either the Sexual Assault Center or the Child Protection Center-Special Unit, since both projects emphasize treatment of the child victim over treatment of the family unit. However, even if the measures do not apply, the cross-sectional longitudinal design used here may be a feasible way to assess the effectiveness of a therapeutic program for child sexual abuse victims. By substituting performance measures that are more suitable to the individual program's treatment goals and objectives, this evaluation technique could probably be adapted to most programs' needs.

[14] Kroth, Child Sexual Abuse, op. cit., p. 90.

[15] Ibid., p. 136.

12.6 Summary

Clearly, both the Sexual Assault Center and the Child Protection Center-Special Unit have taken important steps toward improving society's response to the child victims of sexual abuse. By routinely monitoring certain statistics, they have been able to target their efforts on those areas most in need. For example, when the Sexual Assault Center discovered that a rising proportion of children were receiving their initial medical examination from doctors in the community, the Center focused new training programs on physicians in private practice and community clinics. When the Special Unit discovered that key evidentiary information had been misinterpreted by police investigators, they revised the evidence collection form to make it more understandable to non-medical personnel.

In addition, both projects have documented solid accomplishments in virtually every aspect of their multifaceted programs. While neither project has undertaken the complex and difficult task of impact evaluation, their attempts to demonstrate goal achievement, both quantitatively and qualitatively, represent an important first step toward designing and conducting studies of program effectiveness in this innovative area of child victim assistance. The URSA Institute is completing a comprehensive study of the two Exemplary Projects as part of an evaluation of the Law Enforcement Assistance Administration's Family Violence initiative. The results of this study, expected later in 1982, should represent a major contribution to the literature on treatment of child sexual abuse victims.

CHAPTER 13: REPLICATION ISSUES

As the problem of child sexual abuse has gained public recognition, victim assistance programs like the Sexual Assault Center in Seattle and the Child Protection Center-Special Unit in Washington, D.C., have emerged across the country. The National Center on Child Abuse and Neglect estimates that at least 150 such programs are presently operating, but little documentation exists to describe how they operate or what the results of their intervention have been. Examination of the two Exemplary Projects and other available documentation does reveal certain key issues that must be addressed by program planners or administrators seeking to improve services for sexually abused children.

For example, in order to construct a coherent and effective treatment strategy, program staff must arrive at a consensus on basic philosophical issues such as the causes of incest and the advisability of criminal justice system involvement in child sexual abuse cases. Second, program staff must be fully aware and knowledgeable of the legal requirements and conventions that tend to define the management of reported cases of child sexual abuse in their jurisdictions. Also, staff should consider the ways in which their impact on the community may be enhanced or constrained by the program's independence or affiliation with other agencies. There may be ways to expand or strengthen the program's formal or informal links to criminal justice and social service agencies to improve coordination in case management. Many of these agencies could benefit from specialized training provided by project staff. Finally, in the face of rapidly declining federal, state, and local government budgets, staff must give serious thought to their program's future and potential funding sources. This chapter introduces and discusses these issues so that readers can benefit from the experiences of others in formulating their own programs.

13.1 Philosophical Issues

There is no standard, universally accepted approach to treatment of child sexual abuse, particularly when the abuse occurs within the family. As discussed briefly in Chapter 1, child victim assistance programs sharply disagree on two major points: the etiology of incest and the need for involvement in the criminal justice system. The positions taken on these issues by program staff guide the course of the treatment they provide.

Thus, in designing or expanding a program for child sexual abuse victims, it is important to consider the program options associated with differing perspectives.

13.1.1 The Etiology of Incest

The mere acceptance of the fact that incest does happen is, in itself, a breakthrough. Freud dismissed reports of incest as symptoms of the child's supposed sexual desire for the parent.[1] In this tradition, many psychiatrists and mental health counselors have treated such reports as fantasies or dreams without considering whether their clients might, in fact, be telling the truth.

Today, most therapists and counseling professionals accept reports of incest as factual accounts. The mystery now is why it occurs: Why do some adults turn to children for sexual gratification, even when adult partners are available?

There are two major schools of thought on this subject. One maintains that incest is a symptom of disturbed family dynamics, that an unfortunate mix of personality and circumstances leads a father to turn from his wife to his daughter. An example of such a situation appeared in a 1980 newspaper article:

> Joe was desperately trying to cope with several personal crises. His mother had just died, his father was dying of cancer, and his marriage was breaking down. His wife had recently embraced religion and her new interest drove her apart from her family. Her interest in sexual activity dissipated after she had a hysterectomy. Joe began to look to his stepdaughter, 14, for comfort.[2]

Many authorities in incest treatment cite cases like this one, in which the mother is either absent entirely or lacks authority in the home and adopts a dependent role. At the same time, an elder daughter gradually assumes her mother's responsibilities--housekeeping, child care, and, sometimes, conjugal mate for her father. In such cases, an apparent role reversal within the family "sets the stage" for incest.

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[1] Sigmund Freud, The Basic Writings of Sigmund Freud, ed. A.A. Brill, Book Two: The Interpretation of Dreams (New York: The Modern Library, 1938), pp. 308, passim.

[2] Excerpted from Linda Matchan, "He Knew It Was Wrong, But..." The Boston Globe, October 26, 1980.

Counselors who espouse this "family dynamics" view of incest typically provide therapy to all involved family members, both individually and, if all agree, as a family. The Child Sexual Abuse Treatment Program in Santa Clara County is an example of this treatment modality. There, the aim of individual therapy is to help each family member to recognize his or her role in the incest and to adopt a more appropriate role in the family.

Proponents of this theory generally believe that incest offenders are an entirely different "breed" from pedophiles, or child molesters. While both types of offenders seek children for sexual partners, pedophiles are thought to be responding primarily to psychological rather than family disturbances. Hence, the approach to treatment of pedophiles and their victims differs markedly from the approach to incest treatment.

The Seattle Sexual Assault Center takes a very different perspective. Counselors there believe that incest offenders are quite similar to other child molesters: both suffer from sexual behavior disorders and are solely responsible for their actions. Center counselors cite these facts to support their view:

- incest offenders have been known to molest more than one child in a family;
- incest offenders have been known to molest children outside the family; and
- incest offenders have often been found to have pedophilic histories prior to their marriages.

This belief has led the Sexual Assault Center to employ a treatment modality that differs markedly from the approach used by the Santa Clara County program and most "family dynamics" therapists. The Sexual Assault Center does not counsel offenders or provide family therapy, even if an incestuous family wishes to maintain the family unit. Instead, Center staff routinely refer offenders to other therapists who specialize in sex offender treatment. If an incestuous family desires to reunite, the Center maintains contact with the offender's therapist so that the family's treatment can be coordinated.

Regardless of whether a program chooses to employ family therapy or to treat offenders separately, all counselors interviewed in the course of preparing this manual agreed that whether the family continues as a unit is the family's decision, and the counselor's job is to assist each family in reaching its goals.

13.1.2 Involvement of the Criminal Justice System

Sexual abuse of a child (usually defined as an individual under age 16) is a crime in all states. Like adult rape, however, child sexual abuse is vastly underreported. A retrospective study of 796 college students found that 63 percent of the women and 73 percent of the men who had experienced sexual abuse as a child had not reported the incident to anyone, not even parents or siblings.[3] Even if an incident is reported to police, the case may not be prosecuted. In the District of Columbia, for example, only 37 percent of suspects named in child sexual abuse cases between February 1978 and December 1980 were indicted (or waived indictment).[4]

There are many reasons why a case of child sexual abuse might not be prosecuted. Police may be unable to apprehend a suspect. A child may be unable to testify satisfactorily or supply enough evidence to support a viable case. Or an untrained prosecutor may not know how to make the most of available evidence in a case that appears to be "hopeless." However, according to many counselors, a major reason so few incidents of child sexual abuse are prosecuted or even reported is the families' fear of the impact of investigation and prosecution on their child.

Aspects of criminal prosecution that can be especially damaging to the child are those that increase the pressure on her as a key witness: repeated interviews, protracted proceedings, the need for the child to identify the suspect in a lineup and to confront him at trial. When the offender is a family member, critics have charged, the criminal proceedings contribute unnecessarily to family dissension and force mothers and children to turn to public assistance when the father is incarcerated or required to live apart from his family. Anticipating that criminal proceedings would only aggravate an already stressful situation, many families decline to report the crime, regardless of the relationship between the child and the offender. Many child victim counselors, particularly those who work predominantly with incest cases, agree with this view of the criminal justice system and strive to keep their clients out of that system whenever possible.

Both the Sexual Assault Center in Seattle and the Child Protection Center-Special Unit in Washington, D.C., strongly endorse criminal prosecution of child molesters, regardless of their relationship to the victim. The principal advantage of criminal prosecution, they argue, is the threat of sanction for the offender. In Seattle, counselors believe that only under court sentence will a sex offender complete the prescribed course of therapy. In contrast, opponents of criminal justice system involvement assert that such

[3] David Finkelhor, Sexually Victimized Children (New York: The Free Press, 1979), p. 67.

[4] Child Protection Center-Special Unit statistics, February 22, 1978-December 15, 1980.

coercion is not necessary to keep an offender in treatment and may even be detrimental to the rehabilitative process. One researcher has asserted that the mere fact that a report has been filed may be sufficient in itself, even without prosecution, to deter recidivism among incestuous families.[5]

Staff of both the Sexual Assault Center and the Child Protection Center-Special Unit are fully cognizant of the potential for added stress and trauma inherent in criminal proceedings. Because they believe so strongly that the perpetrators of child sexual abuse should be held accountable for their actions, however, these projects have undertaken to make the experience of prosecution less threatening for the child. Staff of both projects point out that, regardless of a program's philosophy concerning the need for criminal prosecution of child sexual abuse cases, many such cases will enter the criminal justice system nevertheless. The projects' experience has shown that there are ways to change that system, to work within it for the child's benefit, and to prepare the child for upcoming legal proceedings. These and other issues pertaining to the legal environment are discussed in the following section.

13.2 The Legal Environment

If program staff are to build an effective strategy for assisting child victims and their families, they must begin with a working knowledge of the reporting practices and prosecution procedures for child sexual abuse cases in their jurisdictions. A sound understanding of local laws and practices is essential for two reasons: first, it helps program staff to gain acceptance and credibility with police and prosecutors; and second, it enables staff to identify problems in the "system" and to recognize avenues for change. This "system" can be quite complex, since it may involve social service agencies as well as criminal and juvenile justice agencies, and civil as well as criminal proceedings.

13.2.1 Understanding the "System"

The relationship between the child and the offender will determine the extent to which law enforcement and social service agencies become involved when an abusive incident is revealed. If the offender is not a member of the child's family and there is no evidence that parental neglect contributed to the abusive incident, then the only relevant authorities are police and the criminal or juvenile courts (depending on the age of the offender). Of course, these

[5] Jerome A. Kroth, Child Sexual Abuse: Analysis of a Family Therapy Approach (Springfield, Ill.: Charles C. Thomas, 1979), pp. 125-126.

agencies only enter the picture if someone (usually the victim or family) chooses to report the incident and prosecute the offender.

If, however, the child was abused by a member of his or her immediate family, the system of agencies involved is far more complex. Child abuse and neglect statutes in most states require that such cases be reported to some "mandated agency," typically the jurisdiction's child protection agency. In Santa Clara County, California, however, the Juvenile Probation Department is the mandated agency. In the District of Columbia, such cases may be reported either to police or Child Protective Services, although in practice, abuse cases are first reported to police and neglect cases are reported to CPS. Any program seeking to assist child victims of intrafamily abuse must develop a solid relationship with the mandated agency in its jurisdiction if it hopes to receive referrals for treatment. (Many programs are directly affiliated with a mandated agency; see Section 13.3.)

By law, the mandated agency is responsible for investigating every report of child sexual abuse by a family member or resulting from parental neglect. If the report is substantiated, the mandated agency must take steps to protect the child from continued abuse. These steps may include, among others, filing a petition with the juvenile or family court to initiate civil proceedings on behalf of the child, or reporting the case to police to initiate criminal proceedings. The child may be removed from her home pending the results of the agency's investigation and the court's finding. Alternatively, the offender may be placed under a no-contact order requiring him to vacate the home until the case reaches disposition. In some instances, both criminal and civil actions may be initiated.

Many child protection workers prefer to take intrafamily child sexual abuse cases to the juvenile or family court rather than criminal court. Because the role of the juvenile court is to protect and assist children, the proceedings of such courts are sensitive to the child's concerns. For example[6]:

- A judge may interview a child privately in chambers, rather than in full view of her family and others present at the hearing.
- Juvenile proceedings are closed to the public, and jury trials are rare.

[6] Much of this discussion is drawn from Josephine Bulkley and Howard A. Davidson, Child Sexual Abuse: Legal Issues and Approaches, National Legal Resource Center for Child Advocacy and Protection, American Bar Association, Washington, D.C., September 1980.

- Child abuse and neglect proceedings require a less rigorous burden of proof (preponderance of evidence rather than proof beyond a reasonable doubt); frequently, the child's testimony is not necessary to support a case.

These attributes offer compelling reasons to favor juvenile proceedings, but there are certain drawbacks. For example, juvenile proceedings tend to move slowly. A child who is "temporarily" placed outside the home pending the results of investigation and the court's findings may be separated from her family for weeks or even months. Another, perhaps more serious, disadvantage is the juvenile court's lack of authority over adult offenders. A juvenile court may order family therapy, for example, but the parents may ignore the order, knowing that the court cannot sanction them directly. In such cases, the court's most "effective" recourse to protect the child may be to place her in foster care.[7] It should be noted, though, that a sizable proportion of the offenders in child sexual abuse cases are themselves juveniles, over whom the juvenile court does wield sanctioning power. In Washington, D.C., for example, 56 percent of the suspects in cases reported to police between February 1978 and December 1980 were juveniles.

In many cases, criminal proceedings are initiated in conjunction with child abuse and neglect proceedings to provide for judicial authority over an adult offender. While the criminal justice system also has disadvantages, particularly for the child victim, many child victim assistance programs have found ways to mitigate its negative effects.

13.2.2 Mitigating the Negative Impact of Criminal Proceedings

Because many child sexual abuse cases are ultimately prosecuted in the criminal courts, a child victim assistance program should seek to improve the child's experience in the criminal justice system even if program staff believe that criminal prosecution is unnecessary or undesirable. There are three avenues by which a program can have an impact: reducing the need for court appearances and trial, changing certain investigative and prosecutorial procedures, and providing direct support for successful prosecution.

Reducing the Need for Court Appearances and Trial. There are two ways by which a child victim assistance program can work to reduce the child's involvement in criminal proceedings: (1) to lobby for increased use of plea bargaining, and (2) to advocate for the expanded use of diversionary programs for the offenders.

[7] Domestic violence statutes in 34 states do allow the juvenile or family court to remove an offender from the home via a protection or no-contact order. See Bulkley and Davidson, supra at pp. 8-9.

It should be recalled that, both in Seattle and Washington, D.C., most child sexual abuse cases are settled by guilty plea: in Seattle, only 36 cases (19 percent of all cases filed in 1980) involving adult defendants went to trial; in Washington, D.C., only six adult defendants went to trial between February 1978 and December 15, 1980. Thus, only a small minority of child victims are subjected to the repeated interviews and court appearances that typify the trial experience.

In King County (Washington), prosecutors cite a dual incentive for plea bargaining. First, because conviction on statutory or forcible rape charges carries a mandatory sentence of incarceration, many families are unwilling to pursue their cases if the suspect is a family member or close friend. Second, conviction on a charge of indecent liberties, a lesser offense, typically carries a sentence of probation or work-release on condition of treatment. This is the outcome preferred by members of the child sexual abuse treatment "network" created in King County by the Sexual Assault Center. Thus, pursuing a plea to a reduced charge is likely to win the family's continuing cooperation, not only by relieving the child from numerous court appearances, but by removing the threat of incarceration for the offender. At the same time, it ensures that the offender will be enrolled in a rehabilitation program under the court's supervision.

In other communities, the preferred approach is to channel the offender into a diversionary program. This usually takes the form of deferred prosecution, in which court proceedings are delayed pending the outcome of the offender's participation in a rehabilitative program as specified by the court.[8]

It is evident that both the approach to prosecution taken in Seattle and the use of diversionary programs rely on the availability of offender therapy resources in the community. Not every community enjoys the range of treatment providers that exist in the Seattle area; project staff advise that such resources must be cultivated by identifying mental health counselors who may be interested in treating this client population and working with them to ensure that their methods will be effective and consistent with the goals of the child's therapist. Of course, where the child victim assistance program treats intrafamily offenders as well as victims, the need for additional therapy resources will not be as critical.

Changes in Investigative and Prosecutorial Procedures. There are other ways to minimize the pain inflicted on the child and family whose case enters the criminal justice system. The accomplishments of the projects in Seattle and Washington, D.C., were described in Chapters 5 and 10, respectively:

[8]Josephine Bulkley (ed.), Innovations in the Prosecution of Child Sexual Abuse Cases (Washington, D.C.: American Bar Association, National Legal Resource Center for Child Advocacy and Protection, 1981).

- accompaniment and advocacy in court proceedings;
- in D.C., the staff attorney's dual role as child advocate and general counsel for the project;
- in Seattle, joint interviews by police and prosecutors;
- special interviewing rooms at the hospital or prosecutor's office;
- extensive training of police and prosecutors; and
- vertical prosecution in the King County Prosecuting Attorney's Office.

Other remedies that have been suggested in the literature include:

- videotaping the child's first interview to obviate the need for repeated questioning, as has been done for adult rape victims in Baton Rouge, Louisiana;[9]
- appointing a special child advocate who conducts all official interviews with the child as is done in Israel, Denmark, and Sweden;[10] and
- designating a "child courtroom" in which the child would interact only with the judge, prosecutor, defense attorney, and the special child advocate; the defendant, jury, audience, and family would observe through a one-way glass.[11]

While many of these changes cannot be implemented directly by a victim assistance project itself, the project can certainly supply the impetus required to stimulate innovative thinking and see that changes are made. Project staff must try to work closely with other agencies and encourage them to adopt the program's philosophy toward treatment. Methods of achieving the

[9]U.S. Department of Justice, Law Enforcement Assistance Administration, National Institute of Law Enforcement and Criminal Justice, An Exemplary Project: Stop Rape Crisis Center, by Debra Whitcomb, Deborah A. Day, and Laura R. Studen (Washington, D.C.: Government Printing Office, October 1979).

[10]See discussion in Christine McKenna, "A Study in King County of Child Victims of Sexual Assault: Results and Recommendations for Police and Prosecutors," unpublished manuscript, Seattle, Washington, Summer 1975, pp. 37-38.

[11]David Libai, "The Protection of the Child Victim of a Sexual Offense in the Criminal Justice System," 15 Wayne L. Rev. 977, 1016-17 (1969).

interagency coordination necessary for instituting changes in the system are discussed in Section 13.4.

Direct Support for Prosecution. The prosecution of child sexual abuse cases is often hampered by lack of evidence, for two reasons: (1) usually there are no witnesses other than the child, and (2) frequently there are no physical signs of abuse. It is the responsibility of the prosecutor to address these concerns, but a child victim assistance program can assist in two ways: (1) by enhancing the quality of evidence available, and (2) by supplying expert witnesses.[12]

Only the District of Columbia, Georgia, Nebraska, and New York still require corroboration in all sex offense cases involving minors; 17 states require corroboration in special or limited circumstances. As was shown in Chapter 12, this requirement poses a significant obstacle to prosecuting child sexual abuse cases in Washington, D.C. However, even in states where corroborative evidence is not required, such evidence may be considered desirable to "shore up" the child's testimony.

Medical evidence of sexual abuse is perhaps the most commonly used form of corroboration, and there are ways in which a child victim assistance program can help to improve the quality of this evidence. In Harborview Medical Center, for example, external signs of abuse are photographed by the examining physician. In Washington, D.C., the Child Protection Center-Special Unit revised the medical evidence form used by police to record all pertinent information regarding sexual abuse. In both locations, physicians are trained in methods of gathering evidence and in the use of examination protocols that ensure that nothing is overlooked.

In both Seattle and Washington, D.C., prosecutors are increasingly looking to project staff for expert witness testimony. The purpose of such testimony is to add weight to the child's case; unfortunately, some judges and jury members still have trouble believing a child's testimony regarding incidents of sexual abuse. While project staff in D.C. typically do not themselves provide expert testimony, they do recommend others who can, usually child psychiatrists or pediatricians from Children's Hospital. In Seattle, the project's staff pediatrician and, more recently, project counselors have testified on the nature of child sexual abuse and its effects on the child and family.

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[12] Again, for greater detail, see Bulkley and Davidson, supra, at pp. 15-18.

13.3 Program Affiliation

A project's affiliation significantly affects the number and type of clients referred, the project's relationship to other agencies, and its policy toward reports to authorities. Both Exemplary Projects are physically located in hospitals and are independent of local criminal justice or mandated child abuse reporting agencies. Other programs are operated as special units of the mandated agencies in their communities. There are definite advantages and disadvantages to both options.

13.3.1 The Independent Agency

The staff of the Sexual Assault Center and the Child Protection Center-Special Unit cite several advantages of their independent status, and particularly their location in a hospital:

- An independent agency is perceived as a "neutral" setting (in contrast to police or CPS) by families who otherwise might be reluctant to report an incident.
- Location in a hospital allows the project to train physicians and nursing staff in more sensitive examination techniques for children. It also allows the project to reach many sexually abused children when they are brought to a hospital emergency room.
- In some jurisdictions, the independent program may be in a better position, as an "outside catalyst," to advocate for change within CPS or the criminal justice system.
- The project is in a better position to treat all child victims, regardless of their relationship to the offender. Projects affiliated with a child protection agency, for example, are likely to receive only children who are abused by family members. In contrast, projects affiliated with a criminal or juvenile justice system may be missing incestuous families who fear the system's intervention.

In sum, the independent program is likely to be viewed as less threatening to the victim and family, can establish its own policies and practices with less bureaucratic interference, and can advocate for change in other agencies' practices as an outside catalyst. The two Exemplary Projects value these benefits of their independence. At the same time, they recognize some distinct disadvantages:

- Funding may be perennially uncertain, since it may depend on grants or other "soft" sources of support. An independent project must compete with other human services agencies for limited funds from local government and private foundations.

- Because they are outsiders to the official "system" for child sexual abuse case management, project staff may lack credibility in the eyes of some personnel from other agencies (e.g., police, prosecutors). Also, cases may not be routinely referred to the project by the mandated agencies.

The Sexual Assault Center and the Child Protection Center-Special Unit have found ways to mitigate these disadvantages. Staff in Seattle have become skilled at grantsmanship and presently have several sources of funding. In addition to diversified grant support, the Special Unit in D.C. has instituted a third-party billing system that covers much of its direct services. Both projects are receiving local funding and continued support from the hospitals in which they are located. Issues of funding are discussed further in Section 13.6.

Second, both Exemplary Projects have developed agreements with the mandated reporting agencies in their respective jurisdictions, whereby those agencies refer sexually abused children to the projects for counseling and medical care. However, in D.C., police are prohibited from making direct referrals to the project because it is in a private facility (Children's Hospital). The proportion of child victims who are not treated by the project for this reason is unknown.

Third, both projects have taken steps to enhance their credibility in their communities. In D.C., the project formed a Community Advisory Council composed of representatives of all relevant agencies. As high-level administrators in their respective agencies, Council members lend credence to the project and can ensure that their staffs will respond favorably to the project's efforts. Counselors in Seattle emphasize that their comprehensive understanding of the "system" as it relates to child sexual abuse victims has persuaded skeptics of their credibility. Direct contacts with individuals in other agencies and weekly interagency meetings have reinforced the project's standing in the community.

13.3.2 The Affiliated Agency

Many child sexual abuse victim assistance projects are branches of their jurisdiction's child protection agency. The principal advantages of such an affiliation are:

- a guaranteed source of referrals of victims abused by a member of the immediate family;

- less need for external funding; and

- availability of staff who are experienced with the counseling and protection needs of abused children, although additional training in the special needs of sexual abuse victims may still be necessary.

Potential disadvantages include:

- inability to treat children who are abused by someone outside the family (unless parental neglect was a contributing factor);

- constraints on advocacy efforts with agencies other than the parent organization. It may be inappropriate for an agency of one bureaucracy to press for changes in another; and

- unwillingness of existing staff to "specialize" in child sexual abuse, forcing the project to bring in new staff and provide more comprehensive training.

Some child sexual abuse projects are affiliated with agencies of the criminal or juvenile justice system. The Child Sexual Abuse Treatment Program (CSATP) in Santa Clara County, California, for example, is administered by the Juvenile Probation Department, which is the mandated reporting agency in the county. While it is unusual for a juvenile justice agency to be the mandated agency for receiving child abuse reports, this arrangement has a dual advantage for CSATP. First, virtually all known cases of intrafamily sexual abuse are referred to the project for counseling. At the same time, because the project is also part of the juvenile justice system, it is likely to receive reports of cases involving offenders who do not share the child's household. Moreover, the project's extensive community outreach has made it visible to the general public. Many families come directly to the project for assistance rather than reporting first to Juvenile Probation.

13.4 Approaches to Interagency Coordination

The need for a child sexual abuse victim assistance program to develop cooperative working relationships with other agencies is critical to the program's success. Police and child protection workers who do not support the project may not routinely refer victims and families for counseling. Optimally, if all agencies involved in the handling of child sexual abuse cases can achieve a consensus on the best approach to meeting the needs

of all family members, including the offender, the child victim will be the ultimate beneficiary. This section discusses several strategies used by the Exemplary Projects for developing a coordinated approach: advisory boards, formal agreements and contracts, and advocacy and "networking."

13.4.1 Advisory Boards

The Child Protection Center-Special Unit in Washington, D.C., is served by a 32-member Community Advisory Council. Its membership includes the key administrators of schools and most criminal/juvenile justice, social service, and mental health agencies in the metropolitan area. The Special Unit emphasizes especially the need to involve each agency's top officials, if possible, for they alone have the authority to institute change within their agencies and to require training for their staff who deal directly with child victims. It was particularly important for the Special Unit to include Child Protective Services on the Council, for that agency and the Special Unit's parent project, the Child Protection Center, had experienced conflicts which the Special Unit wished to avoid. CPS' membership on the Advisory Council ensured that the agency would have input in the Special Unit's development.

13.4.2 Formal Agreements and Contracts

Both of the Exemplary Projects have used formal agreements and contracts to establish ongoing cooperation with other agencies. In D.C., the Special Unit has obtained agreements from the Metropolitan Police Department, Child Protective Services, D.C. Corporation Counsel, U.S. Attorney's Office, and the city's Public Health Department to ensure that these agencies will inform victims and families of the medical and counseling services available from the Special Unit. The agreement with the Public Health Department further stipulates that the Special Unit will work with the Department to follow up the source of contact for children diagnosed with venereal disease.

In Seattle, the Sexual Assault Center began with a formal approach, using funds from its LEAA grant to secure contracts with representatives of the Seattle and King County Police Departments, King County Prosecuting Attorney's Office, and Children's Protective Services. In return for a specified consultant fee, those individuals agreed to meet weekly with project staff, participate in project training, and work cooperatively with Center counselors to fashion the optimal intervention plan for each child victim. According to a Center staff member, in the early stages of the project's development, financial remuneration was necessary to ensure that personnel of other agencies would devote their personal time and energy to efforts which were not part of their work responsibilities. This strategy proved extremely effective. Today, even though the LEAA grant has expired and consultant fees

are no longer provided, the weekly meetings continue and the level of cooperation has grown. The contracts served to initiate a working relationship which later became wholly voluntary and routine.

13.4.3 Advocacy and Networking

Staff of the Exemplary Projects consider both advocacy and networking to be critical elements of their treatment programs. Effective advocacy means that many avenues must be explored to further the child's cause. It often entails confronting and surmounting obstacles that block the advocate's ultimate goal, thus creating an adversary relationship between the advocate and the target agency. For example, in order to boost child sexual abuse cases to a high priority position among agencies involved in the treatment "system," staff of both projects make frequent informal contacts with key individuals who can, in turn, advocate for change within their own agencies. In addition, the staff criminal justice specialist in D.C. has testified before Congress and the D.C. City Council in support of statutory changes that would make the legal environment more favorable to prosecution of child molesters. In Seattle, project staff appealed to city, county, state, and even federal authorities in their attempts to persuade the Seattle and King County Police Departments to create special divisions for investigating child sexual abuse cases. Staff of both projects accompany child victims to all interviews and legal proceedings to ensure that their rights are protected and that their stories are clearly understood.

Both Exemplary Projects have worked to build child sexual abuse networks in their communities. Networking implies the development of cooperative relationships among the various parts of the "system," oriented toward a common goal. The projects have taken different routes to establish their local networks: in D.C., through the Community Advisory Council, and in Seattle, through weekly meetings at the prosecutor's office. While the weekly meetings are perhaps the most visible manifestation of the network in Seattle, the underlying strength of the network lies in the consensus as to how these cases must be handled and what the optimal outcomes are. Sexual Assault Center staff emphasize that the agencies that comprise such a network are present in every community; what is needed is a "catalyst" (and compatible personalities) to bring them together. In Seattle, Center staff perform that role: they initiated the weekly meetings and now work to maintain high levels of enthusiasm and cooperation among participants. Center staff point out that the network is a process that requires constant support if it is to continue and grow. Without a catalyst, the commitment and dedication of network members might slacken in the face of conflicting work demands. Center staff also point to the involvement of "working-level" people, rather than agency officials, as a key to the network's success: these people can make immediate changes in their own behavior and can work to influence their peers (and supervisors) to change accordingly.

In contrast, the Special Unit in D.C. deliberately invited top-level administrators from relevant criminal justice and social service agencies to sit on the Community Advisory Council. Project staff believe that only individuals at high levels wield the authority necessary to institute major changes in policy and procedure, and to ensure that these changes are adopted by "working-level" people. Clearly, in selecting an approach to networking, project staff must consider both the structural characteristics of relevant agencies and personality traits of agency personnel to determine an appropriate fit.

13.5 Professional Training

Front-line personnel of every agency that works with children who have been sexually abused should be trained in techniques of interviewing children and working comfortably with victims and families. Police, child protection workers, prosecutors, and mental health and medical personnel may be among the most critical groups for training. Additional audiences that may be tapped for training include:

- school personnel (teachers, counselors, nurses);
- probation officers;
- guardians ad litem (individuals who represent the child's interests in child abuse and neglect proceedings initiated in juvenile or family court);
- staff of day care and recreational facilities; and
- staff of private and community medical and mental health facilities.

The cross-indexed curriculum developed by the Child Protection Center-Special Unit is a useful guide to topics for training each of these professional groups (see index in Appendix B-1).

The primary intent of training professional groups is, of course, to enable them to identify sexual abuse in children and to see that the victims receive appropriate treatment. In addition, both the Seattle and D.C. projects see their training sessions as an effective way to explain the special needs of child sexual abuse victims and to introduce to other agencies new procedures and approaches for addressing these needs. Training can also serve as an initial step towards "networking," i.e., establishing referral agreements and a coordinated approach to treatment and case management.

13.6 Potential Funding Sources

Both the Child Victim/Witness Project (in the Sexual Assault Center in Seattle) and the Child Protection Center-Special Unit in Washington, D.C., were launched with LEAA funds. Today, such funds are no longer available. Those who are starting a new program or expanding an existing one must look elsewhere for support.

The largest funding source to date at the federal level has been the National Center on Child Abuse and Neglect of the Department of Health and Human Services (formerly Health, Education and Welfare), which in FY 1980 received a $4 million appropriation to institute programs for sexually abused children. The Child Protection Center-Special Unit currently has a grant from NCCAN to counsel juvenile intrafamily sex offenders, and the Sexual Assault Center in Seattle received NCCAN funds to operate a regional treatment-training institute. Due to recent budget cuts, however, future funding opportunities from NCCAN are uncertain.

At the state and local level, many human service projects operate under contractual arrangements with appropriate public agencies, such as departments of human services or their counterparts. Both the Seattle and D.C. projects currently appear as line items in their cities' budgets. While such status is difficult to accomplish and must be renegotiated each year, once it is captured it should be somewhat easier to maintain. The Sexual Assault Center, for example, has received funding from the City of Seattle since 1973. A parent agency may also support the project, either with direct funding or with in-kind contributions such as free space and utilities, use of equipment, etc., as are provided by the hospitals that sponsor the Seattle and D.C. programs.

Finally, the Special Unit in Washington, D.C., has successfully approached private foundations for small grants. Recently, the project instituted a third-party billing system (discussed in Chapter 7) that may be applicable elsewhere.

Conclusion

The recent development of projects like the Sexual Assault Center in Seattle and the Child Protection Center-Special Unit in Washington, D.C., attests to the growing realization that sexual abuse of children occurs far more frequently than was once believed. No one now disputes the need for special services for child victims. By designating these two projects Exemplary and offering this manual on their policies and practices, the National Institute of Justice seeks to encourage others to build on the successes of these projects and to explore new ways of helping sexually abused children.

APPENDIX A

MATERIALS FROM THE SEXUAL ASSAULT CENTER, SEATTLE, WASHINGTON

APPENDIX A-1

HARBORVIEW MEDICAL CENTER - SEXUAL ASSAULT CENTER

EMERGENCY ROOM PROTOCOL - CHILD/ADOLESCENT PATIENTS

INFORMATION FOR ALL INVOLVED WITH PATIENT:

1. See immediately. Even though no physical trauma may be present, victims of sexual assault should receive high priority (immediately following acutely ill or injured patients).
2. Provide maximum support to parents as well as to the child/adolescent victim. Do not be judgmental nor allow emotional responses (e.g. anger, outrage) to interfere with providing optimal care.
3. Only those DIRECTLY involved in care should talk with the patient; give the patient and parents your name and explain your role.
4. Do not discuss sexual assault cases with anyone without the consent of the parent or legal guardian and the patient, if an adolescent.
5. "Rape" and "Sexual Assault" are legal, not medical terms. Do not use other than as "History of Sexual Assault".
6. The chart may be legal evidence. "Hearsay" statements from those who first see the child/adolescent may be admissible in court. All statements should be accurate, objective and legible.

EMERGENCY ROOM PERSONNEL:

1. Provide private facilities for the victim (ER 9 or the Quiet Room). Complete registration there.
2. Contact the ER physician immediately if there is evidence of moderate to severe physical trauma.
3. Obtain consent for care from the parents or legal guardian. If such consent cannot be obtained, contact the hospital administrator or the Juvenile Court for temporary consent. Examination of the adolescent should not be done without her/his consent unless a life-threatening emergency exists.
4. Contact social worker immediately.
5. If the assault occurred within the past 48 hours, contact the pediatric resident immediately. If the assault occurred more than 48 hours ago, the social worker will ascertain need for medical care.
6. The sexual assault tray and vaginal kit (containing Pedersen and pediatric specula) should be placed in exam room. (Check and replace items daily.)
7. Chaperone pelvic examination. A female chaperone (hospital employee) should be present for all pelvic examinations. Do not have the patient undress until just before the physical examination.

SOCIAL WORKER:

1. Assess immediate emotional needs of child and parents. Respond appropriately.
2. Confirm that the pediatric resident has been notified.
3. History: Obtain alone or in conjunction with the physician.
   a) Ascertain as much of the history as possible from parents or accompanying persons first, away from patient.
   b) See patient alone to obtain history (unless parent or other person is needed for support, i.e., in the very young child).
   c) Determine and use the patient's terminology for parts of the body, sexual acts, etc. Use aids, i.e., toys and picture books, as needed. Questions should be appropriate for age and developmental level.
   d) Obtain a directed history of the assault. Do not ask "why" questions, e.g., "Why did you go to his house?". Phrase questions in terms of "who, what, where, when", e.g., "Did the offender use oral, finger, penile contact to mouth, vulva, vagina, rectum?"; "How long ago did it happen?"; "Did penetration or ejaculation occur?"; "What kind of force, threat or enticement was used?"; "From whom did the patient seek help?".
   e) When the physician arrives, present history and impressions (out of patient's hearing) and complete history-taking conjointly.
4. Explain to patient and parents the reasons for questions asked, types of medical/legal tests needed, and possible treatment.
5. Obtain special consents, i.e., for photographs, release of clothing, release of information (specify to whom).
6. Assist with the physical examination, if indicated.
7. Discuss reporting to police and/or Children's Protective Service. Police may be contacted to come to the Emergency Room for an initial report.
8. Assessment and Counseling:
   a) Assess behavior and affect. Ascertain support systems of patient and family. Do not return child home unless the environment is safe. Document changes in housing.
   b) Explain anticipated emotional problems. Give patient and parents SAC handout.
   c) Encourage consulting with the Sexual Assault Center.
9. Record on Sexual Assault Report form services offered to patient:
   a) Medical appointment for follow-up care.
   b) Ongoing counseling or advocacy by SAC.
   c) Children's Protective Service referral, when indicated. (Referral to CPS is legally mandated when the offender is a family member or when the home environment does not protect the child from further sexual abuse.)
   d) Referrals made to other agencies.
   e) Victim's Compensation brochure, form, and brief explanation.

PHYSICIAN:

1. Medical History: Ascertain history from social worker and parents. Corroborate with patient. Do not needlessly repeat questions. Use "History of Sexual Assault" form #0245.
   a) Use vocabulary appropriate for age and developmental level. Use patient's words to describe and explain meaning if needed, i.e., "He put his 'thing' in me."(penis). Use picture books or toys as aids as needed.
   b) Ascertain activity post-assault: changes of clothing; bathing; douching; urinating; defecating; drinking.
   c) Obtain menstrual, contraceptive, VD history as needed.
   d) Obtain pertinent medical history: chronic illnesses; allergies; etc.
   e) Discuss VD prophylaxis, hormonal pregnancy prevention and abortion. Ascertain patient's feelings in these areas.
2. Approach to Examination:
   a) Be gentle and empathetic. Explain what you are doing in a calm manner and voice. Take time to relax the apprehensive patient.
   b) If supportive, have parent stay with child during the examination. Allow the adolescent the option of having whom s/he wishes to be present.
   c) Allow the patient to feel as much in control of his/her body during the exam as possible. Verbalize an understanding of his/her anxiety.
   d) Use appropriate gowns and drapes to ensure modesty and decrease feelings of vulnerability.
   e) Unless there is physical trauma which is apparent or must be ruled out, the complete examination does not need to be done (i.e. use of stirrups, speculum). All tests can be done with a glass pipette and cotton swabs.
      1) A small child may lie across the mother's lap in a "frog-leg" position.
      2) An older child may lie on the exam table in the same position.
      3) An adolescent may lie on the table in the same position or in stirrups.
   f) Use a REASONABLE approach. Use only those parts of the protocol appropriate for age of child and type of assault.
3. Physical Examination: Perform with hospital employee as chaperone.
   a) General: Document emotional status; general appearance of patient and clothing.
   b) Document areas of trauma on TRAUMAGRAM and describe in detail.
   c) Examine areas involved in sexual assault, i.e., oral, vaginal, rectal, penile. Very carefully document even minor trauma to these areas. Photograph areas of trauma as indicated (per evidence collection checklist).
   d) Ask patient to point with finger to exact area involved. Ask how much further offender penetrated.
   e) Describe developmental level (Tanner Stage), external genitalia, type and condition of hymen and diameter of introitus.
   f) Do exam as indicated by age of patient, type of assault and degree of injury. If injuries are extensive or cannot be determined due to lack of cooperation, consider examination and treatment under general anesthesia.
4. Medical Tests:
   a) Culture body orifices involved for gonorrhea. If history is uncertain, culture all orifices.
   b) Obtain gravindex to rule out pregnancy as indicated.
   c) Obtain VDRL baseline. May be deferred in the young child or apprehensive adolescent.

PHYSICIAN (continued):

5. Legal Tests:

a) UV light - semen fluoresces. Examine areas of body and clothing involved (in dark after visual adaptation).
   1) Save clothing fluorescing for police (as per evidence collection checklist).
   2) Swab body areas fluorescing with saline moistened swabs. Place swabs in red top tubes. (Follow evidence collection checklist.)

b) Wet mount preparation:
   1) Aspirate or swab areas of body involved (pharynx, rectum, vaginal pool). Saline moistened swabs may be used; however, aspiration with a glass pipette after flushing area with 2cc. of saline is preferred.
   2) Place drop of secretions on glass slide, plus drop of saline; examine immediately.
   3) Physician should examine several fields under high power with light source turned down. Document presence or absence of sperm and number of motile/nonmotile seen per high power field.

c) Permanent smears:
   1) Physician will make two preparations. One slide will be a routine PAP from the endocervix and vaginal wall areas (may be deferred in child). The second slide will be a smear from the posterior vaginal pool, rectum, pharynx as indicated. Obtain in the same manner as the Wet Mount.
   2) Put both slides promptly into the PAP bottle, back to back. DO NOT ALLOW TO AIR DRY. (Follow evidence collection checklist.)
   3) Physician will complete and sign PAP form noting "History of Sexual Assault; please do routine PAP and document presence or absence of sperm".

d) Acid Phosphatase:
   1) Collect in same manner as for wet mount preparation.
   2) Place saline moistened swabs or secretions from pipette in red top tube. (Follow evidence collection checklist.)

e) Other tests - as indicated or as police request (mainly to identify assailant), i.e., ABO antigens (collect as for acid phosphatase); fingernail scrapings; pubic hair combings.

6. Treatment:

a) Injuries - treat and/or consult with other specialties as indicated. Give tetanus prophylaxis as indicated by history; follow CDC-Public Health recommendations (available in ER).

b) Pregnancy prophylaxis - may be given IF a vaginal assault occurred at mid-cycle, without contraception, and patient understands risks and side effects of estrogens to be given and is willing to have an abortion should pregnancy occur despite medication. Do not prescribe if there has been other unprotected intercourse during this cycle or any possibility of pre-existing pregnancy. Obtain a negative gravindex before instituting therapy.
   1) Hormonal therapy - Estinyl: 2.5 mg b.i.d. for 5 days . (Prepacks in ER).

   2) Antinauseant therapy - Bendectin (ii h.s. as needed for nausea and vomiting). Give routinely to use as needed (Prepacks in ER).

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Harborview Medical Center
Seattle, Washington

PHYSICIAN (continued):

c) VD prophylaxis
   1) Not given routinely but as indicated, e.g., high patient anxiety, possibility patient will not return for follow-up care, known disease, multiple rapists.
   2) Therapy (over 12 years of age):
      a) Probenecid 1 gm orally + Ampillicin 3.5 gm orally stat; OR
      b) Probenecid 1 gm orally followed in 30 minutes by procaine penicillin G 4.8 million units IM; OR
      c) If penicillin allergy, spectinomycin 4 gm IM OR tetracycline 500 mgm q.i.d. x 4 days.
   3) Therapy (under 12 years of age): use age and weight appropriate dosages.

d) Treatment for anxiety and/or difficulty sleeping - as indicated (rarely needed in children under 12 years; use age appropriate dosage when given). Adult therapy as follows:
   1) Mellaril 10 mgm one-half hour before sleep (may repeat once, if necessary; do not exceed 20 mgm/day. Give a 3-day supply (60 mgm); OR
   2) Valium 5 mgm one-half hour before sleep (may repeat once p.r.n.). Do not exceed 10 mgm/day. Give 3-day supply (30 mgm).

7. Final Care

a) Verbally express concern and availability for help as needed.
b) Reinforce social worker information; reinforce that patient is physically intact and is not responsible for the assault/abuse.
c) Discuss medical problems which may arise and encourage family to call as needed.

8. Final Diagnosis

a) History of Sexual Assault.
b) Presence or absence of sperm.
c) Specific diagnosis of injuries, contusions, lacerations, etc.
d) Other pertinent medical diagnoses.

9. Follow-up

a) Pediatric Clinic appointment in one week.
b) Repeat gonorrhea cultures at follow-up visit; VDRL in 8 weeks; other as indicated.
c) Consultation from other specialties as indicated.

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APPENDIX A-2

CHILDREN'S PROTECTIVE SERVICES - SEATTLE POLICE DEPARTMENT SEX CRIMES UNIT

- PROTOCOL FOR CHILD SEXUAL ABUSE CASES -

RCW 26.44.030 Reports - Duty and authority to make - Duty of receiving agency

(3). The department or any law enforcement agency receiving a report of an incident of abuse or neglect pursuant to this chapter, involving a child or adult developmentally disabled person who had died or has had physical injury or injuries inflicted upon him other than by accidental means or who has been subjected to sexual abuse shall report such incident to the proper county prosecutor for appropriate action.

As this RCW mandate relates to cases of child sexual abuse and where the offense occurred within the Seattle city limits and involves an adult offender, CPS workers and SPD Sex Crimes Detectives are encouraged to use the following protocol:

(1). TIMELY NOTIFICATION BY CPS TO SPD.

Immediately after the initial CPS interview with the child victim and/or other family members and when the CPS worker substantiates the allegations of the referral or strongly suspects them to be true a referral shall be made to the SPD, Sex Crimes Unit.

(2). USE OF CPS REFERRAL FORM TO SPD.

In order to facilitate more timely notification by CPS to SPD, the attached form has been developed. The CPS worker shall fill in as much of the identifying information in the appropriate blanks as possible and then use the rest of Page 1 and 2 to provide any additional information.

(3). EMERGENT CASES.

In the initial CPS investigation where there is an emergency, especially involving the placement of a child, the CPS worker shall call 911 and ask for the assistance of a Patrol Officer. The Sex Crimes Unit is not involved in the placement of children. If there is an emergency in regard to the seriousness of the offense committed and immediate apprehension of the offender should be considered, the CPS worker shall call 911 for Patrol Assistance and/or the Sergeant of Sex Crimes.

However, in those cases where child victims want to give their statement immediately or where there are additional reasons to have the "joint interview" set up as quickly as possible or where there are other emergent circumstances, the CPS worker shall immediately call the Sex Crimes Unit Sergeant and report the case, also explaining the emergent needs. A referral form should follow as soon as possible after this contact.

(4). JOINT INTERVIEW.

It will be the responsibility of the assigned SPD detective to set up the "joint interview" with a Prosecuting Attorney and to then notify the CPS worker of the date and time. It will then be the responsibility of the CPS worker to notify the Sexual Assault Center and/or any other involved parties about the "joint interview."

(5). CPS INVESTIGATION.

The CPS investigation and initial interview shall focus on the child victim and other non-offending family members, not on the alleged offender. Since the legal rights of the alleged offender may be compromised if statements are made prior to constitutional cautions being given, there shall be no interrogation of the alleged offender by CPS in regard to the specific allegations until SPD begins their investigation and agrees to any CPS interrogation. It is the responsibility of the assigned SPD detective to interview the alleged offender and to carry out an investigation which may result in criminal charges being filed.

If in the initial CPS family interview, the alleged offender is present, it is appropriate for the CPS worker to notify him of the allegations, to explain the CPS role in the investigation, to inform him that the RCW mandates CPS to report the situation to the police and to inform him that there is the possibility of criminal charges. The CPS worker shall not give legal advice to the alleged offender nor shall they make statements about the police investigation other than the fact that there may be one.

(6). CASES WITH INCONCLUSIVE EVIDENCE.

In those cases where CPS has made a referral to SPD but where there is inconclusive evidence for criminal charges, SPD will prepare an offense report to keep on file in the event of future offenses. This information will only be available to people within the Criminal Justice System and CPS.

(7). STATUTE OF LIMITATIONS.

CPS workers shall make referrals of child sexual abuse to SPD regardless of whether or not the time of the offense is beyond the statute of limitations. Timely notification to SPD is important.

Any question in regard to this protocol should be directed to:

Jane Morgan
Casework Supervisor
CPS Child Sexual Abuse Unit
721-4102

Sergeant Dick Ramon
SPD Sex Crimes Unit
625-2457

INTERVIEWING CHILD VICTIMS

GUIDELINES FOR CRIMINAL JUSTICE SYSTEM PERSONNEL

BACKGROUND INFORMATION

The following issues affect the child's ability to give a history of sexual assault and influence the cooperativeness of victim and family.

I. Child's Developmental Level

A child's cognitive, emotional and social growth occurs in sequential phases of increasingly complex levels of development. Progression occurs with mastery of one stage leading to concentration on the next.

Cognitive—Preconceptual, concrete, intuitive thinking in the young child gradually develops toward comprehension of abstract concepts. Time and space begin as personalized notions and gradually are identified as logical and ordered concepts.

Emotional—The young child perceives her/himself egocentrically with little ability to identify her/himself in a context. S/he is dependent on the family to meet all needs and invests adults with total authority. The child often reflects the emotional responses of the parents. S/he gradually shifts to greater reliance on peer relationships and emotional commitments to people outside the family.

Behavioral—The young child is spontaneous, outgoing and explosive with few internal controls and only a tentative awareness of external limits. S/he has a short attention span. A child most often expresses feelings through behavior rather than verbally. As the child grows, s/he develops internal controls and establishes a sense of identity and independence. Peers and other adults have increasing influence on behavior.

II. Sexual Assault

Characteristics of the assault affect the child's emotional perception of the event and to a great extent determine the response. The closeness of the child's relationship to the offender, the duration of the offense, the amount of secrecy surrounding the assault, and the degree of violence are the factors which have the greatest impact on the child's reaction. The child may very well have ambivalent feelings toward the offender or be dependent on him for other needs.

III. Response to Child

The child is fearful of the consequences of reporting a sexual assault. The response of the family support system and official agencies will directly affect the resolution of the phychological trauma and her/his cooperativeness as a witness. The child fears s/he will be disbelieved or blamed for the assault and almost always is hesitant about reporting.

INTERVIEWING CHILD VICTIMS

I. Preparing for Interview

Prior to interviewing the child, obtain relevant information from parents/guardian, and if applicable, Child Protective Services caseworker, physician, and/or Sexual Assault Center/Rape Relief counselor.

A. Explain your role and procedures to above personnel, and enlist their cooperation.

B. Determine child's general developmental status: age; grade; siblings; family composition; capabilities; ability to write, read, count, ride a bike, tell time, remember events; any unusual problems: physical, intellectual, behavioral; knowledge of anatomy and sexual behavior; family terminology for genital areas.

C. Review circumstances of assault (as reported already by child to other person): what, where, when, by whom, and to whom reported; exact words of child; other persons told by child; how many have interviewed child; child's reaction to assault; how child feels about it and what, if any, behavioral signs of distress (nightmares, withdrawal, regression, acting out) have occurred.

D. Determine what reactions and changes child has been exposed to following revelation of the assault(s): believing; supportive; blaming; angry; ambivalent; parents getting a divorce; move to a new home.

II. Beginning the Interview

A. Setting—The more comfortable for the child, the more information s/he is likely to share.

1. Flexibility—A child likes to move around the room, explore and touch, sit on the floor or adult's lap.
2. Activity—Playing or coloring occupy child's physical needs and allows her/him to talk with less guardedness.
3. Privacy—Interruptions distract an already short attention span, divert focus of interview, and make self-conscious or apprehensive child withdraw.
4. Support—If the child wishes a parent or other person present, it should be allowed. A frightened or insecure child will not give a complete statement.

B. Establishing a relationship

1. Introduction—Name, brief and simple explanation of role, and purpose: "I am the lawyer (or legal person) on your side; my job is to talk to children about these things because we want to them to stop happening."
2. General exchange—Ask about name (last name), age, grade, school and teacher's name, siblings, family composition, pets, friends, activities, favorite games/TV shows. (It often helps to share personal information when appropriate, e.g., children, pets.)
3. Assess level of sophistication and ability to understand concepts—Does child read, write, count, tell time; know colors or shapes; know the day or date; know birthdate; remember past events (breakfast, yesterday, last year); understand before and after; know about money; assume responsibilities (goes around neighborhood alone, stays at home alone, makes dinner, etc.)

III. Obtaining History of Sexual Assault

A. Preliminaries

1. Use language appropriate to child's level; be sure child understands words. (Watch for signs of confusion, blankness, or embarrassment; be careful with words like incident, occur, penetration, prior, ejaculation, etc.)
2. Do not ask WHY questions ("Why did you go to the house?" "Why didn't you tell?") They tend to sound accusatory.
3. Never threaten or try to force a reluctant child to talk. Pressure causes a child to clam up and may further traumatize her/him.

(over)

4. Be aware that the child who has been instructed or threatened not to tell by the offender (ESPECIALLY if a parent) will be very reluctant and full of anxiety (you will usually notice a change in the child's affect while talking about the assault). The fears often need to be allayed.
   —"It's not bad to tell what happened."
   —"You won't get in trouble."
   —"You can help your dad by telling what happened."
   —"It wasn't your fault."
   —"You're not to blame."
5. Interviewer's affective response should be consonant with child's perception of assault (e.g., don't emphasize jail for the offender if the child has expressed positive feelings toward him.)
6. Ask direct, simple questions as open-ended as allowed by child's level of comprehension and ability to talk about the assault.

B. Statement

1. WHAT
   —"Can you tell me what happened?"
   —"I need to know what the man did."
   —"Did he ever touch you? Where?"
   —"Where did he put his finger?"
   —"Have you ever seen him with his clothes off?"
   —"Did you ever see his penis (thing, pee pee, weiner) get big?"
   —"Did anything ever come out of it?"

   Once basic information is elicited, ask specifically about other types of sexual contact.
   —"Did he ever put it into your mouth?"
   —"Did he ever make you touch him on his penis?"

2. WHO
   Child's response here will probably not be elaborate. Most children know the offender and can name him, although in some cases the child may not understand relationship to self or family. Ascertain from other sources what is the exact nature/extent of the relationship.

3. WHEN
   The response to this question will depend on child's ability, how recently assault happened, lapse between last incident and report, number of assaults (children will tend to confuse or mix separate incidents). If the child is under six, information re: time is unlikely to be reliable. An older child can often narrow down dates and times using recognizable events or associating assault with other incidents.
   —"Was it before your birthday, the weekend, Valentine's Day?"
   —"Was it nighttime or daytime?"
   —"Did it happen after dinner, 'Happy Days', your brother's bedtime?"

4. WHERE
   The assault usually occurs in the child's and/or offender's home. Information about which room, where other family members were, where child was before assault may be learned.

5. COERCION
   What kind of force, threat, enticement, pressure was used to insure cooperation and secrecy?
   —"Did he tell you not to tell?" "What did he say?"
   —"Did he say something bad would happen or you would get in trouble if you told?"
   —"Did the man say it was a secret?"

C. Assessing credibility and competency

1. Does child describe acts or experience to which s/he would not have normally been exposed? (Average child is not familiar with erection or ejaculation until adolescence at the earliest.)
2. Does child describe circumstances and characteristics typical of sexual assault situation? ("He told me that it was our secret"; "He said I couldn't go out if I didn't do it"; "He told me it was sex education".)
3. How and under what circumstances did child tell? What were exact words?
4. How many times has child given the history and how consistent is it regarding the basic facts of the assault (*not* times, dates, circumstances, sequence of events, etc.)?
5. How much spontaneous information can child provide? How much prompting is required?
6. Can child define difference between truth and a lie? (This question is not actually very useful with young children because they learn this by rote but may not understand the concepts.)

IV. Closing the Interview

A. Praise/thank child for information/cooperation.

B. Provide information

1. Child—Do not extract promises from child regarding testifying. Most children cannot project themselves into an unknown situation and predict how they will behave. Questions about testifying in court or undue emphasis on trial will have little meaning and often frightens the child (causing nightmares and apprehension).
2. Parent—Provide simple, straightforward information about what will happen next in the criminal justice system and approximately when, the likelihood of trial, etc.

C. Enlist cooperation—Let them know who to contact for status reports or in an emergency; express appreciation and understanding for the effort they are making by reporting and following through on process.

D. Answer questions; solicit responses.

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APPENDIX A-4

SEXUAL ASSAULT CENTER
BROCHURE FOR CHILD VICTIMS

This pamphlet is for you.

We hope that by reading it you will understand a little better what has happened to you and to other kids.

We are called the Sexual Assault Center or S.A.C. for short. All of the girls and boys we see here at S.A.C. have been sexually assaulted or molested by a grown-up or an older kid. Sexual assault or molestation is when a grown-up or older kid does something sexual with a child, like touching the child's private parts or making the child touch him. The grown-up may touch the private parts of his body to the child's or make the child lick or suck his private parts. He may make the child undress or make the child look at him with no clothes on. Maybe one of these things happened to you.

It is wrong for an adult to do these things with a child. It is against the law, like stealing or shooting someone. Most of the time it is a grown-up man or teenage boy who has this problem. Sexual assault happens a lot to kids, both boys and girls. Usually the person who does this, called the offender, is someone you know. It may be a babysitter, a neighbor or friend of the family, mom's boyfriend, or a relative, like an uncle, grandfather, dad or step-dad. Sometimes the person who does this is a stranger.

The grown-up who does this to a child has a serious problem and needs help. Even if the offender has stopped doing this with you now, he may do these things with another child. He can't stop doing it unless he gets help. You did not cause him to do these things to you. It is not your fault that it happened. It is the grown-up's fault, and he must get help to change.

You know who molested you. For some other kid, it might be some other person. But there are a lot of things that are probably the same for you as for other children who've been molested.

Most offenders get the kids to go along with it by hurting or scaring or tricking them. Some of the things offenders say to get a child to give in are things you may have heard before:

"What I'm doing is okay: it's sex education."

"I'm doing this to punish you."

"I'm doing this to help you, so you won't have problems with boys."

"This won't hurt you."

"I'm doing this because I love you."

"I need you to do this because your mom (or my wife) doesn't give me enough sex."

"I need this. Do it to make me feel better."

"If you don't do this, you'll get in trouble."

"I'll hurt you or kill you if you don't do this."

"If you do this, I won't touch your little sister."

Sometimes an offender will give a kid things the kid really wants, like money or toys or special treats. Sometimes the offender doesn't do anything to get the kid to go along, he just does it. He just starts touching you or having you touch him.

The offender tries to make the kid keep quiet about what has happened. Things that offenders say to kids to keep them from telling are:

"You will get in trouble if you tell."

"This is our secret."

"Just forget what happened."

"This is nobody's business."

"If you tell, you will be sent away or go to jail."

"If you tell your mother, she won't believe you."

"If you tell, I will be sent away or go to jail."

"The family will break up if you tell."

"Your mother will have a nervous breakdown."

"I will beat you up if you tell anybody."

"I will say that you are lying."

"Your mother will hate you."

Sound familiar? Sometimes the offender won't even have to say any of these things. You just feel that something bad would happen if you told and when it happened it would be all your fault.

Were you scared to tell? Most girls and boys are. Some kids never do tell because they are so afraid of what might happen. Sometimes, after a long time when they finally do tell someone, like mom or another relative, the person doesn't believe them. Then they have to keep telling and maybe even have to tell in front of the offender. All of this can be really scary. Usually there are a lot of upset feelings.

What has happened to you and to other kids when they told or when someone found out can be very different. Feelings about what has happened can be different, too. Each of you has different feelings because each person is a little different, and each situation is different. How you feel about what happened to you depends on a lot of things. It depends on how much you like or don't like the person who molested you, or if you got really scared or hurt when it happened. How you feel also depends on whether or not you have people in your life who help you and take care of you. Some of the different feelings kids have are:

"It was all my fault."

"I did something wrong."

"I caused a lot of problems."

"I feel different from kids my age."

"I don't like him to do that."

"I'm really mad."

"I'm really scared, and I don't know what to do."

"I'm really sad."

"I made more trouble by telling."

How you feel now that people know what has happened is probably different from other kids. The feelings you have are your special feelings. Feelings can't be wrong. The way you feel is probably different than the way other kids or even your best friend or your mom feel. It's not okay for anyone to tell you what feelings you should have.

When children have been sexually assaulted, like you, they might have some worries or feelings they don't understand. Some kids have problems, some don't. Some kids have a whole bunch of problems. For some the worst problems happen when they are being molested, before anyone else knows what's happening; for others the worst problems don't happen until later. There are lots of different kinds of problems boys and girls who have been molested might have.

They might find it hard to fall asleep or have nightmares.

They might not feel like eating.

They might be upset and feel like crying or want to be around mom.

They might not want to be left alone at night or any other time.

They might be afraid of men.

They might find that they can't concentrate in school.

They might be afraid of the offender.

They might not be able to stop thinking about what happened.

Have you had any special problems or feelings you don't like?

We know that when somebody first found out or you told somebody about what was happening, you and everyone else were probably pretty upset. Maybe everyone still is upset. Even when what has happened is over and you are safe, it is a hard thing for you and the people who love you to forget. Sometimes some pretty big changes can happen. If a kid isn't safe at home, she or he may have to stay somewhere else or in a foster home for a while. If the offender was the father, he may have to leave home. A kid may also have to go to the doctor and have a check-up to make sure she or he hasn't been physically hurt. This may be scary and confusing.

All of these changes and scary feelings can really make a person pretty upset, whether they're young or old. You may be upset, too, because some of these things have happened to you.

Do you need someone to talk to? Lots of kids do. You might want to talk about the feelings you have or get some help with problems you're having.

We have counselors here at S.A.C. who are called social workers. They will let you talk to them about anything you want. They've talked to lots of other kids and have an idea about what you might be going through.

The social worker can talk to you about:

- what has happened or is happening now
- how you feel about yourself or the offender
- how you feel about your parents
- things you are afraid of
- what is going to happen to you, to the offender, to your family

The social worker can help you:

- talk to the police or caseworker
- understand what court is all about
- work on problems at school
- get out of trouble

There may be other things that you want to talk about or that you want help with. You can write them here.

Things I want to talk about _____

_____

Things I want help with _____

_____

Later on if you want to talk to some other kids your age who've had the same thing happen to them, the social worker can introduce you to a group of kids you can talk with.

It is important to remember that S.A.C. is on your side and other people are too. You probably know some of the people who are on your side now. Who are they? Are they your mother? your friends? your teacher? the police?

My name is _____ and I will be your social worker at S.A.C. I am on your side and I'm ready to listen and answer your questions. You can call me at 223-3047.

These are some words you may have heard lately:

Caseworker: a person who works for Children's Protective Services and talks with kids and families about what is happening; this person tries to make sure that kids will be taken care of by their parents and that they won't be hurt or assaulted anymore.

Children's Protective Service or CPS: this is a group of people who work for the state to protect children who are not being taken care of or who are being hurt or sexually assaulted.

Counselor or Social Worker: a person who understands the emotional side of problems, or someone you talk to about things you are thinking or feeling.

Court: this is the place where judges decide if a person has done something wrong. If an offender goes to court the judge will decide if he did assault a child and what his punishment should be and what kind of help he should get.

Feeling: what happens inside of you when you think about certain things, like being mad or sad or happy.

Foster Home: a family who takes care of kids who cannot stay at their own home for awhile because of problems there.

Offender: a grown-up or teenager who makes a child do sexual things with him or with her.

Sexual: anything that has to do with the private parts of a person's body, those parts of the body which are different for boys and girls.

Sexual assault/sexual abuse/molestation/rape/incest: these words all mean a grown-up or older kid doing something sexual to a child. It is a crime for a grown-up to do these things with a child.

Victim: a child who is made to do sexual things by a grown-up or teenager.

Worry: to feel troubled or uneasy.

Are there other words you don't understand? Write them down here and ask your counselor what they mean:

_____ _____

_____ _____

ROUGH DRAFT OF FORTHCOMING BROCHURE FROM:

Sexual Assault Center
Harborview Medical Center
325 Ninth Avenue
Seattle, WA 98104

APPENDIX A-5

CHILD SEXUAL ABUSE TREATMENT/TRAINING INSTITUTE

MONDAY 1/26	TUESDAY 1/27	WEDNESDAY 1/28	THURSDAY 1/29	FRIDAY 1/30
AM 9:00- 10:15 Introduction - Welcome - Review of Agenda Explanation of Seminars (K. Kennelly D. Stevens S. Anderson) 10:15- 10:30 Break 10:30- 12:00 Sex between adults & kids: Why its not okay. Sex roles/ sexism Victimization (L. Berliner) 12:00- 1:30 Lunch PM 1:30- 2:15 Double Jeopardy (film) 2:15- 3:15 Medical/legal overview (S. Anderson) 3:15- 4:30 Overview Child Sexual Abuse Range of CSA Incest Incest Victim movie Incest video - optional	AM 9:00- 12:00 Children's Protective Service (J. Ramon) PM 12:00 -1:30 Lunch 1:00- 2:00 Offender Treatment - outpatient (R. Wolfe) 2:00- 3:30 Child Development - normal vs. child sex abuse (E. Ernst) 3:30- 4:30 Community Education & Prevention (S. Anderson)	AM 9:00- 10:00 Criminal Justice System Role of the Police (D. Ramon) 10:00- 11:00 Role of the Prosecutor (M. Barbieri) 11:00- 12:00 Networking Between Community Agencies (L. Berliner) PM 12:00- 1:30 Lunch 1:30- 3:00 Advocacy in the Criminal Justice System (E. Brom)	The Victim & Treatment Approaches AM 9:00- 10:30 Interviewing the Sexually Abused Child Male Victims (O. Manaois) 10:30- 12:00 Assessment & Treatment of the Sexually Abused Child 1-1 Approaches (L. Berliner) 12:00- 1:30 Lunch PM 1:30- 3:00 Group Treatment for the Sexually Abused Child (E. Ernst) 3:00- 4:00 Mothers - Treatment Approaches Individual/Group (K. Kennelly) 4:00- 5:00 Issues for Minority Victims (M. Sorenson)	AM 9:00- 10:00 Adult Women Victimized as Children (N. Ousley/ C. Monastersky) 10:00- 11:30 Juvenile Sex Offender Program 11:30- 12:30 Offender Treatment- Cognitive Restructuring Confrontive Group Treatment (F. Wolfe) 12:30- 1:30 Lunch 1:30- 3:30 Information Sources in Your Community (K. Markey/ P. Gregorio 3:30- 4:30 Wrap-Up Plan for Next Week (K. Kennelly)

CHILD SEXUAL ABUSE TREATMENT/TRAINING INSTITUTE

Institute Presentors

Shirley Anderson, MD, MPH
Pediatrician
Sexual Assault Center

Mary Kay Barbieri
Special Assault Unit
King County Prosecutor's Office

Lucy Berliner, MSW
Social Worker
Sexual Assault Center

Evelyn Brom
Project Coordinator
LEAA Sexual Assault
Prevention Grant
Seattle Rape Relief

Elise Ernst, MSW, M.Ed.
Social Worker
Sex Abuse Unit
Children's Protective Service

Paul Gregorio, MLS
Librarian
Region X Child Abuse
and Neglect Resource Center

Kathleen Kennelly, MSW
Project Coordinator
Child Sexual Abuse
Treatment/Training Institute

Orlando Manaois, MSW
Social Worker
Sexual Assault Center

Kate Markey, MLS
Librarian
Sexual Assault Center

Caren Monastersky, MSW
Social Worker
Sexual Assault Center

Nancy Ousley , MSW
Social Worker
Sexual Assault Center

Jane Ramon, MSW
Casework Supervisor
Child Sexual Assault Unit
Children's Protective Service

Richard Ramon
Sergeant
Sex Crimes Unit
Seattle Police Department

Florence Wolfe, MA
Behavioral Therapist
Northwest Treatment Associates

Roger Wolfe, MA
Director
Northwest Treatment Associates

Doris Stevens, MA, ACSW
Director
Sexual Assault Center

SAMPLE ELECTIVES*

POSSIBILITIES FOR 2nd WEEK SEMINARS

Name _____

Please indicate your first 3 choices of the below listed seminar topics:
(use #1 to show your 1st choice)

1. ___ Collection of Medical/Legal Evidence (S. Anderson)
2. ___ Issues for Rural Communities (M. Fortune)
3. ___ Evaluation and Research (M. Bell)
4. ___ Grant Writing and Funding Sources (D. Stevens)
5. ___ Education in the Schools on Child Sexual Abuse (K. Kennelly)
6. ___ Development of a Specialized CPS Unit for Child Sexual Abuse (J. Ramon)
7. ___ Development of Expert Witness Expertise (L. Berliner)
8. ___ Religious Concerns in Family Violence (M. Fortune)
9. ___ Counseling and Advocacy for the Developmentally Disabled Child and Adolescent (E. Ryerson)
10. ___ Awareness of Sexual Abuse and Self Protection Techniques for Developmentally Disabled People (E. Ryerson)
11. ___ Adolescent Rape Victims (B. Grav)
12. ___ Development of a Community Task Force on Incest Treatment (J. Taylor)
13. ___ An Historical Feminist Perspective on Child Sexual Abuse (K. Markey)
14. ___ Team Building (C. Monastersky)

*Curriculum and electives will vary with each session although basic materials will remain the same

APPENDIX A-6

S E X U A L A S S A U L T C E N T E R

Harborview Medical Center
Seattle, Washington

Client Characteristics - 1980

	SAC TOTAL		ADULT TOTAL			CHILD TOTAL		
	Number of SAC Clients	% of SAC (N=1379)	Number of Adult Clients	% of SAC (N=1379)	% of Adults (N=649)	Number of Child Clients	% of SAC (N=1379)	% of Children (N=730)
GENDER OF VICTIM:								
Female	1231	89.3%	625	45.3%	96.3%	606	43.9%	83.0%
Male	148	10.7%	24	1.8%	3.7%	124	9.0%	17.0%
	1379	100.0%	649	47.1%	100.0%	730	52.9%	100.0%
ETHNIC ORIGIN:								
Caucasian	1032	74.8%	481	34.9%	74.1%	551	40.0%	75.5%
Black	127	9.2%	67	4.9%	10.3%	60	4.3%	8.2%
Native American	35	1.5%	19	1.4%	2.9%	16	1.1%	2.2%
Hispanic	21	2.5%	11	0.8%	1.7%	10	0.7%	1.4%
Asian	11	0.9%	6	0.4%	0.9%	5	0.4%	0.7%
Other	23	1.7%	5	0.3%	0.8%	18	1.3%	2.4%
Unreported	130	9.4%	60	4.4%	9.3%	70	5.1%	9.6%
	1379	100.0%	649	47.1%	100.0%	730	52.9%	100.0%
POINT OF ENTRY TO SAC:								
Emergency Room	467	33.9%	344	24.9%	53.0%	123	8.9%	16.9%
Sexual Assault Center (SAC)	908	65.8%	304	22.1%	46.8%	604	43.8%	82.7%
Other or Unreported	4	0.3%	1	0.1%	0.2%	3	0.2%	0.4%
	1379	100.0%	649	47.1%	100.0%	730	52.9%	100.0%
INITIAL MEDICAL CARE AT HMC:								
Emergency Room	453	32.9%	335	24.3%	51.6%	118	8.5%	16.2%
Clinic (Pediatric or Gynecology)	167	12.1%	21	1.5%	3.2%	146	10.6%	20.0%
None	759	55.0%	293	21.3%	45.2%	466	33.8%	63.8%
	1379	100.0%	649	47.1%	100.0%	730	52.9%	100.0%

1,379 represents the total count of victims who sought services through the Sexual Assault Center (SAC) in 1980. It does not reflect counseling with victims' friends and families.

Adult is a client 17 years of age or older. Child is a client 16 years of age or younger.

SEXUAL ASSAULT CENTER - Client Characteristics - 1980 Page 2

	SAC TOTAL		ADULT TOTAL			CHILD TOTAL		
	Number of SAC Clients	% of SAC (N=1379)	Number of Adult Clients	% of SAC (N=1379)	% of Adults (N=649)	Number of Child Clients	% of SAC (N=1379)	% of Children (N=730)
SERVICES PROVIDED:								
Medical Only	42	3.1%	24	1.7%	3.7%	18	1.3%	2.5%
Medical and Counseling	486	35.2%	301	21.8%	46.4%	185	13.4%	25.3%
Counseling Only	540	39.2%	234	17.0%	36.0%	306	22.2%	41.9%
Counseling and Legal Advocacy	170	12.3%	42	3.1%	6.5%	128	9.3%	17.6%
Medical, Counseling, & Legal Adv.	141	10.2%	48	3.5%	7.4%	93	6.7%	12.7%
	1379	100.0%	649	47.1%	100.0%	730	52.9%	100.0%
WHO REFERRED CLIENT TO SAC:								
Police	365	26.5%	236	17.1%	36.4%	129	9.3%	17.7%
Child Protective Services (CPS)	273	19.8%	22	1.6%	3.4%	251	18.2%	34.4%
Rape Relief	98	7.1%	75	5.4%	11.5%	23	1.7%	3.1%
Family of Client	101	7.3%	29	2.1%	4.5%	72	5.2%	9.9%
Social Service Agency	98	7.1%	44	3.2%	6.8%	54	3.9%	7.4%
Other Medical Facility	108	7.8%	55	4.0%	8.5%	53	3.8%	7.3%
Friend or Neighbor	74	5.4%	41	3.0%	6.3%	33	2.4%	4.5%
Self	114	8.3%	80	5.8%	12.3%	34	2.5%	4.7%
Prosecutor	49	3.5%	22	1.6%	3.4%	27	2.0%	3.7%
Other	52	3.8%	27	2.0%	4.1%	25	1.8%	3.4%
Unreported	47	3.4%	18	1.3%	2.8%	29	2.1%	3.9%
	1379	100.0%	649	47.1%	100.0%	730	52.9%	100.0%
LOCATION OF ASSAULT:								
Victim's Home	634	46.0%	256	18.6%	39.4%	378	27.4%	51.8%
Assailant's Home	216	15.7%	92	6.7%	14.2%	124	9.0%	17.0%
Public Place	206	14.9%	127	9.2%	19.6%	79	5.7%	10.8%
Assailant's Car	88	6.4%	63	4.5%	9.7%	25	1.8%	3.4%
Other's Home	39	2.8%	19	1.4%	2.9%	20	1.5%	2.7%
Victim's Car	13	0.9%	10	0.7%	1.5%	3	0.2%	0.4%
Other	29	2.1%	16	1.2%	2.5%	13	0.9%	1.8%
Unreported	154	11.2%	66	4.8%	10.2%	88	6.4%	12.1%
	1379	100.0%	649	47.1%	100.0%	730	52.9%	100.0%

SEXUAL ASSAULT CENTER - Client Characteristics - 1980 - Page 3

RELATIONSHIP OF ASSAILANT TO VICTIM:	SAC TOTAL Number of SAC Clients	SAC TOTAL % of SAC (N=1379)	ADULT TOTAL Number of Adult Clients	ADULT TOTAL % of SAC (N=1379)	ADULT TOTAL % of Adults (n=649)	CHILD TOTAL Number of Child Clients	CHILD TOTAL % of SAC (N=1379)	CHILD TOTAL % of Children (N=730)
Stranger	374	27.1%	277	20.1%	42.7%	97	7.0%	13.3%
Known to Victim - Not Incest:								
Acquaintance	199	14.4%	124	9.0%	19.1%	75	5.4%	10.3%
Friend	107	7.8%	37	2.7%	5.7%	70	5.1%	9.6%
Neighbor	37	2.7%	6	0.4%	0.9%	31	2.3%	4.2%
Babysitter	50	3.6%	0	0.0%	0.0%	50	3.6%	6.8%
Ex-husband/Ex-lover	15	1.1%	14	1.0%	2.2%	1	0.1%	0.1%
Husband/Lover	10	0.7%	8	0.6%	1.2%	2	0.1%	0.3%
Co-Worker	4	0.3%	4	0.3%	0.6%	0	0.0%	0.0%
Total Known - Not Incest	(422)	(30.6%)	(193)	(14.0%)	(29.7%)	(229)	(16.6%)	(31.3%)
Known to Victim - Incest:								
Natural Parent	211	15.3%	82	5.9%	12.6%	129	9.4%	17.7%
Step-Parent	137	10.0%	34	2.5%	5.2%	103	7.5%	14.1%
Adoptive Parent	7	0.5%	0	0.0%	0.0%	7	0.5%	1.0%
Foster Parent	6	0.4%	1	0.1%	0.2%	5	0.4%	0.7%
Parent's Partner	44	3.2%	2	0.1%	0.3%	42	3.0%	5.7%
Grandparent	29	2.1%	5	0.4%	0.8%	24	1.7%	3.3%
Total Parental Figure	(434)	(31.5%)	(124)	(9.0%)	(19.1%)	(310)	(22.5%)	(42.5%)
Cousin	12	0.9%	2	0.1%	0.3%	10	0.7%	1.4%
Uncle	21	1.5%	2	0.1%	0.3%	19	1.4%	2.6%
Other Relative	18	1.3%	9	0.7%	1.4%	9	0.7%	1.2%
Sibling	39	2.8%	14	1.0%	2.2%	25	1.8%	3.4%
Total Non-Parental Figure	(90)	(6.5%)	(27)	(2.0%)	(4.2%)	(63)	(4.6%)	(8.6%)
Total Known - Incest	(524)	(38.0%)	(151)	(11.0%)	(23.3%)	(373)	(27.1%)	(51.1%)
Total Known to Victim	946	68.6%	344	25.0%	53.0%	602	43.7%	82.4%
Unreported	59	4.3%	28	2.0%	4.3%	31	2.2%	4.3%
Grand Total	1379	100.0%	649	47.1%	100.0%	730	52.9%	100.0%

	SAC TOTAL		ADULT TOTAL			CHILD TOTAL		
	Number of SAC Clients	% of SAC (N=1379)	Number of Adult Clients	% of SAC (N=1379)	% of Adults (N=649)	Number of Child Clients	% of SAC (N=1379)	% of Children (N=730)
TIME LAPSE Since Last Incident & SAC Contact:								
Less than 48 hours	479	34.7%	346	25.1%	53.3%	133	9.6%	18.2%
2 days up to 2 weeks	237	17.2%	70	5.1%	10.8%	167	12.1%	22.9%
2 weeks up to 6 months	215	15.6%	43	3.1%	6.6%	172	12.5%	23.6%
6 months or longer	271	19.7%	167	12.1%	25.7%	104	7.5%	14.2%
Unreported	177	12.8%	23	1.7%	3.6%	154	11.2%	21.1%
	1379	100.0%	649	47.1%	100.0%	730	52.9%	100.0%
NUMBER OF ASSAILANTS & INCIDENTS:								
Single Assailant/Single Incident	568	41.2%	352	25.5%	54.2%	216	15.6%	29.6%
Single Assailant/Multiple Incidents	512	37.1%	159	11.5%	24.5%	353	25.6%	48.3%
Multiple Assailants/Single Incident	84	6.1%	57	4.2%	8.8%	27	2.0%	3.7%
Multiple Assailants/Mult. Incidents	108	7.8%	54	3.9%	8.3%	54	3.9%	7.4%
Unreported	107	7.8%	27	2.0%	4.2%	80	5.8%	11.0%
	1379	100.0%	649	47.1%	100.0%	730	52.9%	100.0%
REPORTS TO POLICE AND/OR CPS:								
Reports Only to Police:								
Seattle	354	25.7%	265	19.2%	40.8%	89	6.5%	12.2%
King County	114	8.2%	60	4.3%	9.2%	54	3.9%	7.4%
Other Police Departments	58	4.2%	27	2.0%	4.2%	31	2.2%	4.2%
Total Only to Police	526	38.1%	352	25.5%	54.2%	174	12.6%	23.8%
Reports Only to CPS	211	15.3%	14	1.0%	2.2%	197	14.3%	27.0%
Reports Both to Police & CPS:								
Seattle	59	4.3%	4	0.3%	0.6%	55	4.0%	7.5%
King County	102	7.4%	5	0.4%	0.8%	97	7.0%	13.3%
Other	91	6.6%	8	0.6%	1.2%	83	6.0%	11.4%
Total Both To Police & CPS	252	18.3%	17	1.3%	2.6%	235	17.0%	32.2%
Not Reported	357	25.9%	247	17.9%	38.1%	110	8.0%	15.1%
Unknown	33	2.4%	19	1.4%	2.9%	14	1.0%	1.9%
Grand Total	1379	100.0%	649	47.1%	100.0%	730	52.9%	100.0%

BREAKDOWN OF AGE BY GENDER OF TOTAL SAC POPULATION

AGE:	SAC TOTAL Number of SAC Clients	SAC TOTAL % of SAC (N=1379)	MALES Number of Male Clients	MALES % of SAC (N=1379)	MALES % of Males (N=148)	FEMALES Number Female Clients	FEMALES % of SAC (N=1379)	FEMALES % of Females (N=1231)
0 - 4 years old	127	9.2%	29	2.1%	19.6%	98	7.1%	8.0%
5 - 8 years old	172	12.5%	51	3.7%	34.4%	121	8.8%	9.8%
9 - 12 years old	155	11.2%	26	1.9%	17.6%	129	9.3%	10.4%
13 - 16 years old	275	19.9%	18	1.3%	12.2%	257	18.6%	20.9%
Child: Age Unknown	1	0.1%	0	0.0%	0.0%	1	0.1%	0.1%
Total Children	730	52.9%	124	9.0%	83.8%	606	43.9%	49.2%
17 years old	57	4.1%	2	0.1%	1.4%	55	4.0%	4.5%
18 years old	41	3.0%	0	0.0%	0.0%	41	3.0%	3.3%
19 years old	46	3.4%	3	0.2%	2.0%	43	3.2%	3.5%
20 years old	29	2.1%	0	0.0%	0.0%	29	2.1%	2.4%
21 - 30 years old	276	20.0%	11	0.8%	7.4%	265	19.2%	21.5%
31 - 40 years old	81	5.9%	2	0.1%	1.4%	79	5.8%	6.4%
41 - 50 years old	26	1.9%	2	0.1%	1.4%	24	1.8%	2.0%
51 - 60 years old	10	0.7%	0	0.0%	0.0%	10	0.7%	0.8%
61 - 80 years old	6	0.4%	1	0.1%	0.6%	5	0.3%	0.4%
Adult: Age Unknown	77	5.6%	3	0.2%	2.0%	74	5.4%	6.0%
Total Adults	649	47.1%	24	1.7%	16.2%	625	45.4%	50.8%
Grand Total	1379	100.0%	148	10.7%	100.0%	1231	89.3%	100.0%

WOMEN VICTIMS OF CHILD SEXUAL ABUSE - (ADULTS WHO WERE ABUSED AS CHILDREN)

	Number of Women	% of SAC (N=1379)	% of Adults (N=649)	% This Group (N=119)
PRESENT AGE:				
18 - 20 years old	22	1.6%	3.4%	18.5%
21 - 24 years old	21	1.5%	3.2%	17.7%
25 - 44 years old	40	2.3%	6.2%	33.6%
45 - 54 years old	5	0.4%	0.8%	4.2%
60 - 64 years old	1	0.1%	0.2%	0.8%
Adult: Age Unknown	30	2.2%	4.6%	25.2%
	119	8.6%	18.4%	100.0%
TYPE OF ASSAULT:				
Child Molestation-Stranger/Acquaintance	18	1.3%	2.8%	15.1%
Child Incest	101	7.3%	15.6%	84.9%
	119	8.6%	18.4%	100.0%

SEXUAL ASSAULT CENTER - Client Characteristics - 1980

	BREAKDOWN OF TOTALS FOR CHILD CLIENTS							
	CHILD VICTIMS OF NON-FAMILY ASSAULT				CHILD VICTIMS OF INCEST			
	Number Children Non-Fam.	% of SAC (N=1379)	% of Children (N=730)	% of Non-Fam. (N=357)	Number of Child Incest	% of SAC (N=1379)	% of Children (N=730)	% of Incest (N=373)
GENDER OF VICTIM:								
Female	274	19.8%	37.5%	76.8%	332	24.1%	45.5%	89.0%
Male	83	6.0%	11.4%	23.2%	41	3.0%	5.6%	11.0%
	357	25.8%	48.9%	100.0%	373	27.1%	51.1%	100.0%
ETHNIC ORIGIN:								
Caucasian	268	19.4%	36.7%	75.1%	283	20.5%	38.8%	75.9%
Black	28	2.0%	3.8%	7.9%	32	2.3%	4.4%	8.6%
Native American	8	0.6%	1.1%	2.2%	8	0.6%	1.1%	2.1%
Hispanic	4	0.3%	0.6%	1.1%	6	0.4%	0.8%	1.6%
Asian	3	0.2%	0.4%	0.8%	2	0.2%	0.3%	0.5%
Other	11	0.8%	1.5%	3.1%	7	0.5%	0.9%	1.9%
Unreported	35	2.5%	4.8%	9.8%	35	2.6%	4.8%	9.4%
	357	25.8%	48.9%	100.0%	373	27.1%	51.1%	100.0%
POINT OF ENTRY TO SAC:								
Emergency Room	105	7.6%	14.4%	29.4%	18	1.3%	2.5%	4.8%
Sexual Assault Center (SAC)	250	18.1%	34.2%	70.0%	354	25.7%	48.5%	94.9%
Other/Unreported	2	0.1%	0.3%	0.6%	1	0.1%	0.1%	0.3%
	357	25.8%	48.9%	100.0%	373	27.1%	51.1%	100.0%
INITIAL MEDICAL CARE AT HMC:								
Emergency Room	102	7.4%	14.0%	28.6%	16	1.2%	2.2%	4.3%
Clinic (Pediatrics or Gynecology)	53	3.8%	7.2%	14.8%	93	6.8%	12.7%	24.9%
None	202	14.6%	27.7%	56.6%	264	19.1%	36.2%	70.8%
	357	25.8%	48.9%	100.0%	373	27.1%	51.1%	100.0%

357 represents the total count of child victims (16 years or under) who sought services through the Sexual Assault Center (SAC) in 1980, who were assaulted by a stranger or by an acquaintance not in the victim's family.

373 represents the total child victims who were assaulted by a family member, that is, who were incest victims.

SEXUAL ASSAULT CENTER - Client Characteristics - 1980

	BREAKDOWN OF TOTALS FOR CHILD CLIENTS							
	CHILD VICTIMS OF NON-FAMILY ASSAULT				CHILD VICTIMS OF INCEST			
	Number Children Non-Fam.	% of SAC (N=1379)	% of Children (N=730)	% of Non-Fam. (N=357)	Number of Child Incest	% of SAC (N=1379)	% of Children (N=730)	% of Incest (N=373)
SERVICES PROVIDED:								
Medical Only	10	0.7%	1.4%	2.8%	8	0.6%	1.1%	2.1%
Medical and Counseling	118	8.6%	16.2%	33.0%	67	4.9%	9.2%	18.0%
Counseling Only	133	9.6%	18.2%	37.3%	173	12.6%	23.7%	46.4%
Counseling and Legal Advocacy	60	4.3%	8.2%	16.8%	68	4.9%	9.3%	18.2%
Medical, Counseling, & Legal Adv.	36	2.6%	4.9%	10.1%	57	4.1%	7.8%	15.3%
	357	25.8%	48.9%	100.0%	373	27.1%	51.1%	100.0%
WHO REFERRED CLIENT TO SAC:								
Police	105	7.6%	14.4%	29.4%	24	1.8%	3.3%	6.4%
Child Protective Services (CPS)	59	4.3%	8.1%	16.5%	192	13.9%	26.3%	51.5%
Rape Relief	20	1.4%	2.7%	5.6%	3	0.2%	0.4%	0.8%
Family of Client	38	2.8%	5.2%	10.7%	34	2.5%	4.7%	9.1%
Social Service Agency	24	1.7%	3.3%	6.7%	30	2.2%	4.1%	8.0%
Other Medical Facility	22	1.6%	3.0%	6.2%	31	2.3%	4.2%	8.3%
Friend or Neighbor	20	1.4%	2.7%	5.6%	13	0.9%	1.8%	3.5%
Self	24	1.7%	3.3%	6.7%	10	0.7%	1.4%	2.7%
Prosecutor	19	1.4%	2.6%	5.3%	8	0.6%	1.1%	2.2%
Other	10	0.7%	1.4%	2.8%	15	1.1%	2.0%	4.0%
Unreported	16	1.2%	2.2%	4.5%	13	0.9%	1.8%	3.5%
	357	25.8%	48.9%	100.0%	373	27.1%	51.1%	100.0%
LOCATION OF ASSAULT:								
Victim's Home	93	6.7%	12.7%	26.0%	285	20.7%	39.1%	76.3%
Assailant's Home	74	5.4%	10.1%	20.7%	50	3.6%	6.9%	13.4%
Public Place	76	5.5%	10.4%	21.3%	3	0.2%	0.4%	0.8%
Assailant's Car	24	1.7%	3.3%	6.7%	1	0.1%	0.1%	0.3%
Other's Home	17	1.2%	2.3%	4.8%	3	0.2%	0.4%	0.8%
Victim's Car	2	0.1%	0.3%	0.6%	1	0.1%	0.1%	0.3%
Other	12	0.9%	1.7%	3.4%	1	0.1%	0.1%	0.3%
Unreported	59	4.3%	8.1%	16.5%	29	2.1%	4.0%	7.8%
	357	25.8%	48.9%	100.0%	373	27.1%	51.1%	100.0%

CONTINUED

2 OF 3

SEXUAL ASSAULT CENTER - Client Characteristics - 1980

RELATIONSHIP OF ASSAILANT TO VICTIM:	BREAKDOWN OF TOTALS FOR CHILD CLIENTS: CHILD VICTIMS OF NON-FAMILY ASSAULT — Number Children Non-Fam.	% of SAC (N=1379)	% of Children (N=730)	% of Non-Fam. (N=357)	CHILD VICTIMS OF INCEST — Number of Child Incest	% of SAC (N=1379)	% of Children (N=730)	% of Incest (N=373)
Stranger	97	7.0%	13.3%	27.1%				
Known to Victim - Not Incest:								
Acquaintance	75	5.4%	10.3%	21.0%				
Friend	70	5.1%	9.6%	19.6%				
Neighbor	31	2.3%	4.2%	8.7%				
Babysitter	50	3.6%	6.8%	14.0%				
Ex-husband/Ex-lover	1	0.1%	0.1%	0.3%				
Husband/Lover	2	0.1%	0.3%	0.6%				
Total Known - Not Incest	(229)	(16.6%)	(31.3%)	(64.2%)				
Known to Victim - Incest:								
Natural Parent					129	9.4%	17.7%	34.6%
Step-Parent					103	7.5%	14.1%	27.6%
Adoptive Parent					7	0.5%	1.0%	1.9%
Foster Parent					5	0.4%	0.7%	1.3%
Parent's Partner					42	3.0%	5.7%	11.3%
Grandparent					24	1.7%	3.3%	6.4%
Total Parental Figure					(310)	(22.5%)	(42.5%)	(83.1%)
Cousin					10	0.7%	1.4%	2.7%
Uncle					19	1.4%	2.6%	5.1%
Other Relative					9	0.7%	1.2%	2.4%
Sibling					25	1.8%	3.4%	6.7%
Total Non-Parental Figure					(63)	(4.6%)	(8.6%)	(16.9%)
Total Known - Incest					(373)	(27.1%)	(51.1%)	(100.0%)
Total Known to Victim	229	16.6%	31.3%	64.2%	373	27.1%	51.1%	100.0%
Unreported	31	2.3%	4.3%	8.7%	0	0.0%	0.0%	0.0%
Grand Total	357	25.9%	48.9%	100.0%	373	27.1%	51.1%	100.0%

	BREAKDOWN OF TOTALS FOR CHILD CLIENTS							
	CHILD VICTIMS OF NON-FAMILY ASSAULT				CHILD VICTIMS OF INCEST			
	Number Children Non-Fam.	% of SAC (N=1379)	% of Children (N=730)	% of Non-Fam. (N=357)	Number of Child Incest	% of SAC (N=1379)	% of Children (N=730)	% of Incest (N=373)
TIME LAPSE Since Last Incident & SAC Contact:								
Less than 48 hours	115	8.3%	15.7%	32.2%	18	1.3%	2.5%	4.8%
2 days up to 2 weeks	86	6.2%	11.8%	24.1%	81	5.9%	11.1%	21.7%
2 weeks up to 6 months	69	5.0%	9.5%	19.3%	103	7.5%	14.1%	27.6%
6 months or longer	27	2.0%	3.7%	7.6%	77	5.6%	10.5%	20.7%
Unreported	60	4.3%	8.2%	16.8%	94	6.8%	12.9%	25.2%
	357	25.8%	48.9%	100.0%	373	27.1%	51.1%	100.0%
NUMBER OF ASSAILANTS & INCIDENTS:								
Single Assailant/Single Incident	179	12.9%	24.5%	50.1%	37	2.7%	5.1%	9.9%
Single Assailant/Multiple Incidents	77	5.6%	10.6%	21.6%	276	20.0%	37.8%	74.0%
Multiple Assailants/Single Incident	22	1.6%	3.0%	6.2%	5	0.4%	0.7%	1.3%
Multiple Assailants/Mult. Incidents	24	1.7%	3.3%	6.7%	30	2.2%	4.1%	8.1%
Unreported	55	4.0%	7.5%	15.4%	25	1.8%	3.4%	6.7%
	357	25.8%	48.9%	100.0%	373	27.1%	51.1%	100.0%
REPORTS TO POLICE AND/OR CPS:								
Reports Only to Police:								
Seattle	83	6.0%	11.4%	23.2%	6	0.4%	0.8%	1.6%
King County	50	3.6%	6.9%	14.0%	4	0.3%	0.5%	1.1%
Other Police Departments	28	2.0%	3.8%	7.8%	3	0.2%	0.4%	0.8%
Total Only to Police	161	11.6%	22.1%	45.0%	13	0.9%	1.7%	3.5%
Reports Only to CPS	63	4.6%	8.6%	17.7%	134	9.8%	18.4%	35.9%
Reports Both to Police & CPS:								
Seattle	20	1.4%	2.7%	5.6%	35	2.5%	4.8%	9.4%
King County	32	2.3%	4.5%	9.0%	65	4.7%	8.9%	17.4%
Other	12	0.9%	1.6%	3.4%	71	5.2%	9.7%	19.1%
Total Both to Police & CPS	64	4.6%	8.8%	18.0%	171	12.4%	23.4%	45.9%
Not Reported	60	4.4%	8.2%	16.8%	50	3.6%	6.9%	13.4%
Unknown	9	0.6%	1.2%	2.5%	5	0.4%	0.7%	1.3%
Grand Total	357	25.8%	48.9%	100.0%	373	27.1%	51.1%	100.0%

APPENDIX B

MATERIALS FROM THE CHILD PROTECTION CENTER – SPECIAL UNIT, WASHINGTON, D.C.

APPENDIX B-1

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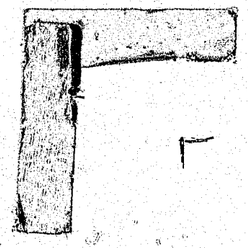

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APPENDIX B-2

Medical-Legal Sexual Assault Evidence Form

P.D. 124 3/79 METROPOLITAN POLICE DEPARTMENT - Washington, D.C. - MEDICAL EXAM OF ALLEGED SEXUAL ASSAULT VICTIM

1. General Information: a. Name _____ b. Alleged Assault: Date _____ Time _____
   c. DOB _____ d. Age _____ e. Sex _____ f. Race _____ g. Police Notified: Date _____ Time _____
   h. Address _____ i. Medical Exam: Date _____ Time _____
   j. Phone _____ Location (Name) _____
   k. Parent/Guardian _____ l. Type of Alleged Assault _____

TO BE COMPLETED BY EXAMINING PHYSICIAN - PLEASE USE INSTRUCTIONS ON REVERSE SIDE

2. General Appearance: _____

3. General Physical Complaints

	Head	Face	Neck	Chest	Abdmn	Back	Arms	Legs	Perineum	Anus	Ext. Genitalia	Description:
a. Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
b. Soreness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
c. Tenderness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
d. Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

4. General Physical Exam

	Head	Face	Neck	Chest	Abdomen	Back	Arms	Legs	Description:
a. Bruises	☐	☐	☐	☐	☐	☐	☐	☐	
b. Redness	☐	☐	☐	☐	☐	☐	☐	☐	
c. Swelling	☐	☐	☐	☐	☐	☐	☐	☐	
d. Lacerations	☐	☐	☐	☐	☐	☐	☐	☐	
e. Blood	☐	☐	☐	☐	☐	☐	☐	☐	

5. Gynecological/Anal Exam

	Perineum	Labia	Introitus	Vagina	Cervix	Anus	Penis/Scrotum	Description:
a. Bruises	☐	☐	☐	☐	☐	☐	☐	
b. Redness	☐	☐	☐	☐	☐	☐	☐	
c. Swelling	☐	☐	☐	☐	☐	☐	☐	
d. Lacerations	☐	☐	☐	☐	☐	☐	☐	
e. Blood	☐	☐	☐	☐	☐	☐	☐	
f. Discharge	☐	☐	☐	☐	☐	☐	☐	

Additional Description:
a. Introitus (incl. approx. size in children) _____
b. Hymen Condition _____
c. Anal Tone _____

6. General Behavior

a. Calm	☐ Yes	☐ No	b. Sluggish	☐ Yes	☐ No	Description:
c. Yes-No Response Only	☐ Yes	☐ No	d. Withdrawn	☐ Yes	☐ No	
e. Crying	☐ Yes	☐ No	f. Angry	☐ Yes	☐ No	
g. Over-Talkative	☐ Yes	☐ No	h. Restless	☐ Yes	☐ No	
i. Agitated	☐ Yes	☐ No	j. Hysterical	☐ Yes	☐ No	
k. Support Person Needed	☐ Yes	☐ No	l. Other	☐ Yes	☐ No	

7. Additional Observations/Remarks _____

8. Diagnosis/Impressions _____

9. Medical Evaluation: In your opinion are the medical findings above suggestive of and/or compatible with:

	Yes-Recent	Yes-Past	No	Unknown	Comments:
a. General Physical Exam					
1. Injury Resulting From Violence	☐	☐	☐	☐	
b. Gynecological/Anal Exam					
1. External Genital Contact	☐	☐	☐	☐	
2. Labia Penetration	☐	☐	☐	☐	
3. Vaginal Penetration	☐	☐	☐	☐	
4. Anal Penetration	☐	☐	☐	☐	
5. Oral Contact	☐	☐	☐	☐	

10. Testing

	Done	Not Done	Type	Result	Vagina	Anal	Oral	Comments:
a. Semen	☐	☐			☐	☐	☐	
b. Sperm	☐	☐			☐	☐	☐	
c. Gonorrhea	☐	☐			☐	☐	☐	
d. Syphilis	☐	☐						
e. Pregnancy	☐	☐						
f. Other	☐	☐						

11. Diagnostic Procdrs

	Done	Not Done	Type	Result
a. X-Ray	☐	☐		
b. Consultation	☐	☐		
c. Other	☐	☐		

12. Treatment

	Done	Not Done	Type	Purpose
a. Hospitalization	☐	☐		
b. Suturing	☐	☐		
c. Medication	☐	☐		
d. Other	☐	☐		

13. Instructions for Follow-up: _____

Signature of Examining Physician _____ *Signature of Police Representative* _____

I hereby authorize _____ to release the original copy of this report and copies of any other reports pertaining to this examination (including reports of laboratory and diagnostic procedures) to the D.C. Metropolitan Police Department, the D.C. Department of Human Resources, the Office of the United States Attorney of D.C., and the Office of the Corporation Counsel of D.C. to be used for official purposes.

Signature of Person Examined _____ *Signature of Parent/Guardian of Person Examined* _____

INSTRUCTIONS FOR COMPLETING MEDICAL EXAMINATION FORM

PURPOSE OF FORM

This form for recording the results of the "Medical Examination of Alleged Sexual Assault Victim" is a form designed to be used for legal purposes, including investigation of the alleged crime and prosecution of persons alleged to have committed the crime of sexual assault. The medical examination and information recorded on the form are aimed at obtaining a record of medical evidence with regard to questions indicating occurrence of recent penetration, previous penetration, and other recent and/or previous genital and/or oral contact.

GENERAL INSTRUCTIONS

All sections of this form, except section 1 (General Information), shall be completed by the examining physician using medical examination findings, and in the manner indicated in these instructions. All sections should be completed, and no questions left unanswered.

The use of medical abbreviations and terms should be avoided so that police and court representatives may have a complete understanding of the conditions described.

SPECIFIC INSTRUCTIONS

1. General Information: All items in this section shall be completed by the police representative prior to the medical examination by the physician.

2. General Appearance: Indicate and describe general appearance including condition of clothes and presence of foreign matter such as dirt on clothes or body.

3. General Physical Complaints: Use check marks in appropriate blocks to indicate the current physical complaints expressed by the person examined. Under description, indicate the complaint and describe further.

4. General Physical Examination: Use check marks in appropriate blocks to indicate the findings of the examination. Under description, indicate the injury and describe further.

5. Gynecological/Anal Examination: Use check marks in the appropriate blocks to indicate the findings of the examination. Under description, indicate the injury and describe further. Under additional description, indicate and describe the appearance of the introitus including the approximate size in children; the condition of the hymen; and the condition of the anus, where applicable.

6. General Behavior: Check ALL of the terms listed, indicating either by "yes" or "no" which best describes the general behavior of the person at the time of the examination. Under description, comment and/or describe further, as appropriate.

7. Additional Observations/Remarks: Describe any additional medical findings not already indicated and/or described in other sections.

8. Diagnosis/Impressions: Indicate any specific diagnosis and/or impressions made based on medical examination findings. Label each of these as appropriate, i.e., diagnosis, impressions.

9. Medical Evaluation: Answer ALL questions by indicating either "Yes-Recent", "Yes-Past", "No", or "Unknown" in the appropriate blocks. "Yes-Recent" and "Yes-Past" allow for an approximate time frame in which the condition occurred.

10. Testing: Check either "Done" or "Not Done" to indicate testing done. Indicate name and/or type of test done. Indicate results of test if known at the time of medical examination. Check "Vaginal" and/or "Anal" and/or "Oral" to indicate the type of tests done.

11. Diagnostic Procedures: Check either "Done" or "Not Done" to indicate diagnostic procedures done. Indicate name and/or type of procedure done. Indicate results of procedure if known at the time of medical examination.

12. Treatment: Check either "Done" or "Not Done" to indicate treatment given. Indicate type and/or name and purpose of treatment done.

13. Instructions for Follow-up: Indicate specific instructions given to the person at the time of the medical examination for medical and/or health follow-up.

Signature of Patient: Signature of patient is obtained by the representative of the Metropolitan Police Department. If the patient is a minor, the responsibility for obtaining the signature of the parent or guardian is assumed by the representative of the Metropolitan Police Department. If the parent or guardian cannot be located, the representative of the Metropolitan Police Department will authorize the examination and release of reports. See D.C. Code Title 2, Section 161, et. seq. (1973 edition).

Distribution: Original- MPD, Copy 1- Prosecutor, Copy 2- Hospital, Copy 3- Public Health Nurse, DHR

APPENDIX B-3

MANAGEMENT GUIDELINES FOR INTRAFAMILY SEXUAL ABUSE CASES

INTRODUCTION

IN CASES INVOLVING ALLEGATIONS OF INTRAFAMILY SEXUAL ABUSE (SEE PROJECT DEFINITION) THE CHILD VICTIM AND THE FAMILY UNIT IS OUR PRIMARY CONCERN. SERVICE PROVIDED TO THE CHILD VICTIM AND FAMILY MEMBER IS DESIGNED TO MEET THE BEST INTEREST OF THE CHILD, WHICH IS DETERMINED BY COMBINING MAXIMUM INPUT FROM THE CHILD AND CAREFUL ASSESSMENT OF FAMILY DYNAMICS. AN INITIAL TEMPORARY SEPARATION OF THE VICTIM AND THE OFFENDER IS ESSENTIAL: THE OFFENDER IS ENCOURAGED TO LEAVE THE HOME. BUT IF THE OFFENDER DOES NOT LEAVE, THE CHILD SHOULD BE PLACED IN A SAFER ENVIRONMENT PENDING LEGAL DISPOSITION OF THE CASE.

SUPPORT TO THE FAMILY, EITHER TO RECONSTITUTE OR SEPARATE, SHOULD BE BASED ON THE DECISION OF THE NON-OFFENDING PARENT AND SIGNIFICANT OTHERS WITHIN THE FAMILY UNIT.

INITIAL CONTACT IN THE EMERGENCY ROOM:

1- THESE CASES ARE CONSIDERED AS MENTAL HEALTH EMERGENCIES AND ARE HIGH PRIORITY FOR SAT INTERVENTION.

2- THE EMERGENCY ROOM PROTOCOL ON SEX ASSAULT CASES SHOULD BE FOLLOWED, SUCH AS THE PHYSICAL EXAMINATION, LAB TEST, NOTIFICATION OF SEX OFFENSE BRANCH (727-4151) AND NOTIFICATION OF THE YOUTH DIVISION (576-6762) IF THE OFFENDER IS EITHER A JUVENILE LIVING IN THE HOME OR A PARENT, A GUARDIAN OR CARETAKER.

TEAM INTERVENTION:

3- AN ASSESSMENT OF FAMILY DYNAMICS IS NECESSARY IN ORDER TO INCURE THE SAFETY AND WELL BEING OF THE CHILD. ISSUES FOR DISCUSSION SHOULD INCLUDE:

- A- AGE OF CHILD
- B- RESIDENCE OF CHILD
- C- RESIDENCE OF OFFENDER
- D- RESPONSE AND ATTITUDE OF NON-OFFENDING PARENT OR SIGNIFICANT ADULT.
- E- FAMILY STRUCTURE AND RELATIONSHIPS
- F- DISCLOSURE PATTERN (TO WHOM, WHEN, WHY)
- G- FAMILY RESPONSE TO DISCLOSURE (CHILD-ORIENTED, OFFENDER-ORIENTED, SELF-BLAME)
- H- DYNAMICS OF SEXUAL ABUSIVE INCIDENCE: (ONSET, DURATION, BEHAVIOR OF CHILD, IMMEDIATE REACTION OFFENDER)
- I- FAMILY SUPPORT SYSTEMS WITHIN THE HOME OR OUTSIDE INFLUENCES(SUCH AS: WHO ARE DECISION MAKERS, WHAT IS THE COPYING STYLE, WHO IS A FAMILY CHANGE AGENT AND WHAT IS THE FAMILY'S EXPECTATION OF OUTCOME)

4- AN ASSESSMENT OF THE VICTIM IS IMPORTANT IN ORDER TO GAIN A BETTER UNDERSTANDING OF THE IMPACT OF THE INCIDENT AND THE SYSTEMS INVOLVEMENT ON THE CHILD. THIS ASSESSMENT SHOULD INCLUDE SEPARATE CLINICAL SESSIONS WITH THE NON-OFFENDING PARENT OR SIGNIFICANT ADULT AND THE CHILD VICTIM.

A- THE PARENT (OR SIGNIFICANT ADULT) INTERVIEW SHOULD INCLUDE:

-HIS OR HER REACTION AND ATTITUDE TOWARD THE VICTIM
-HIS OR HER SENSE OF PERSONAL RESPONSIBILITY OR BLAME
-HIS OR HER KNOWLEDGE OR OBSERVATION OF ANY BEHAVIORAL CHANGES
-HIS OR HER IMPRESSION OF THE CHILD'S RELATIONSHIP TO THE OFFENDER
-HOW HE OR SHE WOULD DESCRIBE THE CHILD'S GENERAL PERSONALITY TRAITS AND
-WHAT IS THIS CHILD'S NORMAL SCHOOL PERFORMANCE LEVEL

B- THERE SHOULD NOT BE EXTENSIVE QUESTIONING OF THE CHILD REGARDING THE DETAILS OF THE INCIDENT. WHENEVER POSSIBLE, THIS INFORMATION SHOULD BE OBTAINED FROM OTHERS SUCH AS THE PARENT, OTHER FAMILY MEMBERS, POLICE,ETC.

THE CHILD ASSESSMENT SHOULD INCLUDE:

-HIS OR HER PERCEPTION OF TOTAL SITUATION (DISCLOSURE, PARENTAL REACTIONS, POLICE, OFFENDER ROLE, CHILD'S ROLE)
-QUALITY OF REPORT
-AGE-APPROPRIATE COMMUNICATION SKILLS
-AGE-APPROPRIATE COGNITIVE SKILLS
-DEVELOPMENTAL/EMOTIONAL LEVEL
-EMOTIONAL STABILITY
-EXPECTATIONS AND CONCERNS

5- IF IT BECOMES NECESSARY FOR TEMPORARY SEPARATION BETWEEN THE CHILD AND OFFENDER, THE FOLLOWING RECOMMENDATIONS SHOULD BE MADE TO THE YOUTH DIVISION OFFICER,P.O. OR P.S. WORKER:

-THE OFFENDER SHOULD BE ENCOURAGED TO LEAVE THE HOME
-IF THE CHILD MUST BE REMOVED, THERE SHOULD BE ATTEMPTS TO ASCERTAIN SUGGESTIONS FROM FAMILY MEMBERS AS TO PLACEMENT WITH A RELATIVE OR FRIEND

6- EACH CASE WILL REQUIRE CLOSE INTERAGENCY COORDINATION WITH THE ASSISTANT CORPORATION COUNSEL, VOLUNTEER ATTORNEY'S OFFICE, AND THE PROBATION OFFICER OR PROTECTIVE SERVICE WORKER. THE PURPOSE OF SUCH COORDINATION IS TO:

- HELP EVALUATE THE BASIS OF ANY BEHAVIORAL OR EMOTIONAL CHANGES
-ASSESS THE IMPACT OF FAMILY SEPARATION
- ASSESS THE IMPACT OF SEXUAL ABUSE
- MAKE RECOMMENDATIONS FOR TREATMENT INTERVENTIONS
- ASSESS THE CHILD'S ABILITY TO TESTIFY AND THE IMPACT OF SUCH TESTIMONY ON THE CHILD
-MAKE RECOMMENDATIONS FOR FAMILY RECONSTITUTION AND ONGOING SUPERVISION.

7- IF THE OFFENDER IS AN ADOLESCENT OR SIBLING WHO LIVES IN THE HOME, IT IS RECOMMENDED THAT THE ADOLESCENT OR SIBLING IS EVALUATED FOR CHARACTER DISORDER

-PSYCHOSIS
-REALITY TESTING
-IMPULSE CONTROL
-CAPACITY FOR VIOLENCE
-DELUSIONAL SYSTEMS
-MOTIVATION/AMBITION
-SEXUAL DEVELOPMENT (AGE APPROPRIATE)
-EMOTIONAL STABILITY
-DEGREE OF FORCE
-ATTITUDE TOWARD AUTHORITY
-ACCEPTANCE OF RESPONSIBILITY
-RELATIONSHIP TO OFFENDER

IT IS RECOMMENDED THAT THESE EVALUATIONS BE DONE BY CHNMC PSYCHOLOGY DEPARTMENT, FORENSIC PSYCHIATRY, CHILD PROTECTION CENTER/SPECIAL UNIT OR OTHER COMMUNITY MENTAL HEALTH FACILITIES.

8- IF THE OFFENDER IS AN ADULT RELATIVE WHO LIVES INTHE HOME, A SIMILAR EVALUATION SHOULD BE DONE BY FORENSIC PSYCHIATRY OR OTHER COMMUNITY MENTAL HEALTH FACILITIES.

MANAGEMENT OF CASES INVOLVING A CHILD WHO IS TWO YEARS OLD OR YOUNGER WITH NO EVIDENCE OF PHYSICAL INJURY

INTRODUCTION:

IN SITUATIONS IN WHICH A PARENT OR OTHER ADULT SUSPECTS A CHILD UNDER TWO YEARS HAS BEEN SEXUALLY ABUSED, THESE CASES SHOULD BE REFERRED TO THE SAT ON-CALL WORKER FOR EVALUATION. THESE ARE MEDIUM PRIORITY CASES, THEREFORE EACH CASE IS ASSESSED ON A CASE BY CASE BASIS. FOR MANAGEMENT OF THESE TYPE CASES, USE THE FOLLOWING PROCEDURE.

1- THE PROTOCOLS FOR INTAKE SHOULD BE FOLLOWED AS USUAL
2- THE TRAUMA INDEX CARD SHOULD BE COMPLETED FOR FUTURE REFERENCE
3- IF A SUSPECT IS IDENTIFIED OR IF ANY LAB TESTS ARE POSITIVE, THE SEX OFFENSE BRANCH SHOULD BE NOTIFIED. IF A PARENT, GUARDIAN OR CUSTODIAN IS THE SUSPECT, THE YOUTH DIVISION MUST BE NOTIFIED. SPECIAL ATTENTION SHOULD BE FOCUSED ON THE RELATIONSHIP TO THE OFFENDER, RESIDENCE OF THE CHILD/OFFENDER, PARENTAL REACTIONS, OBSERVATIONS OF PARENT/CHILD INTERACTIONS, BEHAVIOR OF CHILD, ETC.
4- THE INTERVIEW OF THE PARENT OR ACCOMPANYING ADULT SHOULD INCLUDE:

- WHAT IS THE BASIS OF HIS OR HER SUSPICION AND AREA OF CONCERN
- INFORMATION ABOUT THE INCIDENT
- WHAT PARENTAL ACTION WAS TAKEN (REPORTING TO POLICE, CALLING NEIGHBOR, ETC.)
- WHO IS THE SUSPECT
- WHAT IS THE PARENT'S EXPECTATION NOW THAT THE CHILD HAS BEEN BROUGHT IN
- HOW DOES THE PARENT USUALLY COPE WITH STRESSFUL SITUATIONS
- WHAT IS THE CHILD'S USUAL BEHAVIOR LIKE; HOW IS THE BEHAVIOR DIFFERENT AND OVER WHAT TIME FRAME HAS IT CHANGED
- WHAT ARE THE CARETAKING ARRANGEMENTS

5- PARENT COUNSELING SHOULD INCLUDE:

- IDENTIFICATION AND RECOGNITION OF PARENTAL FEELINGS
- SUPPORTIVE COUNSELING RE: FEARS, FEELINGS OF HELPLESSNESS, ANXIETY, DEPRESSSION
- ALLEVIATION OF PARENTAL ANXIETY TO INCLUDE EXPECTED REACTIONS, PROVISION OF INFORMATION REGARDING MEDICAL/LEGAL IMPLICATIONS.

6- FOLLOW-UP SHOULD INCLUDE:

- PHONE CONTACT TO ALLOW CLOSURE IF NO LAW ENFORCEMENT ACTIVITIES ARE INVOLVED
- OFFICE VISIT IF THERE IS CONTINUED PARENTAL CONCERN OR BEHAVIORAL CHANGES IN CHILD

APPENDIX B-4

CRIMINAL JUSTICE SYSTEM: SEXUAL ABUSE CASE TRACKING FORM

1. Name of child:_____ Intake date:_____

2. Case reported to the police?____Y ____N If no, give reason:_____

_____

If yes, give: Complaint No.:_____ Complaint date:_____
Sex Offense Br. Detective:_____ Y.D. Officer:_____
Date of formal interview with victim/family:_____

3. Probable offender identified? ____Y ____N
If yes, arrested by the police?____Y ____N
If no, give reason:?_____

_____

Charged by the govt.?____Y ____N
If no, give reason:_____

_____

If yes, for violations of which code sections?

____22-103 ____22-501 ____22-503 ____22-1112(b) ____22-1901

____22-2705 ____22-2801 ____22-3501(a) ____22-3501(b) ____22-3502

____Other (_____)
Division: _____ Criminal _____ Family
Jacket No.: _____ Govt. Attorney: _____
Victim identification of offender: _____ Known to victim
_____ Show-up _____ Photo array _____ Line-up

4. Disposition:

_____Dismissed by judge (please place an "X" on the graph below to indicate when) Reason:_____

_____

_____All charges dropped or dismissed by government attorney (please place an "X" on the graph below) Reason: _____

_____

_____No indictment
_____Acquitted at trial by _____Judge _____Jury
_____Mistrial. Reason: _____

_____

_____Convicted:

_____ At trial by _____Judge _____Jury
_____ Pled guilty
_____ Charges found or pled guilty to: _____

_____

5. Sentence received (if any): _____

6. Motions to Suppress:

	Made	Granted	Item(s)
a) Tangible evidence			
b) Documents			
c) Statements			
d) Identification			
e) Other			

7. Continuances (enter total number)
   a) missing witness (include subpeonas not issued) Govt.____ Defense _____
   b) missing defendent Govt. _____ Defense _____
   c) preparation Govt. _____ Defense _____
   d) no judge available Govt. _____

   Total number of days lost thru continuances: Govt.____ Defense _____

8. Graph (Insert date(s) in parenthesis below graph line)

Arrest	Presen-tation	Prelim. hearing	Grand Jury	Arraignment	Pretrial motions	Trial	Sentencing
( )	( )	( )	( )	( )	( )	( )	( )

9. Additional comments about case outcomes:

APPENDIX B-4

Cumulative Law Enforcement Status of
Project Intake Cases, February 22, 1978-December 15, 1980
Child Protection Center-Special Unit

A. 420/___ *CPC-SU reports to D.C. M.P.D. Sex Offense Branch
- 12/___ Reports "Unfounded" (miscellaneous investigations)
- 134/___ Reports "Information Only" (miscellaneous investigations)
- 2/___ Reports with continuing investigation

272/___ Reports established as cases
- 5/___ Cases "Unfounded"
- 18/___ Cases with continuing investigation

242/244 Cases forwarded to prosecutors
7/ 6 Case closed, charged on other victim

B. 122/107 Cases with adult suspects
- 6/ 6 Cases closed because family refused to press charges
- 42/ 38 Cases closed because arrest warrant application denied by Asst. U.S. Attorney
- /___ Cases closed because arrest warrant application denied by judge

2/ 2 Arrest warrants issued and outstanding
72/ 61 Suspects arrested
- 2/ 2 Defendants not charged ("No papered")
- 17/ 13 Defendants not indicted by grand jury

6/ 6 Defendants awaiting indictment by grand jury
47/ 40 Defendants indicted or waiving indictment
- 6/ 3 Defendants awaiting trial
  - 3/ 3 Defendants with charges dismissed
  - 2/ 2 Defendants acquitted at trial

4/ 4 Defendants convicted at trial
32/ 28 Defendants convicted by guilty plea
6/ 5 Defendants awaiting sentencing
14/ 12 Defendants sentenced to imprisonment
16/ 15 Defendants placed on probation

C. 120/137 Cases with juvenile suspects
- 4/ 4 Cases closed because family refused to press charges
- 37/ 48 Cases closed because custody order application denied by Asst. Corporation Counsel
- /___ Cases closed because custody order application denied by judge

1/ 1 Custody orders issued and outstanding
78/ 84 Suspects taken into custody
- 15/ 15 Respondents not petitioned ("No papered")

63/ 69 Respondents petitioned
- 9/ 10 Respondents awaiting trial
  - 18/ 21 Respondents with petitions dismissed
  - /___ Respondents acquitted at trial

7/ 9 Respondents waiving trial by consent decree

*Number of victims/number of offenders.

4/ 4 Respondents adjudged delinquent at trial
25/ 25 Respondents adjudged delinquent by guilty plea
/ Respondents awaiting disposition
2/ 2 Respondents with cases closed at disposition
8/ 9 Respondents committed to residential care
26/ 27 Respondents placed on probation*

D. 51/ Cases reported to D.C. M.P.D. Sex Offense Branch in which later investigation by D.C. M.P.D. Youth Division or D.C. D.H.R. Protective Services found supported allegations of child abuse or neglect
11/ Respondents not petitioned ("No papered") by Asst. Corporation Counsel
40/ Respondents petitioned
10/ Respondents awaiting trial
7/ Respondents with petitions dismissed
/ Respondents found not to be abused or neglected at trial
/ Respondents adjudged abused or neglected at trial
23/ Respondents adjudged abused or neglected by stipulation of facts
/ Respondents awaiting disposition
16/ Respondents committed to foster care
7/ Respondents placed under protective supervision

3 non-DC not reported

50 non-DC reported

14 DC no police (consult)

37 DC no police (not sex abuse)

18 DC no police (gonorrhea only)

*Includes respondents receiving consent decrees

Source: Child Protection Center-Special Unit, Fourth Quarterly Report to LEAA, 1980.

APPENDIX B-5

CHILD SEXUAL ABUSE
PUBLIC HEALTH NURSING INTERVENTION
PRE-TEST

I.D.#
(last 4 digits of home telephone #)

Section I.

For the questions in this section, please choose the one best answer for each.

1. The incubation period for gonorrhea is usually:
___1 to 3 days ___5 to 20 days
___3 to 9 days ___1 to eight weeks

2. Jane Doe, age 7, was found to have an active case of vaginal G.C. She was treated with L.A. Bicillin 300,00 3 days post Rx the culture was negative. When retested 6 weeks later, the results were once again positive. The most likely explanation is:
___ a penicillinase-producing strain of G.C.
___ reinfection
___ inappropriate treatment
___ false-positive testing results

3. Jane, 5 years old tells you that she has been sexually assaulted by her uncle who frequently babysits with her. You legally must report this case:
___if the uncle is also found to have G.C.
___if a medical examination supports the child's story
___regardless of whether there is additional supporting evidence
___if you feel reporting is in the child's best interests

4. Gonorrhea in children under 12 years of age appears to be most frequently transmitted through:
___kissing
___sexual play
___sexual abuse
___bathing with others
___contact with exposed objects (towels, sheets, etc.)

5. The primary goal of crisis intervention counseling is to:
___cure family members of underlying psychopathologies
___help family members regain pre-crisis levels of functioning
___establish behavioral criteria for crisis resolution.
___identify existing family problems and refer them to appropriate agencies for help

6. Which of the following is not true of cases of child sexual abuse?
___the offender is usually someone known to the child or family
___force is seldom used
___few children under 7 years of age are abused
___most incidents occur in the child's or offender's home

7. In treating pharyngeal G.C., the treatment of choice should be (assuming no specific contraindications):

____Pro Benecid 1.q/Pro Penicillin G I.M.
____Pro Benecid 1.q/Ampicillin or Amoxicillin
____PedPro Spectinomycin
____Pro Bececid 1.q/L.A. Bicillin

6. Which of the following would not routinely be considered part of G.C. home visit assessment
____verifying who lives in the household
____establishing when symptoms first appeared
____exploring whether other family members have had symptoms
____discouraging testing of all family members

Section II.

For the questions below, please mark all of the responses for a particular question that are correct (i.e., more than one response may be correct.

1. The best current evidence suggests that gonorrhea in children is:
____extremely rare for those under 11 years of age
____mainly contracted from inanimate objects (towels, etc.)
____non-infectious after the first week of symptoms
____usually asymptomatic
____usually associated with some form of sexual contact

2. Which of the following groups are required under D.C. laws to report all cases of physical abuse, neglect, or sexual abuse perpetrated by a parent or caretaker?
____private pediatricians
____public health nurses
____hospital emergency room personnel
____teachers
____social workers

3. When conducting a home assessment when a child has been found to have G.C., you should:
____begin with general questions and move to the more specific
____avoid directly asking about family sleeping arrangements
____assess the child's developmental level
____assess parental knowledge about the disease
____be insistent that the child must tell you who gave him or her the disease

4. Which of the following staments are generally true about mothers in families where father/daughter incest has occurred?
____they consciously or unconsciously sanction the relationship
____they fear close relationships
____they have feelings of hostility toward their daughters
____they have feelings of hostility toward their mothers

5. Father/daughter incest usually:
____begins well before the daughter reaches puberty
____occurs between the father and the youngests daughter
____reflects a psychotic pattern of adjustment in the father
____involves all daughters in the family if left untreated
____stops when the daughter is capable of becoming pregnant

Section III.

1. List 3 medical indicators of possible sexual abuse:

_____

_____

_____

2. List 3 behavioral indicators of possible sexual abuse:

_____

_____

_____

3. List 4 components of a home assessment for G.C. cases:

_____

_____

_____

_____

APPENDIX B-5

PUBLIC HEALTH NURSES TRAINING:
PARTICIPANT EVALUATION

I.D.# _____
(last 4 digits of home tel. #)

Date _____

I. Part I

Please rate each of the training sessions listed below on the two scales provided. One scale is concerned with the quality of the presentation, i.e. how well organized the presentation was and how the presenter was able to hold your interest. The second scale is concerned with how useful the actual content will be in your own professional work. If you missed a session or can't remember a session enough to make a rating, check the appropriate statement.

A. Introduction to the problem: CSAVAP Activities

very poorly done ___1 ___2 ___3 ___4 ___5 very well done

not at all useful in my work ___1 ___2 ___3 ___4 ___5 very useful in my work

___ can't rate session

B. Child Sexual Abuse: A Community Health Problem

very poorly done ___1 ___2 ___3 ___4 ___5 very well done

not at all useful in my work ___1 ___2 ___3 ___4 ___5 very useful in my work

___ can't rate session

C. Common Medical, Behavioral & Family Indicators

very poorly done ___1 ___2 ___3 ___4 ___5 very well done

not at all useful in my work ___1 ___2 ___3 ___4 ___5 very useful in my work

___ can't rate session

D. Reporting Responsibilities of the PHN

very poorly done ___ ___ ___ ___ ___ very well done
1 2 3 4 5

not at all useful in my work ___ ___ ___ ___ ___ very useful in my work
1 2 3 4 5

___ can't rate session

E. Home Evaluation: A Technique for Assessment

very poorly done ___ ___ ___ ___ ___ very well done
1 2 3 4 5

not at all useful in my work ___ ___ ___ ___ ___ very useful in my work
1 2 3 4 5

___ can't rate session

F. Attitudes, Myths & Concerns in Case Management

very poorly done ___ ___ ___ ___ ___ very well done
1 2 3 4 5

not at all useful in my work ___ ___ ___ ___ ___ very useful in my work
1 2 3 4 5

___ can't rate session

G. Interviewing Skills: Parent & Child

very poorly done ___ ___ ___ ___ ___ very well done
1 2 3 4 5

not at all useful in my work ___ ___ ___ ___ ___ very useful in my work
1 2 3 4 5

___ can't rate session

H. Crisis Intervention: Suicide Prevention

very poorly done ___ ___ ___ ___ ___ very well done
1 2 3 4 5

not at all useful in my work ___ ___ ___ ___ ___ very useful in my work
1 2 3 4 5

___ can't rate session

I. Dynamics of Incest

very poorly done ___ ___ ___ ___ ___ very well done
1 2 3 4 5

not at all useful in my work ___ ___ ___ ___ ___ very useful in my work
1 2 3 4 5

___ can't rate session

J. Sexually Transmitted Diseases & Child Abuse

very poorly done ___ ___ ___ ___ ___ very well done
1 2 3 4 5

not at all useful in my work ___ ___ ___ ___ ___ very useful in my work
1 2 3 4 5

___ can't rate session

K. Prevention/Parent Education

very poorly done ___ ___ ___ ___ ___ very well done
1 2 3 4 5

not at all useful in my work ___ ___ ___ ___ ___ very useful in my work
1 2 3 4 5

___ can't rate session

L. Community Referrals

very poorly done ___ ___ ___ ___ ___ very well done
1 2 3 4 5

not at all useful in my work ___ ___ ___ ___ ___ very useful in my work
1 2 3 4 5

___ can't rate session

M. Overall, did you think the training was a worthwhile use of your time?

not worthwhile at all ___ ___ ___ ___ ___ very worthwhile
1 2 3 4 5

II. Part II

A. Please specify what you thought were the most important points made during the training.

_____

_____

_____

B. Please specify up to three things you might do differently or ways in which your feelings have changed as a result of this training. (If any)

_____

_____

_____

C. In terms of the handouts you received, which were the three that you think will be most useful to you?

_____

The least useful?

_____

Taking a wild guess, how often do you think you will refer to any of these handouts during the next year?

___ once a week ___ once a month ___ every couple of months

___ couple of times ___ not at all

D. Did the slide/tape presentation give you a good picture of the issues involved in child sexual abuse? What did you like most about this presentation? _____

_____

_____

E. In terms of organizing this type of training in the future, are there any changes you would have us make that would make the training better? (i.e., which things should be covered more, which less, which not at all, or comments on the style of presentation used by the project staff)

_____

_____

_____

F. Additional comments

_____

_____

_____

APPENDIX B-6

CHILD BEHAVIORAL CHECKLIST
(PARENTAL REPORT)

Child's Name: _____ Date: _____

Problem Status*			Severity of Problem**				
On-going	In-creased	Emer-gent	Not a Prob.	Slight Prob.	Mod. Prob.	Maj. Prob.	
							PHYSICAL
			1	2	3	4	Speech prob. (_____)
			1	2	3	4	Enuresis (___day___night)
			1	2	3	4	Encopresis
			1	2	3	4	Headaches
			1	2	3	4	Stomach aches
			1	2	3	4	Other (_____)
			1	2	3	4	Other (_____)
							INTERPERSONAL (P=parents; A= other adult; PE=peers; S=sibs)
			1	2	3	4	Verbal aggres. P A PE S
			1	2	3	4	Phys. aggres. P A PE S
			1	2	3	4	Withdrawn P A PE S
			1	2	3	4	Soc. Sex. Act. P A PE S
			1	2	3	4	Picked on P A PE S
			1	2	3	4	Sex.Expl.Lang. P A PE S
			1	2	3	4	Disobedient P A
			1	2	3	4	Disruptive (school)
			1	2	3	4	Other (_____)
			1	2	3	4	Other (_____)
							AFFECT
			1	2	3	4	Crying
			1	2	3	4	Temper tantrums
			1	2	3	4	Fear of dark
			1	2	3	4	Other fear (_____)
			1	2	3	4	Nightmares
			1	2	3	4	Nervous or jittery
			1	2	3	4	Lethargic
			1	2	3	4	Acts guilty
			1	2	3	4	Acts depressed
			1	2	3	4	Flat affect
			1	2	3	4	Other (_____)
			1	2	3	4	Other (_____)
							GENERAL BEHAVIORAL
			1	2	3	4	Thumb-sucking
			1	2	3	4	Under-eating
			1	2	3	4	Over-eating
			1	2	3	4	Masturbation
			1	2	3	4	School avoidance
			1	2	3	4	Poor academic performance
			1	2	3	4	Other (_____)
			1	2	3	4	Other (_____)

*Ongoing = problem existed before incident and not heightened by incident;
Increased = problem existed before incident but is worse since incident;
Emergent = new problem

**Parental assessment of how serious or important the problem is.

APPENDIX B-6

PARENTAL RESPONSE FOLLOW-UP FORM

Date_____

Child's Name:_____

Parent or Caretaker's Name:_____

SA Project Caseworker:_____

Instructions: Based on today's discussion with the parent or caretaker, please circle the number which, in your opinion, most closely reflects their feelings at this time on each of these dimensions. (If both parents were present, please complete for each, initialing each answer with an "f" for father or an "m" for mother.)

	Not at all	Slightly	Moderately	Very
Concerned for well-being of the child (protective)	1	2	3	4
Angry, hostile, or punitive toward the child (blaming)	1	2	3	4
Self-blaming, angry, or punitive toward self	1	2	3	4
Sorry for self, concerned with impact on own life	1	2	3	4
Concerned for, protective of the offender	1	2	3	4
Angry, hostile, punitive toward the offender	1	2	3	4
Concerned about the impact of this event on other family members (excluding offender)	1	2	3	4

APPENDIX B-6

CLINICAL SERVICES SUMMARY FORM

NAME OF CHILD: _____ CASE COORDINATOR: _____

I. Clinical Intake
- A. Date: ___/___/___
- B. Intake Worker: _____
- C. Conducted: ___in person ___via tel.
- D. Source: ___self-presenting
  ___police
  ___other
- E. Site: ___ER ___OPD ___Other
- F. Time: From _____AM PM
  To _____AM PM

II. Referrals Made

To*	
_____	___/___/___
_____	___/___/___
_____	___/___/___
_____	___/___/___
_____	___/___/___
_____	___/___/___

III. Case Consultations

With*	Date
_____	___/___/___
_____	___/___/___
_____	___/___/___
_____	___/___/___
_____	___/___/___
_____	___/___/___
_____	___/___/___
_____	___/___/___

IV. Case Closure
- A. Date: ___/___/___
- B. Reason:
  ___unable to locate
  ___family terminated against caseworkers advice
  ___case transferred or referred to another agency
  ___transferred for long-term mental health services
  ___crisis resolved
  ___other

V. Direct Service Appointments

Date	Worker	With**	Purpose(s)***	Length (in min.)
___/___/___	_____	_____	_____	_____
___/___/___	_____	_____	_____	_____
___/___/___	_____	_____	_____	_____
___/___/___	_____	_____	_____	_____
___/___/___	_____	_____	_____	_____
___/___/___	_____	_____	_____	_____
___/___/___	_____	_____	_____	_____
___/___/___	_____	_____	_____	_____

VI. Therapeutic Telephone Contacts

Date	Length (in min.)	Date	Length (in min.)
___/___/___	_____	___/___/___	_____
___/___/___	_____	___/___/___	_____
___/___/___	_____	___/___/___	_____
___/___/___	_____	___/___/___	_____

*
- P.S.-Protective Services
- Y.D.-Youth Division
- S.O.B.-Sex Offense Branch
- O.J.-Other Police Jurisdiction
- P.H.S.-Public Health
- D.H.R.-Other Dept. Human Resources
- CMHC-Community Mental Health Ctr.
- C.P.C.-Child Protection Center
- PSY-CHNMC Psychiatry
- Ad.Med.-CHNMC Adolescent Medicine
- CHNMC-Other Hospital Staff
- U.S. Att.-U.S. Attorney
- C.C.-Corporation Counsel
- Ch.Att.-Childs Attorney
- O-Other

**
- V-Victim
- M-Mother
- F-Father
- S-Sibling(s)
- P.C.-Other Primary Caretaker
- A.R.-Adult Relative
- O-Other

***
- 1-Medical Services
- 2-Counseling
- 3-Legal Accompaniment
- 4-M.H., R.N., or S.W. Assessment
- 5-Home Visit
- 6-Other

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