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FROM VICTIM TO SURVIVOR, WITH YOU IN THE PROCESS

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PRRCC Program Description

The program has its origin in the 70's when a group of women claimed for services that would respond to the needs of rape victims. They moved the public opinion with strength moving legislatures to produce the Joint Senate Resolution #2471, may 30 of 1976, which creates the *Centro de Ayuda a Víctimas de Violación*. It was initially located in the University of Puerto Rico School of Medicine, transferred later on to the Department of Health.

RCS # 2471 has the following assignments:

- Immediate medical and psychosocial services
- Prevention, treatment and rehabilitation services
- Data collection useful for grants and proposals
- Problem analysis for legal reform
- Establish safety campaigns
- Educate for community attitude modification around victim issues
- Collaborate with the Commission of Women's Affairs

As is other efforts, the budget assigned was meager when related to the tasks to fulfill. Since then our budget has changed from \$75,000 to \$500,000 in the 90's to what it is now, seven years later and four more offices, to around \$1,500,000. Our Budget is some from the local government but mostly federal, and is still insufficient.

PRRCC Program Location

Puerto Rico is composed by a group of islands. Its mayor dimensions are 100 x 35 miles with a population of 4 million. Its people are American citizens under a Commonwealth Government related to the United States of America.

The PRRCC Central Office is located in the metropolitan area of San Juan. The other offices are located in Caguas, Arcibo, Mayaguez and Ponce. These are the biggest and largest in population cities, covering the north, west, central and south. The office for the east and adjacent islands, Fajardo, is in the process of opening. All the offices have facilities that are private, safe and confidential. Public transportation and parking is available.

The Central San Juan Office has a Specialized Library for references, research and consultation for students and professionals. It also has a conference room for training, case discussions and interdisciplinary interagency meetings.

PRRCC Program Organization

The PRRCC is organized in Task Units and in Offices, each with their respective Coordinator. Some professionals have permanent positions, others have different hours contracted. Our working hours is the usual government range from 8AM - 4:30PM, including lunch hour. There are exceptions to these hours: prearranged psychosocial services, help line of 24 hours, prearranged educational activities, meetings with community programs, and governmental agencies, and situations in process.

Each Coordinator supervises the work done, facilitating them, intervening when necessary and has a monthly meeting with the Director and Sub Director. Each Office has a monthly administrative meeting and a weekly interdisciplinary case discussion meeting. Once a month there is a Vicarious Trauma meeting.

Relevant Experiences

Some of the experiences that have marked our way are the following:

- The opening of the PRRCC brought an unexpected but not surprising reality, that there the needs are for more complex and diverse than thought. Sexual assaults were more frequent than known, affecting also children, adolescents and men. Rape was only one of the many sex crimes for which victims needed specialized services. From then on, the PRRCC opened its doors to anyone surviving any type of sexual assault.
- Being part of a government agency with its changes in Public Policies and budget priorities has an effect, sometimes negative sometimes positive. Associated to this there has always been an acceptance that the impact of sexual assaults merits the use of public funds. Its continues growth has been a commitment of the group of women and community programs who gave it birth. Some of the mayor benefits of being in the Health Department is the access to all the Hospitals, requirement of protocol compliance, the administrative support, access to other Government Agencies and collaboration in the making of Public Policy towards the goal of the well-being of the victim.
- The gradual opening of the Offices throughout the island since 1996 has shown us the needs are even more than previously thought and more complex. This means we need to individualize the services according to the particular needs in different regions of the island.
- Our work experiences have evidenced that an effective and efficient intervention requires an interdisciplinary interagency community intervention. From the needs assessment to the intervention agreed, all need to pursue the same goal, the victim's welfare.
- As time has passed we have been able to include professionals trained in violence intervention without losing the community perspective. We consider ourselves a Specialized Intervention Center.
- Our frequent participation in the Legislature is due to our being part of the Department of Health. This allows us to participate in Public Policy. Since 1994 we have presented our opinion in over 40 pieces of legislature, which most have taken into account our opinion and our recommendations.
- When the PRRCC opened, everyone did a little of everything. We created the Work or Tasks Units to be more efficient and effective. These are Administrative, Clinical Services, Social Work, Education, Statistics, Help Line, Volunteers, and Interagency. Each Unit has its Coordinator who supervises the work, facilitating

them and intervening when necessary. The Units have monthly meetings for announcements, procedure and case discussions. The Unit Coordinators have a weekly meeting with the Director and Sub Director.

- The Interagency Unit was the last one to be created. Its main goal was to structure the interagency work being done. This Unit receives all concerns with regards to agency services to survivors brought to us by our own personnel or by other agencies or community programs. There is an Interagency meeting every three months, provides a training and discusses cases to find the most effective and efficient way to provide services as a team. It's a forum where we can openly talk and look for solutions. All discussions are directed to how and what needs to improve.
- The PRRCC participation in the Community Coalition Peace for Woman Coordinator and likewise their participation in the Interagency meetings provides continues feedback so the work maintains its course in benefit of the survivor.
- The 24 hour Help Line joined, about two years ago, the Health Department Interactive Line in which we appear as the first option of the menu. It provides a free long distance access and educational menu for those persons that are not ready to talk to someone, what to do in case of assault and where to get help.
- Accessing grants is a difficult but one of our routine tasks. The bigger ones, outside of the Health Department, are: FORSSA *Fortalecimiento de Servicios de Salud a Sobrevivientes de agresión Sexual y Violencia Doméstica* (reinforces the monitoring of hospital services to victims, adjacent islands and the Units); PIC *Proyecto InterDisciplinario Coordinado: De Víctima a Sobreviviente* (allows to contract professionals for the Offices in the Island); INTERSERV Interagency Services in Cases of Sexual Assault and Domestic Violence (allows the monitoring and educational needs assessment of the health professionals); LA *Línea de Ayuda a Sobrevivientes de Agresión Sexual* (provides services beyond regular government hours).
- The inclusion of services for survivors through the Health Reform is evidence of violence being considered a health issue. Reimbursement includes time spent at court.

Difficulties

There is still a lot to do. Our difficulties are similar to those of other programs. The mayor one is not having a *budget* consistent with the needs. It seems that while more services are given more are needed. We believe this is due to we haven't reached a level close to reality. This makes us have to look continuously for new possibilities even if it means changing strategies. Grants should be a help not *the* help, should last at least 2 years.

Another difficulty is the lack of *human resources* with knowledge, skills and commitment. To work with violence everyday takes a great toll on the professionals which already has cost a lot to train. The PRRCC has to be competitive with the work market. The majority of our professionals are contracted for some hours, no security and no benefits.

Being part of a *Government Agency* can be a disadvantage when the Chief of the Agency does not have violence as a priority. In our case we have been fortunate because violence has been visualized as a public health problem and that interdisciplinary interagency intervention is the principal strategy endorsed.

The services provided has many differences from other health issues. *Statistical evidence* of the diverse needs and complex interventions interagency wise are crucial to know the magnitude of the problem. This has been very difficult because each Agency has different objectives and priorities. We have been since last year trying to develop a system that would serve all the Agencies.

Even though everyone agrees the strategy is interdisciplinary interagency, it has been a long road. The Interagency Team we have has helped but there is still much more to do. It is time that the *Professionals Schools* teach this as the principal strategy once the own discipline is clear on how to intervene. Fragmentation of the interventions in violence is a sure way to perpetuate it.

The Team is a good strategy but needs consistent participation. Different professionals at different meetings makes it difficult to carry out analysis with follow up. We are working to get the endorsement for the same representative at the meetings.

Achievements

Among our most significant achievements:

1. Protocols for the Intervention with Survivors of Sexual Assault 1984
 - Last revised distribution since 1997: 124
 - Each recipient agency copies and distributes to its own professionals
2. Protocols for the Intervention with Survivors of Domestic Violence 1998
 - Distribution since 1999: 64
 - Each recipient agency copies and distributes to its own professionals
3. Legislature presentations since 1994: 49
4. Media Educational Campaign: Theaters, TV, Radio, Newspaper Advertisements, Posters, Newspaper supplements
 - More than \$450,000 were used
5. Two videos were produced related to health professionals intervention in cases of sexual assault and domestic violence with the cost of over \$55,000 using a known reporter.
6. Educational fora related to the media were given:
 - Victim confidentiality and the media
 - Victims rights' in the media and to use them
 - Advertisement Impact and to handle it
 - Sexual harassment: reality today
7. Participate in the National Coalition Against Sexual Assault, allowing us to share with other similar programs and refer clients among us.
8. Interagency Protocol Trainings:
 - 1998 / 2 act / 97 participants
 - 1999 / 1 act / 79 participants
 - 2000 / 5 act / 175 participants
 - 2001 / 1 act / 25 participants
9. Interagency Interdisciplinary Seminar: presented in 1996; participation included social workers, psychologist, police, district attorney, forensic pathologists, victim advocates, shelters and others. We learned how to work together.

Assignment Results 1999

1. 2,316 calls through the 24 hour Help Line.
2. Social Work and Clinical Services Units provided 199 crisis interventions.
3. Clinical Services Units provided 3,161 individual therapeutic sessions.
4. Clinical Services Units provided 221 group therapeutic sessions
5. 3,629 interagency coordinations were done.
6. Social Work Unit personally assisted in different agencies by going and advocated 233 survivors.
7. 1,343 orientations were provided through the Help Line.
8. The educational activities impacted 10,373 persons in the communities.

9. 4,225 students of elementary, intermediate and high school were impacted by educational sessions on the prevention of sexual assault .
10. 15 Hospitals only reported 55 months of the 180 months that they are supposed to. Of these 459 survivors were seen within the emergency period of 7 days. If all the months had been reported, an estimated total of victims within 7 days would be 1,043 .
11. The PRRCC intervened personally with 318 new cases: of these 205 were women younger than 12 years old, 77 were older than 12 and 36 males.

Interagency Meetings

It is important to point out that the Interagency Team has changed over the years. The number and diversity of participants has grown as its own members determine that it should:

1. 1995 / 4 agencies
2. 1996 / 10 agencies
3. 1997 / 13 agencies
4. 1998 / 13 agencies
5. 1999 / 14 agencies
6. 2000 / 15 agencies
7. 2001 up to 6/2001 15 agencies.

The Agencies are: Hospitals, Police Sex Crimes Division, District Attorneys, Victims and Witness Program, representatives of Community Programs, Family Department, Social Services Emergency Program, Mental Health Department, Health Insurance Companies, Courts System, Department of Health Programs, Institute of Forensic Sciences, Department of Education, Legislative Advisors, Executive Advisors and others.

In January 2001 we assessed the opinion of the Teams participants (30) about certain aspects of the team:

1. 66% of the participants are women.
2. The age range in greater proportion, 33%, was 41 - 50.
3. The majority of the participants are more in the administrative area than in direct service, 60 vs. 40%.
4. Most of the participants have been 14 years in their agency with 12 years of these working with victims.
5. The majority of persons participate in educational programs with 73% to communities, 56% to professionals and 53% to agencies.
6. The turn over in the assistance to the meetings is evident when the participants state they have gone to 29% of the meetings.
7. 96% of the participants believe the Team should continue.
8. The Team has more strengths than weaknesses, 93% vs. 33%.
9. 90% of the participants report that the Team has helped them while 83% says they have used the services the Team offers.

Protocol Use Monitoring

Many places only have estimates of cases of sexual assaults. The FBI tells us that only 10 – 30% of the cases are reported. In Puerto Rico, even though we know more than before, the true magnitude is unknown. In 1994 we surveyed finding more than 800 cases of sexual assault in Hospitals and more than 1600 in the Police. The number of survivors reported depends on the Agency reporting.

The Health Department has two mechanisms that can provide the number of cases of sexual assault that have occurred and been reported within seven days. These are the Protocols mentioned before which Hospitals have to comply with in order to have their License. These Protocols were revised and written with an Interagency perspective such that the needs of the survivors and agencies are met.

In spite of these efforts, the Interagency Team continues to complain that the services are slow, difficult, incomplete and revictimizing. This has a negative impact on the survivor's well-being and in the Agencies help process. Close to 50% of our clients have not had a medical exam before coming to us. There was a definite need to supervise the services in the 66 Hospitals but we had no resources to allocate this task.

We elaborated a procedure y obtained in 1999 a grant from the Office of Women's Affairs, Governor's Office. This procedure has three mayor areas:

1. Inspect physically the area where exams are taken place:
 - In 1999 we visited 40% of the Hospitals (27/66)
2. We assessed the knowledge health professionals had of the Protocols:
 - We received 281 questionnaires answered
3. Review chart documentation and differences with the Protocols:
 - 104 charts were reviewed

Hospital Service Monitoring Findings

Criteria evaluated:

1. Appropriate physical facility: 88% had an adequate area (private, confidential and safe).
2. Rape forensic kits availability: 74% had them in places the health professionals knew.
3. Protocols availability: in 66% of the Hospitals professionals had access.
4. Data registrar: found in 11% of the Hospitals.

Professional Protocol Knowledge Monitoring Findings

% of Professionals with specific knowledge:

1. 3%: know when to give sexually transmitted diseases prevention in cases of sexual violence(SV); who is responsible in the Hospital to evaluate an adult and a minor victim of SV.
2. 6%: know what lab tests are done and which need to go to the lab in SV; when to do the exam of a SV survivor who reports after seven days of the assault; which are the diagnosis most used in cases of SV.
3. 8%: know when a minor surviving SV should be evaluated.
4. 20%: know the treatment to prevent Sexually Transmitted Diseases in cases of SV; what tests are included in the rape kit examination.
5. 26%: know where to refer cases of minors suspected of SV; what are the parts of the physical exam in cases of SV; what labs need to be repeated after two weeks of the initial evaluation.
6. 41%: know what tests need to be repeated after 12 weeks of the initial evaluation; when to do the exam of a survivor that reports the SV within 7 days of the assault.
7. 52%: know what are the parts of a forensic exam in cases of SV and domestic violence; that a police report can't be required to provide services to a survivor
8. 55%: know there is a need for a written consent before intervention is done; what are the physical indicators of domestic violence.
9. 60%: know when to utilize a rape kit.

10. 68%: know what are possible emotional indicators in cases of SV and domestic violence.
11. 80%: know when to examine a SV survivor that accesses a Hospital within 7 days of the assault.
12. 93%: know there is a need to refer survivors to the Hospital Social Worker; when and where to give follow up to the emotional needs of a survivor.
13. 95%: know there is a law that requires to report cases suspect of child sexual abuse.

Chart Protocol Monitoring Findings

Chart observations:

1. The interventions differ from the protocol in the history (health, social, family, past, developmental capacity, others) and in the physical exam (general and genital).
2. 88% have some kind of forensic documentation (what, who, when, how, where)
3. 49% of the survivors had been referred to the PRRCC.
4. The diagnosis used are not consistent with a forensic evaluation. Some terms used are "virgen", "no signs of rape", "intact", among others.

Conclusions of the Findings

We don't know the magnitude of the problem and were not even close. 89% of the Hospitals don't even have a data registrar system. Institutional factors that can impact negatively the services include not having available in 1/4 - 1/5 of Hospitals the rape kit or the protocols to read, revise and consult. The average professional knowledge of the protocols is around 42%. This explains why the Team continuously brings concerns. The charts certainly impact the ability to follow up and to prosecute the cases. When one part of the Team fails, we all fail.

Recommendations

Hospital services to victims need to be continuously monitored. Professional schools need to reevaluate their curriculums and professional organizations need to include violence, its different manifestations and interventions as part of their continued education programs. Budget assignments need to correspond to needs.

Community Programs and Government Agencies need to come together such that their goals meet, from different perspectives, towards one, the well being of survivors of violence, health protection and violence prevention.

Violence

*If we don't accept that violence exists
If we don't know how to detect it
We won't find it ...
And we'll be part of the problem*

Suzanne Sgroi