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# Exemplary Project Screening and Validation Reports

Project Candidate:

**CHILD SEXUAL ABUSE VICTIM ASSISTANCE PROJECT**

**District of Columbia**



sociates

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# EXEMPLARY PROJECT VALIDATION REPORT

## Project Candidate:

Child Sexual Abuse Victim Assistance Project

District of Columbia



Submitted to:

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Washington, D.C. 20531

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## 1.0 INTRODUCTION

The problem of sexual abuse and exploitation of children has received increased public attention only in recent years. While crisis centers and treatment programs have begun to proliferate across the country, little information on the state of the art exists. The American Humane Association documented 6,078 substantiated cases of child sexual abuse in 1978,* but the National Center on Child Abuse and Neglect (NCCAN) estimates that 60,000-100,000 children are victimized annually. Nationally, NCCAN is aware of about 150 special projects to treat child victims of sexual abuse.

The Child Sexual Abuse Victim Assistance Project (CSAVAP) operates out of Children's Hospital National Medical Center, Washington, D.C. CSAVAP grew out of the Child Protection Center (CPC), a project funded by the National Center on Child Abuse and Neglect (U.S. Department of Health, Education and Welfare) to treat victims of child abuse and neglect. Because the terms of its grant did not permit the Child Protection Center to treat victims of non-family abuse--which comprised nearly 80 percent of its sexual abuse cases--a separate project was needed to treat these children.

CSAVAP began operations in January 1978 as a short-term crisis intervention and treatment program. In addition to medical, counseling and advocacy services provided directly to the client, CSAVAP has developed extensive curricula for professional training as well as less technical publications for general consumption.

CSAVAP was asked to submit an Exemplary Project application on a recommendation from the project monitor at the Office of Criminal Justice Programs, LEAA. This validation report is based on an interim report on CSAVAP operations prepared by the URSA Institute (February 1980), Exemplary Project application materials, the project's guidelines and procedures manual, quarterly reports and other documentation provided by project staff. In addition, a two-day site visit was conducted by Debra Whitcomb and Jean Layzer of Abt Associates and Maureen O'Connor and Frank Shults of the National Institute of Justice. The following persons were interviewed:

- Joyce Thomas, RN, MPH--CSAVAP Project Director;
- Carl Rogers, Ph.D.--CSAVAP Research Director;
- Regina Berg, MSW--CSAVAP Clinical Coordinator;
- David Lloyd, J.D.--CSAVAP Criminal Justice Specialist;
- Alan Schuman--Director, Social Services Division, D.C. Superior Court, Intra-family Branch;

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* American Humane Association, National Analysis of Official Child Abuse and Neglect Reporting, 1978, Englewood, Colorado, November 1979, p. 34.

- Joan Danzansky--Director, FACT (Families and Children in Trouble) Hotline;
- Betty Queen--Chief, Bureau of Family Services, Department of Human Services;
- Karen Leaman--Psychiatric Nurse, Psychiatric Institute; and
- Vanette Graham--Howard University Resource Center.

In addition, telephone interviews were conducted with:

- Jason Kogan--Assistant U.S. Attorney for the District of Columbia;
- Noelle Kramer--Chief, Grand Jury Section, U.S. Attorney's Office;
- Natalie Nash--Coordinator, Child Abuse Project, Office of the Corporation Counsel;
- Robert Mertens--Attorney, Public Defender Service; and
- Sgt. Joe Satterfield, Chief, Sex Offenses Branch, D.C. Metropolitan Police Department.

## 1.1 Project Development

As noted above, the Child Sexual Abuse Victim Assistance Project (CSAVAP) is a special unit of the Child Protection Center (CPC), a demonstration project of the National Center for Child Abuse and Neglect (HEW). The parent project had been funded to treat intra-family cases of child abuse and neglect, but by 1977 CPC found that only 21 percent of its sexual abuse victims were intra-family cases. Moreover, CPC staff recognized that handling cases of sexual abuse and assault required different procedures and linkages with different agencies than did cases of physical abuse and neglect. A grant proposal for a separate project was developed with the following goals:

- To improve the knowledge and skills of law enforcement personnel in the sensitive management of victims, witnesses, and families involved in cases of child sexual abuse.
- To improve the knowledge, skills, and cooperation of medical and social service personnel in the collection and transmission of evidence and information to the legal system in cases of child sexual abuse.



- To improve interaction, coordination, and cooperative case management among the legal, medical and social service systems with respect to cases of child sexual abuse.
- To document the special needs of victims of child sexual abuse and their families and methods of addressing those needs.
- 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 child victims and their families.

In October 1977, the Department of Health, Education and Welfare awarded $110,115 to launch the project, although the grant was administered by LEAA. Due to difficulties in recruiting qualified staff, the project did not begin operations until January 1978. Within the first few months it became apparent that additional staff were needed and the project received supplemental funding from LEAA in the amount of $51,373.

In its second year the project set forth two additional goals:

- To provide the specialized case management services needed by victims of sexual abuse and their families.
- To provide the basis for national dissemination and/or replication of project methods, approaches, strategies, and findings.

CSAVAP was funded at $260,324 for its second year and at $265,857 for its third and final year of LEAA support. Plans for future funding are discussed in section 2.5, Accessibility.

## 1.2 Approach

CSAVAP treatment philosophy explicitly requires consideration of the child's needs above those of the family, if the two conflict. If there is a conflict between the child's needs and the family's interests, CSAVAP will treat only the child and refer the family elsewhere (frequently to the hospital's Psychiatry Department). Moreover, the project believes that all suspected cases of child sexual abuse and assault should be reported to authorities (law enforcement and/or protective services), citing four reasons:

1) As a private non-profit facility, Children's Hospital has no authority to protect the child from future danger;

2) Staff believe that offenders should be held accountable to the community for their conduct;

3) In some instances the child's parents/guardians may be unwilling to report the incidents themselves;

4) D.C. law requires the project to report certain classes of incidents (i.e., incidents of intrafamily abuse must be reported to protective services or police; venereal disease must be reported to public health).

As discussed in greater detail below, courtroom preparation and accompaniment as well as continued counseling are provided to the child once the case enters the criminal justice system. CSAVAP treatment philosophy has been documented as a formal statement and is attached in the appendix.

## 1.3 Organization

Located in the Children's Hospital National Medical Center, the Child Sexual Abuse Victim Assistance Project is considered a "special unit" of the Child Protection Center. However, CSAVAP functions independently of CPC aside from CPC staff assistance in the 24-hour on-call schedule. Most CSAVAP staff are headquartered in open office space on the hospital's research floor; the project also has a small conference room on that floor. A small waiting room is set aside for CSAVAP clients immediately within the Emergency Room entrance.

Original project staff included the project director (a registered nurse and public health administrator with advanced training as a pediatric nurse-practitioner), the Director of Research (a Ph.D. psychologist), a social worker (MSW), a pediatrician (half-time), a data coordinator (half-time), and two part-time research associates for a total of 4.2 full-time equivalent staff. None of these individuals was recruited from the parent project.

By March 1978, it was apparent that the project was understaffed to accomplish the full scope of its objectives, and additional funding was requested and secured to expand the staff by a second social worker, a criminal justice specialist, a registered nurse and an administrative assistant. The current staffing configuration is as follows:

- Project Director
- Director of Research (recently named Assistant Project Director)
- Coordinator of Clinical Services (the original social worker)
- Criminal Justice Specialist



- Two social workers (each half-time)
- Psychiatric nurse
- Clinical psychologist (half-time)
- Data coordinator (half-time)
- Administrative assistant

The project pediatrician who was on the original staff was moved to a consultant status in the third year, reflecting the reduced need for his assistance in developing medical protocols and providing initial training to hospital staff. Funds for his salary were reallocated to the clinical psychologist position to supplement the direct services staff.

The individual currently serving as criminal justice specialist is an attorney who was initially hired as a consultant to research the progress of child sexual abuse cases throughout the District of Columbia criminal justice system. Later he was placed on staff to provide direct client services of explanation and guidance, court accompaniment, and class advocacy in the criminal justice system; to provide legal services (e.g., interpretation of statutes and regulations) to project staff; and to track cases as they progress through the criminal justice system. Project staff believed an attorney was necessary to fill this role because of the complexity of the District of Columbia's criminal justice system, and because his law degree would facilitate a rapport with key personnel in the system.

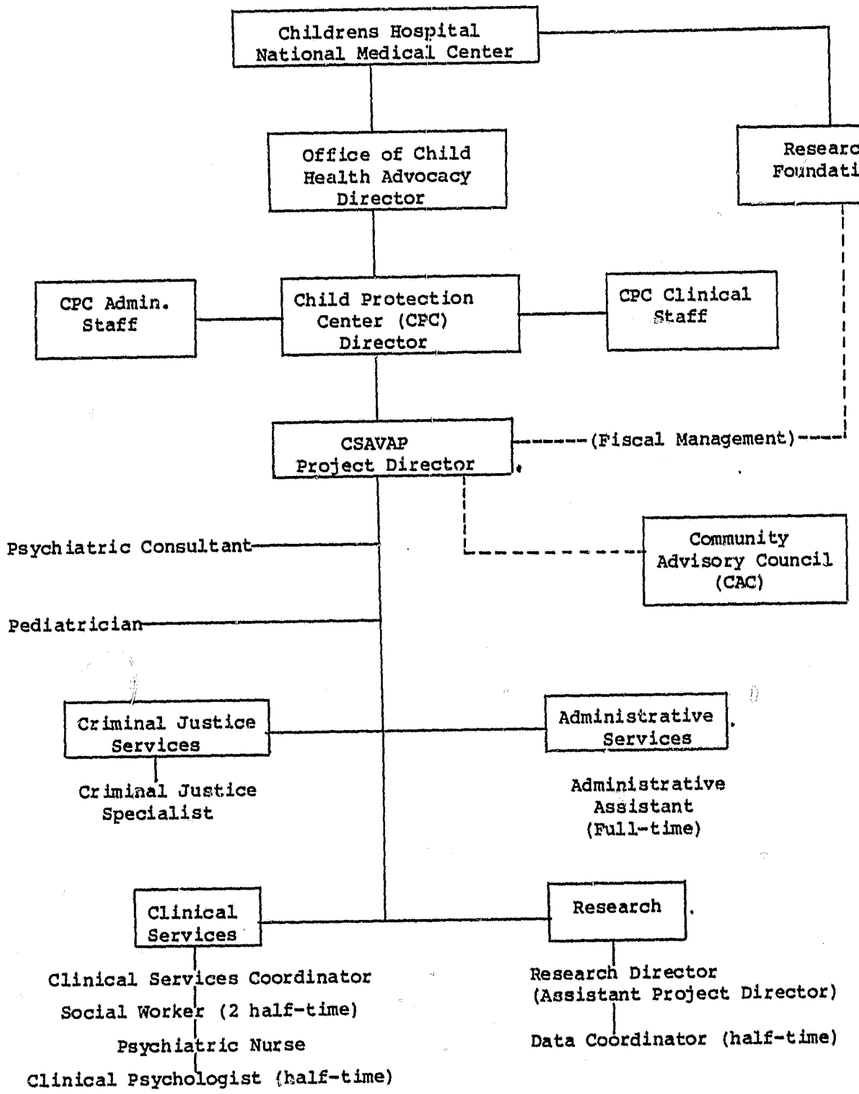
In addition to the pediatrician who now serves on a consultant basis, a child psychiatrist from hospital staff also meets bi-weekly with the project to discuss and supervise selected cases.

Figure 1 represents the organizational structure of CSAVAP. In addition to the internal supervisory structure, each staff member is responsible to the appropriate specialized department within the hospital, e.g., the psychiatric nurse is responsible to the nursing department and the psychologist is responsible to the psychology department. Project staff meet weekly as a team to discuss case progress and make decisions regarding termination and referral.

Since its initial start-up, CSAVAP has been served by a Community Advisory Council comprised of three subcommittees: Public Education, Case Management, and Medical-Legal Education and Mental Health. Council membership represents a broad array of professionals in the fields relating to child sexual abuse: District of Columbia public schools, other crisis assistance programs, law enforcement, prosecutors, probation, family services, other medical facilities, and the general community. The most recent Council roster lists 32 names.

Figure 1

CSAVAP Organizational Chart






In early phases of CSAVAP the Community Advisory Council was particularly instrumental in developing medical protocols, case management guidelines, and the curricula that have been used for training professionals from numerous related fields. More recently the Council has turned its interest to securing continued funding for the project.

## 1.4 Client Characteristics

CSAVAP has developed an operating definition of child sexual abuse, as follows:

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

And/or

b. 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

c. 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.

Applicable legal definitions were considered unacceptable: the D.C. child abuse law is too narrow because it refers only to abuse perpetrated by a parent or caretaker (thereby excluding all non-family assaults); criminal statutes are too broad because they include sexual activity between consenting children, a circumstance which project staff consider to be within the range of normal development (particularly among adolescents). Although such activities are considered illegal under D.C. law, CSAVAP does not consider them as incidents of sexual abuse.

As will be discussed in the following section, project staff also believe that diagnosed gonorrhea in a pre-pubertal child is evidence of sexual abuse, unless proven otherwise. Hospital physicians have been instructed to refer all such cases to CSAVAP for follow-up. This method of case-finding through diagnosed cases of gonorrhea is a unique aspect of CSAVAP.

Initially, CSAVAP treated only victims age 12 and under. However, because Children's Hospital accepts adolescents up to 18 years of age, and because 18 is the legal age of consent in the District, and because the treatment needs of teenaged victims were perceived to be similar to those of younger children, CSAVAP expanded its services to adolescents in May 1979. Based on a sample of 51 clients seen in the summer of 1979, the URSA Institute computed an average client age of 9 years 3 months.

Table 1 below summarizes other descriptive data from project statistics and the URSA Institute Interim Report. Project statistics show that to date, more than one-fourth of their clients are male. Forty-one percent of the cases are intrafamily cases and 59 percent are nonfamily cases. Limited data from the URSA report show that vaginal intercourse occurred in 64.7 percent of the cases; anal intercourse occurred in nearly half. Forty-five percent of the alleged offenders were under age 17.

In keeping with its crisis intervention orientation, the project requires that cases referred for treatment involve either a recent incident of sexual abuse or a recent disclosure. (Victims reporting past incidents are referred to therapy services in the community.) Although the project was established to treat victims residing in the District of Columbia, the lack of comparable services in surrounding communities of Maryland and Virginia has resulted in a number of referrals to CSAVAP from those states. Still, the project prefers to limit its resources to D.C. residents and consequently has convened a Cross-Jurisdictional Council to deal with this problem (discussed below in section 1.6.5).

## 1.5 Services

CSAVAP provides nine services, five of which are direct services to the client, and four of which are more general in scope. Each service is described below:

### 1.5.1 Direct Services

1. Initial and Follow-Up Medical Services--detection and treatment of physical injury; provision of information on the victim's condition to the victim and her family; documentation of physical indicators of sexual activity and collection of medical evidence; and tests for and treatment of possible pregnancy and venereal disease. An existing Emergency Room protocol for examining child victims of sexual abuse was revised and expanded; new protocols were developed for venereal disease diagnosis and laboratory procedures (all are in appendix). Most victims return for a follow-up exam within two weeks. Occasionally victims are hospitalized because of extensive injuries or as a means of protecting them from further abuse.



TABLE 1

CSAVAP CASE CHARACTERISTICS

| | | |
|---|---|---|
| Total Intakes (January 1, 1978–July 20, 1980) | | 461 |
| **Age Distribution** | | |
| 0–3 yrs. | | 28 ( 6%) |
| 3–6 | | 101 (22%) |
| 6–9 | | 138 (30%) |
| 9–12 | | 107 (23%) |
| 12–15 | | 69 (15%) |
| 15–18 | | 18 ( 4%) |
| | | 461 (100%) |
| **Sex Distribution** | | |
| Male | | 134 (29%) |
| Female | | 327 (71%) |
| | | 461 (100%) |
| **Relationship to Offender** | | |
| Non-family | | 272 (59%) |
| Stranger | 74 (16%) | |
| Acquaintance/ neighbor/friend | 198 (43%) | |
| Intra-family | | 189 (41%) |
| Parent/stepparent/ mother's boyfriend | 101 (22%) | |
| Related by blood or marriage | 88 (19%) | |
| | 461 (100%) | |

**Type of Abuse*** (Total exceeds 100% due to multiple abuses per victim)

| | |
|---|---|
| Fondling | 15 (29.4%) |
| Anal intercourse | 25 (49.0%) |
| Vaginal intercourse | 33 (64.7%) |
| Oral-genital contact | 3 ( 5.9%) |
| Digital | 5 ( 9.8%) |
| Object penetration | 4 ( 7.8%) |
| Exposure/voyeurism | 9 (17.6%) |
| Unspecified | 6 (11.8%) |

**Offender Age Distribution****

| | |
|---|---|
| 17 years or less | 23 (45%) |
| 18–21 | 4 ( 8%) |
| 22–26 | 1 ( 2%) |
| 27–35 | 14 (27%) |
| 36 or over | 5 (10%) |
| Adult, age unknown | 4 ( 8%) |
| | 51 (100%) |

* URSA Report, based on 51 clients seen by CSAVAP staff between July 16 and September 16, 1979.

**Ibid. Project data show that juveniles represent 57 percent of the suspects in CSAVAP cases forwarded to the prosecutor between February 1978 and June 1980.

2. Initial Crisis Intake and Case Findings--preliminary interviews with the child and family for all cases of alleged sexual abuse or sexual assault, all cases of prepubertal gonorrhea, and all cases of inordinate sex play or masturbation arriving for treatment at Children's Hospital. Intake is defined as a face-to-face interview with the victim conducted by a CSAVAP clinician. Typically the clinician on-call assumes continuing responsibility for all intakes during her shift.

3. Assessment, Evaluation and Case Planning--meeting with the child and/or family at Children's Hospital and sometimes at home to assess further the home situation, the child's emotional condition, and the family dynamics. The project places a heavy emphasis on formal psychological assessment and diagnosis. In some cases a psychiatric evaluation of the child is requested of the hospital's Psychiatry Department. Case planning is accomplished largely through weekly staff meetings and biweekly consultation with a hospital psychiatrist.

4. Ongoing Crisis Counseling and Psychosocial Treatment--frequency and duration of project contact determined by type of case (stranger assault vs. incest, young child vs. adolescent). Although primarily a crisis intervention project, staff learned quite early that incest cases required more intensive and long-term therapy, and consequently the average length of treatment is estimated at 12-14 weeks instead of the 6-8 weeks originally projected.

5. Case Advocacy, Legal Counseling and Court Preparation/Accompaniment--advocacy and referrals to social service agencies (i.e., welfare, housing) when necessary; for cases proceeding to prosecution, preparation and accompaniment for court proceedings. Court preparation typically involves a tour of the courtroom, explanation of terms, and practice questioning.

As Table 2 shows, between January 1978 (when CSAVAP began providing services) and July 20, 1980, the project provided some services to 735 alleged victims of sexual abuse. Of those, approximately 461 are classified as project intakes, that is, those that received at least the preliminary interview with a CSAVAP staff clinician. As described in greater detail in Section 1.6, most intakes arrive through the Emergency Room and are seen by a project clinician shortly after arrival. Ninety-three are classified as incoming referrals (cases referred to CSAVAP but never showing up for services); 181 are classified as consults (cases for which CSAVAP provided only consultation and no direct treatment).



TABLE 2

CSAVAP INTAKES, REFERRALS AND CONSULTS
January 1, 1978-July 20, 1980

| | |
|---|---|
| Total Clients Served | 735 |
| Project Intakes* | 461 (63%) |
| Sexual Abuse/Sex Play | 391 (85%) |
| Gonorrhea | 49 (11%) |
| Other | 21 ( 5%) |
| Incoming Referrals (pending CSAVAP treatment) | 93 (13%) |
| Consults only | 181 (25%) |

*CSAVAP clients are identified as project "intakes" only after a personal interview with staff.

Source: CSAVAP data.

The distribution of direct services provided to clients (intakes) for cases closed since 1979 is provided below. The project does not record these data in terms of how many clients receive various combinations of services.

| | |
|---|---|
| Medical follow-up services (excludes intake exam) | 11% |
| Counseling/therapy | 46% |
| Court accompaniment/case tracking | 9% |
| Psychological assessment and evaluation | 26% |
| Other (interviews with client attorneys, related problems with siblings, consultation with other hospitals or physicians) | 8% |

1.5.2 Indirect Services

1. Professional Training and Curriculum Development--Written curricula have been developed and cross-indexed for police, medical personnel, nurses and social workers. Subjects range from child development to applicable laws, to the medical examination and crisis intervention. (See Appendix for contents of the curricula.) Formal training sessions have been conducted with the following groups:

- officers from the Youth Division and Sex Offense Branch, D.C. Metropolitan Police Department;
- Juvenile Branch, Assistant Corporation Counsel's Office (which prosecutes juvenile offenders);
- the Volunteer Attorney's Office (which represents the children in abuse/neglect petitions);
- U.S. Attorney's Office (which prosecutes adult offenders in the District);
- other law enforcement/criminal justice personnel (probation officers, other police officers);
- Children's Hospital personnel (medical, social services and nursing staff; special training sequence for emergency room and outpatient department physicians and nurses and all hospital social workers);
- other medical and nursing personnel (public health nurses and personnel from other hospitals in the vicinity); and
- social service personnel (from agencies in the D.C. metropolitan area, Maryland and Virginia).

CSAVAP also hosted a three-day national conference in November 1979 attended by 300 participants representing a variety of agencies involved in child sexual abuse treatment.

In addition to the curricula mentioned above, CSAVAP has produced a number of documents for educational purposes:

- medical evidence booklet for law enforcement officers and other non-medical personnel;
- guidelines for legal reporting requirements summarizing applicable D.C. criminal laws and child abuse and neglect statutes;
- overview of D.C. law enforcement system, prepared for project staff but available to others;
- hospital protocols--covering emergency room procedures for handling sexually abused children and adolescents, gonorrhea, and the appropriate laboratory procedures (see Appendix);



- Medical-Legal Sexual Assault Form, a revised form used by D.C. police in reporting incidents of sexual abuse (see Appendix); and;
- professional publications and formal papers.

A film produced for the project has been shown to diverse audiences.

2. Public Education--speakers, lectures and media appearances. The project's Community Advisory Council, Public Education Subcommittee maintains a Speakers Bureau to respond to requests. The project has produced three brochures for purposes of public education.

3. Evaluation and Applied Research--Data collection forms are attached in the appendix: Clinical Intake Case Summary, Medical Summary, Parental Response Follow-Up, Case Tracking Form, Child Behavioral Checklist. All data are stored on computer and staff have documented the demographic and epidemiological characteristics of their clients as well as case progress in the criminal justice system. CSAVAP staff have published articles in Pediatrics Annals entitled "Medical-Legal Aspects of Sexual Abuse" and "Crisis Management of Sexually Abused Children." The project director has presented a paper on childhood venereal disease to the American Public Health Association.

## 1.6 Procedures

### 1.6.1 Referral Sources

The majority of CSAVAP cases arrive through the Children's Hospital Emergency Room. The D.C. police cannot directly refer victims to Children's Hospital because it is a private facility, requiring payment for services.* Police responding to a call on alleged sexual abuse will indicate to the victim and/or family the need for a medical examination and that such services are available free of charge at D.C. General Hospital. Sgt. Joe Satterfield, Chief of the Sex Offenses Branch of the D.C. Metropolitan Police Department, estimates that about 40 percent of sex abuse victims (adult and child) go to D.C. General; the remaining 60 percent will go to any of the ten or 12 hospitals with emergency rooms serving the D.C. area. The fraction of child victims who report to police and choose to go to Children's Hospital is unknown.

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* CSAVAP requires payment only for inpatient services, and the project estimates that fewer than 4 percent of its clients require hospitalization.

Of cases closed by the project since 1979, 33 percent were brought in by police, 59 percent were walk-ins or referrals from within the hospital. The remaining 8 percent were referred by private physicians or other hospitals.

### 1.6.2 Intake Procedures

Child sexual abuse victims entering through the Children's Hospital Emergency Room are accorded first priority after life-threatening situations. A special waiting room directly within the Emergency Room entrance has been designated for CSAVAP clients and is furnished with toys and books for the child's comfort. CSAVAP clinicians carry bellboy pagers and maintain a 24-hour on-call schedule (some evenings are covered by staff of the Child Protection Center). Emergency room staff (both physicians and nurses) have received periodic training in handling child victims and highly detailed protocols were developed by the project to guide the initial examination (see Appendix). The medical exam is of particular importance in the District of Columbia since it is one of five states that require corroborating evidence for all child testimony. A trusted adult (usually a parent or nurse) is allowed to accompany the child during the exam.

The role of the CSAVAP clinician in the emergency room is to ascertain from the police the details of the incident and from the examining physician the results of the exam. This eliminates the necessity for the victim to relate her story first to police and again to the clinician. The preliminary interviews with victim and family are directed toward assessing the parental response to the incident (since this factor may largely determine the direction of future counseling) and laying the groundwork for ongoing counseling. An attempt is made to schedule the first counseling session to coincide with the follow-up physical examination because the project has found that parents are more likely to comply with medical requirements than with appointments for counseling. Where the parents' interests or attitudes conflict with those of the child, the project will refer the parents to the hospital's Psychiatry Department for counseling; occasionally the victims are referred there as well. Cases referred to the Psychiatry Department are those considered by project staff to be highly complex, e.g., incest cases where the child has run away from home and is not supported by her mother.

Each new intake is scheduled for a team review within six weeks of the first appointment. All case management and planning decisions are made jointly by the staff clinical team with biweekly input from the consultant psychiatrist. The project's guidelines and procedures include explicit instructions for prioritizing cases. Those receiving highest priority include cases involving physical injury, incest, rectal sodomy, adolescent rape, and gonorrhea in children under age 12.



The project considers a number of factors in case termination:

- medical examination reveals no further problems;
- social service referrals have been made;
- the case is disposed in the criminal justice system;
- the short-term crisis is resolved (as assessed by the project).

Frequently cases are temporarily closed pending further action in the courts. Shortly before each proceeding, the case will be reopened for preparation and counseling.

Other reasons for case termination include inability to locate clients or clients refuse treatment; transfer of client to another agency (e.g., Children's Protective Service); no indication of sexual abuse in medical/psychological evaluation; and inability to identify venereal disease contact. The project reports the following outcomes for 399 cases treated between January 1978 and March 1980:

| | |
|---|---|
| Crisis resolved (as determined by clinical staff) | 34% |
| Referred for treatment | 27% |
| Referred for long-term inpatient mental health care | 17% |
| Terminated against advice | 12% |
| Unable to follow-up | 9% |

Project staff estimate the average length of treatment to be 12-14 weeks.

To assist the project in making appropriate referrals for continuing treatment, CSAVAP and its Advisory Council developed a directory of public and private treatment resources in the D.C. Metropolitan area (including suburban Maryland and Virginia). Resources were identified largely by Advisory Council members and project staff verified their services and eligibility requirements by telephone.* The directory is mostly used by project staff and has had limited distribution. Project staff do not routinely follow up on referrals.

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* One Advisory Council member interviewed stated that she had opposed the development of this directory because there are no resources in D.C. with a particular expertise in treating victims of child sexual abuse.

### 1.6.3 Reports to Child Protective Services

Although the District of Columbia child abuse and neglect statute stipulates that cases of child abuse may be reported either to the D.C. police or to Child Protective Services (a division of the D.C. Department of Human Services), in practice, abuse is reported to police (see Section 1.6.4) and neglect is reported to CPS. Consequently, cases referred to CPS are likely to be those in which CSAVAP staff believed that parental neglect contributed to the abusive or assaultive incident. CPS is not likely to receive CSAVAP cases in which the parents themselves abuse the child until after court disposition, when CPS may be assigned to provide services to the family and/or monitor the child's continuing protection from threat.

Historically, Child Protective Services had experienced strained relations with CSAVAP's parent project, the Child Protection Center, due to some competitive interest in handling similar cases. CSAVAP was able to avoid that problem by including the Chief of CPS in its Community Advisory Council and hence in much of the planning for case management. Presently CSAVAP and CPS make reciprocal referrals: CSAVAP to CPS for neglect investigations (only 4 percent of all CSAVAP referrals) and CPS to CSAVAP for medical evaluations in cases of suspected sexual abuse (no data available regarding these referrals).

### 1.6.4 Reports to Law Enforcement

As noted above, CSAVAP is legally mandated to report all cases of intra-familial sexual abuse to the D.C. Metropolitan Police Department. Project data indicate that from February 1978 to June 1980, only 61 cases were not reported: 16 were consults (CSAVAP not directly involved), 28 did not involve sexual abuse, 11 were cases of gonorrhea only (no substantiated abuse), and 6 were incidents outside the District of Columbia.*

Investigations of adult suspects are conducted by a male/female team of plain-clothes detectives from the Sex Offense Branch; efforts are made to assign this team throughout the life of the case. Juvenile offenders are questioned by detectives from the Youth Division and the Sex Offenses Branch. CSAVAP clinicians do not accompany the victim during police interviews. Sgt. Satterfield indicated that his detectives prefer to isolate the victim from an audience situation and develop a close rapport that will continue throughout the investigation and prosecution. This "vertical investigation" procedure has been utilized by the D.C. Police Sex Offenses Branch for many years.

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* 39 non-D.C. cases were reported to appropriate authorities.



Continuing contact between police and CSAVAP is maintained for information sharing; CSAVAP informs police of medical and psychological evaluation results; police keep CSAVAP apprised of the status of their investigation (via the Criminal Justice Specialist). Representatives of the Sex Offenses Branch (which investigates cases involving alleged adult offenders) and the Youth Division (which investigates juvenile offenders and neglect cases) sit on the Community Advisory Council and were involved in developing the project's Medical/Legal Sexual Assault Form and revising the emergency room protocol.

### 1.6.5 Prosecution

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. The Corporation Counsel is also responsible for the conduct of abuse and neglect proceedings (civil proceedings). Both agencies are represented on the Community Advisory Council and their staff have received intensive training from CSAVAP staff. Persons interviewed considered the training to be highly useful in terms of enhancing their understanding of child victims and sensitivity to the child's concerns. However, none could identify procedural changes in processing child sexual abuse cases resulting from CSAVAP training.* Individuals interviewed said that project staff were helpful in gathering medical evidence and providing counseling for the children and their families, including court preparation. Interagency agreements have been formulated with the U.S. Attorney's Office and the Corporation Counsel to allow information sharing with CSAVAP; the project also successfully obtained a special court order allowing the Criminal Justice Specialist to track information on juvenile offenders. Project data on cases entering the criminal justice system are reported in Section 2.2, Goal Achievement.

CSAVAP occasionally receives clients who are residents of the neighboring jurisdictions of Maryland and Virginia. Although the project prefers to serve D.C. residents, medical and counseling services may be provided to nonresidents because similar resources are scarce in other areas. However, criminal justice system accompaniment and case tracking are not provided. In an attempt to resolve the many problems and questions encountered, for example, in handling a child from Maryland who was assaulted in the District, CSAVAP convened a Cross-Jurisdictional Council of representatives from relevant agencies in the nearby counties. The purpose of this council is to understand the variations in procedure across jurisdictions and to identify resources available throughout the metropolitan area.

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* The Office of the Corporation Counsel maintains a special Child Abuse Project, originally an LEAA grant but now funded by the City. This project was intended to develop close relations with the Child Protection Center at Children's Hospital and, later, with CSAVAP.

In sum, CSAVAP staff appear to have developed cordial working relationships with the various agencies involved in the treatment and prosecution of child sexual abuse. These agencies are represented on the project's Community Advisory Council, but they do not coordinate as a group in the day-to-day management of individual cases. The Medical-Legal Sexual Assault Evidence form designed by the project (see Appendix) has been adopted by D.C. police for investigating all sexual assault cases--both adult and child victims. CSAVAP has been unable to effect notable procedural changes in any agency other than Children's Hospital. Advisory Council members interviewed agreed that project training had been helpful and believed that the project was fulfilling a vital role in the District of Columbia since no similar resources exist for treating victims of child sexual abuse.



## 2.0 EXEMPLARY PROJECT SELECTION CRITERIA

This section discusses the extent to which the Child Sexual Abuse Victim Assistance Project meets the criteria for selection as an exemplary project. The discussion is based on information contained in the project's grant proposals and progress reports to LEAA; interviews with project staff and staff of other community agencies and a review of the Draft Interim Report: Process Analysis of the Child Sexual Assault Projects, February 1980. This document was prepared by URSA Institute as part of their evaluation of the LEAA Family Violence Demonstration Program. It was prepared as part of the Process Study and describes project implementation and the delivery of services. The report includes some quantitative data on client and case characteristics, services provided and the responses of legal, medical and social service agencies. A final report on the URSA evaluation is due in the summer of 1981. However, review of the evaluation's data collection forms and conversations with an URSA site evaluator suggest that the final report will refine the findings of the process evaluation rather than provide quantitative data on the impact of the program. This is due in part to the primitive state of the art of client outcome measurement in this field and, in part to the availability of data within the criminal justice system in the early years of the project and before its inception.

The discussion in this section was prepared by Jean Layzer, former Abt Project Director of the Impact Evaluation of Twenty Child Abuse and Neglect Demonstration Programs. Her experience and ongoing contact with researchers in the field provided a basis for the discussion. In addition, Kee MacFarlane, Project Officer at the National Center on Child Abuse and Neglect, provided information on the range of programs available to treat the problem. Because the problem has only recently been recognized, most treatment projects are in their infancy.

Because the state of the art is so limited, it is not possible to compare the Child Sexual Abuse Victim Assistance Project with its counterparts in other locations in a systematic way. Any comparisons made in this section draw on the 1980 Annual Report of the American Humane Association and on expert knowledge of the field. In Section 4.0, some comparisons will be made with the Child Victim/Witness Project (CVWP) in Seattle, Washington, which has also been validated for consideration by this Review Board as an exemplary project and which is a contemporary of the Washington, D.C. project.

### 2.1 Measurability

In its original grant application, the Child Sexual Abuse Victim Assistance Project (CSAVAP) stated its goals as follows:

1. To assure improved responses to the needs of victims of child sexual abuse and their families in the District of Columbia by the medical, legal and social services systems.

   - To improve the knowledge and skills of law enforcement personnel in the sensitive management of victims, witnesses, and families involved in cases of child sexual abuse.
   - To improve the knowledge, skills, and cooperation of medical and social service personnel in the collection and transmission of evidence and information to the legal system in cases of child sexual abuse.
   - To document the special needs of victims of child sexual abuse and their families and methods of addressing those needs.
   - 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 child victims and their families.

During CSAVAP's second year of LEAA funding, two additional goals, which had been implicit during the project's first year of operations, were made explicit. These were:

2. To provide the specialized case management services needed by victims of sexual abuse and their families.

3. To provide the basis for national dissemination and/or replication of project methods, approaches, strategies, and findings.

To clarify our presentation for purposes of this validation, CSAVAP goals have been restated in three categories: Victim Support Goals, in which the project strives to improve the response of community systems to the needs of children who have been sexually abused; Community Awareness Goals, in which the project strives to alert the wider community to the problem to allow prompt identification of victims and offenders and to move toward prevention; and Training and Documentation Goals, in which project staff seek to pass on their findings and skills to advance the state of the art. We have, accordingly, regrouped the project's goals under these three headings, as follows:



Victim Support Goals:

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

Community Awareness Goals

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

Training and Documentation Goals

- to provide training to professionals in related fields;
- to document the special needs of child sexual abuse victims and their families, and to provide the basis for national dissemination and/or replication of project methods, approaches, strategies and findings.

### 2.1.1 Data Requirements for Measuring Goal Achievement

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

There are two assumptions underlying this goal--first, that supportive counseling can ameliorate the trauma for the victim and second, that it will help to maintain the cooperation of victims and families throughout the criminal justice process. While these assumptions are untested, the literature on sexual abuse makes frequent reference to the damage inflicted on

victims and families by careless handling of cases by all the services involved. Improving the response of the social service system is one of several ways that the project has chosen to address this problem.

To assess achievement of this goal, data needed include:

- information on the availability of specialized counseling services prior to project inception, and as a result of project operations;
- information on handling of such cases by the social service system before the advent of the project, or in comparable communities without such a project compared to the project's approach to such cases.

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

Data needed include:

- rates of incidence of sexual abuse before and after project operation;
- rates of reincidence of sexual abuse before and after project operation;
- proportion of intrafamily and neglect cases in which the offender or the child is removed from the home.

Goal 3: To provide sensitive medical care and obtain forensic evidence.

Data needed include:

- procedures followed by hospital and other medical personnel before the project's inception, both to examine and treat child sexual abuse victims and to collect medical evidence, and;
- changes instituted by the project.

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



Data needed include:

- the procedures followed by agencies and individuals within the criminal justice system before the project's inception;
- changes in procedures initiated or fostered by the project;
- changes in arrests of offenders, rates of prosecution and conviction.

The assumption underlying these related goals is that the criminal justice system in the past has been ineffective in dealing with sexual abuse. In each case it is important to know what happened before the project began its operations and what changes have occurred wholly or in part attributable to project activities.

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

Data needed include:

- information on the handling of child sexual abuse cases before the project began operations, from identification of possible cases, through investigation and assessment of needs to legal resolution of the case and termination of social and medical services;
- information on attrition and reasons for attrition at critical points in the handling of the case before project operations began; and
- information on gaps in services and coordination/cooperation problems before and during the project's existence.

Goal 6: To increase community awareness of the problem of child sexual abuse.

Data needed include:

- direct evidence of changes in community awareness of the problem, such as population survey data for the years before and after project operation;

- indirect evidence of changes in public awareness, such as increases in the rate of reporting of child sexual abuse.

Goal 7: To increase community awareness of the resources available to deal with the problem.

Data needed include:

- evidence of increased caseloads in this and similar projects.

Goal 8: To provide training to professionals in related fields.

Data needed include:

- enumeration of training provided to medical, social service and criminal justice personnel;
- evaluation of training effectiveness.

Goal 9: To document the special needs of child sexual abuse victims and their families, and to provide the basis for national dissemination and/or replication of project methods, approaches, strategies and findings.

Data needed include:

- epidemiological studies of child victims treated by the project;
- materials developed by the project that detail project implementation.

## 2.2 Goal Achievement

The data needs identified in the preceding section presuppose an ideal state of affairs in which each of the community systems has maintained complete and accurate information over a period of several years. In reality, this community, like most others, has maintained fragmentary and inadequate records of cases of sexual abuse. Sexual abuse of children, like adult rape, has been a largely unreported problem in the past. This section, therefore, adds to the available statistics, an enumeration of efforts made, descriptions of changes



in processes and the subjective judgments of staff of other community agencies on project impact.

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

Only in recent years have medical, legal and social service personnel realized that the phenomenon of child sexual abuse requires special and sensitive handling to avoid added trauma. In the years before project operation cases seen in hospitals or by the police were treated in the same way as adult victims of sexual assault, with no recognition of the special needs of child victims. Indeed, staff in the social service system, as well as the medical and legal systems, were hampered by their lack of information on appropriate treatment.

Prior to CSAVAP inception, the Child Protection Center (CPC) in Children's Hospital National Medical Center accepted referrals in all cases of intrafamily child abuse, including sexual abuse. Eventually CPC became known within the hospital as a treatment resource for all cases of child sexual abuse, regardless of the child's relationship to the offender. While CPC accepted these cases and provided some counseling and referrals, the terms of its grant did not extend to nonfamily cases. Hence, such cases received only limited services and CPC applied for funding to launch the "special unit," CSAVAP.

The project clinical staff originally included only one full-time social worker and a half-time pediatrician. Because this limited the services the project could provide, in June 1978 additional staff were added: one additional social worker and one registered nurse. Project staff at this time also included a full-time Director of Evaluation and Research, a half-time data coordinator, two part-time research associates, a criminal justice specialist and an administrative assistant. In the second year of the project, the pediatrician's time was further reduced and a half-time clinical psychologist was hired. Given these staffing patterns, the staff has focused on crisis intervention and short-term counseling; cases are referred to other hospital departments or to outside agencies for long-term assistance.

Shortly after project inception the criminal justice specialist was hired in recognition of the complexity of D.C. criminal proceedings and the need for someone to explain the system to project staff and victims and their families. Hence, CSAVAP clients who are prosecuting their cases receive supportive counseling from the criminal justice specialist, as well as accompaniment in court.

It is unclear what fraction of child sexual abuse victims in the District of Columbia are treated at Children's Hospital. Sgt. Satterfield of the Metropolitan Police Department estimated that 40 percent of victims reporting to

the Sex Offenses Branch (both adult and child) go to D.C. General Hospital and the remaining 60 percent are distributed among the various other emergency rooms in the city. It is possible that many child sexual abuse victims are not receiving project services, and persons interviewed stated there were no comparable services available elsewhere.

As described above in section 1.5.1, the majority of CSAVAP direct client services are devoted to crisis intervention and psychological assessment/evaluation (46% and 26% of all services provided, respectively). Other support services provided by CSAVAP include continuing medical treatment, court accompaniment/case tracking, and miscellaneous consultations with client attorneys or other hospitals (comprising 11, 9, and 8 percent of project services, respectively).

As shown on p. 15, in 34 percent of 399 cases treated by the project, project staff ascertained that the crisis was resolved upon termination of services. An additional 44 percent were referred elsewhere for treatment (with no routine CSAVAP follow-up); 21 percent were not counseled either because the client terminated against the project's advice or because project staff were unable to follow up on the case. Consequently, we can only say with certainty that 34 percent of CSAVAP cases were resolved successfully by project standards. All individuals interviewed for the validation believed that CSAVAP was performing a vital role in providing direct services to child victims and their families.

We still know little about the impact of counseling and treatment services on victims. Little is known with certainty about the effects of sexual abuse on the child's development, though it is currently believed that there are both short-term and long-term effects. CSAVAP, like other similar projects, has operated on the assumption that crisis support with short-and long-term counseling will help to ameliorate the trauma to the child and will also help to prevent added trauma as a consequence of the revelation and investigation of the abuse.

Early in the project's first year, a 12-page interview instrument was developed to assess client satisfaction with all aspects of their treatment, from medical care to police treatment to criminal justice system outcome, as well as specific CSAVAP services. This attempt was abandoned soon thereafter due to the project's inability to locate clients, and numerous refusals to respond.



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

Neither in this or any other community are data available on the true incidence of child sexual abuse. Data on reincidence are similarly difficult to obtain. In both cases, the difficulty arises because of the hidden nature of the offense and the general belief that only a small proportion of offenses are actually reported and investigated.

It is important to note that statistics on the number of offenders of children removed from home are both difficult to collect and to interpret. 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 instances a mother will leave the home with her children. An additional factor is the length of the separation and its timing in relation to initial disclosure. For example, if a father and daugher are not separated until a court sentences the father then there remains the potential for re-incidence.

In the District of Columbia, intrafamily cases of child sexual abuse are investigated first by the Youth Division of the D.C. Metropolitan Police Department, which is authorized to remove the child from the home on a five-day hold and/or to arrest the offender. Child Protective Services then is responsible for investigating the potential for further abuse. According to Sgt. Satterfield, accused intrafamilial sex offenders are frequently released pending trial,* and the child cannot be removed from the home (beyond the five-day hold) until the court rules that the child should remain on hold pending the results of a CPS investigation, a process which may take months. Child abuse and neglect decisions, which are civil proceedings, are made entirely independent of any criminal proceedings taking place against the offender. Hence, the decision as to whether a child returns home does not consider the pretrial custody/release status of the offender.

Between October 1975 and March 1978 (a 2-1/2 year period), when the Child Protection Center treated cases of child sexual abuse, post-incident data were available on 130 of 151 cases. Only four percent of those 130 children had been removed from their homes.** In the two years of CSAVAP operations

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* Indeed, pretrial release data for 224 suspects on charges of carnal knowledge and indecent acts on a minor show that between 1976 and 1979 all were released to the community except three who were placed under mental observation. PROMIS Management Report Package, U.S. Attorney's Office, Washington, D.C. (See further discussion under Goal 4.)

** Neil K. Makstein, Ann Marie McLaughlin, and Carl M. Rogers, "Sexual Abuse and the Pediatric Setting: Treatment and Research Implications," paper presented to the American Psychological Association, New York, New York, September 1979.

between February 22, 1978 and March 15, 1980, of 399 project intakes only 12 (3 percent) were placed in foster care, and six children were placed under protective supervision. Of course, it should be noted that such proceedings only apply when the offender is the natural parent or legal caretaker--which represents about one-fifth of CSAVAP cases (see Table 1).

Children who are assaulted or abused by persons outside the home normally do not require continuing protection beyond the parent's attention and watchfulness. However, in cases where parental neglect is believed to have contributed to the abusive incident, CSAVAP staff are required to report to Child Protective Services. Project data indicate that only 4 percent of their cases have been referred to CPS.

Data are not available on reincidence of sexual abuse within the home or resulting from parental neglect. The project's research director indicated that he was not aware of any clients who had been re-abused.

Efforts made by the project to increase public awareness, discussed below, are likely to result in additional protection for children. Adult guardians, teachers and medical professionals may report earlier and more frequently, once they are alerted to the problem and the resources for treating it.

Goal 3: To provide sensitive medical care and obtain forensic evidence.

Child victims of sexual assault require medical attention for two reasons. First, to treat injuries that may result from the assault; secondly, to collect medical evidence of assault, such as the presence of sperm, genital or rectal trauma, gonorrheal infection or pregnancy, all of which may be used for purposes of criminal prosecution. Insensitive handling of the medical examination will not only inflict additional psychological injury, but is likely to reduce the victim's (or the family's) willingness to pursue the matter.

Because of its location in the large and prestigious Children's Hospital of Washington, D.C., CSAVAP was in a good position to influence the medical handling of cases, both within Children's Hospital and in other medical facilities.

During the first year of its existence, the project identified the need to revise the existing emergency room protocol for dealing with cases of child sexual abuse. This was developed during the second year of project existence. Additional protocols were developed during the second year to deal with the management of cases of pediatric venereal disease, treatment of sexually-abused adolescents and laboratory procedures for handling evidentiary testing specimens. These protocols are now used by the staff at



Children's Hospital, and project staff indicate that parts of their protocols have been incorporated into existing protocols at D.C. General Hospital. (Protocols are attached in the Appendix.)

All emergency room medical personnel have been trained by CSAVAP in the special needs of child victims and in the use of the protocols (see Goal 8 below). CSAVAP clinicians do not typically accompany the child during the examination but another "trusted" person (usually the mother or a nurse) is always present.

Goal 4: To improve the response of the criminal justice system.

The controversy that exists among medical and mental health professionals about the appropriateness of criminal justice involvement in child sexual abuse cases is fueled by several concerns. First is the concern that the prosecution process itself is damaging to the child, possibly more damaging than the original abuse. Additionally, it is argued that the criminal justice system is a punitive one which can only punish the offender without solving the problem. Proponents of prosecution argue that sex offenders should be held accountable for their actions, i.e., that child sexual abuse is a crime and offenders should be treated accordingly. CSAVAP written policy supports prosecution "because many children are vulnerable to repeated victimization, and because the perpetrator should be held accountable for his conduct." (See appendix for complete text of CSAVAP philosophical statement.)

The Medical-Legal Sexual Assault evidence form developed by CSAVAP (see Appendix) has been adopted by the D.C. Police for use in all sexual assault cases, both child and adult victims, in all hospitals. Both police and prosecutors interviewed indicated that the quality of medical evidence obtained had been much improved.

None of the persons we interviewed in the Police Department, U.S. Attorney's Office, or Corporation Counsel was able to identify procedural changes that had been incorporated since CSAVAP inception. Likewise, the evaluation of the project's activities conducted at the end of Year 1 by the Community Advisory Council at the project's request, reported some improvement in the medical handling of cases but noted little observed impact on the legal sector and no impact on the community sector. This was not a final evaluation of the project and does not take into account the later activities of the project.

Another means of assessing change in the criminal justice system response to cases of child sexual abuse is to look at the statistics on arrest, conviction and dispositions for such cases in a period prior to project inception and during project operations. As is the case in many jurisdictions, reliable data are not available to describe the progress of cases of child sexual

abuse within the District of Columbia criminal justice system in years prior to CSAVAP inception.* This is not unusual among criminal justice agencies which have historically focused their attention on offenders, not victims, and their records reflect this emphasis.

The U.S. Attorney's Office was, however, able to track cases entering the criminal justice system from 1976 through 1979 on only two charges: carnal knowledge and indecent acts upon a minor, crimes which involve child victims by definition. Hence, these data (reported in Table 3) represent only a fraction of all child sexual abuse cases prosecuted in the District of Columbia from 1976 through 1979. The table reflects only cases involving adult suspects; it does not indicate the fraction of cases disposed by police discretion, i.e., prior to arrest and presentment for prosecution; nor does it differentiate between CSAVAP cases and non-CSAVAP cases in 1978 and 1979. Still the figures do allow a guarded view of how child sexual abuse cases fared in the D.C. criminal justice system for two years prior to CSAVAP inception, and two years during project operations.

The data on the table do not appear to reflect any consistent pattern that can be attributed to CSAVAP intervention. There appeared to be a relative "surge" of carnal knowledge and indecent acts cases charged by police in 1977, the year prior to project inception; after that, cases leveled off again. The actual number of carnal knowledge/indecent acts charges filed in court remained relatively stable over the four years. Dispositions increased steadily until 1979, when carnal knowledge dispositions dropped to about half the number disposed in 1976 and indecent acts dispositions also dropped to a level nearly 20 percent lower than that of 1976.

Conviction rates fluctuated between 70 and 100 percent for carnal knowledge, and between 71 and 88 percent for indecent acts. The only consistent trend discernible on the table is the rate of guilty pleas to the charge of carnal knowledge: from 53 percent in 1976 to 78 percent in 1979. This pattern does not hold for indecent acts charges.

It should be emphasized that the table omits many charges that may pertain to child sexual abuse, e.g. forcible rape and incest, because victim age information was not available. Also, the figures on the table represent charges. A single case may involve multiple charges, and charges pertaining to a particular case may change at various points in the criminal justice process. For example, police may present a case charged as carnal knowledge and prosecutors may file it under indecent acts. In other words, the table does not portray a straight-line progression of cases entering the criminal justice system.

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* According to Ms. Sue Ellen Hais, Director of Computer Processing (PROMIS) in the Washington, D.C. U.S. Attorney's Office, victim/witness information (e.g., age, sex, other demographics) has not been recorded since 1976. Prior to 1976 such data were only kept haphazardly.



Table 3

CASE TRACKING: CARNAL KNOWLEDGE AND INDECENT ACTS UPON A MINOR 1976-1979

| | 1976 | 1977 | 1978 | 1979 |
|---|---|---|---|---|
| **CARNAL KNOWLEDGE** | | | | |
| Police-Initiated Charges | 17 | 23 | 18 | 15 |
| Cases Filed with Court* | 13 | 17 | 17 | 15 |
| Dispositions* | 17 | 19 | 23 | 9 |
| Guilty | 16 (94%) | 15 (79%) | 16 (70%) | 9 (100%) |
| Plea | 9 (53%) | 11 (58%) | 14 (61%) | 7 (78%) |
| Verdict | 7 (41%) | 4 (21%) | 2 (9%) | 2 (22%) |
| Not Guilty | 0 ( - ) | 2 (11%) | 4 (17%) | 0 ( -- ) |
| Dismissal | 1 (6%) | 2 (11%) | 3 (13%) | 0 ( -- ) |
| **INDECENT ACTS** | | | | |
| Police-Initiated Charges | 44 | 80 | 40 | 40 |
| Cases Filed with Court* | 42 | 43 | 39 | 38 |
| Dispositions* | 21 | 24 | 26 | 17 |
| Guilty | 15 (71%) | 19 (79%) | 23 (88%) | 14 (82%) |
| Plea | 10 (48%) | 14 (58%) | 20 (77%) | 10 (59%) |
| Verdict | 5 (24%) | 5 (21%) | 3 (12%) | 4 (24%) |
| Not Guilty | 0 ( - ) | 4 (17%) | 2 (8%) | 1 (6%) |
| Dismissal | 6 (29%) | 1 (4%) | 1 (4%) | 2 (12%) |

SOURCE: PROMIS Management Report Package, U.S. Attorney's Office, District of Columbia.

* Proportions cannot be computed because prosecutors may change charges on a given case at various points; each entry represents an independent count of cases reflecting carnal knowledge/indecent acts charges at each point.

That task has been performed for the period of CSAVAP operations by the project's Criminal Justice Specialist, who has entered into formal agreements with the relevant agencies to allow him access to case jackets for purposes of case tracking. As a result, CSAVAP has detailed information on case outcomes since February 22, 1978. The project has not yet documented the outcomes of cases initially reported in 1980.

The figures in Table 4 were provided by the project, and represent cases reported by CSAVAP to D.C. Police by year in which the report was made.* Cases are tracked for the duration of their involvement in the criminal or juvenile justice system.

The number of reports by CSAVAP to police nearly doubled from 1978 to 1979, from 108 to 211, a 95 percent increase. The project attributes the increase in reports to (1) the absence of data for January and February 1978, (2) the training provided by CSAVAP to medical personnel in identifying instances of sexual abuse, and (3) the heightened visibility of the project among the general community. Those reports resulted in only 13 adult defendants and 19 juveniles indicted/petitioned in 1978; 14 adults and 32 juveniles were indicted/petitioned in 1979. Most case attrition occurred between the initial report to police and referral to prosecution: some reports are "unfounded," but most are recorded by police as "information only," i.e., they lacked sufficient evidence to establish a case for prosecution. (It should be noted that the District of Columbia and only four states require corroborating evidence for all child testimony.) In 1978, 38 percent of the CSAVAP reports "dropped out" in this interval, and 48 percent dropped out in 1979.

The second area of case attrition is the number of cases that result in arrest. The adult arrest rate was only 56 percent in 1978 and 54 percent in 1979; for juveniles it was 81 percent in 1978 but only 57 percent in 1979. A third area of attrition is between arrest and indictment. In 1978, 72 percent of adults and 76 percent of juveniles arrested were indicted (petitioned for juveniles); in 1979 only 56 percent of adults and 82 percent of juveniles were indicted or petitioned. Sgt. Satterfield of the D.C. Police indicated that the criminal courts in the District are severely backlogged and consequently prosecutors are highly selective in accepting cases for prosecution.

In sum, we cannot conclude that there have been any significant changes in attrition rates for CSAVAP cases entering the criminal justice system in 1978 and 1979.

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* Sgt. Joe Satterfield of the D.C. Police Sex Offenses branch indicated that it is misleading to say that these reports were all initiated by CSAVAP. Rather, the figures represent all child sexual abuse cass known to both the D.C. Police and the project, regardless of the source of the initial report.



Table 4
LAW ENFORCEMENT TRACKING OF CSAVAP CASES

| | 1978* | 1979** |
|---|---|---|
| Total CSAVAP Reports to D.C. Police, Sex Offenses Branch | 108 | 211 |
| Cases forwarded to prosecutor | 67 (62%) | 110 (52%) |
| Number of adult suspects*** | 32 | 46 |
| Refused to press charges | 4 | 3 |
| Arrest warrant denied | 9 | 18 |
| Arrest warrant outstanding | 1 | 0 |
| Suspects arrested | 18 (56%) | 25 (54%) |
| Not charged | 1 | 1 |
| Not indicted | 4 | 10 |
| Pending indictment | 0 | 0 |
| Indicted or waiving indictment | 13 (72%) | 14 (56%) |
| Pending trial | 0 | 3 |
| Case dismissed | 1 | 1 |
| Acquitted | 0 | 1 |
| Convicted | 12 (92%) | 9 (64%) |
| Plea | 12 (100%) | 9 (100%) |
| Trial | 0 | 0 |
| Incarceration | 5 | 3 |
| Probation | 6 | 5 |
| Pending sentence | 1 | 1 |
| Number of juvenile suspects*** | 31 | 69 |
| Refused to press charges | 1 | 1 |
| Custody application denied | 5 | 29 |
| Custody order outstanding | 0 | 0 |
| Suspects taken into custody | 25 (81%) | 39 (57%) |
| Not petitioned | 6 | 7 |
| Petitioned | 19 (76%) | 32 (82%) |
| Pending trial | 0 | 3 |
| Petition dismissed | 7 | 13 |
| Acquitted | 0 | 0 |
| Consent decree | 2 | 3 |
| Adjudicated delinquent | 10 (63%) | 13 (50%) |
| Plea | 7 (70%) | 12 (92%) |
| Trial | 3 | 1 |
| Residential commitment | 2 | 4 |
| Probation (includes consent decrees) | 8 | 12 |
| Pending disposition | 0 | 3 |
| Case closed | 2 | 0 |

Source: CSAVAP data

* Status of cases initially reported in 1978, as of December 31, 1979.
** Status of cases initially reported in 1979, as of July 23, 1980.
*** Some victims were abused by more than one offender; some offenders abused more than one victim.

Very few cases have been disposed through adjudication. Adult cases tend to experience a higher conviction rate than juveniles. All adult convictions in 1978 and 1979 were by guilty plea; juvenile convictions obtained by guilty plea were 70 percent in 1978 and 92 percent in 1979. Adults were more likely than juveniles to be sentenced to incarceration. Table 5 on the following page shows that, cumulatively, as of March 15, 1980, of 210 cases referred to the prosecutor for arrest warrant, only 6 came to trial and in only 42 were guilty pleas offered. According to the project's research director, half of the convicted offenders were sentenced to probation; of those, 56 percent (both adult and juvenile) were required to undergo some form of treatment.

It should be noted that the project's original goal statement made no mention of effecting structural change within the criminal justice system. Rather, their focus has been on enhancing the skills and knowledge of criminal justice personnel who deal with child sexual abuse victims. The project's extensive training activities are detailed in our discussion of Goal 8.

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

CSAVAP's Community Advisory Council was convened shortly after the project began and represents key personnel of many agencies involved in treating cases of child sexual abuse (including law enforcement, prosecution, Child Protective Services, and probation). The Council has been active in reviewing all project documentation and identifying potential sources of funding. Council members contributed to the development of CSAVAP's directory of referral sources and maintain a speakers bureau for making community presentations. While generally quite supportive of the project and the services it provides to child victims, none of the CAC members interviewed was intimately involved in the project's day-to-day operations and none could identify changes in his or her agency resulting from involvement in CSAVAP.

The project has also convened a Cross-Jurisdictional Council representing law enforcement and counseling agencies from the several jurisdictions surrounding the District of Columbia. This Council is intended to identify treatment resources in the metropolitan area and to contribute to a general understanding of procedural variations across jurisdictions.



Table 5

D.C. CRIMINAL JUSTICE SYSTEM OUTCOME
OF
CHILD SEXUAL ABUSE VICTIM ASSISTANCE PROJECT D.C. CASES
(Feb. 22, 1978 through Mar. 15, 1980)

| Total CSAVAP Cases Reported to D.C. Metropolitan Police Dept. | No. of Victims* | |
|---|---|---|
| | 362 | |
| **Police Action** | | |
| Report unfounded[1] | 10 | |
| Investigation closed, elements of offense lacking[2] | 121 | |
| Case exceptionally cleared[3] | 7 | |
| Case open, no suspect identified | 13 | |
| Case open pending referral to prosecutor | 1 | |
| Case referred to prosecutor for arrest warrant application | 210 | |
| **Prosecutorial Action**[4] | | |
| Case dismissed prior to arrest warrant application | 74 | |
| (No corroborative evidence[5]) | | (36) |
| (Victim refused to press charges[6]) | | ( 9) |
| (Other reason given[7]) | | (24) |
| (Reason unknown) | | ( 5) |
| Arrest warrant not executed | 1 | |
| Case dismissed after arrest | 18 | |
| Pending action | 7 | |
| Informations/Petitions filed | 110 | |
| **Court Action** | | |
| Case dismissed, no indictment | 15 | |
| Case dismissed, juvenile consent decree[8] | 4 | |
| Case suspended at prosecutor's request[9] | 17 | |
| Case pending indictment or trial | 25 | |
| Case tried, mistrial | 1 | |
| Case convictions | 48 | |
| (Guilty plea)[10] | | (42) |
| (Trial) | | ( 6) |
| **Sentence** | | |
| Probation | 24 | |
| Incarceration | 14 | |
| Juvenile disposition closed | 2 | |
| Pending sentence | 8 | |

SOURCE: CSAVAP data.

[1] Report categorized as false.

[2] Insufficient description of the suspect, of the offense, or of the location to establish that an offense occurred within the District of Columbia. This is largely attributable to the inability of a young child to give a satisfactory narrative to the investigator.

[3] Suspect was arrested on other charges, or was arrested in another jurisdiction and could not be returned for prosecution.

[4] "Prosecutor" includes the Office of the U.S. Attorney for the District of Columbia, which prosecutes all sexual offenses committed by persons age 18 and older in the District of Columbia, and the Office of the Corporation Counsel of the District of Columbia, Juvenile Branch, which prosecutes all sexual offenses committed by juveniles under age 18 in the District of Columbia.

[5] Current D.C. Court of Appeals decisions require evidence to corroborate the testimony of "immature" victims of sexual offenses in order to sustain a conviction.

[6] In most cases the victim's parent refused to press charges.

[7] These include "lack of victim credibility," "consensual intercourse between peers," and "incest case better handled by the child abuse system."

[8] The agreement by an accused juvenile to undergo six months of probation before trial; if successfully completed the case is dismissed. This is rarely offered in sex offense cases, and may only be offered to first offenders.

[9] Includes dismissals as part of a plea bargain when the accused is charged in a second case and pleads guilty in the second case.

[10] Includes guilty pleas to lesser included offenses to the counts charged.

*A victim may have been victimized by one or more suspects. Other suspects victimized more than one victim. Therefore, the numbers of suspects do not match the numbers of victims for each category and are accordingly unreported. If a victim was victimized by several offenders, the victim is counted in each category.

Goal 6: Increase community awareness of the problem of child sexual abuse.

Because there have been no surveys that measure directly the community's understanding of this problem, assessment of goal achievement must depend, for the most part, on efforts made and an examination of indirect evidence such as changes in reporting of the offense.

Project staff have appeared on numerous radio and television talk shows Between September 1979 and June 1980, CSAVAP staff appeared on five television shows (including The Baxters, a nationally syndicated issues program) and six radio shows (including "Parenting Plus" which is nationally syndicated). News articles about the project appeared in the New York Times and the CBS Editorial Service. Brochures have been developed describing the project to the general public and are distributed by various agencies on the CSAVAP Community Advisory Council, as well as local libraries, hospitals and day care centers. In addition, a parent information booklet is given to parents of all children seen by the project. Both brochures are in the Appendix.

The major target of the project's direct community outreach has been professionals in related fields, i.e., nurses, school psychologists, crisis hotline workers, etc. The project tabulates these activities under Training (see Goal 8).

As is the case in many jurisdictions, reliable reporting data are unavailable. Sgt. Satterfield of the Metropolitan Police Department observed an increase in reports over the last five years but was reluctant to attribute the increase solely to project efforts, stating that community awareness had been heightened by other agencies' efforts (including his own) as well as those of CSAVAP.

Goal 7: Increase community awareness of resources available to deal with the problem.

One measure of this is the changes in the project's own caseload over the three years of its existence. Between October 1, 1975 and March 7, 1978 (prior to the start-up of CSAVAP client services), the Child Protection Center at Children's Hospital (the parent project) saw 151 cases of child sexual abuse or assault. * The grand total of clients having some contact

* Neil K. Makstein, Ann Marie McLaughlin, and Carl M. Rogers, "Sexual Abuse and the Pediatric Setting: Treatment and Research Implications," paper presented to the American Psychological Association, New York, New York, September 1979.



with CSAVAP (including incoming referrals and consults) increased from 195 in 1978 to 344 in 1979 (a 76% increase), and to an estimated 356 (annualized) in 1980. Of the 195 clients counted in 1978, the project estimates 40-50 were consults only, leaving approximately 150 actual intakes. In 1979 intakes rose 23 percent to 185. From January 1 to July 20, 1980, the project had recorded 90 intakes, which annualizes to 164 for 1980, an 11 percent decrease from 1979 intakes. (The project indicates, however, that September and December are both periods of heightened activity, and thus 164 for 1980 may be an under-estimate.)

In sum, the project's caseload has been increasing over the course of its existence. The majority of that increase was in consultations, suggesting that awareness of the project's activities has been heightened among professionals in the D.C. area. The project's own counseling caseload is somewhat constrained by limited staff resources. It is unclear what the impact of its activities on the general community has been. Families may still not find it helpful to pursue cases, particularly intra-family cases, in the absence of treatment alternatives or court compulsion.

Goal 8: To provide training to professionals in related fields.

Training is perhaps the project's strongest contribution. Model curricula for police officers, prosecutors, and probation officers were developed in the project's second year (see Appendix).

Medical Training

Over the first two years of the project's existence, staff conducted at least 15 separate training sequences for a total of 550 staff members of Children's Hospital, including medical and nursing staff as well as social workers.* The content of the training included: collection and transfer of medical and laboratory evidence; interviewing the child victim; reporting requirements; hospital treatment procedures; and childhood venereal disease and sexual abuse.

For medical staff in other hospitals and clinics, project staff provided 78 total hours of training to a total of 700 medical professionals, including 2 training sessions for Public Health Nurses, focusing primarily on investigation of childhood venereal disease cases, legal reporting requirements, medical evidence and family assessment. The project seems to have had little contact with private pediatricians in the area beyond mailing them the

* Cumulative figures given here and elsewhere in this report are taken from the project's July 17, 1980 quarterly report in which the first two years' activities are summarized.

project brochure, parent booklet and an invitation to a half-day seminar held at Children's Hospital. Registration for the seminar was limited to 35 physicians and there is no indication of the extent of the response.

Training activities continued at a similar level during the third year, with sessions lasting from one to eight hours depending on the format used. One two-day and one three-day workshop were held in the middle of the third year, but more typically, lectures and training sessions lasted between two and four hours. After the first year, however, no attempt was made to evaluate the effectiveness of training sessions, partly because of scheduling complexities and partly because the staff felt it inappropriate to ask trainees to spend 30 minutes evaluating a two-hour presentation.

## Criminal Justice Training

During the second year of the project, staff conducted one-hour training sessions for combined groups of two dozen officers from the Youth Division and the Sex Offense Branch of the D.C. Police Department. Staff were able to educate police officers about the nature and limitations of physical evidence and about ways of obtaining corroborative evidence.

Thirty attorneys from the Office of the Assistant Corporation Counsel, who have primary responsibility for prosecution in juvenile delinquency cases and who are responsible for initiating abuse/neglect petitions took part in a four and one-half hour training session. Training focused on minimizing trauma to the victim, medical and forensic corroboration, and techniques for interviewing victims.

Seventy-five Assistant U.S. Attorneys and 22 attorneys in the Volunteer Attorney's Office participated in training sessions. In addition, project staff provided over 20 hours of training for over 220 members of the criminal justice system, mainly in Washington, D.C.

Individuals interviewed in the U.S. Attorney's Office, the Office of the Corporation Counsel, and F.A.C.T. (Families and Children in Trouble) Hotline valued the training provided by CSAVAP quite highly. In contrast, however, Sgt. Satterfield indicated that the curriculum that was developed and later presented to his officers was too elementary but would be "excellent" for a small town department with little experience in handling child victims. (For example, the materials assumed an interview occurring in a clinical setting, not in a ghetto environment.) Sgt. Satterfield attributed the apparent mismatch in training to the fact that police had not been involved in curriculum development.

A complete listing of training activities undertaken in a single quarter (March-June 1980) is provided on the following pages.



PROFESSIONAL SEMINARS, LECTURES, WORKSHOPS AND OTHER TRAINING ACTIVITES

TIME FRAME: MARCH 16, 1980 TO JUNE 15, 1980

| | AGENCY | TYPE OF AUDIENCE | SIZE | LENGTH | DATE | STAFF |
|---|---|---|---|---|---|---|
| 2 | CHNMC OPD LECTURE SERIES | M.D.'S | 35 | 2.5 HRS. EACH | 3/16/80 | SIMREL LLOYD |
| | CHILDREN'S LEGAL DEFENSE FUND/JUVENILE JUSTICE CLINIC | ATTORNEYS | 30 | 2HRS. | 3/18/80 | BERG LLOYD |
| | PSYCHIATRIC GRAND ROUNDS | CHNMC MENTAL HEALTH, AND SOC.SERVICE AND CHILD PROTECTION WORKERS | 30 | 2HRS. | 3/21/80 | THOMAS |
| | UNIVERSITY OF MARYLAND | UNDERGRADUATE STUDENTS | 10 | 1.5HRS. | 3/27/80 | NEAL |
| | UNIV. OF ILL. MED.SCHOOL | M.D. S.WORKERS HEALTH WORKERS LAW ENFORCEMENT | 100 | 8HRS. | 3/31/80 | THOMAS |
| | ST. ELIZABETH HOSPITAL | IN-PATIENT MENTAL HEALTH WORKERS | 10 | 3HRS. | 4/15/80 | THOMAS |
| | GEORGE WASH. UNIVERSITY | MEDICAL STUDENT | 70 | 2HRS. | 4/7/80 | ROGERS |
| | ACTION VOLUNTEERS | FOSTER GRANDPARENTS | 65 | 1HR. | 4/7/80 | BERG |
| | AWARENESS PROGRAM | PARENTS | 50-70 | 4HRS. | 4/16/80 | TERRY |
| | CHNMC PSYCH. DEPT. | PSYCHOLOGISTS, SOCIAL WORKERS | 30 | 2HRS. EACH | 4/17/80 4/24/80 | BERG |
| | LEAA COLLOQUIUM | MULTIPROFESSIONALS | 35 | 24HRS. | 4/23/80 TO 4/25/80 | LLOYD THOMAS |
| | FAMILY VIOLENCE CONFERENCE | P.S.,M.S.W.'S PUBLIC HEALTH WORKERS | 40 | 2HRS. | 4/25/80 | ROGERS |

PROFESSIONAL SEMINARS, LECTURES, WORKSHOPS AND OTHER TRAINING ACTIVITIES (CONT.)

TIME FRAME: MARCH 16, 1980 TO JUNE 15, 1980

| AGENCY | TYPE OF AUDIENCE | SIZE | LENGTH | DATE | STAFF |
|---|---|---|---|---|---|
| ALEXANDRIA HEALTH DEPT. | PUBLIC HEALTH PROFESSIONALS | 50 | 3.5HRS. | 5/6/80 | THOMAS |
| BALTIMORE CITY HOSP. | MULTIPROFESSIONAL | 30 | 8HRS. | 5/7/80 | THOMAS LLOYD |
| FAMILY PLANNING TRAINING INSTITUTE, BALT., MD. | MULTIPROFESSIONAL | 50 | 8HRS. | 5/14/80 | BERG |
| JUVENILE JUSTICE CONFERENCE | JUVENILE COURT PERSONNEL + COMMUNITY | 300 | 8HRS. | 5/14/80 5/15/80 | THOMAS |
| GRAND ROUNDS | NURSES | 50 | 1HR. | 5/14/80 | NEAL |
| D.C. INTERAGENCY TRAINING | P.S. AND P.O. WORKERS | 100 | 16HRS. | 5/20/80 + 6/3/80 | LLOYD BERG TERRY THOMAS HORSTMANN |
| IPO TRAINING SESSION | MCH + PH PERSONNEL | 75 | 4HRS. | 5/28/80 | THOMAS |
| WOMEN IN CRISIS CONFERENCE | MULTIPROFESSIONAL | 300 | 4HRS. | 6/6/80 6/7/80 | THOMAS |



Goal 9: To document the special needs of child sexual abuse victims and their families, and to provide the basis for national dissemination and/or replication of project methods, approaches, strategies and findings.

CSAVAP procedures and observations have been documented prolifically. Following is a partial listing of papers presented or published by project staff:

Thomas, Joyce N., Program Status Report. Presented to the Mayor's Interagency Committee on Abuse and Neglect, April 14, 1980.

Lloyd, David W., An Overview of the Statutory, Police Investigative, and District of Columbia Superior Court Procedures Relating to Children Who Are Victims of Sexual Abuse, 1978. (Copyright pending).

Simrel, Kermit; Berg, Regina; Thomas, Joyce; "Crisis Management of Child Sexual Abuse Cases," Pediatric Annals; March, 1979.

Thomas, Joyce; "Venereal Diseases in Children: A Case of Sexual Abuse," Response Vol. 2 No. 6., April 1979.

Thomas, Joyce; Simrel, Kermit M.D.; 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, New York, November, 1979.

Thomas, Joyce; 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, New York, November, 1979.

Thomas, Joyce, "Nursing Management of Child Sexual Abuse." RN Magazine 1980. (in press)

Makstein, McLaughlin, 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.

Lloyd, David, "Medical-Legal Aspects of Sexual Abuse," Pediatric Annals, March, 1979.

The staff research director has developed a set of data collection forms (see Appendix) that have been revised periodically. They tap a wealth of epidemiological information that, once compiled, should comprise a valuable contribution to the state-of-the-art.

In addition, CSAVAP hosted a national conference on the subject of child sexual abuse in the fall of 1979 as well as a smaller conference under LEAA auspices. Approximately 260 professionals from across the country attended the national conference. Agenda topics included federal funding patterns, human sexuality and incest treatment. Topics for small group discussion included:

- current research: trends and implications
- prevention: outreach and education
- emergency medical management
- crisis intervention: theory and practice
- male victims: special needs
- offenders: psychological, sociological and legal issues
- preserving the chain of evidence
- the role of the prosecutor: preparing and presenting the case
- the burned-out case: staff selection, training and turnover
- models for assessing treatment/intervention impact
- constitutional issues in management of sexual victimization cases
- sexual victimization and the law: a primer
- interviewing the child victim
- preparing the child and family for court proceedings
- clinical assessment and treatment goals
- the child victim: short-term and long-term reactions
- approaches to group treatment
- evaluating sexual abuse/assault programs
- promoting professional collaboration in case management
- childhood gonorrhea

The project has received requests for information from across the country and staff have traveled to lecture on the request of various groups (e.g., University of Illinois Medical School).



## 2.3 Efficiency

The Child Sexual Abuse Victim Assistance Project is completing its third and final year of LEAA discretionary funding. The table below shows the project's funding history since 1978. Initially funded at $127,480, the project requested additional funding in its first year to support an increase in staff, thereby raising total first-year funding to $179,398. In Year 2 the project's total budget was $260,324, and its current funding level is $265,857. Children's Hospital contributes approximately 30 percent of the project's current operating costs in the form of matching funds.

CSAVAP Funding History

| | Initial Funding 10/77-9/78 | Year 1 Total 10/77-12/78 | Year 2 1/79-12/79 | Year 3 1/80-12/80 |
|---|---|---|---|---|
| Personnel | $ 90,000 | $114,003 | $161,631 | $165,198 |
| Fringe | 7,650 | 9,690 | 13,738 | 14,041 |
| Travel | 1,000 | 3,975 | 2,222 | 1,862 |
| Equipment | 2,830 | | 700 | 1,300 |
| Supplies | 2,400 | 2,400 | 2,496 | 1,000 |
| Consultants | 10,700 | 13,350 | 4,100 | 3,950 |
| Other[1] | 5,000 | 6,950 | 9,330 | 10,940[2] |
| Indirect | 7,900 | 29,030 | 66,107 | 67,566 |
| TOTAL | $127,480 | $179,398 | $260,324 | $265,857 |
| (LEAA funds) | ($110,115) | ($161,176) | ($206,628) | ($188,423) |
| (Children's Hospital) | ($17,365) | ($18,222) | ($53,696) | ($77,434) |

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

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

The project does not compute its cost-effectiveness in any manner. A rough cost per client can be derived by dividing the total annual budget by the number of clients served. As shown below, the project's cost per client has increased, from $1272 in Year 1, to $1407 in Year 2, to a projected $1562 in the third year.

| | Year 1 | Year 2 | Year 3 |
|---|---|---|---|
| Total funding | $179,398 | $260,324 | $256,142[1] |
| Clients served[2] | 141 | 185 | 164[3] |
| Cost per client | $1272 | $1407 | $1562 |

[1] Excludes $9715 special award for cluster conference.

[2] Intakes only (excludes incoming referrals and consultations).

[3] Annualized from 90 clients served, January 1-July 20, 1980.

One important caveat attaches to these figures, however. The project does not isolate costs by type of service provided (i.e., direct client services vs. professional training and community education). Nor are data available on number of staff hours devoted to clinical services. As a result, there is no way to extract the precise cost of clinical services provided per client.

## 2.4 Replicability

### State of the Art

Sexual abuse of children encompasses a range of sexual misconduct, ranging from genital fondling and exhibitionism to sexual intercourse, and includes oral and anal sexual activity. Force, or the threat of force may be used to coerce the young victim. Contrary to common belief, most sexual assaults are carried out by an adult who is known to the child, either a family member, a family friend, or an acquaintance. The incidence of sexual abuse is not known and is difficult to measure partly because, like rape, most cases are believed to go unreported, and also because of problems in tabulation. Statistics on incest or other intra-familial sexual abuse are usually collected and reported by different agencies from those that deal with extra-familial assault. Available statistics on extra-familial or "stranger" assault usually do not differentiate victims by age; thus, child victims and adult rape victims are grouped together. The National Center on Child Abuse and Neglect estimates that between 60,000 and 100,000 children are sexually abused each year. The approximately 6,000 cases reported last year to mandated agencies (AHA, 1979) thus probably depict only a portion of the true problem.



Nationally, approximately 150 projects exist to serve child victims of sexual abuse and their families, according to Kee MacFarlane. They range from small projects that serve 80 families a year to large ones that provide services to 300 or more families. The number of projects is growing rapidly, under a variety of auspices and with diverse program techniques. There is no general agreement about preferred modes of treatment and indeed no good evidence of the success of treatment either for victims or for offenders. Indeed, as we noted earlier, there are no descriptive data on these programs, since the majority have only been in existence for a year or two.

Section 4.0 of this report draws some comparisons between CSAVAP and the Child Victim/Witness Project in Seattle, another candidate for Exemplary Project designation.

### Adaptability

Many features of CSAVAP would be adaptable to existing programs. The medical protocols developed to deal with various types of problems within the general category of child sexual abuse could be utilized by medical and social service programs elsewhere. The curricula developed for various parts of the criminal justice system can be adapted for use by similar projects. The use of a criminal justice specialist may be valuable to similar projects that must interface with a variety of criminal justice agencies and deal with several different legal jurisdictions.

### Key Program Features

The main features of the program which are replicable are the following:

- The procedures and protocols for management of child sexual abuse cases have been carefully worked out and have already been disseminated to other hospitals in the Washington, D.C. area.
- The project has produced a variety of training materials and utilized a number of different training strategies involving widely differing audiences. Presentations and films prepared by the project have been utilized many times. Staff can probably produce appropriate training materials for any group, with the exception of school children--an area they have not yet explored.
- The project's MIS which has been continuously revised during the life of the project may prove a useful tool for other projects interested in compiling data about clients, families and services provided.

## 2.5 Accessibility

CSAVAP has been funded by LEAA with Children's Hospital providing matching funds, since project inception in October 1977. LEAA funding expires September 30, 1980. At this writing, the project had just received a $50,000 grant from the National Center on Child Abuse and Neglect to provide psychological assessment and screening and family treatment for incestuous juvenile sex offenders. The Assistant Project Director indicated that the hospital "will not let basic clinical services end," but the meaning of this commitment in terms of funding is open to interpretation.

A third party billing system designed for and employed by the Child Protection Center has been adapted for CSAVAP and is planned to become effective upon termination of the LEAA grant. Clients who possess medical insurance (or who are eligible for medicaid, which includes all child victims of intrafamily abuse) will be charged for the project's services, both outpatient and inpatient. Covered services will include all medical examinations, crisis intervention, screening mental health evaluation, screening public health evaluation, counseling, psychosocial treatment and family therapy. A trial application of the third party billing system indicated that approximately 30 percent of the project's total costs, and 45 percent of clinical services, could be covered this way.

Presently, CSAVAP is written into the Mayor's proposed budget for the District of Columbia, fiscal year 1982, at a level of $239,000 (funds would become available October 1981). The Mayor's decision on the proposed budget will not be known until October or November of 1980. In an interview with an official of the D.C. Department of Human Services, we learned that the FY1982 budget had been reduced and although a commitment of support had been made to the project, there were no funds available.

In sum, it is not clear at this writing whether the project will continue in its current form, continue but at a reduced capacity due to decreased funding, or cease to exist altogether. Individuals interviewed both on-site and by telephone believed that the project filled a valuable role in the community.

Project staff are extremely interested in assisting other jurisdictions, as evidenced in their role as host of the national conference last fall, in their sponsorship of the Cross-Jurisdictional Council, and in their prolific documentation of guidelines and procedures. The project's four core staff members (Project Director, Director of Research, Clinical Coordinator, and Criminal Justice Specialist) were responsive during our site visit and continued to assist our efforts in later telephone contacts.



# 3.0 STRENGTHS AND WEAKNESSES

## 3.1 Major Project Strengths

- The project provides specialized crisis intervention and short-term counseling services to victims of child sexual abuse and their families, services that did not exist for victims of non-familial assaults before the project's inception.
- The tracking system devised by the criminal justice specialist on the staff allows for the first time, careful tracking of cases through the criminal justice system.
- The project has succeeded in obtaining support for its activities from other community agencies whose staff value the services provided by the project.
- The project has developed and implemented new medical protocols within Children's Hospital emphasizing detection and treatment of physical injury as well as collection of medical evidence for use in any eventual criminal justice proceeding.
- Model curricula, cross-indexed for police, medical personnel, nurses and social workers, have been developed by the project for use in formal training sessions with a variety of criminal justice, medical and social service personnel. Extensive training has been provided by the project throughout the D.C. area.
- The project has produced and disseminated a number of professional papers, brochures and other documentation on its activities as well as in the general area of child sex abuse in an effort to enhance both community and professional awareness and expertise in dealing with the problem. The project has witnessed an increase in requests for information and consultation.

## 3.2 Major Project Weaknesses

- The project has had little identifiable impact on the operating procedures of the criminal justice system, particularly those involving case management activities. Further, an analysis of the number of arrests, filings and dispositions in child sex abuse cases since the inception of the project revealed little measurable impact on these criminal justice outcome measures.
- Interagency coordination on a case-by-case basis--e.g., counseling recommendations, criminal justice options--between the project and social service or criminal justice system personnel does not exist.

- The project data are incomplete in terms of some impact indicators such as change in overall incidence, reincidence and reporting rates for child sex abuse cases and case attrition in the criminal justice system. However, as discussed in Measurability and Goal Achievement section, past underreporting of this crime in all communities make such data extremely difficult, if not impossible, to collect.

- The project has been unable to secure community financial support for its efforts. Originally included in the budget of the city's Department of Human Services, budget cuts and shortages make such funding problematic. The project's continued existence is thus threatened.



# APPENDICES

APPENDIX A

Exemplary Project Application

#627

Approved: OMB No. 43 R0578

# Exemplary Project Application

## I. Project Description

1. Name of the Program THE CHILD SEXUAL ABUSE VICTIM ASSISTANCE PROJECT (CHILD PROTECTION CENTER - SPECIAL UNIT)

2. Type of Program (ROR, burglary prevention, etc.)

VICTIM ASSISTANCE

3. Name of Area or Community served

(a) Approximate total population of area or community served WASHINGTON, D.C., GREATER METROPOLITAN AREA

(b) Target subset of this population served by the project (if appropriate) APPROXIMATELY 1,250,000

| No. Served | Period | Population |
|---|---|---|
| | 1/78-1/80 | CHILD SEXUAL ABUSE/ASSAULT VICTIMS AND THEIR FAMILIES |

4. Administering Agency (give full title and address)

CHILD PROTECTION CENTER
CHILDREN'S HOSPITAL NATIONAL MEDICAL CENTER
111 MICHIGAN AVE. N.W.
WASHINGTON, D.C. 20010

(a) Project Director (name and phone number; address only if diffnrent from 4 above.)

JOYCE N. THOMAS, M.P.H. (202) 745-5682

(b) Individual responsible for day to day program operations (name and phone number)

JOYCE N. THOMAS, M.P.H. (202) 745-5682

(c) Individual to contact concerning this application (name and phone number)

CARL M. ROGERS, PH.D. (202) 745-5682

5. Funding Agency(s) and Grant Number (agency name and address, staff contact and phone number)

LAW ENFORCEMENT ASSISTANCE ADMINISTRATION
GRANT # 79DF-AX-0018
CONTACT: MS. JEANNIE SANTOS (202) 724-5905

6. Project Duration (give date project began rather than date LEAA funding, if any, began)

JANUARY 1, 1978 TO PRESENT

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This report is a voluntary submission by applicants for the LEAA Exemplary Projects Program.



LEAA Form 2300/6 (11/75)

7 Project Operating Costs (Do not include costs of formal evaluation if one has been performed. See Item 8).

Breakdown of total operating costs, specify time period: 1/12/80 - 1/11/81

Federal: $176,828.00

State:

Local:

Private: $68,950.00

Total: $245,778.00

Of the above total, indicate how much is:

(a) Start-up, one time expenditures: -0-

(b) Annual operating costs: $245,778.00

(A complete budget breakdown should be included with the attachments to this form)

(SEE BELOW)

8. Evaluation Costs (Indicate cost of formal evaluation if one has been performed)

| Total Cost | Time Period | Principal Cost Categories |
|---|---|---|
| $21,109 | 1/12/80 - 1/11/81 | SALARIES, FRINGE, SUPPLIES, COMPUTER SVCS. |

9. Continuation. Has the project been institutionalized or is it still regarded as experimental in nature? Does its continuation appear reasonably certain with local funding?

| OPERATING BUDGET: | FEDERAL | NON-FEDERAL | TOTAL |
|---|---|---|---|
| PERSONNEL | 108.903 | 45,282 | 154,185 |
| FRINGE BENEFITS | 9,022 | 3,848 | 12,870 |
| EQUIPMENT | -0- | 1,300 | 1,300 |
| CONSULTANTS | 6,650 | -0- | 6,650 |
| SUPPLIES | 1,000 | -0- | 1,000 |
| TRAVEL | 5,812 | -0- | 5,812 |
| PRINTING | 900 | -0- | 900 |
| TOTAL DIRECT | 132,287 | 50,430 | 182,717 |
| OVERHEAD | 44,541 | 18,520 | 63,061 |
| TOTAL | 176,828 | 68,950 | 245,778 |
| **EVALUATION COSTS:** | | | |
| PERSONNEL | 8,100 | 5,678 | 13,778 |
| FRINGE BENEFITS | 688 | 483 | 1,171 |
| SUPPLIES | 300 | -0- | 300 |
| COMPUTER | 325 | -0- | 300 |
| TOTAL DIRECT | 9,413 | 6,161 | 15,574 |
| OVERHEAD | 3,313 | 2,322 | 5,635 |
| TOTAL | 12,726 | 8,483 | 21,209 |



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THE CHILD SEXUAL ABUSE VICTIM ASSISTANCE PROJECT (LEAA GRANT #79DF-AX-0018) IS CURRENTLY IN ITS THIRD, AND FINAL, YEAR OF FEDERAL FUNDING AS A DEMONSTRATION PROJECT. THE PROJECT HAS BEEN FORMALLY INTEGRATED INTO CHILDREN'S HOSPITAL'S ADMINISTRATIVE AND DEPARTMENTAL STRUCTURE AS THE CHILD PROTECTION CENTER-SPECIAL UNIT (CPC-SU) OF CHNMC.

ALTHOUGH THE MAJORITY OF OPERATING FUNDS ARE CURRENTLY PROVIDED BY LEAA, CHNMC HAS INDICATED ITS ONGOING COMMITMENT TO SERVICES IN THIS AREA BY COVERING OVER ONE-FOURTH OF THE TOTAL DIRECT COSTS OF THE PROJECT. IN ADDITION TO THE HOSPITAL'S DEMONSTRATED COMMITMENT TO PROVISION OF THESE SERVICES, THE PROJECT HAS BEEN CAREFULLY EXPLORING OPTIONS AND PLANNING FOR TRANSITION TO THE NON-LEAA FUNDED PERIOD. THE PROGRAM, IN ADDTION TO DIRECT HOSPITAL SUPPORT, IS ADDRESSING FUTURE FUNDING NEEDS THROUGH THREE PRIMARY AVENUES.

FIRST, WE ARE VIGOROUSLY PURSUING FEDERAL AND LOCAL GRANT AND CONTRACTUAL MONIES TO SUPPORT INDIRECT SERVICES SUCH AS TRAINING AND RESEARCH ACTIVITIES. STEPS IN THIS DIRECTION INCLUDE SUBMISSION OF A $140,000 PER YEAR RESEARCH GRANT PROPOSAL TO THE NATIONAL CENTER FOR PREVENTION AND CONTROL OF RAPE (NIMH), A JOINT SUBMISSION WITH TWO OTHER PROGRAMS OF A $200,000 PER YEAR TRAINING GRANT TO THE NATIONAL CENTER ON CHILD ABUE AND NEGLECT (AYCF), AND NEGOTIATIONS WITH THE REGION III RESOURCE CENTER ON CHILD ABUSE AND NEGLECT FOR A $30,000 TECHNICAL ASSISTANCE CONTRACT.

SECOND, TO SUPPORT DIRECT CLINICAL SERVICES, THE PROJECT HAS A THIRD-PARTY BILLING SYSTEM (E.G., BLUE CROSS/BLUE SHIELD; MEDICAID; ETC.) "IN PLACE" ALTHOUGH NOT CURRENTLY IN USE. PRACTICE BILLING EXERCISES CONDUCTED BY PROJECT STAFF INDICATES THAT UP TO 45% OF DIRECT CLINICAL SERVICES COSTS COULD BE READILY COVERED BY THIRD-PARTY BILLING.

FINALLY, THE DISTRICT OF COLUMBIA MAYOR'S COMMITTEE ON CHILD ABUSE AND NEGLECT RECENTLY UNANIMOUSLY VOTED TO RECOMMEND THAT CPC-SU OPERATING COSTS BE INCLUDED IN THE FISCAL YEAR 1982 (BEGINNING OCT., 1981) CITY BUDGET AS A DIRECT LINE ITEM FOR A SOLE SOURCE SERVICES CONTRACT. FINAL DECISION REGARDING INCLUSION OF PROGRAM COSTS IN THE CITY BUDGET WILL BE MADE IN JUNE, 1980.

APPENDIX B

Endorsements

F.A.C.T. Hotline
628-F.A.C.T.

# F.A.C.T.* Hotline

in care of

Box C
1690 36th Street N.W.
Washington, D.C. 20007

Director's Office
965-1900

October 3, 1978

Ms. Joyce Thomas, Director
Child Sexual Abuse Victim Assistance Project
Children's Hospital National Medical Center
Room 123
111 Michigan Avenue, N. W.
Washington, D. C. 20010

Dear Ms. Thomas:

This letter is an attempt to state in print what we and your staff have already discussed -- our delight that such a project as the Child Sexual Abuse Victim Assistance Project has been started in the Washington area and our desire and intent to work closely and cooperatively with you.

I hope that together we will be able to develop and offer alternative means for children to learn about sexual abuse and/or to self-report such cases.

As you know, FACT* is already involved in this area and therefore, we strongly feel this need. We would also like to work with you to develop some specific training modules for assisting us in training our para-professional volunteers in sexual abuse.

We are looking forward to working together.

Sincerely yours,

Joan C. Danzansky
Executive Director

*Families And Children in Trouble

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DISTRICT OF COLUMBIA GENERAL HOSPITAL
19TH ST. AND MASSACHUSETTS AVE., S. E.
WASHINGTON, D. C. 20003
TELEPHONE 626-5000

September 25, 1978

To Whom It May Concern:

The "Child Sexual Abuse Victims Assistance Project" at Childrens' Hospital National Medical Center is a vitally needed program. It has made a great impact in the past year in many areas concerning the sexually abused child.

They developed a Police Training Curriculum because of a growing need for specialized training in this area.

The project also has an actively functioning Community Advisory Council which includes three sub-committee. They include Medical-Legal, Case Review and Public Education-Information Committees.

Because of the projects involvement, it is more evident that a program which is concerned with the many ramifications of treating the sexually abused child was long over due.

Continued funding is needed to carry on the work started by the project.

Sincerely yours,

Juanita N. Kydd

(Mrs) Juanita N. Kydd
Social Worker

September 27, 1978

Joyce Thomas
Project Coordinator
Children's Hospital
111 Michigan Avenue NW
Washington, DC 20010

Dear Miss Thomas,

I am writing you on behalf of the D.C. Rape Crisis Center, Inc. and also as a member of the Community Advisory Council of the Child Sexual Abuse Victims Assistance Program (Public Education Sub-Committee) to express my support of the Sexual Abuse Project.

As you are aware, provision of effective services for sexually abused children remains a very serious problem in the District of Columbia. We feel that in order to effectively combat this problem a network of social service agencies, hospitals, law enforcers, and the community have to compile resourcesto solve a problem of such a phenomenal size. I feel that Childrens Hospital Has taken one step in that direction.

We find the Sexual Abuse Project to be a worthwhile service and again express our support for the Child Sexual Abuse Victims Assistance Program.

Sincerely,

Paula Stevens

Paula Stevens
Comm. Ed. Coordinator

rsr

Rape Crisis Center p.o. box 21005, washington, d.c. 20009 · 333-RAPE

September 21, 1978

Mrs. Joyce N. Thomas
Project Coordinator
Child Sexual Abuse Project
Children's Hospital National
Medical Center
111 Michigan Avenue, N. W.
Washington, D. C. 20010

Dear Mrs. Thomas:

The American Association of Psychiatric Services for Children would like to express our support for the continuation of the Child Sexual Abuse Victims Assistance Project. We have been concerned for quite some time about the absence of specific services for children who have experienced sexual abuse in the Washington area. Your project has filled the void.

We have been extremely impressed with the quality of service the project provides. Of particular note is the comprehensiveness of the project in that it services the child's medical and emotional needs. We have also been impressed with the approach taken by the project which not only provides direct service to the child and his/her family, but coordinates resources for the legal and social service sectors.

In view of the magnitude of the problem in the Washington area, the child victims would suffer a severe loss if the project is not continued. Therefore, we hope and strongly urge that the project be refunded.

Sincerely,

Debora D. Kramer

Debora D. Kramer
Executive Director

DDK:ch

The American Association of Psychiatric Services for Children, 1725 K St., N.W., Wash., D.C. 20006 Phone (202) 659-9115



October 19, 1978

Mrs. Joyce N. Thomas, Director
Child Sexual Abuse Victim Assistance Project
Children's Hospital National Medical Center
111 Michigan Avenue, N.W.
Washington, D.C. 20010

Dear Mrs. Thomas:

As a member of the Child Health Board of Children's Hospital, serving as a member of the Advisory Board of the Child Sexual Abuse Assistance Project, I have been impressed by the high standard of services provided by the very capable staff members of the program. You have succeeded in bringing together a highly trained, energetic and caring group of individuals who have provided a service to the hospital and to the community.

During the last year, as a member of the Advisory Board, I have had discussions with other Board members from the U.S. Attorney's Office, the D.C. Superior Court, the Psychiatric Institute of D.C., the D.C. Department of Human Resources, the Metropolitan Police Department and the D.C. Medical Society, who have on several occasions expressed their approval and respect for the accomplishments of the program. Client services have been available twenty-four hours a day, seven days a week. Hospital staff has been provided with extensive training, as well as other professional agencies. Representatives of law enforcement agencies have particularly expressed their awareness of the successful implementation of the program and of the high degree of services provided to the community.

Children's Hospital is fortunate to have such a competent, multi-disciplinary team working on the project, and I wish you all success in your future endeavors.

Sincerely,

Carolyn Y. Coursen

(Mrs.) Carolyn Y. Coursen
5053 Loughboro Road, N.W.
Washington, D.C. 20016

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA

WASHINGTON, D. C. 20001

42/84-DO
October 26, 1978

Ms. Joyce N. Thomas, Director
Child Sexual Abuse Victim Assistance Project
Children's Hospital National Medical Center
111 Michigan Avenue, N. W.
Washington, D. C. 20010

Dear Ms. Thomas:

It is a pleasure to forward this letter of endorsement and pledge of support for the Child Sexual Abuse Victim Assistance Project at Children's Hospital. Probation Officers from the Social Services Division of the Superior Court for the District of Columbia have over the past year utilized this program not only as a direct client service referral resource but also as a consultative resource for a variety of treatment efforts with troubled families. On a personal note, it has been a privilege to cooperate directly with the program as a member of the Public Education Subcommittee in its efforts to create a productive relationship with the community at large.

It is obvious that this program offers a vital and unique service to the children and families of this city as well as the social service agencies which support them.

The Social Services Division of the Superior Court for the District of Columbia, therefore, heartily endorses the Child Sexual Abuse Victim Assistance Project, and pledges continued support and cooperation for this valuable community program through its coming years of federally funded operation.

Sincerely,

Alan M. Schuman, Director
Social Services Division

W-9

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN RESOURCES
COMMUNITY HEALTH AND HOSPITALS ADMINISTRATION
WASHINGTON, D. C. 20009

October 6, 1978

Joyce N. Thomas, Director
Child Sexual Abuse Victim Assistance Project
Children's Hospital National Medical Center

Dear Ms. Thomas:

I am pleased to respond to your request for a letter regarding the Child Sexual Abuse Victim Assistance Project.

The direct clinical services provided by the project for sexually abuse children and their families can do much in minimizing the immediate and long-term trauma which occurs in these situations. With the expertise of a multi-diciplinary team and the experience of the staff at Children's Hospital National Medical Center appropriate immediate and anticipatory care can be provided to children in need.

The sharing of the expertise developed by the project staff along with the use of the research information resulting from the project efforts will also benefit the entire D.C. community via specific educational programs for persons, both professional and non-professional, who come in contact with the sexually abuse child.

I hope to continue the relationship I personally have with the project staff and look forward to working with Children's Hospital in the further development of efforts to provide a comprehensive services to children in D.C.

Sincerely,

Charlene Lanza
Program Administrator
Follow-up Unit-Sexual Assault Program

cc: Dr. Oner

DHR-34
Formerly PH-1090-9

3/71

APPENDIX C

The Philosophical Bases for Policies
of the Child Sexual Abuse Victim Assistance
Project

THE PHILOSOPHICAL BASES FOR POLICIES
OF THE CHILD SEXUAL ABUSE VICTIM
ASSISTANCE PROJECT

The Child Sexual Abuse Victim Assistance Project "CSAVAP" has identified its primary goal to be the assurance of improved responses to the needs of child sexual abuse victims and their families in the District of Columbia by the legal, medical, and social service systems. This goal can be divided into the following objectives:

1. To document the special needs of victims of child sexual abuse and their families and methods of addressing those needs.

2. To improve the knowledge and skills of law enforcement personnel in the sensitive management of victims, witnesses and families involved in cases of child sexual abuse.

3. To improve the knowledge, skills and cooperation of medical and social services personnel in the collection and transmission of evidence and information to the legal system in cases of child sexual abuse.

4. To improve interaction, coordination and cooperative case management among the legal, medical and social service systems with respect to cases of child sexual abuse.

5. 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 Project is committed to insuring that any child who has been victimized sexually:

1. Is appropriately evaluated for evidence of physical and emotional trauma, for possible transmission of disease and for possible pregnancy.

2. Is emotionally supported by those persons and agencies which interact with the child, such as the hospital, the police and/or social service agencies.

3. Is protected from additional victimization by the perpetrator.

4. Is assisted in recovering from any deleterious psychological effects caused by the event, ensuing family disruption, or cooperation with the law enforcement system.

The Project is also committed to protecting other children from sexual victimization by a known sexual offender.

In attempting to meet these commitments, the Project is subjected to a number of constraints, such as:

1. The relative limited expertise among medical and mental health professionals in the management of cases of child sexual victimization;

2. The controversy surrounding and inadequate research on sexually transmitted diseases in prepubertal children;



3. The Project's interdependence with other systems and persons who interact with the child and the child's family;

4. The wishes and actions of the child's parents;

5. The actions of the perpetrator and his attorney after the event has been disclosed;

6. Rights of the child, his or her parents, and the perpetrator; and

7. Procedures required by statute or regulation.

CSAVAP commitments and these constraints frequently become intertwined in ways that pose conflicting policy dilemmas for Project staff. In such cases, Project staff re-examine the philosophies and assumptions that underlie various Project polices in an attempt to find a solution to the problem.

The following sections describe CSAVAP philosophies and assumptions at the present time. They may change as warranted by the experience of the Project.

## The Project Definition of Sexual Abuse

In the process of normal development children encounter feelings related to sexuality and may engage in different behaviors of exploration and experimentation based on their age, physical development, and psychological maturity. In addition to parental nurture and guidance, many

children need counseling in sexuality from professionals in the medical and social service systems.

When a child is exploited sexually, however, he or she usually develops additional special needs that need to be met by the legal, medical, and social service systems. The child may exhibit fear in common with other victims of criminal acts, depression, lowered self-esteem, anger, regressive development, etc., in addition to heightened anxiety about his or her physical well-being and future sexuality. Because the victimization involves sexual activity (with all its cultural taboos, mythology, and stereotypes) the child's family may react in ways that do not meet the child's needs.

CSAVAP found that it is crucial to distinguish between those children brought to our attention with problems related to normal psychosexual development and those who have special needs due to exploitation or victimization. In many cases existing public and private agencies and services can address the former satisfactorily, while the latter require intensive intervention from CSAVAP staff. Examination of the causes of those special needs led to the formulation of a Project definition of sexual abuse.

The existing legal definitions were deemed to be unsatisfactory: sexual abuse as defined in the District of Columbia child abuse law refers only to victimization at the hand of a parent, guardian, or custodian and is thus underinclusive, while the District of Columbia criminal statutes



proscribe sexual activities between consenting children under age of sixteen and is thus overinclusive.

## Definition

1. Child Sexual Abuse is a broad term which refers to:

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

   and/or

   b. 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

   c. sexual contact 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.

2. The experience of sexual abuse may interfere with the child's normal, healthy development on any or all of three levels:

   a. Physical: The incident may be painful, induce physical trauma, or result in the transmission of a venereal disease. Conversely, the incident may arouse pleasurable physical sensations in the child.

   b. Psychological: As a result of the incident, the child may experience feelings of anxiety, vulnerability, fear, shame, or guilt.

   c. Intellectual: The incident may be beyond the child's level of comprehension and, therefore, may result in considerable confusion. By law, children are presumed to be incapable of giving intelligent, informed consent to such sexual contacts or interactions.

The Project's Community Advisory Council participated in the formulation of the definition.

## The Child Victim as the Project Client

CSAVAP staff have been confronted by a choice of potential clients: the child victim, the parent(s)-child relationship, or the family as an entity. Each may have peculiar needs as a result of the incident of sexual



abuse that could justify selection. The Project has opted for the child victim as its client.

In the first place, 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. The needs of the family members, primarily those of the parent(s), can be addressed through collateral services.

Second, the interests of the child victim may not coincide with the interests of other family members. A common example is when the perpetrator is a close friend or relative of the parent, who may value the friendship of the perpetrator or suppression of family scandal over the child's needs for mental health services and protection.

Third, 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. The perpetrator (almost invariably male) has a range of concerns regarding his sexual relationship to the child's mother and his criminal culpability; the mother's concerns include her sexual relationship to the perpetrator, her financial dependence upon him, her relationship to his other relatives, and her relationship with the child; the child's concerns include the impact of disclosure upon family relationships, feelings about sexuality and self-esteem, removal from the home into foster care, etc.

Fourth, many individuals require individual mental health services as a precondition to participation in conjoint family therapy. To select a relationship or group as the client could mean that the child victim's needs would be ineffectively addressed.

Reporting to Public Authorities

CSAVAP personnel routinely report suspected cases of sexual abuse to law enforcement and/or child protective services agencies. In training activities, public speaking engagements, and publications CSAVAP staff have urged medical, mental health, social services and educational professionals and private citizens to report suspected cases of sexual abuse to public authorities.

This procedure is the product of several Project assumptions and legal requirements.

First, the Project believes that many children are vulnerable for repeated incidents of sexual victimization. (Cases seen by the Project tend to give support to this assumption.) Since the Project is located within a private nonprofit medical facility, it has no legal authority to intervene and protect the child by arresting the alleged perpetrator or removing the child from his or her home. The District of Columbia Metropolitan Police Department has the authority to effect arrests, and, under the child abuse law, to remove the child victim from the family home if the suspected perpetrator is a parent, guardian or custodian.



Second, CSAVAP staff believe that the perpetrator should be held accountable to the community for his or her conduct. Criminal justice procedures are intended to indicate community intolerance of criminal behavior, to deter others from such behavior, and to protect the citizenry from future criminal acts either through incarceration of the perpetrator or through rehabilitation of his or her behavior so that it conforms to community norms. The report to police is the step which initiates all criminal justice procedures.

Third, the Project recognizes that in some instances the child's parent or guardian is unable or unwilling to initiate such investigation by reporting the case himself or herself.

Finally, the Project is obligated under law to report certain types of sexual activity to public agencies. Under the child abuse law the Project must report both incidents of physical or sexual abuse committed by the child's parent, guardian or custodian, and also cases where the child does not receive adequate parenting necessary for a child's normal physical, intellectual, and psychological development. As a result, CSAVAP personnel must report instances where a parent, guardian or custodian fails to procure medical or mental health services to meet clearly identified needs of the child. In addition, all cases of venereal diseases must be reported to the Public Health Department.

The Project recognizes that many cases reported to law enforcement agencies never result in the conviction or even arrest of the suspected

perpetrator, and that in a few cases the stress caused by investigation, court proceedings and an unsatisfactory outcome may together have a deleterious effect upon the child. Nevertheless, CSAVAP believes that the law enforcement system should be afforded the opportunity to function correctly, and that support can be given to the child and his or her family during the period following disclosure and reporting.

## CSAVAP Support During Court Proceedings

Project staff support the child victim during the law enforcement process in three ways: by providing technical support to the police and prosecutors to enhance the likelihood of a successful case outcome from the victim's perspective, and by preparing the child for situations likely to be encountered (e.g., police interview, testimony before the grand jury, defense investigation, line-ups, courtroom testimony and cross-examination), and by accompanying the child to court proceedings as a friend.

The Project assumes that the law enforcement process will be stressful to the child for any one or several of a number of reasons.

First, most children are reluctant to recite the details of the sexual abuse incident. In the course of the law enforcement process the child will be asked to recite the details numerous times -- to the police, medical or social work personnel, prosecutor, grand jury, and at trial. Any inconsistencies will be probed, often in a tone of voice that implies disbelief, exasperation, impatience, or hostility. Such experiences are



likely to be stressful.

Second, the fact that such repetitious recitals must be made to different persons means that the child's sense of privacy is perceived by him or her to be ignored. This can generate feelings of anxiety and stress.

Third, the child's normal routine is disrupted by trips to the police station and court building, physical structures that appear imposing, impersonal, and adult-oriented. The unfamiliarity of the surroundings can heighten anxiety.

Fourth, the child and his or her family are largely unfamiliar with court procedures. The formality, seriousness, and arcane language can be intimidating.

Fifth, the people involved in the case tend to have perspectives and orientations different from those of the child victim. The child is seen as a necessary instrument to the more important process of dealing with the defendant, rather than as the primary object of concern. Such a viewpoint comes to the fore when little or no explanation of case progress is made, when continuances are obtained without regard to the convenience and pyschological well-being of the victim, and when personnel disclose information about the child and his or her family to each other without regard for privacy considerations.

Sixth, the slow pace of the proceedings can produce stress. The child cannot put the incident behind and go on with his or her life if he or she must return to court every few weeks or months, for periods frequently as long as a year, to prepare testimony.

Seventh, the child victim will be subjected to defense attempts at investigation and interviews. Defense tactics often include efforts to make the child victim feel guilty for the defendant's legal predicament, to destroy the child's credibility by obtaining inconsistent statements or embarrassing facts about the child's sexual behavior, and outright harassment.

Eighth, the child must physically confront and identify the defendant in the courtroom. Anxiety about retaliation can arise.

Ninth, the child may be subjected to searching cross-examination in the defense attempt to reduce the effect of his or her testimony.

Finally, the child tends to assume the responsibility for the defendant's imprisonment even though this decision is made by a judge based on the defendant's psychological state, employment, and prior criminal activity.

## Recommendations for Psychological Evaluation and Long-term Therapy for Victims of Incest

CSAVAP is designed to offer crisis intervention mental health services to child victims of sexual abuse. The period of crisis is considered to be approximately four to six weeks.



Project staff routinely request psychological evaluations of incest victims and begin planning for referrals for long-term psychotherapy. This is based on the assumption that the problems posed to the child's mental health are more severe.

The dynamics of incest cases indicate deep-seated dysfunction in family relationships between the mother and father, mother and daughter, and father and daughter that are not usually capable of resolution within the crisis period. The daughter may have lowered self-esteem upon recognition that a person she trusted to nurture and protect her violated that trust by using her to gratify his own needs.

In addition, the disclosure of incest causes disruption in the family's socioeconomic functioning when the offender leaves the family home. The victim tends to blame herself or be blamed by other family members for such disruption.

If the child is removed from the home she may develop separation anxiety, especially when this period of removal lasts for many months. She may also begin to blame herself for an action taken by the court in order to protect her from additional incidents.

Finally, if the offender is incarcerated, she may blame herself, or be blamed, for his behavior that led to his sentence.

These problems are not easily treated, certainly not within a short period of time.

## Suspicion of Sexual Abuse in Cases of Pediatric Gonorrhea

The Project believes strongly that a prepubertal child with a sexually transmitted disease has had direct intimate contact with an infected person and that such transmission has occurred by mouth to mouth, mouth to genitals, genitals to genitals, or genitals to rectum contact, especially with secretions from those body parts. This belief is based upon the prevailing view of current researchers.

The Project assumes that gonorrhea in a prepubertal child has been caused by sexual abuse until the results of a carefully taken history of the onset and nature of symptoms, tests of family members, and a detailed view of the child's play, sexual activity, and caretaking arrangements indicate another cause. This assumption is based in part upon the recommendation of the United States Public Health Service, upon the reported research of pediatricians, and also upon preliminary review of cases treated and investigated by the Project.

Project staff recognize that great controversy surrounds the transmission of sexually transmitted diseases, especially to prepubertal children, and that further research is needed to definitively describe such transmission and its relationship to sexual abuse.

## Privacy of Information

CSAVAP recognizes that the sexuality of minors is a currently controversal topic in American society. Child victim of sexual abuse and sexually transmitted diseases may be subjected to curiosity, disparaging



comments upon their morals, and commercial exploitation. Such stigmatization may be deleterious to the emotional well-being of the child and his or her family.

The Project believes that medical and mental health information about a child victim of sexual abuse which identifies the child should be disclosed only to those directly involved in the protection of the child, or in the delivery of medical and social services to the child and his or her family. The Project also believes that permission to disclose such information should be obtained from the child and his or her parent(s) whenever possible.

Project staff are committed to further research in the etiology and epidemiology of sexual abuse; however, CSAVAP believes that the results of such research can be disclosed without disclosing the child's identity.

Project staff conduct themselves with regard to the ethical precepts of confidentiality expounded by their professional organizations and with applicable federal and local statutes that safeguard the privacy of the child, parent, and offender.

children's hospital
national medical center 111 MICHIGAN AVENUE, N.W., WASHINGTON, D.C. 20010 • (202) 745-5000
DEPARTMENT OF CHILD HEALTH AND DEVELOPMENT, GEORGE WASHINGTON UNIVERSITY
CHILD HEALTH CENTER • RESEARCH FOUNDATION OF CHILDREN'S HOSPITAL

CHILD PROTECTION CENTER

SEXUAL ABUSE PROJECT

The Child Protection Center, Children's Hospital National Medical Center (CHNMC), is pleased to announce that the Law Enforcement Assistance Administration has made it possible for the hospital to offer special services to all sexually assaulted children in the District of Columbia. The project has three major components: direct clinical services, education and training, and research. Its primary goal is to coordinate medical, legal, and social services to meet the needs of child victims of sexual abuse and their families.

Patient services are available 24 hours a day and include medical examination and treatment, crisis intervention and counseling, and anticipatory guidance. Assistance is provided both at the time of the reported abuse and throughout any medical, social service, or legal procedures that follow.

Cases may be referred by the D.C. Metropolitan Police Department, other medical or social service facilities, parents, other concerned individuals, or the children themselves. According to District of Columbia law, all cases of sexual abuse in children under age 16 must be reported to the police. All children who are 12 years old or younger who come to CHNMC with the complaint of suspected sexual abuse or is known to have a veneral disease will be assigned a team intake worker.

The project staff includes a pediatrician, public health nurses, social workers, a researcher, and administrative staff. Mental health expertise and legal consultation are also available to staff and patient/clients as needed. Members of the project's clinical team are available on a 24 hour basis for consultation services to physicians and educational programs. Services are also available to medical, law enforcement and social service agencies, as well as other community organizations.

For further information, please contact the Child Protection Center, Special Unit, Children's Hospital National Medical Center: 745-5682 or 745-4100.

Sincerely,

Joyce N. Thomas

Joyce N. Thomas
Project Director

JNT/va
B7/488



JOB DESCRIPTION

Title: Court Liaison/Juvenile Justice Specialist

The Court Liaison/Juvenile Justice Specialist will carry responsibility for case consultation, interagency liaison and class advocacy functions. Case services will include the provision of anticipatory guidance to client families and clinical team members regarding legal alternatives and their implications in individual cases. These include advice regarding court room procedures and possible strategies to insure positive case outcomes for the entire vamily. He/she is responsible to identify and resolve law enforcement related problems as they arise in reference to juvenile offender cases. He/she will also investigate case handling of juvenile offender sexual assault cases in the District of Columbia, identifying specific problem areas and making recommendations for remedial changes in laws, policies and procedure. This includes advice regarding conditions of rehabilitation programs, temporary residence facilities, foster care placement, or other such institutions which are designed to coincide and inhouse the therapeutic milieu.

Case advocacy functions including research and documentation of the legal process of cases of child sexual abuse from the point of view of both the child victim and the offender.

Candidate must have a law degree from an approved university or similar preparation with major focus in criminal justice, law enforcement or social reform. Candidate must have knowledge of investigatory work, legal research and writing in preparation for advocacy on behalf of indigent juveniles in such matters of delinquency, neglect or run away situations.

JOB DESCRIPTION

Title: Project Director and Director of CPC-SU;

The Project Director will be a masters' level senior administration nurse with advanced mental health skills, demonstrated clinical skills with children, adolescents and families, excellent oral and written communication skills as well as training and knowledge of public speaking.

Director will provide administrative supervision for the treatment team. The director will formulate, coordinate and monitor the service delivery process of the program and in addition will act as laison with hospital staff District of Columbia and federal agencies regarding the program. The project Director must have experience in child abuse, child sexual abuse, adolescent services, and knowledge of the District of Columbia. In addition must be familiar with medical, legal and social services agencies in the metropolitan area.

Director will intergate the activities of the treatment team with the generic program (CPCSU). Must have ability to supervise multidisciplinary unit.

The Program Director will be administratively responsible to the Direction of the Child Protection Center and the CHNMC Associate Director-Office of Child Health Advocacy.

JOB DESCRIPTION

Title: Evaluation/Research Director;

The Evaluation/Research Director will be a PH.D. level researcher with expertise in program evaluation and behavioral or applied social science research. He/she will have primary responsibility for the design and implementation of the special intrafamily child sexual abuse treatment program, research and evaluation efforts. These function will include, oversight of all activities related to collection, reduction, analysis, and interpretation of project data, compilation of program performance reports, compilation of statistical reports relating to intrafamily juvenile offender cases for various audiences, and consultation to staff as well as community groups re: the characteristics, and trends regarding service delivery and needs of this population of families.

The Evaluation/Research Director will be directly responsible for the direction of the Child Protection Center/ Special Unit in terms of administrative oversight and job performance.

APPENDIX D

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Program Policies and Guidelines

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CPC COUNSELING SERVICE
CHNMC OUT-PATIENT PSYCHIATRY
PROGRAM PSYCHIATRIC CONSULTANT
ADMISSION/PUBLIC FACILITIES
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APPENDIX E

Medical and Case Management Protocols

children's hospital
national medical center 111 MICHIGAN AVENUE, N.W., WASHINGTON, D.C. 20010 • (202) 745-5000
DEPARTMENT OF CHILD HEALTH AND DEVELOPMENT, GEORGE WASHINGTON UNIVERSITY
CHILD HEALTH CENTER • RESEARCH FOUNDATION OF CHILDREN'S HOSPITAL

PROTOCOL FOR THE MANAGEMENT OF SEXUALLY ABUSED CHILDREN

Children's Hospital National Medical Center (CHNMC) will provide medical services for cases of suspected sexual abuse and/or assault in children and adolescents up to their 19th birthday. These cases will be treated as emergencies. The services rendered will consist of both emergency treatment and follow-up by CHNMC's Sex Abuse (SA) Team or Child Protection Center (CPC). The primary goal is to provide a supportive environment in order to prevent any additional trauma to the child and his or her family.

The responsibilities of ER and other hospital personnel vary according to how the child enters the hospital system. Therefore, this protocol is divided into three sections:

I. Child and Family are Accompanied to Hospital by Police.

II. Child and Family Present With a Chief Complaint of Sexual Assault Without Police Involvement.

III. Hospital Personnel Suspect That Sexual Abuse Has Taken Place. (Presenting symptoms may include G.C., vaginal bleeding, etc.)

I. When Child Victim and Family are Accompanied by the Police

A. Intake Procedures

1. If the police accompany the child and/or family to the hospital, the detective should be directed immediately to the ER physician. The detective should provide the physician with the necessary information about the circumstances of the event.

2. The information obtained from the detective should be recorded by the MD or RN on the ER record.

3. The detective may call an ER nurse prior to coming to the hospital. The triage nurse should then be notified that a case of sexual assault is expected (or has arrived), and routine services should be provided as quickly as possible.

4. As soon as they arrive, the child and family should be taken to a private examining area by an ER nurse. The nurse should attempt to establish rapport with the child and family. The nurse should observe the behavior of the child, the parent/child interactions, and the child's response to the medical setting. Unusual clinging, crying, withdrawal, or distant reactions are some behavioral indications of stress. Observations should be recorded briefly on the ER record.

5. Usually children are not upset or visibly affected by the incident. However, repeating the details of the story to too many people could be traumatic and is usually unnecessary.

6. The nurse should confer with the resident and then notify the SA Team or CPC worker on call. The nurse should provide information to the CPC worker about the incident, the initial reactions of the child and family, and the anticipated medical plan.

7. The nurse should consult with the 2nd year resident regarding preparation of the child for the physical examination.

8. If the parent(s) are visibly upset, the nurse should take them to a private area away from the child and attempt to comfort them. The parent and child should be informed that a Child Protection Worker will be talking with them.

9. Arrangements should be made so that the child is not left alone.

B. Medical History

1. The resident should confirm the information obtained from the detective by talking with the adult(s) who accompanied the child. The parent or guardian should be asked if they believe the child was sexually assaulted and if there is any additional information about the event that they wish to share with the physician.

2. If the child is young, the parent(s) should be asked by the resident to provide the usual medical history.

3. Older children or adolescents can provide medical history, as appropriate, in a private area. Information regarding menstrual history and use of birth control should be recorded.

C. Physical Examination

1. The child and parent(s) should be informed about and prepared for the physical examination by the nurse.

2. The resident should tell the parent(s) what specific lab tests will be done, when the results will be available, and the purpose of each test.

3. The child should be reassured that the examination will not be painful.

4. Permission for the physical examination must be obtained from the parent or legal guardian.

5. All equipment, containers, and other materials should be in the room prior to the child's entry.

   Usual equipment should include:
   a. Woods Lamp
   b. Sex Assault Kit
   c. Routine examination equipment
   d. T.M. culture plate
   e. Appropriate lab slips

6. The young child should be examined in the presence of a trusted adult, either a nurse or the parent. Each step of the examination should be explained to the child.

7. The child should not be restrained in order to do the examination and/or to gather evidence. If the child is visibly upset, the resident should determine what measures should be used to reduce his or her anxiety.

8. Prior to the examination, a Woods Lamp should be passed over the child. Whenever seminal fluid is present, it will floresce a characteristic dark green. The resident should obtain specimens from these areas for motile sperm, non-motile sperm, and acid phosphatase tests.

9. A general physical examination should be done. The behavior of the child should be observed during the exam. Any evidence of forced trauma to the body should be noted.

10. A special medical-legal form brought by the police must be completed by the examining physician. It is essential that the physician be familiar with this form prior to the examination.

11. For the female child, simple observation of the perineum frequently will yield most of the necessary information. The resident should look for:
    a. bruises
    b. petechiae
    c. erythema
    d. vaginal discharge
    e. stretching of introitus
    f. bleeding of the introitus
    g. tears
    h. presence or absence of hymen
    i. condition of hymen
    j. condition of the rectum

12. For the male child, the resident should look for:
    a. bleeding of the penis
    b. abrasions
    c. petechiae
    d. erythema or hematoma formation of the glan
    e. injury to the shaft
    f. condition of rectum

The scrotum and frenulun also should be examined for abrasion and tears.

CONTINUED

1 OF 2

D. Laboratory Tests

1. Laboratory tests should be done with regard to the history of the assault and the time elasped since the assault. (See Table 1)

2. Laboratory specimens that may be obtained include:

   a. Acid Phosphatase - Collect with a cotton swab and place in 0.5 cc of saline in a glass tube.

   b. Motile Spermatazoa - Collect with a cotton swab and place in 0.5 cc of saline in a glass tube.

   c. Non-motile Spermatazoa - Smear a glass slide and air dry.

   d. Thayer-Martin (TM) Culture - Streak 1/4 of a plate.

   e. VDRL - 2 or 3 ml of blood in a red top tube.

   f. Pregnancy test - Random urine specimen.

3. Vaginal specimens should be obtained by using a medicine dropper or cotton swabs. All necessary specimens can be obtained with a medicine dropper during one invasion of the vagina. If the vagina yields scant secretions, sterile saline can be introduced with the medicine dropper and the vaginal content aspirated.

4. All containers and slides must be carefully labeled with the patient's name, the source of the sample, and the initials of the physician who obtained the sample. Laboratory slips are to be stamped with a triple (XXX). The physician obtaining the specimens should transport them to the specimen receiving area of the main lab. The lab representative must sign a receipt indicating that the material was delivered.

E. Medical Treatment

1. Medical treatment should be rendered as indicated in the normal manner and depending upon the injury. For severe lacerations or internal injuries, the surgical resident should be notified.

2. Adolescents should be given a pregnancy test for base line information. (The ER resident should consult with the adolescent Fellow on call regarding the need for diethylstilbestrol)

3. Hospitalization may be indicated depending on:

   a. Medical condition
   b. Severe emotional upset (Consult with the SA Team or CPC.)
   c. Protection of the child from further assault (Consult with the SA Team or CPC.)

F. Follow-up

1. Trauma Index card should be completed and filed by the physician in charge of the case.

2. Patients with medical evidence of trauma who are not hospitalized should be given return medical appointments by the physician in accordance with the nature of their injuries.

3. All patients who receive TM cultures should receive follow-up cultures within two weeks. Appointments should be scheduled by the physicians. (The SA Team will be available to coordinate services for the child and family.)

4. ER physicians should record all laboratory results on the medical-legal form. Results of motile sperm, non-motile sperm, and acid phosphatase tests are available within one hour. The physician should call the lab for results.

5. The medical-legal form should be left with the ER Clinical Coordinator (Nurse Supervisor) for the police to pick up.

6. All medical follow-up for adolescent patients will be provided by the Adolescent Clinic. Patients should be assigned to the service of the Senior Fellow. (The CPC worker will be available to coordinate service for the adolescent and family.)

II. Responsibilities of ER Personnel When the Chief Complaint is Sexual Abuse or Assault and the Police Have Not Been Notified

1. If a parent comes to the ER/OPD and states that the child has been sexually abused, the triage nurse should locate a private area and attempt to get further information concerning the assault from the parent. (If further information is needed from the child, the nurse will interview during evening hours and CPC will interview during the day.)

2. The nurse should inform the parent that the incident must be reported to SA, CHNMC and to the police. The nurse should confer with the 2nd year resident, giving a history of the assault, and then the resident should consult with the SA Team or CPC Worker. The resident and SA Team will assess the need to notify the police. If the police must be notified, the resident must call the police immediately.

3. The nurse should follow all procedures as discussed above, including supportive counseling, clinical observations, preparation for examination, etc.

4. The resident should follow all procedures as discussed above including:
   a. obtaining medical history
   b. physical examination
   c. treatment
   d. follow-up medical plans and information to police

5. The CPC worker is responsible for coordinating service and follow-up activities.

III. Responsibilities of All Hospital Personnel in Cases In Which There is a Suspicion of Child Sexual Abuse

1. The indicators of child sexual abuse are not always concrete. Hospital staff should be alert for subtle signs such as parental reports of:
   a. the child staying inside the house more frequently
   b. the child not wanting to go to school
   c. the child crying without provocation
   d. the child bathing excessively
   e. a sudden onset of bed wetting

2. The more common medical indicators of child sexual abuse are:
   a. positive gonorrhea
   b. unexplained vaginal bleeding
   c. history of age-inappropriate sexual play
   d. child hints about involvement in sexual activity with an adult or child confides in you about sexual experience(s)
   e. suspicious stains or blood in underwear
   f. bruising or swelling of genital area not consistent with history
   g. child with pain in anal or genital area (more subtle gastrointestinal or urinary tract area)
   h. females: vaginal discharge
      urethral inflamation
      lymph gland inflamation

      Males: Pain on urination
      penile swelling
      penile discharge

3. The physician should tell the parent or accompanying adult that there is a possibility of sexual abuse.

4. The physician should tell the parent that a child protection worker will be notified.

5. The SA Team or CPC should be notified for consultation.

6. The child protection worker is responsible for interviewing the child and family to obtain a pscho/social history and to assess the need for notification of police.

7. When police are notified, the physician will proceed as stipulated in Part I (i.e., obtaining lab specimens, providing medical treatment, and follow-up)

TABLE I

LABORATORY TESTS

| TESTS | Hours after the incident of sexual abuse | | | | | | |
|---|---|---|---|---|---|---|---|
| | 3 hours | 6 hours | 12 hours | 18 hours | 24 hours | 48 hours | 48 hours |
| 1. Acid Phosphatase | | | | | | | |
| a. Vagina | x | x | x | x | x | x | |
| b. Rectum | x | | | | | | |
| c. Mouth | x | | | | | | |
| c. Dried secretions | x | x | x | x | x | x | x |
| 2. Spermatozoa (motile) | | | | | | | |
| a. Vagina | x | x | | | | | |
| b. Rectum | x | | | | | | |
| c. Mouth | x | | | | | | |
| 3. Spermatozoa (non-motile) | | | | | | | |
| a. Vagina | x | x | x | x | x | | |
| b. Rectum | x | x | | | | | |
| c. Mouth | x | | | | | | |

Pregnancy and venereal disease tests should be done according to the following schedule:

1. Thayer-Martin Cultures
   a. Obtain in <u>all</u> cases in which there is a history indicating possible direct physical contact with the offender's genitals, regardless of the length of time that has elapsed since the assault.

   b. Repeat in two weeks.

2. VDRL
   a. Obtain in all cases involving adolescents.

   b. Repeat in six to eight weeks.

3. Pregnancy Test
   a. Obtain in all cases involving adolescent girls with a history of direct physical contact with the offender's genitals.

   b. Assess the menstrual cycle.

   c. Consult with Adolescent Fellow.

/bsr
B11/104

# PROTOCOL FOR SEXUALLY ABUSED ADOLESCENTS

ALL SEXUALLY ABUSED ADOLESCENTS MUST BE EVALUATED BY THE SEX ABUSE TEAM (SAT) MEMBER ON-CALL, IN ADDITION TO THE ADOLESCENT FELLOW ON-CALL. THIS FELLOW WILL SHARE IN THE EVALUATION AND PLANNING FOR THE DISPOSITION OF THE CASE. USE THE FOLLOWING PROCEDURES:

1. EMERGENCY ROOM (ER) RESIDENT COMPLETES THE HISTORY AND PHYSICAL AND FORMULATES THE DISPOSITON PLAN. THIS RESIDENT SHOULD THEN CONTACT THE SEX ABUSE TEAM MEMBER AND ADOLESCENT FELLOW (SEE CHILD SEX ABUSE ER PROTOCOL).

2. <u>IF INDICATED</u> (IN SEVERE OR COMPLICATED SEX ASSAULT SITUATIONS BOTH THE SEX ABUSE TEAM CASE WORKER AND THE ADOLESCENT FELLOW MUST COME TO THE HOSPITAL FOR EVALUATION OF THE PATIENT AND MAKE RECOMMENDATIONS.

3. IF THE PATIENT CAN BE SENT HOME, THE SEX ABUSE TEAM MEMBER AND THE ADOLESCENT FELLOW ASSUMES RESPONSIBILITY FOR MAKING. THE APPROPRIATE REFERRALS AND SHARING RECOMMENDATIONS WITH THE PATIENT, AND THE PARENTS OR RESPONSIBLE ADULT.

4. THE ER RESIDENT WILL BE INVOLVED IN AND INFORMED OF THE FINAL DISPOSITION. ADMISSION TO THE CHILDREN'S HOSPITAL NATIONAL MEDICAL CENTER (CHNMC) MAY BE CONSIDERED WHEN:

   A- THERE ARE CLEAR MEDICAL INDICATIONS; THESE PATIENTS ARE TO BE ADMITTED TO ICU OR ADOLESCENT UNIT DEPENDING UPON MEDICAL CONDITION.

   B- THERE IS SIGNIFICANT RISK OF REPETITION

WHEN A PATIENT IS ADMITTED THE RECOMMENDATIONS ARE AS FOLLOWS:

1. THE ADOLESCENT FELLOW ASSUMES RESPONSIBILITY AS PRIMARY PHYSICIAN IMMEDIATELY UPON ADMISSION OF PATIENT AND PROMPT INITIATION OF THE APPROPRIATE STEPS FOR PLANNING PATIENT CARE.

2. THE SEX ABUSE TEAM CONTINUES TO CONSULT AND COLLABORATE REGARDING SOCIAL, LEGAL, AND OTHER HEALTH ISSUES WITH THE ADOLESCENT FELLOW UNTIL FINAL DISPOSITION OF CARE IS MADE.

APPROVED BY:

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ADOLESCENT MEDICINE 5-29-80

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# GONORRHEA CULTURE PROTOCOL

Introduction:

The diagnosis of gonorrhea depends on the culture and identification of the microorgainism Neisseria gonorrhoeae. Gonorrhea should be considered in every child with vaginal or urethral discharge.

Culture:

Type

Thayer-Martin (TM) is a medium composed of chocolate agar containing carefully compounded list of vitamins and co-factors. This agar is designed to inhibit the growth of most microorganisms with the exception of Neisseria gonorrhoeae.

Storage

Thayer-Martin (TM) medium must be stored in a refrigerator at 4°C until it is used.

It is most important that the medium be warmed to either room temperature or preferably 35 to 37°C before inoculation. (N. gonorrhoeae is very sensitive to cold temperatures and will be killed if inoculated to medium just removed from a refrigerator).

Technique

I. Obtaining Culture Specimen

1. Vaginal
   a) Using a medicine dropper or a cotton swab, sample of secretions can be obtained from vaginal orifice.

2. Anal Canal
   a) Insert sterile cotton tipped swab approximately one inch into the anal canal. (If the swab is inadvertently pushed into feces, use another swab to obtain specimen.)
   b) Move swab from side to side in the anal canal to sample crypts; allow 10 to 30 seconds for absorption of organisms to the swab.

3. Urethral
   a) Strip the urethra toward the orifice to express exudate.
   b) Use cotton swab to obtain specimen.

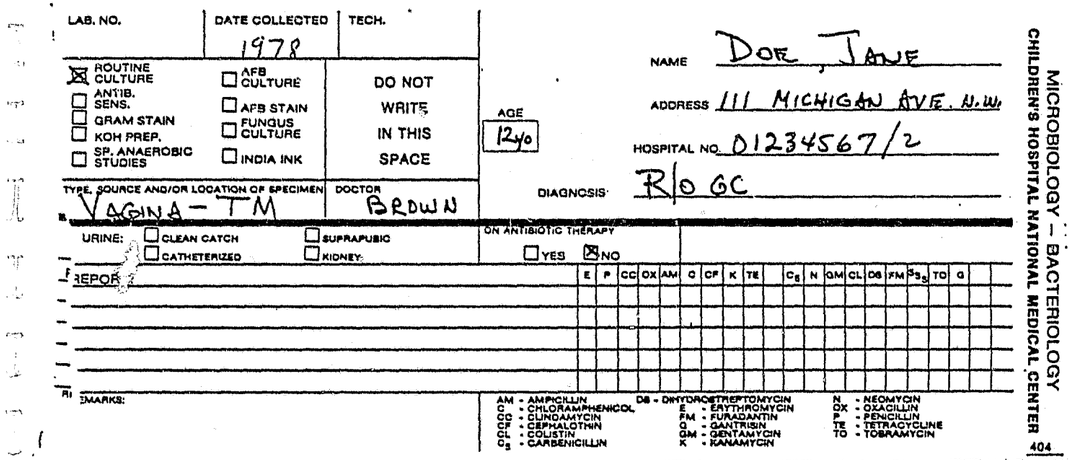
II. Inoculation of Thayer-Martin (TM)

1. Medium should be at room temperature prior to inoculation.

2. Do not place inoculated medium in the refrigerator or expose to extreme temperatures.



a) Roll swab directly on Thayer-Martin (TM) medium using about ¼ of the plate.
b) Complete lab slip as below.



LAB. NO. | DATE COLLECTED 1978 | TECH.

☒ ROUTINE CULTURE ☐ ANTIB. SENS. ☐ GRAM STAIN ☐ KOH PREP. ☐ SP. ANAEROBIC STUDIES
☐ AFB CULTURE ☐ AFB STAIN ☐ FUNGUS CULTURE ☐ INDIA INK
DO NOT WRITE IN THIS SPACE

TYPE, SOURCE AND/OR LOCATION OF SPECIMEN: VAGINA - TM | DOCTOR: BROWN

URINE: ☐ CLEAN CATCH ☐ CATHETERIZED ☐ SUPRAPUBIC ☐ KIDNEY

AGE: 12yo

NAME: DOE, JANE
ADDRESS: 111 MICHIGAN AVE. N.W.
HOSPITAL NO. 01234567/2
DIAGNOSIS: R/O GC

ON ANTIBIOTIC THERAPY: ☐ YES ☒ NO

REPORT | E | P | CC | OX | AM | C | CF | K | TE | $C_3$ | N | GM | CL | DB | FM | $P_{3_5}$ | TO | G

REMARKS:

AM - AMPICILLIN, C - CHLORAMPHENICOL, CG - CLINDAMYCIN, CF - CEPHALOTHIN, CL - COLISTIN, $C_3$ - CARBENICILLIN, DB - DIHYDROSTREPTOMYCIN, E - ERYTHROMYCIN, FM - FURADANTIN, G - GANTRISIN, GM - GENTAMYCIN, K - KANAMYCIN, N - NEOMYCIN, OX - OXACILLIN, P - PENICILLIN, TE - TETRACYCLINE, TO - TOBRAMYCIN

MICROBIOLOGY — BACTERIOLOGY
CHILDREN'S HOSPITAL NATIONAL MEDICAL CENTER
404

c) Transport plate to lab within 5 minutes of obtaining specimen.
d) Forward culturete to lab for routine culture.
C Symptomatic Vag. Discharge.

Reporting

The following reporting records should be complete:
a - Epidemiologic Report
b - PHN Referral
c - CPC Referral

A. Epidemiologic Report -
In establishing the prevalence and incidence of this disease, reporting is of prime importance. The District of Columbia has regulations requiring the reporting of communicable disease.

The team nurse should complete the epidemiology card and foward to Epidemiological Services, V.D. Control Division, 1325 Upshur Street, N.W.

B. PHN Refferal -
The PHN should participate in venereal disease control through contact investigation, case finding, case management, and assisting others in the education and evaluation of possible contacts.

The patient's record should indicate that a PHN referral has been made.

Use the census tract book to locate the correct district to send the referral.

All PHN referrals should be forwarded to the PHN Coordinator of CHNMC.

C. CPC Referrals -

The team nurse or resident should contact the Child Protection Center at ext. 4100 or the intake worker to interview the child and parent on all cases of positive venereal disease.

The primary purpose of this interview is to rule out possible sexual abuse of the child.

If there is evidence of sexual abuse, the CPC worker will make a referral to the Sex Offense Branch of DCMPD, Youth Division or Protective Services.

Interview Techniques for Pediatric Cases of Gonorrhea:

1. Double check address and phone number of patient's record prior to entering room.

2. Meet with parent to verify the data. Establish rapport with patient and family member. Ask about type of work, type of home interest, and activities. Ask about relationships in the home, i.e., other family members, frequent visitors, HX of illnesses, etc.

3. Respond to open ended situations and ask direct questions, i.e., sleeping arrangement of child and family.

4. Review medical instructions such as type of medications received, need for follow-up, possibility of reinfections-- if contact not treated.

5. Educational Section --

   Provide written materials about GC in children. Materials should be directed to the parent and the child.

6. Ask positive questions about the incident. "What do you think is the problem of your child?" "How do you think they got it?"

7. Confront circumstances of the case, i.e., mode of transmission, incubation period, reporting responsibilities. Concern regarding possibility of sexual abuse should be discussed with parent.



8. Reassure about treatment success. Assess mental health status and respond appropriately.

9. Provide follow-up instruction. Return appointment information, etc.

*At each level of the interview, allow for feedback and questions from parent and child.

Obtaining Results - Of Lab Work

Preliminary results are available in approximately 24° from time sample is taken to the lab.

Final results are forwarded to the clinic in about 48°.

Call ext. 5350 or come to the Microbiology Department of the Lab.

APPENDIX F

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c. establishing an alliance
d. establishing details of the assault situation
e. assessing impact of sexual assault
f. therapeutic approach
g. sex stress situation

MAJOR TOPICS

| CODE | TOPIC | AUDIENCE(S)* NUR | PHY | POL | SOC |
|---|---|---|---|---|---|
| I. | General Information | | | | |
| A | Statement of purpose | x | x | x | x |
| B | Statement of definition | x | x | | x |
| C | Summary of the proposal | x | x | x | x |
| II. | Police Curriculum | | | | |
| A | Goals and objectives | | x | x | x |
| B | Suggested topic sets | | x | x | x |
| C | Statistical overview | x | x | x | x |
| D | Criminal Justice statistics | x | x | x | x |
| E | Sex aubse fact sheet | x | x | x | x |
| F | Corroboration (cases) | | | x | x |
| G | Medical corroboration | x | | x | x |
| H | Corroboration (statutes) | | | x | |
| I | Consent to examination | x | x | | |
| J | Accompanying the child to court | | | x | x |
| K | Court accompaniment | | | x | |
| L | Confidentiality | | | | |
| M | Sample Handout Material | | | | |
| | Accompany to court | | | x | x |
| | Reporting | x | x | | x |
| | INFO: needed by police | x | x | | x |
| | Good witness | x | x | | x |
| N- | Persons who may interact | x | x | x | x |
| O- | Court Process | x | x | x | x |
| P- | Case examples | | | x | |
| S | State sex abuse statutes | | x | x | |
| III | Medical Curriculum Materials | | | | |
| A | Goals and objectives | x | x | | |
| B | Purpose of medical intervention | x | x | x | |
| C | History | x | x | | |
| D | Physical Exam | x | x | | |
| E | Health Care Professional and evidence | x | x | | |
| F | Protocol Management | x | x | | x |
| G | Protocol/Veneral Diseases | x | x | | |
| H | Protocol/Lab | x | x | x | |



NURSE/SOCIAL WORKER CURRICULUM
MATERIALS

MAJOR TOPICS

| CODE | TOPIC | AUDIENCE(S)* NUR | PHY | POL | SOC |
|---|---|---|---|---|---|
| A- | Goals | x | | | x |
| B- | Suggested topic sets | x | | | x |
| | Overview | x | | | x |
| | Investigative Info | x | x | | x |
| | Reporting requirement | x | x | | x |
| | Medical process | x | | x | x |
| | Veneral disease | x | | x | x |
| | Feelings/attitudes | x | x | x | x |
| | Myths | x | x | x | x |
| | Effects | x | x | x | x |
| | Sexual development | x | x | | x |
| | Prevention factors | x | | | x |
| | Offender characteristics | x | x | | x |
| | Incest dynamics | x | x | x | x |
| | Assessment issues | x | | | x |
| | Interviewing | x | | | x |
| | Crisis intervention | x | x | | x |
| | Summary comments | x | x | x | x |
| C- | Case Management | | | | |
| | Procedure | x | x | x | x |
| | Clinical Conf | x | x | | x |
| D | Team Approach | x | x | | x |
| E- | Health worker/Police relationship | x | x | | x |
| F | Comprehensive Overview of Medical Process | x | | | |
| G- | Preparation of Physical Exam | x | | | |
| H- | Myths | x | x | | x |
| I | Prevention | x | x | | x |
| J | Offender Profile | x | x | | x |
| K- | Mental Health Aspects | x | | | x |
| | 1. Indicators | | | | |
| | Medical | x | x | | |
| | Behavioral | x | x | | x |
| | Family | x | x | | x |
| | 2. Assessment Issues | x | | | x |
| L | Family Dynamics | x | | | x |
| M | Incest | x | | | x |
| N | Issues/Problems | x | x | x | x |
| O | Crisis Intervention | | | | |
| P- | Child Development | x | x | x | x |
| Q | Interviewing Principles | | | x | x |

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APPENDIX G

Police Reporting Form

and Medical Evidence Booklet

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*

[illegible]

## 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 H

## Data Collection Forms

Data Collection Forms

CHILD PROTECTION CENTER: SEXUAL ABUSE PROJECT

CHILDREN'S HOSPITAL NATIONAL MEDICAL CENTER

INTAKE NOTE

NAME OF CHILD _____ SEX ____ DOB _____ INTAKE DATE _____

ADDRESS _____ PHONE _____

ETHNICITY _____ SCHOOL _____ GRADE _____

HOSPITAL NO. _____ MEDICAID NO _____ OR INSURANCE _____

ACCOMPANIED BY _____ RELATIONSHIP TO CHILD _____

ADDRESS _____ PHONE # _____

PARENT IDENTIFICATION

MOTHER'S NAME _____ FATHER'S NAME _____

D.O.B. _____

ADDRESS _____

PHONE _____

EMPLOYMENT INFORMATION

AGENCY _____

ADDRESS _____

PHONE # _____

POSITION _____

GUARDIAN/CARETAKER (if different than parent)

NAME _____ ADDRESS _____ PHONE _____

EMPLOYED AT _____ ADDRESS _____

POSITION _____

OTHER PEOPLE IN THE HOUSEHOLD (adults and/or children) Y_____ N_____ IF YES, GIVE

| NAME | DOB | RELATIONSHIP TO VICTIM |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

INTAKE NOTE CONTINUED

OTHER SIBLINGS NOT IN THE HOUSEHOLD? Y_____N_____ IF YES, GIVE

NAME DOB WHEREABOUTS

_____ _____ _____

_____ _____ _____

TREATING M.D. ON INITIAL ER/OPD CONTACT_____PHONE EXT._____

ROUTINE HEALTH CARE PROVIDED BY_____

NARRATIVE DESCRIPTION_____

_____

_____

_____

IMPRESSION_____

_____

_____

PLANS (FOR CASE MANAGEMENT)_____

_____

_____

_____

LAB WORK

_____VDRL _____THAYER-MARTIN _____ACID PHOSPHATASE

_____UA _____URINE CULTURE _____GRAM STAIN

_____MOTILE SPERM

_____OTHER (SPECIFY):_____

SUSPECTED OFFENDER (NAME, AGE, RELATIONSHIP TO VICTIM):_____

_____

INTAKE NOTE CONTINUED

CHILD'S EXPLANATION AND RESPONSE TO INCIDENT (INTERVIEW):_____

_____

_____

_____

_____

_____

CARETAKER'S EXPLANATION AND RESPONSE TO INCIDENT (INTERVIEW):_____

_____

_____

_____

_____

_____

CHILD PREVIOUSLY KNOWN TO THE TRAUMA INDEX? _____Y_____N IF YES, GIVE

DATE OF ENTRY_____REASON FOR ENTRY_____

NOW ADDED TO THE INDEX?_____

CHILD/FAMILY KNOWN TO OTHER AGENCIES (IF YES, GIVE DETAILS)_____

_____

_____

POLICE CALLED _____Y_____N HOLD PLACED? _____Y_____N

NAME OF POLICE OFFICERS_____SEX OFFENCE DIV_____YOUTH DIV.

POLICE HEARING DATE AND TIME_____ADDRESS OF HEARING_____

_____

INTAKE WORKER_____

CASE COORDINATOR:_____DATE_____

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* | Date |
|---|---|
| | ___/___/___ |
| | ___/___/___ |
| | ___/___/___ |
| | ___/___/___ |
| | ___/___/___ |
| | ___/___/___ |

III. Case Consultations

| With* | Date |
|---|---|
| | ___/___/___ |
| | ___/___/___ |
| | ___/___/___ |
| | ___/___/___ |
| | ___/___/___ |
| | ___/___/___ |
| | ___/___/___ |
| | ___/___/___ |

IV. Case Closure
- A. Date: ___/___/___
- B. Reason:
  - ___unable to locate
  - ___family terminated against caseworkers advice
  - ___case transfered 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 Center
- C.P.C.-Child Protection Center
- PSY- CHMC Psychiatry
- Ad.Med.- CHMC Adolescent Medicine
- CHMC- 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

## 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 adu PE=peers; S=sibs) | |
| | | | 1 | 2 | 3 | 4 | Verbal aggres. | P A PE S |
| | | | 1 | 2 | 3 | 4 | Phys. agress. | 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. Explic. Lang. | P A PE |
| | | | 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 | Disturbed sleep | |
| | | | 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.

## CASE SUMMARY: CHILD SEXUAL ABUSE VICTIM ASSISTANCE PROJECT

Intake Worker: _____ Intake Date: _____

1. Name of Child: _____
2. Presenting Complaint: _____alleged sexual abuse _____G.C. _____sex play _____inappropriate sexual behavior _____other (_____)
3. Child Demographics:
   a) Date of Birth: _____
   b) Sex: _____male _____female
   c) Racial or Ethnic Group: _____white _____black _____Spanish Speaking or Surname _____other (_____)

* Complete questions four through sixteen for sexual abuse cases only*

4. Initial basis of suspicion: _____observed by someone _____evidence, confirmed by child _____evidence, not confirmed by child _____victim told(relationship:_____) _____other(_____)
5. Date of last alleged incident: _____
6. Number of Alleged Offenders: _____
7. Are multiple incidents alleged: _____Y _____N
   If yes, over how long of a time span? _____
8. Offender Characteristics, if Known (Note: if multiple offenders are alleged, please enter the appropriate number in each category):
   a) Age(s): _____
   b) Sex: _____male _____female
   c) Relationship to Victim: _____(please be specific, e.g., friend, babysitter, step-father, maternal grandfather, etc.)
   d) Does the alleged offender physically live with the victim now? _____
   e) Did the alleged offender live with the victim at the time of the incident? _____
9. Location of last incident: _____victim's home _____offender's home _____home of third party _____out-of-doors _____other
10. What sexual acts are alleged to have occurred during this incident or series of incidents? (Note: mark all that were reported, indicating source of information with either a "C" for child, or an "A" for accompanying adult).

| Type of Activity | Victim Performed | Offender Performed | Reported By | Med. Evidence to Support (Yes or No) |
|---|---|---|---|---|
| Vaginal | | | | |
| intercourse | | | | |
| cunnilingus | | | | |
| manual | | | | |
| foreign object | | | | |
| Anal | | | | |
| intercourse | | | | |
| oral contact | | | | |
| manual | | | | |
| foreign object | | | | |
| Fellatio | | | | |
| Fondling of Genitalia | | | | |
| Exposure of Genitalia | | | | |
| Unspecific | | | | |
| Other (_____) | | | | |

11. Based upon all information available to you at this time, how likely do you believe it is that this child was involved in a sexual abuse incident?

| Not at all likely | Slight likelyhood | Fairly likely | Very likely |
|---|---|---|---|

12. Do you believe that the identity of the offender is known but is being witheld? _____Y _____N

13. In your opinion, to what extent did parental neglect or parental actions contribute to this incident?

| Not at all | Slightly | Moderately | Very Much |
|---|---|---|---|

14. In your opinion, to what extent was the child/victim a willing and active participant in the last reported incident?

| Not at all | Slightly | Moderately | Very Much |
|---|---|---|---|

15. What modes of inducing compliance did the offender use (check all that apply)?

_____ misrepresentation of moral standards
_____ bribery or verbal enticement
_____ reliance on adult authority
_____ non-physical threats
_____ threat of physical harm
_____ use of physical force
_____ other (_____)
_____ unknown

16. Based upon your interview with the parent, please circle the number which, in your opinion, most closely reflects their feelings on each of these dimensions at this time (if both parents were present, please complete for each, initialing each answer with either 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 toward 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 |

## MEDICAL SUMMARY FORM

PATIENT _____

INTAKE DATE _____

1. LABORATORY STUDIES SOURCE

| | | DATE_____ RESULT | DATE _____ RESULT | DATE _____ RESULT |
|---|---|---|---|---|
| (1) | TM CULTURE | | | |
| | VAGINA | | | |
| | URETHRA | | | |
| | THROAT | | | |
| | NASOPHARYNX | | | |
| | RECTUM | | | |
| (2) | GRAM STAIN SITE | | | |
| (3) | ACID PHOSPHATASE | | | |
| | VAGINA | | | |
| | RECTUM | | | |
| | OTHER | | | |
| (4) | MOTILE SPERM | | | |
| | VAGINA | | | |
| | RECTUM | | | |
| | OTHER | | | |
| (5) | NON-MOTILE SPERM | | | |
| | VAGINA | | | |
| | RECTUM | | | |
| | OTHER | | | |
| (6) | VDRL | | | |
| (7) | URINALYSIS | | | |
| (8) | PAP | | | |
| (9) | PREGNANCY TEST | | | |

2. MEDICAL FOLLOW-UP

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:

Child's Name: _____ Date: _____ Time: _____

Address: _____ Child's D.O.B.: _____

_____ Child's Sex: _____

Tel. No.: _____ Hospitalized: ___Y ___N

Parent's Name: _____ Hospital No.: _____
(or Legal Gaurd.)

Address: _____ Sex Branch Officer: _____

_____

Tel. No.: _____ Complaint No.: _____

Name of Accompanying Adult or Caller: _____ Youth Div. Officer: _____

Address: _____ Included in Trauma Index: ___Y ___N

_____

Tel. No.: _____ Intake Done By: _____

Relationship: _____ Caseworker: _____

E.R. Physician: _____

CHILDREN'S HOSPITAL NATION MEDICAL CENTER
PROGRESS NOTES

Patient's Name _____

PATIENT STAMP (ADDRESSOGRAPH PLATE)

| S Subjective Findings | O Objective Findings | A Assessment | P Plans | Resident/Attending Comments |
|---|---|---|---|---|
| | | | | |

(Please write on back of this page)
( if information is to be continued)

#658(Rev.3/75)

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 |

SEX ABUSE PROJECT
CHILD PROTECTION CENTER
DIRECTORY OF INVOLVED PERSONNEL

Name of Child_____ D.O.B._____ SEX_____

Ethnicity_____ Hospital Number_____

| PERSONNEL | NAME | TELEPHONE | ADDRESS (If necessary) |
|---|---|---|---|
| At Children's Hospital: | | | |
| Case Coordinator..... | | | |
| ER/OPD Physician..... | | | |
| Ongoing Physician..... | | | |
| Nurse OPD/ER..... | | | |
| Primary Nurse..... | | | |
| Social Worker..... | | | |
| Therapist - CPC..... | | | |
| Psychiatric Department. | | | |
| Psychologist..... | | | |
| Other: | | | |
| US Attorney..... | | | |
| Patient's Attorney..... | | | |
| Parent's Attorney..... | | | |
| Corporation Counsel.... | | | |
| Court Social Worker/ PO Worker..... | | | |
| Police Officers | | | |
| Sex Offense..... | | | |
| Youth Division..... | | | |
| Protective/Family Services | | | |
| Visiting Nurse/PHN..... | | | |
| School Contact..... | | | |
| Shelter Care..... | | | |
| Forensic Psychiatry.... | | | |
| Foster Placement..... | | | |
| Previous Medical..... | | | |
| Previous Mental Health. | | | |
| Other Family Members... | | | |
| Other: | | | |

JNT/bsh

children's hospital
national medical center 111 MICHIGAN AVENUE, N.W. WASHINGTON, D.C. 20010 • (202) 745-
DEPARTMENT OF CHILD HEALTH AND DEVELOPMENT, GEORGE WASHINGTON UNIVERSITY
CHILD HEALTH CENTER • RESEARCH FOUNDATION OF CHILDREN'S HOSPITAL

HOSPITAL RECORD RELEASE AUTHORIZATION

To: Children's Hospital of the District of Columbia

I, _____, do hereby declare that I am the _____ of _____
(Relationship) (Patient)

that I am the nearest relative and am legally responsible for the release of information with regard to said patient and that I do hereby request and authorize Children's Hospital of the District of Columbia to give, orally or in writing to:

_____

at _____
(Address)

upon request, information contained in any or all of the Hospital's medical records pertaining to said patient, including data regarding venereal diseases, if present.

Signed_____

Address_____

Date_____ Chart Number_____

Witnessed by_____

Official position_____

#150

children's hospital
national medical center 111 MICHIGAN AVENUE, N.W. WASHINGTON, D.C. 20010 • (202) 745-5000
DEPARTMENT OF CHILD HEALTH AND DEVELOPMENT, GEORGE WASHINGTON UNIVERSITY
CHILD HEALTH CENTER • RESEARCH FOUNDATION OF CHILDREN'S HOSPITAL

CHILD PROTECTION CENTER

AUTHORIZATION TO RELEASE MENTAL HEALTH INFORMATION

I Authorize, _____

Title: _____

to release to _____

Title: _____

the following information: _____

_____

_____

regarding: _____
(Indicate "Myself" or name of patient)

I understand that I have the right to inspect my record of mental health information.

I understand that I have the right to revoke this authorization.

Name of Patient: _____ Date of Birth _____

Address: _____
(street) (city) (state) (zip)

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian*: _____

Date: _____

* A parent or guardian must sign on behalf of all clients under the age of 18.



children's hospital
national medical center 111 MICHIGAN AVENUE, N.W. WASHINGTON, D.C. 20010 • (202) 745-5000
DEPARTMENT OF CHILD HEALTH AND DEVELOPMENT, GEORGE WASHINGTON UNIVERSITY
CHILD HEALTH CENTER • RESEARCH FOUNDATION OF CHILDREN'S HOSPITAL

Date _____

To: _____

_____

_____

Re: _____
Last Name First Name

_____
Address

_____
Date of Birth Ch.Hosp.No.

_____
Dates of your treatment

_____
Mother's Last Name Maiden First

_____
Father's Last Name Middle First

The above named patient has been brought to Children's Hospital for care. We would appreciate your sending us in the space below a summary of your findings including dates under your care, diagnosis, treatment, and recommendations. We are sending a duplicate copy for your files.

This information is requested by _____

I hereby authorize _____ to release to Children's Hospital any medical information from my (my child's) records that they may request.

# APPENDIX I

Public Information Brochures

## COMMUNITY SUPPORT...

In order to maintain communication and cooperation with other agencies, the project has established a Community Advisory Council. This council consists of approximately two dozen members and includes representation from:

- Child Health Center Board, CHNMC
- District of Columbia Children's Coalition
- Government of the District of Columbia.
  - Department of Human Resources
  - District of Columbia General Hospital
  - Metropolitan Police Department
  - Office of the Corporation Counsel
  - Public Schools
  - Superior Court of the District of Columbia
- Medical Society of the District of Columbia
- Rape Crisis Center
- Sex Education Coalition
- The Psychiatric Institute
- United Planning Organization
- U.S. Department of Justice, U.S. Attorney's Office
- Women's Medical Center
- Area Citizens

The Community Advisory Council has three subcommittees:

- Medical/Legal/Mental Health Subcommittee
- Public Education Subcommittee
- Case Review Subcommittee

These subcommittees are responsible for reviewing project materials and advising project staff regarding problems and issues related to the care of sexually abused children.

## ALL CHILD VICTIMS OF SEXUAL ABUSE HAVE THE RIGHT...

- To be treated with respect and dignity, with an appreciation of their age and their emotional and intellectual maturity.
- To be protected from further abuse.
- To receive comprehensive medical and psychological services from sensitive, trained, child-oriented personnel at all levels of case management.
- To have the benefit of thorough and complete collection of evidence to enable court prosecution of the alleged offender.
- To be informed about legal responsibilities, including the possibility of pursuing a criminal or civil case.
- To have legal representation that supports and protects.
- To have access to assured continuity of care through child advocacy support services.

## FOR FURTHER INFORMATION...

If you are in need of services or have any questions about child sexual abuse or this project, call the Child Protection Center, Special Unit, at 745-5682. For night or weekend emergencies, call 745-3060.

This material was prepared with support from Grant #77DF-99-0066 awarded to Children's Hospital by the Law Enforcement Assistance Administration, U.S. Department of Justice.

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Children's Hospital National Medical Center
111 Michigan Avenue, N.W.
Washington, D.C. 20010
(202) 745-5682

1979

## ABOUT THE PROJECT...

The Child Sexual Abuse Victim Assistance Project is a special unit of the Child Protection Center of Children's Hospital National Medical Center (CHNMC). The project is supported by a grant from the Law Enforcement Assistance Administration, Department of Justice.

The primary goal of the project is the provision of medical, social, and legal support services to child victims of sexual abuse and their families. The children served by the project come from all ethnic, racial, economic, and social groups.

The primary concern of project staff is to protect the best interests of individual child victims and potential child victims. By understanding the individual needs and expectations of each child and each family and by understanding the family dynamics and the cultural variables involved, staff work to reduce the trauma of sexual abuse and improve services to child victims and their families.

## CHILD SEXUAL ABUSE IS...

The term child sexual abuse may refer to an incident of forcible sexual assault involving a child, or sexual contact between a child and another person in which threats, bribery, or similar methods are used to get the child to participate, or any sexual contact between an adult and a child. Any one of these acts or any combination of these acts constitutes sexual abuse of a child.

## CLIENT SERVICES...

All children 12 years and younger brought to CHNMC with a complaint of suspected sexual abuse are seen by project staff. Children with venereal disease may also receive project services. When incidents of sexual abuse are found to have occured in the District of Columbia, children are eligible for the full range of project services which include:

- Medical examination
- Laboratory tests
- Treatment for physical injuries
- Crisis intervention counseling
- Mental health services
- Assistance with the legal process
- Referrals to other health and social service agencies

Families of eligible children also may receive assistance from the project in the form of:

- Crisis intervention counseling
- Mental health services
- Assistance with the legal process

Project staff will provide consultation and make referrals for counseling and other services to any child or family who comes to CHNMC.

## PROFESSIONAL SERVICES...

A major objective of the project is to coordinate medical, legal, and social services in the District of Columbia for the benefit of child victims of sexual abuse and their families.

Project staff provide training for medical, social service , and law enforcement personnel involved in the care of these children. Case consultation to service providers, agencies, and institutions also is offered.

The commitment of project staff to improving care for victims of child sexual abuse is extended to all children in the nation. The staff is working to develop written training materials that can be helpful to professionals in other settings and other jurisdictions.

The problem of child sexual abuse is complex and has been virtually ignored for many years. Consequently, the project includes a research component that focuses on studying the issues involved and dispelling the myths that have grown up around this taboo subject.

The project staff is convinced that the best way to protect children from sexual abuse is to educate parents and other concerned members of the community. Staff is available to community groups for special presentations. Parent education materials may be obtained from the project.

A Message To Parents About:

# Child Sexual Abuse

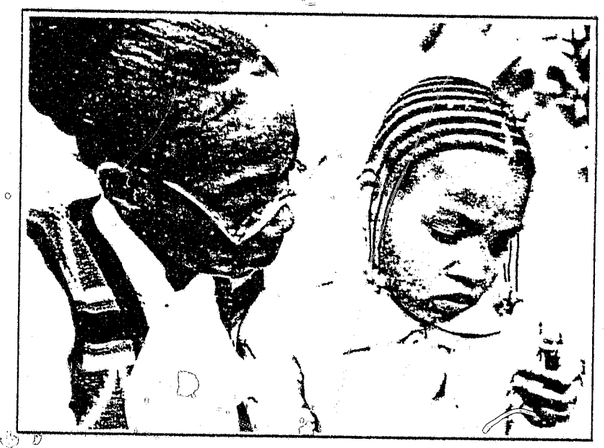
Prepared by:
Child Sexual Abuse Victim Assistance Project
Children's Hospital National Medical Center
Washington D.C. 20010

Joyce N. Thomas, R.N., M.P.H.
Project Director

# Foreword

When a child is sexually abused many parents become very concerned about their child's welfare. Parents want to be helpful, but unfortunately they are not always familiar with how to handle the problem or just what to expect from the agencies which become involved in handling their cases.

If parents of child sexual abuse victims can understand the problem and know what to expect, they will be better able to help their child feel and behave as well as they did before the incident took place.



Child Sexual Abuse Victim Assistance Project
Children's Hospital National Medical Center
111 Michigan Avenue, N.W.
Washington, D.C. 20010
202-745-5682

1979

# Parents Need....

Advice and information to help themselves understand and handle their feelings about what has happened to their child. This experience is usually upsetting and confusing to parents, too.

It is not easy to talk about the abuse with children, relatives or friends. But talking as if it was just another bad experience may help your child not worry as much.

It is important to remember that even though your child does not have major physical injuries, the experience of child sexual abuse can effect them emotionally.

Be patient, be kind, allow your child to express his or her feelings without prying. The sincere wish to understand and a positive attitude are very important to your child.

Never take the law into your own hands. Get help from your police officer, social worker, nurse, physician, minister or other professional.

# You Are Not Alone....

Each year thousands of children in the United States are victims of sexual abuse. In the District of Columbia alone, there are over 300 complaints reported to the D.C. Metropolitan Police Department each year.

Only one out of every ten cases is reported; therefore, it can be estimated that each year there are over 3000 cases of child sexual abuse in Washington, D.C.

# Behavior Changes In Sexually Abused Children....

The behavior of your child may change for a time.

Your child may be very upset.
Your child may have....
....disturbed sleeping patterns such as nightmares, fear of going to bed, fear of sleeping alone or bedwetting
....loss of appetite
....irritable nature and lose patience easily
....more temper tantrums
....the wish to withdraw from usual activities
....difficulty at school such as poor concentration, short attention span and loss of interest in classroom activities.

Some children are *not* changed by the experience, so don't look too hard for things that aren't there.

# How Long Do These Changes In Behavior Last?

They usually last a couple of weeks depending on the age of the child, the relationship of the child to the offender and the specifics of the incident.

The child's reaction depends very much on how the parents and other important people handle the situation. If the child feels loved, many problems can be avoided.

# What Preventive Measures Should Be Taken?

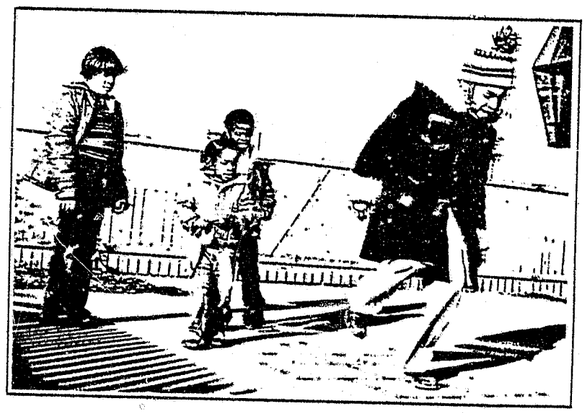
Have the names, addresses and phone numbers of your child's playmates available at all times.

Tell your child when you expect them to come from school and what play activities you will allow.

Tell your child that his or her body is private and to seek help immediately if *any person* attempts to do things to their body that they don't like.

Caution your child against playing alone in isolated places.

Tell your child how to reach you or another adult in cases of emergency.



# What Should Be Done To Help Your Child?

Regardless of the situation, never blame your child for what has happened. Help your child understand that you are not angry with him or her and that he or she did nothing wrong. Let your child know that you are concerned about their feelings.

Seek information and advice from your police officer.

Follow the instructions of the police and hospital staff. It is important to know when and where to bring your child for return appointments. Always ask questions if you are not sure you understand what you have been told.

Answer your child's questions to the best of your ability.

Don't pressure your child to talk about the experience. However, if the subject comes up, discuss it honestly and openly.

Try to return to your family's usual activities as soon as possible.

Respect the privacy of your child; don't tell a lot of people about the abuse.

Avoid becoming "over protective" of your child.

Give your child and other children in your home safety information. But, make sure to avoid making them more afraid of people than they already are. They should know that although there are some bad people to watch out for, there are also a lot of good people around.

Work out *your* feelings with someone you trust, such as a friend, a relative or professional counselor.

Be honest with your child as much as possible. They need to trust you more than ever at this time.

# What To Expect At The Hospital....

When a child has been sexually abused, it is necessary to have proof that the incident did take place.

It is important to take your child to the doctor to make sure he or she has not been seriously injured or contracted an infection.

Therefore a sexually abused child should have a complete physical exam by a doctor as soon as possible after the incident occurs.

The doctor will examine your child, fill out a legal report and do certain lab tests which may be used as evidence in court.

The doctor will ask you what has happened in order to decide what type of lab test must be done.

Most children who are sexually abused are not seriously injured physically. However, if they have been injured in any way, the doctor will tell you how to care for them.

It is usually necessary to have a second medical appointment in two weeks to make sure new problems have not developed.

The doctor or nurse will call a specially trained person from the *Child Protection Center* to speak with you and your child.

The Child Protection Worker will answer any question you may have and help you and your child talk about the experience and what to expect at the hospital or in the court.

The Child Protection Worker will meet with you to make sure there are no serious emotional problems for you and your child as a result of this experience.

# What To Tell A Child About The Police Interview....

A police detective from the Sex Offense Branch will ask you and your child questions about what happened.

The police should know what happened, where, when and who else was present at the time.

This information will help the police officer to decide what to do next.

It is important for the police officer to talk with your child alone.

Usually the child's statement is taken again at the police station and typed up to take to court.

The police may ask your child to look at pictures of suspects and to tell what the person looks like.

The police will ask questions about the person, like who he or she is. The police will ask if the person is known to you or your child, and if he or she is a relative.

It usually takes a while to get all the details that are needed. Be patient and try to help your child by remaining calm.

The detective may ask your child and you to go with him or her to get an arrest warrant from a judge.

# What You And Your Child Can Expect At Court....

If a person is arrested, your child may have to go to the courthouse to speak with the prosecutor. The prosecutor must decide whether or not to file charges against the person who is accused of abusing your child. The prosecutor will review the results of the medical examination and lab tests; he or she will also look at the typed statement your child gave to the police and other information about the incident.

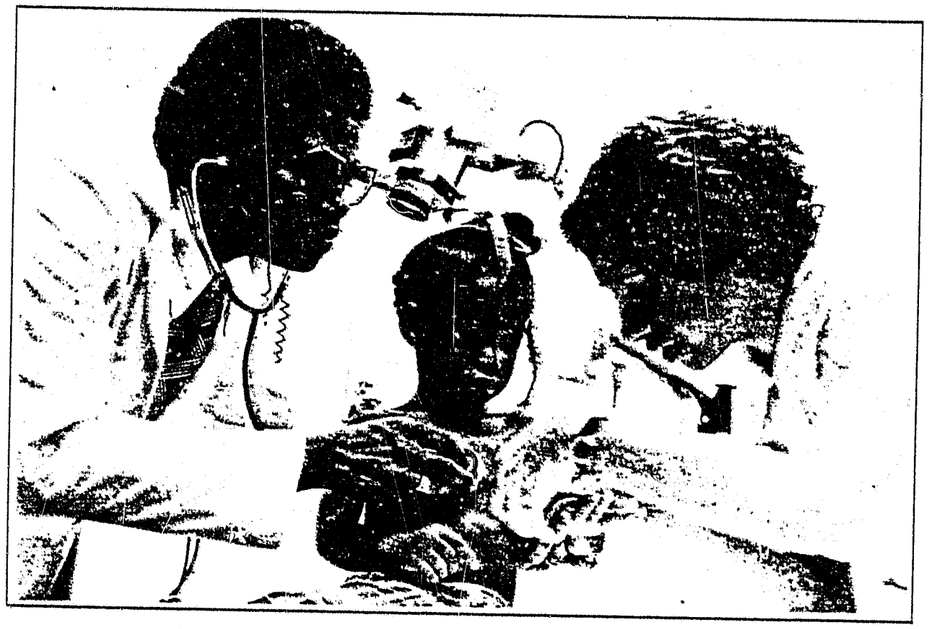
You may be asked if you want to press charges. If you press charges, a judge will decide if the person who abused your child should be kept in jail until the day of the trial, or released until then.

If you or your child must go to court, you will receive a "subpoena." The subpoena will tell the date, time and room where your child must appear.

The person who abused your child may hire a lawyer. This lawyer may want to talk to your child or you before the trial date. *You and your child do not have to talk to this person;* you can if you want to.

If the person who abused your child says he or she is guilty, you and your child will not have to go back to court anymore. If the person who abused your child says he is not guilty, your child should be prepared for the trial. It may take several months from the time an arrest is made until your child may have to go to court for the trial. After the trial is over, you will not have to go to court any more.

When you go to court with your child, take along a quiet toy, coloring book or something to keep your child busy during the long wait.



# What Is Child Sexual Abuse?

Since childhood sexual curiosity is normal, it is important to understand what is meant by child sexual abuse.

In the broadest sense of the term, child sexual abuse may refer to any situation of forcible sexual activity involving a child 16 years old or younger or

...sexual contact between a child and another person in which threats, bribery, or similar methods are used to get the child to participate or

...any sexual contact between a child and an adult or

...sex crimes against children such as rape, fondling, incest, molestation, exhibitionism, sodomy, childhood pornography and child prostitution.

The victim can be found in all social and economic levels and in all ethnic groups.

# Who Are The Offenders?

The offenders come from all economic and ethnic groups and a variety of social backgrounds.

Most children (both boys and girls) are sexually abused by people known to them or members of their family.

Some children are abused by members of their family.

A few children are abused by complete strangers.

**For Additional Information Contact:**

**For Additional Information Contact:**

_____ _____

**Child Protection Worker** **Phone Number**

**Child Sexual Abuse**
**Victim Assistance Project**

**Children's Hospital National Medical Center**
**111 Michigan Avenue, N.W.**
**Washington, D.C. 20010**

**Other Community Agencies:**

_____

_____

_____

Children's Hospital National Medical Center
Washington, D.C.
This brochure was made possible through
Grant #77DF-99-0066 from the Law Enforcement
Assistance Administration.

END