



The Michigan **DVOCATE**

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THE MICHIGAN ADVOCATE was created in 2000 to provide information and resources to VOCA Grantee-agencies, other crime victim programs, and advocates in Michigan and throughout the country. This publication strives to help professionals maintain comprehensive and quality services to victims of crime and to inform advocates of broader issues affecting crime victim services.

THE MICHIGAN ADVOCATE is published twice yearly and has recently evolved into an electronic format allowing for broader distribution of news relevant to crime victim services.

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In the Spotlight: Sexual Boundaries between Patients and Healthcare Providers

The relationship between a health care provider and a patient is a professional relationship based on trust. When a provider behaves in such a way that oversteps his or her professional role with the patient to create a personal relationship, we say that a professional *boundary* has been crossed. When a provider inappropriately uses words or actions of a sexual nature with a patient, a *sexual boundary has been violated*. This includes any words, actions or behavior that could reasonably be interpreted as sexually inappropriate or unprofessional. This is why, for example, a provider must leave the room when a patient is undressing for an examination. The potential for sexual misconduct exists with any health care provider.

According to the statistics identified in our most recent annual report, there were 46 allegations of sexual misconduct made against health care providers in 2006. This is a serious violation and all allegations of sexual misconduct are investigated thoroughly. An allegation, however, is a formal accusation of such conduct by a patient. While some allegations are found to be without a basis in fact, many are found to be supported by the facts. The 2006 report identified 22 allegations of sexual misconduct against medical doctors and doctors of osteopathic medicine (M.D.s and D.O.s) and 16 allegations against three mental health professions (counselors, psychologists and social workers). There were also eight allegations filed against various other health professions.

Unfortunately, these 2006 allegations likely represent only a portion of such violations occurring in Michigan that year, as many patients do not report violations of this nature due to embarrassment or fear of not being believed. In fact, according to the American Medical Association, the percentage of physicians who have crossed sexual boundaries with patients may be as high as 10%. The allegation statistics from our 2006 annual report indicate that less than one percent of licensed health professionals may have crossed sexual boundaries with their patients.

Violations of sexual boundaries between a provider and his or her patient include beginning a personal relationship during or after treatment, engaging in sexual activity, discussing sexual matters that are not relevant to treatment, using “off color” humor or telling “dirty jokes”, or repeatedly engaging in prolonged conversation about personal matters unrelated to treatment.

There are many harmful consequences to the patient when sexual boundaries are violated, including emotional turmoil, shame, fear, rage, guilt, self-blame, identity confusion, sexual dysfunction, depression, self-harm, and even suicide. It is sometimes difficult to know when a provider has violated a personal or sexual boundary. To protect yourself against this type of behavior, be wary if a health practitioner begins to disclose personal problems or discusses personal details

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Sexual Boundaries between Patients and Healthcare Providers continued...

regarding their love life, offers to not charge for appointments, explores any kind of relationship outside the provider-patient relationship, such as a business partnership or exchanging personal favors.

If you or someone you know has been a victim of sexual misconduct by a health professional, you should report it immediately to the appropriate licensing board, seek counseling and consult an attorney to determine if civil or criminal

action may need to be taken. Remember, this type of behavior by health professionals may be quite rare, but it does occur. If you have questions about this article, staff in our Allegation Section may be able to answer your questions. They can be reached at 517-373-9196.

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Children Witnessing Domestic Violence: What Affects Their Well-Being Over Time?

■ By Cris Sullivan, PhD

Millions of children witness their mothers being abused each year (Carlson, 1984; Jouriles, McDonald, Norwood, & Ezell, 2001), and the overlap between woman battering and child abuse has been estimated to be between 30% and 70% (Edleson, 2001), depending on study methodology. Children who witness their mothers being abused are at risk for conduct disorders and psycho-emotional problems such as anxiety and depression (Hughes, Parkinson, & Vargo, 1989; Jaffe, Wolfe & Wilson, 1990; Fantuzzo, DePaola, Lambert, Martino, Anderson, & Sutton, 1990), low social competence, problem-solving and social skills (Jaffe, Wolfe, Wilson, & Zak, 1986), and poor academic performance (Moore et al., 1989; Wolfe, Zak, Wilson, & Jaffe, 1986). A great deal of children's adjustment difficulties have been blamed either directly or indirectly on their mothers. Mothers have been charged with "failure to protect" when their children witness assaults against them, and they have also been portrayed as emotionally unavailable and/or overly harsh with their children, as a consequence of their own abuse. This characterization prevails, despite published studies finding no parenting differences between battered and non-battered women (Hershorn & Rosenbaum, 1985; Holden & Ritchie, 1991; Holden, Stein, Ritchie, Harris, & Jouriles, 1998).

While mothers' availability and parenting skills have received a great deal of attention in the domestic violence field, the assailants and fathers of the children have been virtually ignored. Given that approximately half of mothers' assailants

are the children's biological fathers (Jouriles & Norwood, 1995; O'Keefe, 1994), it is reasonable to expect that at least some are parenting their children (Williams, Boggess, & Carter, 2001). While mothers may traditionally be the primary caretakers of their children, fathers' availability and parenting skills impact their children as well.

The current study examined the behavioral and emotional adjustment of children who had witnessed abuse against their mothers. Following children for eight months, we examined the relationships between their well-being over time and (1) the extent of violence against their mothers, (2) their mothers' parenting stress, (3) their mothers' parenting practices, (4) their relationship to the assailants (whether biological fathers, stepfathers/father figures, or non-father-figures), and (5) their treatment by the assailants.

Research participants were recruited from domestic violence service programs (79%), a community-based family service organization (4%), and a Social Services department (18%), all located in a mid-sized urban city. In order to be eligible for the study, women had to have at least one child between the age of 7 and 11 living with them, they had to plan on remaining in the area for the upcoming 8 months, at least one of their children aged 7-11 had to be interested in participating, and the mother had to have experienced

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some type of physical domestic violence in the prior four months. All interviews were conducted in the community at the families' convenience (primarily in the home), and in separate rooms to ensure privacy and confidentiality of responses.

Forty-nine percent of the mothers were non-Hispanic white, 39% were African American, 5% were Hispanic/Latina, 5% identified as multi-racial, 1% were Asian, and 1% were Native American. Average age was 31 years, with 77% of the sample being under 35 years old. Their mean income was \$1,200 a month, and 44% of the women were employed. The majority (88%) was receiving some form of governmental assistance.

Thirty-seven percent of the assailants were the children's biological fathers (n=30). Forty percent were the children's stepfathers or father figures (n=32), and the remaining 23% were non-father-figures to the children (n=18). Men were classified as stepfathers/father figures if they (a) were legally married to the mother, and/or (b) were reported to play a significant paternal role in the child's life. Non-father-figures were partners or ex-partners who did not play a significant role in the child's life, as determined by the mother and verified by the child.

Retaining families across the eight months was highly successful (95% retention). Of the four women who were not retained in the study, two declined further participation and two could not be located despite intensive retention procedures.

Results

Women reported experiencing a great deal of domestic violence in the four months preceding the first interview, much of which resulted in injuries. Experience of

domestic abuse decreased over time, with 31% of the sample reporting physical abuse at the follow-up interview.

Assailants who were the children's biological fathers were significantly more abusive to the mothers than were assailants from the non-father-figure group ($F(2, 77) = 3.32, p < .05$). Accordingly, children whose mothers' assailants were their biological fathers witnessed more violence than did children whose mothers' assailants were non-father-figures ($F(2, 77) = 7.43, p < .01$). There were no significant differences among the three groups of assailants on the number of physical injuries ($F(2, 77) = 2.33, n.s.$) or amount of psychological abuse ($F(2, 77) = .52, n.s.$) mothers reported experiencing from them.

Women reported a low to moderate level of parenting stress overall, and parenting stress did not change appreciably over time. Individual items in the Parenting Stress Index suggested that the majority of women enjoyed their role and responsibilities as a parent. For example, 91% of women reported enjoying being parents and 90% believed that being a parent was one of the best parts of life.

With regard to discipline tactics, women were asked how often they used timeouts, grounding, spanking, and taking away privileges when their children misbehaved (1="never" to 4="often"). Findings at Time 1 indicated that the women were least likely to spank ($M = 1.95, SD = .70$) and more likely to use timeouts ($M = 2.84, SD = .94$), take away privileges ($M = 2.81, SD = .95$) and ground their children ($M = 2.54, SD = 1.10$). Mothers' discipline strategies did not change appreciably over time.

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Overall the children in the sample reported low depression ($M=0.34$, $SD = .24$ on a scale of 0 [low] to 2 [high] at Time 1) and relatively high self-competence ($M=2.95$, $SD = .54$ on a scale of 1 [low] to 4 [high] at Time 1). Children reported being happy with themselves (83%), liking their physical appearance (83%), and feeling as if they often do the right thing (73%).

Congruent with the children's reports, mothers also reported that children were doing relatively well with regard to behavior problems. Mothers' reports of such problems were low ($M=.75$, $SD = .36$ on a scale of 0 [low/none] to 2 [high] at Time 1). However, 48% of the mothers reported that their children got into fights, and 66% reported their children were at least sometimes restless or hyperactive.

Ninety-three percent of the children mentioned their mothers as sources of social support, while 56% listed their biological fathers. It is important to note that, although all children in the study had regular contact with their mothers (i.e., resided with them), only 3% of the children said they saw their biological fathers in the past week, and almost half of the children had not seen their fathers for at least one year. Of the biological fathers listed by children as sources of social support, 47% were also the women's abusers in this study. In addition, 16% of the children listed assailants who were not their biological fathers as a source of social support in at least one area of their lives.

Children's perceptions of their competency and self-worth were significantly related to their role-relationship to their mothers' abuser. Multivariate analysis of covariance, adjusting for group differences on both the amount of physical violence experienced by the mother and her report

of the child's witnessing of abuse, revealed a significant overall difference among the three groups. Children whose mothers' abusers were not father-figures to them reported higher self-competency and self-worth compared with children whose mothers' abusers were their biological fathers or stepfathers/father figures. There were no significant differences across the three groups on children's depression or mothers' report of behavior problems.

The three groups of assailants did not differ significantly in the amount they physically abused the children (per mother or child report) nor in the amount of injury inflicted upon them (per mother or child report). Stepfathers/father figures, however, were more verbally abusive to the children than were biological fathers ($F=3.49$ (2, 77), $p<.05$). Children whose mothers' assailants were their stepfathers/father figures were also more frightened of the assailants than were children whose assailants were non-father-figures (F (2, 73) =4.37, $p<.05$).

Discussion

The current study provided strong evidence for battered mothers' considerable nurturance toward their children. Mothers and children agreed that the mothers as a whole enjoyed being mothers, supervised their children, and were emotionally available to them. Regarding discipline strategies, mothers used a variety of non-corporal discipline strategies to deal with their children's misbehavior. Although most mothers spanked their children at least sometimes, they were more likely to report using timeouts, grounding, and revoking privileges to discipline their children.

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These findings corroborate the results found by Holden and colleagues (Holden & Ritchie, 1991; Holden, et al., 1998), that women who have been battered spank their children no more often than the general population. Children also reported that their mothers were sources of social and emotional support to them.

Further, this study affirms the need to study the role of women's assailants in children's adjustment over time. It is notable that although stepfathers/father figures were not more physically abusive toward the children than were fathers or non-father-figures, they were more emotionally abusive and instilled more fear in the children. Children also reported the lowest self-competency when abusers were either their biological or step-fathers. Given that biological fathers were no more physically abusive to the children, and that they were considered more emotionally available than the other groups of abusers, there may be something especially painful in witnessing one's own father abuse one's mother. It should be remembered, however, that the children in this sample overall reported relatively high self-competency and self-worth. This study bears out the contention that, as a rule, child witnesses of domestic violence have strong and positive relationships with their mothers and count on them for emotional support and stability. This finding directly challenges the practice in some areas of removing children from homes in which their mothers are being abused, as the stability and love provided by mothers is extremely important to traumatized children. The results of this study also suggest the need to re-examine the prevailing view of battered women as poorly functioning women who are too traumatized to adequately care for their children. While domestic violence is clearly traumatizing

and injurious, most women with abusive partners gather a great deal of inner strength to continue to nurture their children and build better lives for themselves and their families. We must remember that the experience of domestic violence is only one aspect of women's lives, and that women are contending with many other concerns, including feeding, housing, and clothing their children; providing the most stability possible for their children (which sometimes means remaining with an abusive partner); as well as a myriad of other issues. Viewing women with abusive partners as competent adults who are trying their best to protect and provide for their families will result in providing more useful interventions and responses to them. Instead of expecting women to protect themselves and their children when we as their communities have failed to do so, it would be better for both women and their children to institute policies and practices that hold batterers accountable for their violence and that promote women's strengths, competencies, and abilities.

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Identifying the Batterer in Lesbian, Gay, Bisexual and Transgender Relationships

■ By Melissa L. Pope, JD

Domestic violence within the lesbian, gay, bisexual and transgender (LGBT) community poses specific challenges to domestic violence service providers. In this article, we will discuss one of those challenges: identifying the batterer.

When trying to determine who the batterer is in an LGBT relationship, you must keep first and foremost in your mind that domestic violence is about power and control. This helps you cast off any preconceived notions about physical stature. You should remember that when you look at a lesbian couple, the smaller, more “feminine” woman can be the abuser while the woman who looks like what is commonly referred to as “butch” within the LGBT community may be the victim. This is also true with relationships involving gay men and those where one or both of the parties are transgender.

You also must be cognizant of the issues relating to the legal system. Unfortunately, many within law enforcement are not trained in identifying the batterer. This results in the wrong party being arrested for domestic violence. This means that domestic violence service providers have to go the “extra step” when contacted about an LGBT relationship. You cannot assume that the person charged is the abuser. Further, there may be no domestic violence charges at all. Officers sometimes chalk off a domestic violence call by a gay man as two roommates who had a fight. They may not arrest either man – or they may arrest both. The result can be even worse with relationships involving people who are transgender. In Michigan, a person

cannot change the gender on their driver’s license until they have completed sex reassignment surgery. However, you must live full-time as the gender with which you identify before you can get the surgery. Further, many transgender people cannot afford sex reassignment surgery or do not want to have the surgery. This means that they may look very different from the picture on their driver’s license. Law enforcement officers have been known on occasion to concentrate on this factor versus investigating the allegations of domestic violence. Since they believe that the transgender victim has lied about their identity, they figure they have also lied about the abuse. The end result is that you cannot assume that the person who was arrested is, in fact, the abuser.

To determine who the victim is in an LGBT relationship, you should take a similar approach as with heterosexual relationships by looking at who has the power and control in the relationship. You want to look at who controls the couples’ financial resources, whether one party has isolated the other, etc. There are, however, a few differences in LGBT relationships.

One consideration is whether either of the parties is using the other person’s lack of being out as a means to control them. Discrimination and violence against the LGBT community is a fact. The fear of abandonment by family and friends keeps many people in the closet, as does the fear of losing employment. Since Mich-

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Identifying the Batterer in Lesbian, Gay, Bisexual and Transgender Relationships continued...

igan does not include sexual orientation or gender identity or expression in the Elliott Larsen Act, a person can be fired simply for being lesbian, gay, bisexual or transgender. Batterers often exercise power and control in the relationship by threatening to “out” the victim to family, friends and co-workers if the victim leaves or reports the abuse. For those who are not “out” at all, the batterer is the only person who knows the victim for who they really are. The batterer uses the victim’s fear of being all alone to exercise power and control over the victim.

Another consideration is children. We all know that batterers often use children as a means to control the victim. However, there is an important difference with LGBT couples: many LGBT parents do not have a legal right to their children. In cases where the batterer is the birth or sole adoptive parent, the other parent – regardless of how long they have been together or how long they have raised their children together – has sole legal right to the children. In heterosexual relationships, domestic violence is a factor to consider when awarding custody. While it matters to the court if one parent

has abused the other, especially in front of the minor children, generally the court looks for avenues to make sure that the minor children have a relationship with both parents. That is not the case with LGBT relationships. Important to this discussion is that the abuser usually knows this and exercises power and control over the victim by making the very real threat that if they leave, they will never see their children again.

The best way to determine who the batterer is in an LGBT relationship is to look for who has the power and control, keeping in mind the considerations specific to LGBT relationships. Triangle Foundation works with the Michigan Coalition Against Domestic and Sexual Violence LGBT Task Force to offer trainings and distribute materials. The Coalition will have our website up shortly, but until then, you can find a copy of the Lesbian and Gay Power and Control Wheel at the National Center on Domestic and Sexual Violence website: www.ncdsv.org.

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Serving Victims of Human Trafficking

▪ By Shelli Doll, MA, CHES

An Overview of Human Trafficking

Human trafficking can be considered a modern day form of slavery and is widespread throughout the United States. Trafficking is a hidden social problem however, its victims are in plain sight. Victims of human trafficking can include young children, teenagers, men, women, and the elderly. Approximately 600,000 to 800,000 victims annually are trafficked world wide.

There are several different forms of human trafficking. Victims of human trafficking are coerced into sexual exploitation and forced labor. Many victims are forced to work in prostitution or in the sex entertainment industry. Trafficking also occurs in forms of labor exploitation, such as domestic servants (nannies or maids), restaurant work, janitorial work, factory work and migrant work.

Traffickers use various techniques to instill fear in the victims and to keep them from leaving. The victims fear is usually heightened because the majority do not speak English and are from countries with corrupt law enforcement. Most traffickers like to use vague techniques to keep their victims under lock and key including:

- Isolation from the public- including contact with outsiders and making sure that any contact is monitored and superficial in nature
- Isolation from family members and members of their ethnic and religious communities
- Confiscation of passports, visas and/or identification documents
- Use of threat or violence toward victims and/or families victims

- Telling victims they will be imprisoned or deported for immigration violations if they contact authorities
- Control of the victims money or holding their money

Resources: Identifying & Interacting with Victims of Human Trafficking

A victim of trafficking may look like people we see every day. A victim of trafficking can be helped and receive the assistance they need by in-depth interviewing looking for the following clues:

- Evidence of being controlled
- Evidence of the inability to move or leave a job
- Bruises or other signs of being battered
- Fear or depression
- Non-English speaking
- Recently brought into this country from Eastern Europe, Asia, Latin America, Canada, Africa or India
- Lack of passport, immigration or identification documentation

It is always important to speak with a victim in a safe and confidential environment. If they are accompanied by someone who seems to be controlling, try to separate the victim from that person. If the victim is a child, try to seek the help of a social worker who is skilled in interviewing child trafficking or child abuse victims. It is also important to try to find a staff member who speaks the individual's language and understands his/her culture.

Victims have a fear and distrust of the police and government because of past

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Serving Victims of Human Trafficking continued...

experiences in their home country. They have a fear of being deported because they come from countries where law enforcement is corrupt. As a coping mechanism, some may develop loyalties toward their trafficker or even try to protect them from authorities. Many victims of human trafficking may not see themselves as victims.

For more information regarding human trafficking, or if you think you have come in contact with a victim of human trafficking, please call the National Human

Trafficking Resource Center at 1-888-3737-888 or visit the following website: www.acf.hhs.gov/trafficking. This hotline will help you determine if you have encountered victims of human trafficking and can identify resources that are available in your community.

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Child Sexual Abuse

- By N. Debra Simms, M.D. and Tracy Cyrus, LMSW

Child sexual abuse has been defined in many ways. A comprehensive definition states that child abuse occurs when a child is engaged in sexual activities that they cannot comprehend and for which they are developmentally unprepared and cannot legally give consent. The offender exposes the child to inappropriate sexual contact, activity or behavior for reasons of self gratification. This can also include non-touching offences such as subjecting the child to exhibitionism, erotic material and inappropriate solicitation online, or exploitation of a child for purposes of pornography or prostitution.

The exact number of children who are sexually abused is not known, because many victims do not disclose at the time they are victimized. Some children never disclose the abuse to anyone. Children have denied being abused even in cases of perpetrator confessions and photographic evidence of the child being abused. Younger children may not realize that they are being subjected to inappropriate sexual activity and that they are victims of abuse.

Victims of child sexual abuse may be any age, male or female, urban or rural residents, or belong to any socioeconomic level. The median age for reported abuse is nine years old. It is estimated that one out of four females and one out of six males will have experienced some form of unwanted sexual encounter by the time they are 18 years of age. One in five children are solicited for sexual purposes while on the Internet.

Sexual abuse is most often a crime of opportunity. While strangers can abduct, molest and even kill children, sexual

abuse is usually committed by people known to the child, many of whom have been in loving and trusting relationships with the child and their family. Children may be sexually abused by male and female, adult, and adolescent perpetrators. Increasing numbers of cases report abuse to the child by an older child.

Many sexually abusive acts perpetrated against a child (kissing, licking, touching, rubbing or photography) may not leave any kind of physical evidence. The majority of children seen for medical evaluation of pediatric sexual abuse have normal exams – that means there is no physical indication/evidence of physical trauma. This does NOT mean that nothing happened; it simply means that the act did not leave any kind of physical indicator such as a bruise, cut or scar.

Despite the low incidence of physical findings, a sexually abused child needs a medical evaluation. Many times, the child can be seen by their primary care provider. When the child's disclosure and/or findings of the primary care providers screening exam are concerning, there are specialists available to conduct specialized forensic medical evaluations. Instruments that magnify and illuminate the genital area can reveal injuries not seen by conventional examination methods. Medical evaluations are done to assess the risk of infection, detect any injury, and to reassure the child regarding any concerns they may have about their body. This is often a critical first step in the child's emotional healing.

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Child Sexual Abuse continued...

Children who have been sexually abused need counseling. Sexual abuse victims are at risk for drug and alcohol abuse, teenage pregnancy and promiscuity, and health and mental health concerns. Child victims need a safe place to talk about their experience with a specially trained professional who can identify and appropriately respond to all of the child's issues related to feelings of betrayal, shame and blame.

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Reaching Out to Lesbian, Gay, Bisexual and Transgender Victims of Domestic Violence

■ By Melissa L. Pope, JD

Victims of domestic violence face significant risks when leaving an abusive relationship. They are at an increased risk for physical danger. They are afraid of losing their children, pets and home. They are also worried about how they will be able to provide for their family. LGBT victims of domestic violence face all of these same risks. But, the state of the law in Michigan compounds these risks: there is a constitutional amendment that not only bans same-sex marriage, but also threatens domestic partnerships, including health care for LGBT families. Because of the challenges to LGBT equality in Michigan, there are significant issues when assisting LGBT victims of domestic violence.

The first thing you can do to help LGBT clients is to make your agency or shelter welcoming to the LGBT community. Consider whether an LGBT client would feel included in the space. Have posters or paintings that show LGBT families. Make sure that materials do not identify only men as abusers. Have materials about domestic violence in LGBT communities in your library.

Consider whether your intake process is LGBT-friendly. Include trans-gender under the category of gender. List the parties to the actions versus male and female or husband and wife. Include sexual orientation on your form. Make sure to ask detailed questions about children: who the biological parent is; if the other biological parent is active in the children's lives; if the client is not the biological parent, whether there is a second parent adoption giving the client

legal rights to the children. While not provided for by law, some judges have approved second parent adoption in certain cases. If the parties adopted the children, make sure to ask detailed questions about the adoption: who is listed as the adoptive parent; if the client did not adopt the children initially, ask whether there was a second parent adoption. You also need to take detailed notes about real property. Unlike with marriage, there is no assumption about assets acquired during the relationship. It will, therefore, be important to know whose name any real property is in. You want to ask the same detailed questions regarding any personal property, including how it was acquired.

If an LGBT individual is seeking refuge in your shelter, remember that they may have been treated with discrimination in the past. As we all know, it is very difficult to walk away from an abusive relationship. Rejection by shelter staff or residents is another hardship that an LGBT survivor simply cannot bear. While you cannot control the thoughts or attitudes of residents, we have found that there are very few problems when a shelter makes it clear to all residents at all times that discrimination will not be tolerated. However, be careful to not "out" an LGBT client when introducing them to the residents and staff. Whether to be "out" is a decision that should be left to them, especially during such an emotionally difficult time.

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Reaching Out to Lesbian, Gay, Bisexual and Transgender Victims of Domestic Violence continued...

Having gender neutral facilities at all times can make it more comfortable for transgender clients as there is nothing "special" being created for them. Always ask a transgender client what their gender identity is and treat them accordingly. For example, if a person who is transitioning from male to female tells you they identify as being female, only use female pronouns. Also, if you serve primarily female clients, make comparable provisions for male clients. While there is appreciation for shelters that provide temporary accommodations for male victims of domestic violence, these provisions are sometimes inadequate. Three nights in a hotel do not compare to 30 days in a shelter. And don't forget, all of these guidelines apply to children, too. Sometimes, the victim may not be the one who is LGBT.

With regard to any legal proceedings, it is imperative to know the judges' rulings in your jurisdiction regarding LGBT matters. For example, some judges will not approve a Domestic Relations Personal Protection Order in an LGBT relationship – they will only consider Stalking Personal

Protection Orders in same-sex relationships, if at all. Advise your clients accordingly.

Also with regard to legal proceedings, survey any pro bono attorneys to see if they specialize in LGBT relationships. If you do not have any such attorneys, contact Triangle Foundation and we can give you referrals. We can also help arrange trainings for attorneys who are interested in becoming competent in LGBT issues.

Triangle Foundation, along with the Michigan Coalition Against Domestic and Sexual Violence LGBT Task Force, offers trainings for service providers. In addition, Triangle Foundation is involved with the National Coalition of Anti-Violence Programs which produces an annual report on LGBT domestic violence. If you have a client who is LGBT, please contact me so that I can make sure they are counted in our 2008 statistics.

Melissa Pope is the Director of Victim's Services at the Triangle Foundation in Detroit.

Methamphetamine and Child Abuse

■ By Shelli Doll, MA, CHES

Methamphetamine (meth) is the fastest growing drug threat in the United States. It is a highly addictive substance that can be produced in as little as six hours using readily available ingredients. Most meth production in the United States occurs in clandestine meth labs using an extremely dangerous process involving the use of corrosive, flammable, reactive, and toxic chemicals in the presence of open flames. While clandestine meth labs can be set up anywhere, many are set up in the home in a kitchen or a bedroom.

The manufacturing of methamphetamine in home labs is of great concern for children in Michigan. Children in home meth labs are at increased likelihood for health and safety risks including physical, emotional and sexual abuse and medical neglect.

Children are at an increased risk for health hazards because of their behaviors. Activities such as frequent hand to mouth contact, crawling on the floor, picking objects up and placing them in the mouth all greatly increase the chance that a child living or visiting a meth lab being exposed to harmful chemicals or objects. Due to their developing nervous system, the likelihood of these children suffering from the effects of toxic chemicals is increased.

It is clear that law enforcement personnel involved in meth lab seizures should be

adequately prepared to address the immediate needs of the children involved. One approach that has been successful is the development of a multi-disciplinary team to protect children in seized meth labs. The team should include medical and mental health services, Child Protective Services, law enforcement, public safety, and prosecution. This team may be responsible for conducting drug screens on all children in the house, conducting comprehensive physical and emotional assessments, ensuring medical and mental health follow up care, and placing children into protective custody.

Children in meth labs are at an increased risk for many severe physical and emotional problems. With increased awareness of this growing problem and proper referrals and treatment, children can receive the care they need.

For further information, please visit www.ojp.usdoj.gov/ovc. To read the Children at Clandestine Methamphetamine Labs: Helping Meth's Youngest Victims please see: www.ojp.usdoj.gov/ovc/publications/bulletins/children/pg1.html.

Shelli Doll is the Research Associate for the Crime Victim Services Commission Technical Assistance Project at the Michigan Public Health Institute.

Cultural Competence Training Enters Its Second Year!

■ By: Harold Core

Want a good laugh? Do an Internet search for "Cultural Marketing Mistakes" and you will find dozens of humor-laden errors made by well meaning organizations who underestimated the cultural divide. While such examples may be good for a laugh now, I can assure you these incidents were no laughing matter to the company while it struggled with the costs of the mistake.

One of the more interesting examples listed on several Internet sites was that Parker Pen once marketed a ball-point pen in Mexico, with the slogan, "It won't leak in your pocket and embarrass you." However, the company later learned that the word "embarazar," which they assumed meant "to embarrass," actually meant "to impregnate". The ad actually read: "It won't leak in your pocket and make you pregnant."

In the corporate world such a cross cultural mistake would cost that company money and wasted effort. However, among organizations which provide services to victims of crime, cross cultural mistakes can mean crime victims do not receive the vital assistance they need. Even worse, a victim can leave your organization feeling even worse after a cultural miscommunication. For these reasons, it is vital that crime victim service organizations are culturally competent and able to promote and provide their services in multiple communication formats.

To this end, the Michigan Department of Civil Rights (MDCR), Crime Victim Services Commission (CVSC) and Michigan Alliance

Against Hate Crime (MIAAHC) are happy to present a second year of Building Cultural Competence and Hate Crime 101 training to crime victim service providers in the state. As with last year, both trainings are funded by the CVSC and are free to those who provide services to victims of crime.

Included among the agenda items of the Building Cultural Competence (BCC) training are exercises to help participants understand more about cultural protocols and communication styles, and uncover their own hidden biases and stereotypes. The training provides an excellent first step on the road to cultural competence, and leaves the participant with some guidance for further information.

But cultural competence alone will not always be enough to allow providers to serve whoever needs their assistance. New for this year, the BCC training will also cover Limited English Proficiency (LEP) requirements for service providers. Many providers are not aware that their organization may have an obligation to persons who do not speak English well as it relates to their gaining meaningful access to programs or services. This obligation may include translation of written documents as well as interpreter services.

The presentation includes a four factor analysis used by the U.S. Department of Justice as part of its LEP analysis under Title VI and Executive Order 13166. The

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Cultural Competence Training Enters Its Second Year! continued...

analysis is used to help organizations determine whether they have obligations to provide services or publications in other languages. To access this and other resources on LEP issues, please visit www.miaahc.com/midemo.asp for more information.

Also new for this year is an easy online registration process available at <http://www.miaahc.com>. Potential participants can view the training schedules, get more information on presentation topics including LEP issues, and register to attend the classes of their choice. Following registration, participants will receive an email confirmation including directions to the training site. The website is customer friendly and easy to use. For specific program information, please see:

- Hate Crime 101:
<http://miaahc.com/HC101.aspx>
- Building Cultural Competence:
<http://miaahc.com/bcc.aspx>

Also, if you are new to <http://www.miaahc.com>, be sure to look around for information on the Michigan Alliance Against Hate Crime. The newly updated MIAAHC website includes:

- An updated Crisis Response Team page with an on-line form to submit data regarding bias incidents and hate crimes.
- Information on data collection and analysis of trends related to hate crimes in the state and nation.
- Federal, state and non-profit resources for assisting victims of hate and other crimes.

Be sure to take advantage of this wonderful but limited opportunity to prepare your organization to better serve victims of any ethnic or language background. Cross cultural miscommunications are no laughing matter when the lives and futures of crime victims hang in the balance.

For more information visit the website of the Michigan Department of Civil Rights at <http://www.michigan.gov/mdcr> or the website of the Michigan Alliance Against Hate Crime at <http://www.miaahc.com>.

Harold Core is a Public Information Officer at the Michigan Department of Civil Rights.

Program Evaluation Training Update

- By Mary Zack Thompson

Each year the Crime Victim Services Commission (CVSC) and the Michigan Public Health Institute (MPHI) host several one day workshops on program evaluation. The workshops are designed and facilitated by Dr. Cris Sullivan from Michigan State University. The workshops guide agencies serving victims of crime through the process of designing an evaluation that meets their unique needs. Three versions of the workshop have been developed for different types of grantees – a general training suitable for all agencies, a session developed specifically for agencies serving children, and a session for agencies serving small or rural populations.

Last year's workshops were held in Lansing, Detroit, and Baraga. The three events were well attended and received positive reviews from participants. In fact, 97% of the participants thought the workshop training will be useful or very useful when conducting their own pro-

gram's evaluation. Based on ongoing positive feedback, these workshops are again being offered this year.

The first workshop will be held on May 1 at the Henry Center in Lansing. The second workshop, for agencies serving children, will be held on August 7 at the Prince Conference Center in Grand Rapids. The final workshop, for small or rural agencies, will be at the Treetops Resort near Gaylord on September 25.

For more information on these workshops or for registration materials, please contact Mary Zack Thompson at 517-324-8392 or mthompso@mphi.org.

Mary Zack Thompson, MBA, is the Project Coordinator for the Crime Victim Services Commission Technical Assistance Project at the Michigan Public Health Institute.

Tenth Annual Council of Advocates Held

■ By Mary Zack Thompson

The Council of Advocates (COA) event is a day-long, roundtable discussion hosted by the Crime Victim Services Commission (CVSC). The Michigan Public Health Institute (MPHI) coordinates this event. The COA is comprised of a small group of VOCA-funded agency representatives from across the state. The annual meeting offers an opportunity for grantees to network and to discuss issues facing crime victims and victim service agencies. Participants have the chance to provide open feedback to the CVSC and MPHI, and the CVSC is able to relay any new and relevant information regarding VOCA grant administration.

This year's COA meeting took place on November 28, 2007 at the Henry Center in Lansing, Michigan. Participants traveled to the meeting from locations throughout Michigan, including Alpena, Battle Creek, the Detroit area, Flint, Holland, the Lansing area, Mt. Pleasant, Muskegon, and St. Joseph. A variety of VOCA-funded agencies were represented, including those serving victims of domestic violence, sexual assault, and child abuse.

The meeting began with welcoming comments from Leslie O'Reilly, Program Specialist at the CVSC. Ms. O'Reilly introduced John Hubinger, the Interim Director for the CVSC, to the advocates. The meeting agenda focused around the following 14 topics:

- CVSC Commissioner Leadership
- The Uniform Statewide Trauma System

- Increasing Awareness of Victim Services in Michigan
- VOCA Grant Information
- House Bill 5355
- The Commission Website
- Grant Awards
- Grantee Training Needs
- Resource Needs
- Grant Application Schedule
- OVC Training
- Grant Compliance and Needs Assessment
- The Michigan Advocate Website and Newsletter
- Program Evaluation Training

For each topic Ms. O'Reilly provided background information and updates. These updates were then followed by a question and answer session about the topic.

The upcoming Program Evaluation Trainings were also announced. Three trainings will be offered in fiscal year 2008, including a new training that will focus on the evaluation needs of grantees that serve small geographic or rural areas. The first session, a general training, will be held May 1 at the Henry Center in Lansing. The second training, developed for agencies that serve children, will be at the Prince Conference Center in Grand Rapids on August 7. The final training, developed for small or rural agencies, will be held September 25 at Treetops Resort near Gaylord.

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Tenth Annual Council of Advocates Held continued...

The meeting discussion was summarized in a report and will be used to help guide CVSC priorities and VOCA grant administration in Michigan. The report will soon be available online at www.michiganadvocate.org, to help keep all VOCA-funded agencies informed of current issues and developments.

The 11th Annual Council of Advocates' meeting will be held in November of 2008 at the Henry Center in Lansing.

Mary Zack Thompson is the Project Coordinator for the Crime Victim Services Commission Technical Assistance Project at the Michigan Public Health Institute.

Obtaining Medical Records

Question: How can I get a copy of my mental health or medical records? Can the practitioner charge for the copy?

Answer: Public Act 47 of 2004, the Medical Records Access Act, gives patients the right to obtain a copy of their patient records. The request must be in writing and the law provides for a certain length of time for the practitioner to prepare the information. The practitioner is allowed to charge for copies of the records. Currently, the law allows the practitioner to charge an initial fee of \$21.20 per request for a copy of the record. They are also allowed to charge \$1.06 per page for the first 20 pages, \$.53 per page for pages 21 through 50 and \$.22 per page for pages 51 and over. The law describes

some other conditions about requesting the information and about the practitioner providing the information in more detail at <http://legislature.mi.gov/doc.aspx?mcl-Act-47-of-2004>. Another law, Public Act 481 of 2006, requires physicians and hospitals to retain patient records for a minimum of seven years. Dentists are required to retain their patient records for ten years. For complete details, see <http://legislature.mi.gov/doc.aspx?mcl-333-16213>.

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