Victim Confidentiality on Sexual Assault Response Teams (SART)

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Article

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Abstract

The purpose of this study is to examine how professionals and paraprofessionals involved with a Sexual Assault Response Team (SART) understand and navigate different professional statutory requirements for victim confidentiality. Telephone surveys are conducted with 78 professionals: medical (27.8%), criminal justice (44.3%), and victim advocacy (27.8%). The majority of participants (58.2%) disagree with the statement that maintaining victim confidentiality posed a challenge to coordination on SART, 10.1% were neutral, and 31.7% agreed with the statement. Significantly more victim advocates than criminal justice and medical professionals perceive that maintaining victim confidentiality posed a challenge to coordination on SART. Consensus on how best to conceptualize victim confidentiality within SART has not been attained. Findings show that not all criminal justice and medical professionals understood the statutory provision of privilege to communications between rape crisis victim advocates and victims. Implications for practice and research are discussed.

Keywords

multidisciplinary team, interagency collaboration, rape

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Sexual assault is a significant social problem, affecting between 1 in 6 to 1 in 8 women in their lifetime (Kilpatrick, Resnick, Ruggiero, Conoscenti, & McCauley, 2007). Sexual victimization is associated with multiple long-term physical health, mental health, and social-functioning problems (Boudreaux, Kilpatrick, Resnick, Best, & Saunders, 1998; Burnam et al., 1998; Dickinson, deGruy, Dickinson, & Candib, 1999; Faravelli, Giugni, Salvatori, & Ricca, 2004; Golding, 1999; Golding, Wilsnack, & Learman, 1998; Kimerling & Calhoun, 1994; Koss, Heise, & Russo, 1994; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). Inadequacies and limitations of the medical system's, criminal justice system's, and advocacy organization's traditional responses to victims, such as insensitivity to the victim, poor forensic collection, insufficient medical care, and not addressing all of the victim's needs, have been noted in the literature (Campbell, 2005; Campbell & Bybee, 1997; Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; George & Martinez, 2002; Spohn & Holleran, 2001; Taylor, 2002; Ullman, 1996). Traditional responses from the medical systems, criminal justice system, and victim advocacy organizations have been in opposition to each other at times (Martin, 2005), resulting in conflicted and fragmented responses and allowing for many victims to "fall between the cracks" between service providers.

Sexual Assault Nurse Examiner (SANE) programs have been developed to simultaneously (a) provide comprehensive, timely care to victims to minimize trauma and to promote victims' use of community services, and (b) collect high-quality forensic evidence to facilitate investigation and prosecution of the offender (U.S. Department of Justice, 2004). Case reports from local SANE programs suggest that programs with interagency collaboration (e.g., victim advocates, law enforcement, prosecutors, and other medical providers) may increase the ability to address the simultaneous goals of victim treatment and forensic evidence collection (Selig, 2000; Smith, Holmseth, Macgregor, & Letourneau, 1998). In fact, many communities have developed formal teams, Sexual Assault Response Teams (SART) and Sexual Assault Task Force (SATF) or Sexual Assault Interagency Councils (SAIC), to coordinate responses of the medical system, criminal justice system, and victim advocacy organizations to sexual assault victims. Typically SARTs are comprised of a SANE, law enforcement officers, and a rape crisis victim advocate who respond when a sexual assault victim reports the crime to either the hospital or law enforcement. Sexual assault task forces and interagency councils involve the same players with the addition of prosecutors and some other community service providers who meet regularly to coordinate services and to problem solve (Kentucky Association of Sexual Assault Programs [KASAP], 2002; U.S. Department of Justice, 2004). The Violence Against

Women Act (VAWA) supports coordinated community responses to sexual violence because they are believed to be more responsive to victims by providing more comprehensive care, minimizing victim trauma by providing support persons during a crisis period, and reducing the number of times a victim must recount the sexual assault to professionals. VAWA also supports coordinated community responses because of benefits to the criminal justice system, such as facilitating the criminal processing of the case through improved evidence collection, documentation, and communication between agencies (U.S. Department of Justice, 2004).

Some evidence suggests that conflicts between key players on SARTs, such as advocates, medical providers, and law enforcement may occur (Cole & Logan, 2008; Crandall & Helitzer, 2003; Hatmaker, Pinholster, & Saye, 2002; Martin, 2005; Riger et al., 2002). The process of professionalization socializes individuals to have strong allegiances to their own profession (D'Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005; Waugaman, 1994). Hall noted that different professional values may be an obstacle for collaboration; one of these differences involves the degree of importance different professions place on client confidentiality (Hall, 2005; Ovretveit, 2000; Reese & Sontag, 2001).

Problems may occur on teams when professional groups operate under different confidentiality policies (Ovretveit, 2000). The scope and limits of confidentiality with each responder are to be explained to the victim during the informed consent process, and each SART member should have a thorough understanding of the scope of confidentiality each responder has (U.S. Department of Justice, 2004). Even though health care professionals, including nurses, are mandated to uphold patient confidentiality, SANEs who conduct a forensic examination on a victim whose case is reported to law enforcement share information gathered from the victim and in the process of collecting evidence with law enforcement and prosecutors (U.S. Department of Justice, 2004). Information that criminal justice professionals collect during their investigation becomes part of the criminal justice record, which is shared with law enforcement personnel and prosecutors working on the case. This may be available to the defense through the discovery process.

More than half of the states in the United States have statutes that give privilege to communications between victims and victim advocacy personnel (U.S. Department of Justice, 2004), even when discussing cases with other professionals on the SART (Littel, 2001). These laws represent the societal belief that by not granting privilege to communications between rape crisis advocates and counselors more harm is done to the counselor–victim relationship than benefits litigation (U.S. Department of Justice, 1995). Without an

assurance of confidentiality between victim and counselor/advocate, victims may avoid using the counselor/advocate's services, and the counselor's disclosure of information that a victim provided undermines the trust that is necessary for a beneficial therapeutic relationship (U.S. Department of Justice, 1995). No one but the victim has the power to waive privilege. Therefore, on many SARTs in the United States, team members operate under different statutory requirements for treating their communications with clients as privileged. Victim advocacy organizations may ask victims to sign a waiver to allow the organization to share information with other professionals on the SART; however, this is not typically done at the first response, but only after a victim seeks counseling or advocacy services after the medical forensic examination. For example, after a law enforcement officer, SANE, and victim advocate meet with a victim who receives a medicoforensic exam, they may confer with one another about the investigation; however, in states where advocate–victim communications are privileged, the victim advocate may not discuss with the other SART professionals anything that the victim told the advocate in confidence. The purpose of this study was to examine how professionals and paraprofessionals involved with SART understand and navigate different professional statutory requirements for victim confidentiality.

Method

Sample

The only three active SARTS with formal memoranda of agreement in the state, located in three different communities, were selected into the sample. The three SARTs began in 2000 or 2001. SART A covers 4 counties with an estimated population of 376,626 in 2006 (U.S. Census Bureau, 2007). Medicoforensic exams are conducted in two private, competing hospitals that worked out an agreement that their staff would act together under the umbrella of one SANE program. A total of 123 medicoforensic exams were conducted by SART A in 2006. The second site (B) is located in a metropolitan area with an estimated population of 270,789 (U.S. Census Bureau, 2007). The SANE program is located in the police department, and exams are conducted in the emergency department of a Level 1 trauma center. A total of 75 medicoforensic exams were conducted in 2006. The third site (C) includes a metropolitan area with an estimated population of 699,827 in 2006 (U.S. Census Bureau, 2007). Exam sites are in the emergency department of a Level 1 trauma center and in a nonprofit organization for individuals who are medically cleared to be seen outside of the emergency department setting and who

choose this location. A total of 170 medicoforensic exams were conducted in 2006. At all 3 sites, victims must be 14 years old or older and present for care within 96 hr of the sexual assault to receive the medicoforensic exam. The SART coordinators for each of the sites are the SANE program managers.

Survey participants were professionals identified within the three selected SARTs. A total of 88 possible participants were identified with key informant sampling, and a total of 78 surveys were completed between October 2006 and April 2007. Four individuals refused to participate and the remaining 6 were never successfully contacted or completed the survey. The response rate was 89%.

The sample was composed of the following percentages of individuals from the sampled professional groups: (a) 26.9% (n = 21) medical (e.g., SANE, medical director of SANE program); (b) criminal justice 44.9% (n = 35), including 24 law enforcement officers, 8 prosecutors, and 3 victim advocates in the prosecutor's office; and (c) 28.2% (n = 22) rape crisis victim advocates (e.g., staff members and volunteers). Victim advocates in the prosecutor's office were included in the group of criminal justice professionals because their comments indicated they were more closely aligned with prosecutors than with victim advocates in community-based agencies. Participants were from the following SARTs: SART A (44.9%), SART B (25.6%), and SART C (29.5%). About two fifths of the sample (39.7%) participated in interagency council (IAC) meetings. The majority of participants were women (82.1%). The sample comprised highly educated participants, with 46.2% reporting that their highest level of education was a bachelors degree, and 33.3% had a masters degree or other professional degree. Professionals reported a mean period of 11.5 years in their current profession. Participants reported working on sexual assault cases for a mean period of 8.8 years.

Procedures

The protocol for this proposed project was approved by the university institutional review board (IRB). Participants for the telephone survey were recruited with three strategies. First, names of possible survey respondents (e.g., SANEs, prosecutors, rape crisis center personnel, and law enforcement officers who attended the IAC meetings) were collected from each SART coordinator at onsite visits. Second, the researcher contacted the rape crisis centers in each community to inform them about the study and to solicit contact information of staff members and volunteer advocates who had recent experience working as part of a SART (within the past 3 months). This second strategy was used to elicit volunteer victim advocate names, because other professionals on the team did not name volunteer advocates. Third, at

the conclusion of each telephone survey, the researcher asked participants to provide the names and contact information of any other professionals who had recent experience working as a part of SART. New names were recorded and entered into the sampling frame. The researcher attempted to contact these referred individuals to tell them about the study and to ask whether they would be willing to participate in the telephone survey. No identifying information was written on the surveys.

Measures

Victim confidentiality as an aspect of professional role that may be an obstacle to collaboration was measured with two questions. The first item was a Likert-scale item developed by the researcher (1 = *strongly disagree*, 2 = *disagree*, 3 = *neither disagree nor agree*, 4 = *agree*, 5 = *strongly agree*): "Maintaining the confidentiality of victims poses particular challenges to coordinating care between professionals." This question was followed by an open-ended question asking participants who agreed with the statement to discuss the challenges, whereas participants who disagreed with the statement were asked to discuss why maintaining client confidentiality was not a challenge for SART professionals.

Data Analysis

Responses to the open-ended questions were analyzed using an iterative process of analyzing data into codes. First, coding began with the author reading all of the open-ended responses, then creating codes to capture the responses. Second, the codes were grouped into more abstract categories (Strauss & Corbin, 1998). Third, the author coded all of the open-ended responses to each question, modifying the codes and categories when ambiguity in the coding scheme was evident as it was compared to the data. Next, an undergraduate student independently coded 20% of the responses to each question from the telephone survey, using the codes and categories developed by the researcher. When the interrater reliability coefficient was less than .90 for any of the questions, the author and student discussed how to clarify the codes, and then the student independently coded a new sample of randomly selected cases, using the modified codes (see Figure 1). NVivo (v.2) software package was used to organize and manage qualitative analysis. First, categories were analyzed by group (i.e., the three SART programs), and the results were not statistically significantly different by program. Therefore, to render the results more easily interpretable

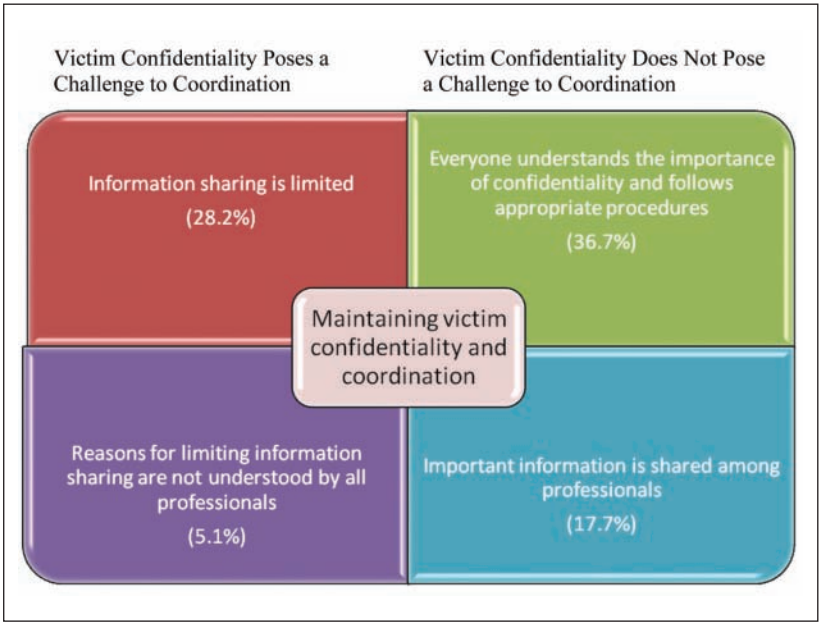

Figure 1. Matrix for explanations of the relationship between victim confidentiality and coordination between professionals

by readers, the results presented here are combined for all three SART programs. Bivariate associations of participants' professional group with the categories for responses to open-ended questions were analyzed with chi-square tests.

Results

The majority of participants (58.2%) disagreed with the statement that maintaining victim confidentiality posed a challenge to collaboration on SART, 10.1% were neutral, and 31.7% agreed with the statement. Even though the majority of participants did not believe that maintaining victim confidentiality posed a challenge to collaboration on the SART, the fact that nearly one third had concerns about confidentiality is significant. It was informative to examine individuals' explanations for why they believed this was the case, in addition to examining individuals' explanations for why they believed maintaining victim confidentiality did not pose a challenge to coordination

on SART. Figure 1 presents a matrix of the most commonly mentioned categories to the open-ended question about why or why not maintaining victim confidentiality posed a challenge to coordination on SART. Among those individuals who reported that victim confidentiality did not pose a challenge to coordinating among professionals, two categories were frequently mentioned as explanations for why this was the case: (1) Everyone understands the importance of victim confidentiality, and (2) maintaining victim confidentiality does not limit the information shared among professionals.

Significantly more medical professionals (61.9%) explained that confidentiality did not pose a challenge to coordination because everyone understood the importance of victim confidentiality (28.6% criminal justice and 27.3% victim advocacy), $\chi^2(2, n = 77) = 7.531$, $p < .05$. A shared and agreed-upon understanding of confidentiality was described by a detective, "We all understand the important of victim's confidentiality. We don't ask each other for information that is protected by the client's confidentiality." Even when there was a recognition that standards for maintaining victim confidentiality are not the same for all professions on the SART, agreement can be reached, as explained by a rape crisis staff member:

> Confidentiality is key to what we strive for. That is a key element of caring for clients and a matter of life and death in some cases. Even though other professions might not be as good at maintaining confidentiality, they understand why we treat it as so important.

One participant described some of the precautions that SART professionals took to protect victim confidentiality:

> The meetings are behind closed doors. Victims are discussed with individuals on a need-to-know basis only. Discussing cases with council members or other community members without identifying the victim or giving information that could lead to identifying the victim. People understand that identifying the victim is not good for the victim or prosecution.

Compliance with HIPAA (Health Insurance Portability and Accountability Act) laws was mentioned often by SART A professionals: "With HIPAA laws, everyone knows the rules and understands them. At first, we had to do some education to explain the regulations but now everyone gets it."

The second major category that explained why maintaining victim confidentiality did not pose a challenge to collaboration was that information

sharing is not limited among professionals. No victim advocates gave this explanation, whereas 28.6% of medical and 22.9% of criminal justice professionals gave this explanation, $\chi^2(2, n = 77) = 6.994$, $p < .05$. Some professionals stated that information is not limited among team members because they have the same requirements for confidentiality, as a prosecutor stated, "The people who are on our team are directly involved with the cases, so they are bound by the same level of confidentiality." A SANE explained:

> We always try to give victims a private area to talk to the advocate. If the advocate found out something that I didn't know, she would tell me and suggest I follow up with her [the victim]. I've never found an advocate say, "I can't tell you." If I found out something the victim forgot to tell the detective, I would call him to say, "She forgot to tell you something."

It is not clear from the previous statement whether any victim advocate actually shared information with the SANE without a signed waiver from the victim or if the SANE had misinterpreted victim advocates' actions. Even within the same SART, different professionals had different perspectives on what information could be shared with other team members. Common among advocacy professionals and volunteers was the assertion that all content the victim communicates to them in private is to be treated confidentially and is not to be shared with other team members, which is in accord with the state statute and notably in contrast to the belief expressed in the previous quote.

Significantly more victim advocates (66.7%) compared to other professionals (5.0% medical and 31.0% criminal justice) reported that maintaining victim confidentiality poses challenges to coordination, $\chi^2(2, n = 77) = 17.522$, $p < .001$. Among those individuals who reported that victim confidentiality did pose a challenge to coordinating among professionals, one category was frequently mentioned as explanation for the source of the difficulty: Information sharing is limited, with a subcategory that was mentioned by 5.1% of participants, not all professionals understand why information sharing is limited. A common scenario described in the primary category was that because victim advocates have a different statutory obligation to maintaining victim confidentiality than SANEs and criminal justice personnel, victim advocacy was perceived as a roadblock to information exchange that would help other professionals carry out their duties. A prosecutor's office victim advocate explained:

> Yes, it's frustrating. The rape crisis center has different goals than we do. You go into meetings with a confidentiality agreement (everyone has signed). When we work on cases at the case review, rape crisis center will say that they can discuss a specific case only if the victim has signed a waiver. That's a road block that hinders our examination and discussion of cases.

> Rape crisis being reluctant to share information with us. They just have a different mindset. They are so concerned with protecting victims they sometimes don't see the value of doing everything we can to put the rapist away. (Prosecutor)

And the same issue from the perspective of two rape crisis staff members:

> Yes, understanding the confidentiality obligation that exists for social service providers is a stumbling block to our collaboration. The SANE and criminal justice system have different obligations to clients than we do as social workers, social service providers, and they perceive our not discussing specific cases without a signed waiver from the client releasing us from this obligation is a hindrance to prosecution.

> From a rape crisis center standpoint, confidentiality is of paramount importance, and other agencies don't place as much importance on it. When we don't share certain information with them, they see that as resistant and us not being cooperative. The information tends to be opinions such as "Do you believe her story? Do you think this is the truth?" rather than factual information.

A few victim advocates described examples of law enforcement officers asking them to report what the victim said to them while the advocates were alone with the victim. Some victim advocates discussed that they did not think that other professionals understood or respected the counselor–client privilege. Thus, even though, overall, participants explained that maintaining victim confidentiality was not an obstacle to coordination on SART, different professional obligations for maintaining victim confidentiality had the potential to create conflict and tension among professionals on SART.

Discussion

Professionals' differing levels of obligation to maintaining confidentiality has been found in a small number of studies as a potential obstacle to

interprofessional collaboration (Darlington, Feeney, & Rixon, 2004, Darlington, Feeney, & Rixon, 2005; Ovretveit, 2000; Reese & Sontag, 2001). Professional differences in the understanding and statutory obligations to maintaining victim confidentiality were found in the current study. To be clear, none of the participants mentioned concerns of SART professionals breaching confidentiality with individuals who were not involved on SART. However, in Kentucky, similar to many other states, rape crisis workers and volunteers are treated as mental health providers and their communication with clients is viewed as privileged (Kentucky Revised Statutes Rule 506), whereas SANEs', law enforcement officers', and prosecutors' communications with victims are not privileged; in fact, their work products related to criminal cases are public record. The rape crisis centers have a protocol in place so that if a victim receives services after the initial medicoforensic exam, a victim may sign a waiver allowing rape crisis center staff to discuss the case with other SART professionals, such as at case review or IAC meetings. If the rape crisis center does not have a signed waiver, staff members are not allowed to even confirm that the victim sought services at the rape crisis center if the victim's case is discussed by other SART professionals at a meeting. In the current study, participants discussed limited information sharing on particular cases when the rape crisis center did not have a signed waiver. In these instances, client-level information exchanges were decidedly one-way, from other professional groups to victim advocacy.

Some professionals viewed the one-way information pathway as evidence of a lack of reciprocity, which engendered some frustration in other professionals, particularly in SART B. Victim advocates were aware of the frustration that other professionals felt, and several spoke of the lack of understanding or lack of respect that other professionals had for their statutory obligation, yet what was largely missing from the data was discussion of conflict resolution strategies to decrease the tension over the issue. Instead, participants with victim advocacy organizations indicated that they primarily confronted the issue by reiterating their statutory and ethical obligation to the victim. In this same community, case review meetings had not been held in over a year and a half. Reestablishing regular meetings could serve as a forum for discussing these differences; however, an attempt to reestablish regular IAC meetings without addressing the current tension over information sharing and victim confidentiality would likely increase the tension. Reciprocity is a key element to teams and the perception that reciprocity of information sharing was lacking on SART contributed to perceptions of diminished collaboration.

Sharing information is the most visible aspect of collaborative work (Darlington et al., 2004), and when there is a breakdown in information

sharing, there are detrimental ripple effects on the overall collaborative relationships. Unresolved tension about sharing information could reduce participants' willingness to engage in the SART process. Nonetheless, not all information can be shared between team members, given different statutory obligations for maintaining victim confidentiality. Strein and Hershenson (1991) discussed two extreme views on conceptualizing confidentiality on multidisciplinary teams: (1) to regard all counselor–client communication as absolutely confidential, and (2) to conceptualize a team as functioning as a corporate practitioner, allowing counselors to share information without restriction with all team members. The authors concluded that the most tenable stance probably lies somewhere in between these extremes, with counselors using the need-to-know rule to guide their decision making about what information to share with team members. The findings from the current study revealed that SART professionals expressed the range of these perspectives on victim confidentiality on SART. Consensus on how best to conceptualize victim confidentiality on SART had not yet been attained. However, using the need-to-know rule may not be a tenable resolution for SART given the statutory requirement that rape crisis staff and volunteers treat their communications with victims as privileged and that only victims have the power to waive that privilege. Instead, a more plausible recommendation is for teams that are encountering tensions about information sharing should involve an outside person or agency to help to mediate the conflict. Furthermore, rape crisis victim advocates could make more transparent their good faith efforts to obtain waivers from victims to allow them to discuss case material on a need-to-know basis with professionals from other agencies on SART.

Findings showed that not all criminal justice and medical professionals understood the statutory provision of privilege to communications between rape crisis victim advocates and victims. Specifically, not all medical and criminal justice system professionals seemed to be aware that victim advocates are held to a different statutory requirement for confidentiality and that they may discuss cases with other SART professionals only when the victim had signed a waiver. Some participants who stated that there were no coordination problems attributable to different professional obligations to confidentiality believed that it was because important information was shared among professionals. Individuals who stated this belief were from all three SARTs and not newcomers to their SARTs. It is possible that some of the individuals who made these statements may have been thinking only of cases where a waiver had been signed by a victim, allowing the rape crisis center staff to discuss the case with other SART professionals; however, the

question asked participants to think in generalities about whether maintaining victim confidentiality poses a problem for collaboration.

Study Limitations

The research findings must be discussed within the context of the limitations of the study. First, the three SARTs selected into the sample—the only three active SARTs in the state at the time of the study—may not be representative of SARTs in other states. Second, it is possible that the purposive sampling may have missed individuals with divergent perspectives on SARTs. Third, some professionals may not have expressed honest responses about the more controversial topics addressed in the data collection instruments, out of concern for social desirability or concern that their responses could be connected to their identities. Nonetheless, gathering data from multiple individuals from each organization within each SART allowed for checking interpretations against alternative explanations and meanings of events. Fourth, the intent of the survey question about victim confidentiality was to gather perspectives on whether different statutory obligations hindered communication and coordination on SART, and not whether SART members violated confidentiality practices and protocols by discussing cases with individuals who were not involved with SART (e.g., emergency room [ER] nurses, friends, public), which is how a small number of participants interpreted the question.

Implications for Practice

The findings of the study support the need for initial and ongoing joint training among professionals and paraprofessionals working on SART. Initial training should address the benefits of the team response, professional roles, communication and conflict resolution skills; the statutory obligations of professionals to maintaining victim confidentiality; and the reasoning that underlies these statutes. Ongoing training should provide professionals the opportunity to raise positive and negative examples of their collaborative efforts and explore existing tensions and constraints on the team. For example, greater education and discussion on the counselor–client privilege and how it prohibits victim advocates from sharing information with other professionals is needed in communities where the communications between victim advocacy personnel and sexual assault victims is treated as privileged. Even though communications between sexual assault victims and rape crisis center staff and volunteers is privileged in Kentucky, where the current study was conducted, not all participants in the study understood that this was the

case. Thus, there is a need for organizations to check in with staff members and volunteers periodically to reinforce roles and obligations.

One of the common struggles that SARTs contend with is the lack of funding for trainings. Even though funding is not a sufficient condition for collaboration, there is evidence that it is a necessary condition (Gittell & Weiss, 2004). Formal evaluation of SART processes and outcomes is needed to identify the fidelity of SART professionals and organizations to the agreed-upon protocols and to identify strengths and weaknesses of the SART protocols. Therefore, more funding opportunities are needed to support team efforts (SART as a whole), in particular, funding for joint training efforts, and evaluation studies of team processes and outcomes (van Eyk & Baum, 2002).

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Bio

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