



# *The Michigan* **DVOCATE**

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## **MICHIGAN CRIME VICTIM SERVICES COMMISSION**

**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.

[www.michiganadvocate.org](http://www.michiganadvocate.org)

## In the Spotlight: [www.mitbitraining.org](http://www.mitbitraining.org)

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■ By Julia Heany

The Michigan Department of Community Health has announced a new web-based training for providers who serve clients with traumatic brain injury (TBI). This training was developed in collaboration with the Brain Injury Association of Michigan, the Department of Human Services, the Department of Education, and the Center for Collaborative Research in Health Outcomes and Policy at the Michigan Public Health Institute, and funded in part by the Health Resources and Services Administration (HRSA).

The training, which is publicly available at [www.mitbitraining.org](http://www.mitbitraining.org) at no cost, includes four, easy-to-use modules. Each module provides critical information about brain injury in a format that is understandable and practical. The first module provides an overview of the significance of TBI and introduces brain functioning. The second module describes common physical, behavioral, and cognitive impairments associated with TBI, as well as strategies for interacting with clients with brain injuries. The third module describes a basic screening tool for TBI. Finally, the fourth module describes public services available in Michigan for eligible persons with TBI. The entire training takes about three hours to complete. The training is self-paced, such that it can be completed over the course of multiple sittings. In addition, the site provides an extensive resource list and a glossary of terms.

Although the training has only been available a short time, it has already

received extremely positive feedback at both the state and national levels. For example, Dr. John Corrigan from the Department of Physical Medicine and Rehabilitation at Ohio State University wrote:

“Introducing professionals to the complex issues surrounding brain injury is no easy task, but the Michigan Brain Injury Training website has distilled the most important information and made it available in an easily accessible format. Professionals who have not worked with clients with brain injury will find this introduction concise and practical. The case examples and use of video reinforce the information presented in each module. Nicely done!”

Too often TBI goes unrecognized and untreated. This training gives service providers the opportunity to familiarize themselves with the causes and consequences of TBI, as well as practical tools for meeting the needs of injured individuals.

Continuing education credit will soon be available for this training. For more information about the training or the availability of CE credit, please contact Clare Tanner at [ctanner@mphi.org](mailto:ctanner@mphi.org) or 517-324-7381.

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# Overcoming Barriers to Screening for Physical and Sexual Abuse in Medical Settings

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■ By Jeff Sander

Physical abuse and sexual violence are public health problems of epidemic proportions with far-reaching consequences. They have widespread public health ramifications in the United States among all ethnic and socioeconomic groups, resulting in death, serious injury, and chronic medical and mental health issues for survivors. Studies indicate that patients who have experienced violence have more general health and mental health problems, reporting worse health status, greater disability, and higher levels of depressive symptoms. Survivors are also more likely to suffer anxiety or depression than patients without a history of violence.

Healthcare providers see the manifestations of family violence on a regular basis, but may not connect a patient's symptoms to the abuse they are experiencing. Identifying people who have experienced abuse will help providers uncover the underlying causes of some physical and mental health issues, providing an opportunity to improve these patients' overall well-being.

Basic screening for abuse involves a healthcare provider asking a patient a few questions about abuse she/he may have experienced, and this is beneficial in many ways. Asking about abuse lets patients know their provider is interested in what they have experienced and is willing to listen. It tells the patient that this is an important issue. It emphasizes to the patient that the abuse is not her/his fault, and that there is someone available to talk with her/him. It also tells the patient that her/his care provider is a person who

is concerned and capable of helping if and when the survivor is looking for a way to escape her/his batterer. When survivors of domestic violence are identified, providers are able to help patients understand their options, live more safely within the relationship, or safely leave the relationship.

## Why Should Health Care Providers Screen for Abuse?

A substantial amount of evidence exists suggesting that healthcare providers regularly encounter survivors of abuse. Consequently, screening truly provides an opportunity for providers to make a difference in the lives of survivors, as these findings illustrate:

- Nearly one-third of American women (31%) report being physically or sexually abused by a husband or boyfriend at some point in their lives.
- Domestic violence is more prevalent among women than diabetes, breast cancer, and cervical cancer, all health problems routinely assessed for in clinical settings.
- Women make 693,933 visits to the health care system per year as a result of injuries due to physical assault.
- 50% of men who frequently assault their wives also frequently assault their children.
- Approximately one in five female high school students reports being physically and/or sexually abused by a dating partner.
- Annually, about 324,000 pregnant women in this country are battered by their intimate partners. That means

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## **Overcoming Barriers to Screening for Physical and Sexual Abuse in Medical Settings continued...**

abuse is more common for pregnant women than gestational diabetes or preeclampsia – conditions for which providers routinely screen.

- Approximately 37% of women who seek treatment in emergency rooms for violence-related injuries were injured by a current or former spouse, boyfriend, or girlfriend.
- Each year in this country approximately 1 million elders are victims of domestic violence.
- The health-related costs of rape, physical assault, stalking, and homicide committed by intimate partners exceed \$5.8 billion each year.
- The approximate health care costs attributed to a domestic violence incident are \$948 in incidents with a female victim and \$387 in incidents with a male victim.
- Victims of domestic violence use almost twice as many health care resources and dollars annually as people who aren't being abused.
- Regular abuse screening is endorsed by the:
  - American Medical Association
  - American College of Physicians
  - American College of Emergency Physicians
  - American College of Obstetricians and Gynecologists
  - American Nursing Association

### **Why Health Care Providers Don't Assess Patients for a History of Abuse**

Although healthcare providers are likely to regularly see survivors of abuse, fewer than 10% of primary care physicians routinely screen for domestic violence during regular office visits. Healthcare professionals commonly cite several reasons for not screening for abuse, which can be addressed through education and support, as the following examples illustrate.

*Even if I do offer resources the patient won't do anything; she always goes back to the guy anyway.*

Abuse isn't an illness or injury that a healthcare provider can cure, which makes it frustrating for providers, particularly when survivors make choices that are inconsistent with what providers believe is best. It can help providers to understand that screening is important whether or not it leads to the termination of a relationship because it lets patients know that abuse is serious and common, and that there is help available. Also, providers can find it helpful to learn that leaving a batterer can be extremely difficult, it may require many attempts, and it is the most physically dangerous part of the relationship for a survivor.

*Patients will be offended by being asked these questions.*

While the discomfort providers feel asking questions about abuse is understandable, most women report that they would not be offended if their doctor asked them a screening question about abuse. Moreover, women who have experienced abuse report that one of the most important aspects of their interaction with their physicians was being listened to about the abuse. Some patients, who at first don't know why they're being asked, return several months later to acknowledge the violence they've experienced and to talk about it.

*The answers to these questions are none of our business.*

Providers often do not realize that for some survivors of abuse, going to the doctor is the only contact they have with people other than their batterer. Consequently, survivors have no source of help or support other than their healthcare provider. Moreover, survivors indicate that

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## ***Overcoming Barriers to Screening for Physical and Sexual Abuse in Medical Settings continued...***

they do not agree with the assertion that abuse is not their providers' business. In four different studies of survivors of abuse, 70 to 81% of the patients studied reported that they would like their healthcare providers to ask them privately about intimate partner violence.

*If a patient answers 'yes' to these questions, I'll be opening a Pandora's box of issues that I have no training or ability to help with.*

Not surprisingly, providers' lack of confidence in their abilities regarding domestic violence results in lower screening rates. However, with the appropriate training and supports, providers can develop the ability to respond in a way that is helpful, appropriate, and not overly taxing. Through educating providers and establishing a response system within healthcare settings, this concern can be overcome.

*We don't have any real help to offer.*

Having a response system in place and training providers on that system is imperative. This system can involve anything from giving the patient printed materials on abuse and a private place from which they can call the National Domestic Violence Hotline or a local domestic violence service provider, to having a social worker or domestic violence advocate come talk with the survivor.

*The patient will bring it up if they want to talk about it or if it's important to them.*

This is a common misconception. It can be corrected by providing more accurate information. The vast majority of patients will not mention the subject of abuse on their own, even though they might discuss it if asked simple, direct questions in a non-judgmental way.

*Abuse doesn't affect my patient population.*

This is another very common misconception, which is related to popular stereotypes about women who experience abuse. Nearly all physicians underestimate the prevalence of domestic violence among women in their practices, which correlates with less screening. It can be helpful for providers to understand that abuse reaches beyond sociodemographic boundaries and is quite prevalent in the population.

*My personal experiences make screening uncomfortable for me.*

Physicians who have been abused are not more likely to screen, perhaps due to ambivalent feelings about their own experiences or an unwillingness to identify too closely with their patients. While this is a complex and highly personal challenge, training can help providers appreciate the importance of screening their patients for an abuse history.

*In the course of an exam it's easy to forget to ask about domestic violence.*

With extraordinary demands on their time, it is understandable that providers might find it difficult to remember to screen each patient. Reminders on patient charts or check-off boxes on standardized patient history forms can play an important role in addressing this issue. Such reminders have been shown to greatly increase domestic violence detection in an emergency department. Mirror clings, posters, pins, and other resources can be helpful as well, and are often available at no cost.

### **Screening Patients for an Abuse History**

One of the most important strategies for overcoming the reluctance of providers to

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## ***Overcoming Barriers to Screening for Physical and Sexual Abuse in Medical Settings continued...***

screen is developing and instituting a screening system. A screening system can provide the structure and guidance necessary to successfully identify and respond to survivors within medical settings. Many systems of screening for abuse are currently being used with great success, including:

- Adding questions about abuse on a paper document/questionnaire which patients are already routinely asked to fill out during each visit;
- Adding screening questions to an overall health questionnaire which patients complete on a computer;
- Giving patients a handheld computer on which they can answer the questions while waiting to be seen by their health care provider; and
- Verbal screening by the health care provider.

If verbal screening is done, there are steps which can be taken to greatly increase its effectiveness.

- Separating any accompanying person from the patient protects the patient's safety and confidentiality, as does interviewing the patient in a private location.
- Prefacing questions with a lead-in or framing statement as to why the questions are being asked, such as "Because violence is so common in people's lives and there is help available, we now ask every patient about abuse," can make screening questions feel less threatening.
- Asking direct questions about abusive behaviors increases the likelihood that abuse will be identified, such as:
  - Are you afraid of anyone close to you?
  - Have you ever been hit, slapped, kicked, pushed or shoved, or otherwise physically hurt by your partner or someone close to you?

- Has anyone forced you to have sexual activities?
- It is important that all patients who disclose abuse receive therapeutic messages. These messages serve to underscore the seriousness of their situations, acknowledge your belief in their disclosures, and validate their experiences. Providers can learn to use phrases such as:
  - "This is not your fault."
  - "You are not alone, help is available to you."
  - "You do not deserve to be hit or hurt, no matter what."
  - "I am very concerned about you. We are here to help you."

### **Resources / More Information**

If you are interested in learning more about medical screening for abuse, the following resources may be of interest.

For more information about screening for abuse and developing a screening system within medical settings visit the Family Violence Prevention Fund website at: <http://www.endabuse.org/programs/healthcare/>. The Family Violence Prevention Fund also offers technical assistance in screening, as well as practical screening tools and resources.

For more information about the University of Michigan Health System's Abuse Prevention Initiative, please visit: <http://www.med.umich.edu/abusehurts/>

Other helpful resources:

To find the domestic violence program nearest you, call the National Domestic Violence Hotline at (800) 799-SAFE (799-7233) or visit <http://www.ndvh.org/>.

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## ***Overcoming Barriers to Screening for Physical and Sexual Abuse in Medical Settings continued...***

To get help and information about sexual assault call the National Sexual Assault Hotline at (800) 656-HOPE or visit [www.rainn.org](http://www.rainn.org).

For state and local resources check the Michigan Department of Human Services website at:

<http://www.michigan.gov/dhs/> and search 'domestic violence'.

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*Jeff Sander is the Coordinator of the Abuse Prevention Initiative, Women's Health Program for the University of Michigan Health System.*

# Interpreting Michigan's Stalking Law

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■ By Thomas Nelson

All states, including Michigan and the federal government, have enacted statutes that criminalize stalking for very good reasons. Over 1 million women and nearly 400,000 men are victimized by stalking every year, and 1 in 12 women and 1 in 45 men will be stalked in their lifetime (Tjaden & Thoennes, 1998).

Stalking was a hot legislative issue after the murder of actor Rebecca Schaeffer in 1988, who had been stalked and killed by an obsessive fan. At the time, there was little legal recourse for a victim unless the stalker actually committed an act of harm. In Schaeffer's case, the stalker's first and last act of physical violence against her was murder.

As a result of the Schaeffer case and other similar cases of obsessive fans stalking Hollywood figures, the majority of state legislatures in the U.S. passed anti-stalking laws over a relatively short duration from the early to mid-1990s. Most legislatures adapted model anti-stalking statutes that were created through a collaboration of state and federal advocates and legal experts. As a result, most states have very similar definitions of the conduct constituting stalking and comparable penalties when a perpetrator is convicted. Thirty-four states deem stalking a misdemeanor on the first offense and a felony on a subsequent offense and/or if the stalking behavior involves aggravating factors. Fifteen states make stalking a more serious felony crime for the first offense. Michigan's stalking law took effect in 1993, with additional penalties added in 1997.

## The Elements of Michigan's Stalking Law

There are two statutes embodying Michigan's law on the crime of stalking (MCL 750.411h and MCL 750.411i). Under these statutes, a first offense involving a victim age 18 or older is a misdemeanor unless listed aggravating factors are present. These are:

1. The perpetrator has made a credible threat against the victim or the victim's family or household member, or
2. At least one of the acts constituting stalking is in violation of a condition of parole, or
3. At least one of the acts constituting stalking is in violation of a court order listed in the statutes, namely: a civil restraining order of which the offender has actual notice; an injunction or preliminary injunction; a probation condition; or, a condition of release prior to trial or pending appeal. Although not specifically listed in the statutes, violation of a personal protection order (PPO) constitutes an aggravating circumstance because a PPO is a form of injunctive relief.

Where the foregoing aggravating factors are present, stalking is a felony. Felony penalties for aggravated stalking also apply if the perpetrator's conduct involves a second or subsequent stalking conviction.

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## *Interpreting Michigan's Stalking Law continued...*

If the victim of stalking is less than 18 years of age at any time during the offense, and the perpetrator is 5 or more years older than the victim, Michigan's stalking statutes also provide for enhanced felony penalties in all cases.

Michigan's law defines stalking as:

1. A willful course of conduct (two or more intentional, separate, noncontinuous acts evidencing a continuity of purpose, perpetrated with disregard for the victim's desire that the behavior stop)
2. Involving repeated or continuing harassment of another individual (Harassment means conduct including, but not limited to, repeated or continuing unconsented contact that would cause a reasonable person to suffer emotional distress. Harassment does not include constitutionally protected activity or conduct that serves a legitimate purpose. Emotional distress of the victim does not need to result in medical treatment or attention.)
3. That would cause a reasonable person to feel, and that actually does cause the victim to feel ("reasonable person" is a standard by which a court judges a person's reactions to acts of a perpetrator):
  - a. Terrorized
  - b. Frightened
  - c. Intimidated
  - d. Threatened
  - e. Harassed, or
  - f. Molested

The law is atypical in criminal law because it provides 7 real-life examples of stalking behavior. The examples are not all inclusive, but they are quite specific. They include:

1. Following or appearing within the sight of the victim
2. Approaching or confronting the victim in a public place or on private property
3. Appearing at the victim's workplace or residence
4. Entering onto or remaining on property owned, leased, or occupied by the victim
5. Contacting the victim by telephone
6. Sending mail or electronic communications to the victim
7. Placing an object on, or delivering an object to, property owned, leased, or occupied by the victim

In Michigan, misdemeanor stalking carries a fine of up to \$1,000 and/or up to one year of incarceration and as many as five years of probation. Felony aggravated stalking against a victim age 18 or older is punishable by imprisonment for not more than 5 years and/or a maximum fine of \$10,000. The court may also impose a term of probation for any term of years; however, the minimum term of probation ordered in felony aggravated stalking cases must be at least 5 years.

In cases where the victim is less than 18 years old at any time during the offense and the offender is 5 or more years older than the victim, penalties are enhanced. For a second or subsequent offense, or an offense involving a listed aggravating factor, an offender may be sentenced to imprisonment for not more than 10 years and/or a maximum fine of \$15,000. The court may also impose a term of probation for any term of years; however, the minimum term of probation ordered must

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## Interpreting Michigan's Stalking Law continued...

be at least 5 years. In other cases, the punishment is imprisonment for up to 5 years and/or a fine of up to \$10,000, with a possible maximum 5 year probation term.

If a convicted offender is given probation, the law authorizes courts to order that the offender:

1. Refrain from stalking any individual during the term of probation,
2. Refrain from having any contact with the victim of the offense, and
3. Be evaluated to determine the need for psychiatric, psychological, or social counseling and, if determined appropriate by the court, to receive psychiatric, psychological, or social counseling at his or her own expense.

### The Stalking Law Challenged as Unconstitutional

Michigan's stalking law makes an exception for a certain category of behavior. It states that "constitutionally protected activity or conduct that serves a legitimate purpose" is not considered harassment for the purposes of defining stalking in the law.

*Staley v. Jones*, 239 F3d 769 (CA 6, 2001) (Electronic Citation: 2001 FED App. 0037P, 6th Cir.) raised the question of the constitutionality of Michigan's stalking law. This case reached the federal courts in 2001 and involved a four-time habitual offender. The perpetrator had been convicted of aggravated stalking for repeated physical attacks and threats upon the survivor's life and the lives of her family members over a period of several weeks. He was sentenced to life in prison, which was later reduced on appeal to 15-25 years. He then challenged Michigan's

stalking law on grounds that it violated the Constitution by being too broad, a common argument in constitutional cases. The language a law uses to define criminal conduct cannot be so vague or overbroad that people engaging in perfectly legal behavior could be convicted of a crime. This would make such a law unconstitutional and, therefore, invalid.

In *Staley*, the perpetrator's attorney argued that the aggravating stalking statute violated the First Amendment because the legislature included language in the law that excluded certain conduct from the stalking law. This conduct involves "constitutionally protected activity" and "conduct that serves a legitimate purpose." The attorney argued that since the statute was unclear as to what kinds of conduct were excluded from the statute's reach, the statute violated the First Amendment and the perpetrator's due process rights under the Fourteenth Amendment.

On appeal in the district court, the judges agreed. They cited examples of labor picketing and organized protests as activities that could be subject to the stalking law. The court also gave the example of a press reporter who is persistent in her efforts to question a juror, which cause the juror emotional distress. If the juror had a reasonable feeling of harassment or fear, the reporter could be prosecuted under the statute. The court also suggested that a citizen who repeatedly calls a congressman or the filing of numerous documents with a court clerk could fit the definition of stalking. Finally (though many might not protest), the court indicated that repeated telephone calls from a telemarketer or visits by a door-to-door salesman could subject them to prosecution for stalking under Michigan's law. As a result, the district

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## *Interpreting Michigan's Stalking Law continued...*

court overturned the defendant's conviction. The prosecution appealed to the U.S. Court of Appeals for the 6th Circuit.

### **The Federal Court Holds the Law Constitutional**

In a lengthy and highly technical court opinion, the U.S. Court of Appeals reversed the lower court's decision, holding that Michigan's stalking law was not unconstitutional. First, under standards established by the U.S. Supreme Court, statutes must define the criminal offense with sufficient definiteness that ordinary people can understand what conduct is prohibited and in a manner that does not encourage arbitrary enforcement. Finding that the Staley's conduct easily met all the elements of the statute, applying the stalking law to him was not an arbitrary act by law enforcement.

Second, unlike the cases the perpetrator cited in his argument, such as an anti-loitering law where totally innocuous behavior could be criminalized, the court held that the Michigan stalking statute was dissimilar to the statutes at issue in these cases. Conversely, the detailed nature of the Michigan stalking statutes prevents such arbitrary enforcement. As a result, the Federal Court reinstated the conviction.

For more information about stalking, stalking laws, and how to advise those who are being stalked, please refer to the following resources:

The Michigan Coalition Against Domestic and Sexual Violence (MCADSV)  
[www.mcadsv.org](http://www.mcadsv.org)

The National Center for Victims of Crime  
[www.ncvc.org](http://www.ncvc.org)

AARDVARC (An Abuse, Rape and Domestic Violence Aid and Resource Collection)  
[www.aardvarc.org](http://www.aardvarc.org)

### **References**

Tjaden, P. Thoennes, N. (1998). *Stalking in America: Findings From the National Violence Against Women Survey*. National Institute of Justice.  
<http://www.ojp.usdoj.gov/nij/pubs-sum/169592.htm>.

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## Protect the Crime Victims' Fund

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■ By Leslie O'Reilly

The President's FY 2007 Budget, introduced on February 6, 2006 proposed seizing the balance of the Crime Victims' Fund, **\$1.255 billion**; leaving a zero balance at the beginning of FY 2008. It also requested a cap of \$625 million for this program. This budget proposal would leave no funds available for any VOCA supported grant activities for FY 2008. This is the second year that the Administration attempted to wipe out the Fund balance putting essential funding for over 4,400 direct services programs in serious jeopardy. Last year's rescission was soundly defeated by Congress; not one vote was recorded favoring the Administration's proposal. This year, both the House and the Senate have rejected the Administration's request to rescind the Crime Victim's Fund and have set the FY 2007 cap at \$625 million. (Please visit the National Association of Victim Assistance Administrators website at [www.navaa.org](http://www.navaa.org) for the updates regarding the FY 2007 VOCA Crime Victims' Fund.)

According to latest DOJ budget projections, the FY 2007 cap must be at least \$665 million, excluding amounts for the Anti-terrorism Emergency Reserve, in order to maintain state victim assistance grants at their FY 2007 levels. Final action on the Department of Justice's Appropriation bill for the FY 2007 is not expected until after the mid-term elections.

Thank you to everyone who has been fighting to save the Fund and ensure adequate VOCA funding for crime victims.

### Background on the Crime Victims' Fund

The Victims of Crime Act (VOCA) Fund was created by Congress in 1984 to provide federal support to the many state and local programs that assist victims of crime. The VOCA Fund is derived entirely from fines and penalties paid by offenders at the federal level, not taxpayer revenues. The Crime Victims' Fund is distributed to the states through a formula grant. The state money funds both crime victim compensation programs, which pay many of the out-of-pocket expenses incurred by victims, and victim assistance programs such as rape crisis centers, domestic violence shelters, victim assistants in law enforcement and prosecutor offices, and other direct services to victims of all types of crime. The amount of funding available to the states is affected by earmarks and set-asides. Avoiding the creation or expansion of additional earmarks and preserving the balance of the Fund for future years will make a tremendous difference to crime victims across the country.

### Continuing Need for Funds

VOCA assistance grants are a key source of funding for programs that directly assist crime victims, including crisis intervention, assistance with the criminal justice process, safety planning, counseling, support, court accompaniment, and much more. Domestic violence, sexual assault, and

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## *Protect the Crime Victims' Fund continued...*

and general victim services programs all have pressing needs to expand their outreach and service components. Some 4,400 agencies rely on continued VOCA funding to serve 3.8 million victims a year. And yet, there are still too few services for disabled victims, rural victims, teen victims, elder victims, non-English speaking victims, and others.

Because the Fund consists entirely of criminal fines on federal offenders, the amount collected each year fluctuates greatly. The balance has allowed Congress to maintain consistent funding for VOCA

Assistance. The money at risk would have already been distributed to the states for much needed funding for victim assistance, but for Congress' creation of the reserve for the express purpose of preserving the money to ensure stable funding in future years. Diverting or earmarking money for specific projects undermines this important aspect of the Fund and depletes the funding available to meet future needs.

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*Leslie O'Reilly is the Program Specialist with the Crime Victim Services Commission.*

## Forensic Nurses Assist Law Enforcement

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- By Renae Diegel (Originally printed in Michigan Trooper, Vol. 41, No. 5)

In the tough world of law enforcement, dealing with Criminal Sexual Conduct (CSC) cases is always a challenge and often not a favorite for law enforcement to investigate. Forensic nurses have come forward to assist in this difficult process by providing medical forensic examinations in cases with a complaint of sexual assault.

In the past, if someone had a complaint of sexual assault they would report to local emergency departments to receive what's commonly known as a "rape kit" to be completed by the hospital staff. But what's not known to law enforcement is the very little training, if any, that the health worker had in completing these kits. Emergency department staff often has no training on how to perform a rape examination. Furthermore, if they have had the education the hospital staff is usually busy providing care to what some would consider as more urgent cases such as heart attacks, strokes, and trauma patients. This process would often leave the sexual assault victim/patient to wait long hours while waiting to receive care from the assault.

"I witnessed two nurses arguing over who was going to perform the task of the rape kit," said Detective Thomas McMullen of the Sterling Heights Police Department. Eventually one of them read the instructions as she went along – hardly a reassuring sight, for either the cop or the victim. When it's something you're not proficient at, patients are going to pick up on it. Equally important, the kit being collected properly could be the key to the crime being solved. "With a sexual as-

sault, one or two things are going to happen. Someone is going to say, 'It was consensual,' or 'No, it didn't happen at all,'" McMullen added.

Sexual Assault Nurse Examiner (SANE) programs are opening up throughout the State of Michigan and are here to bridge the gap between health care and the criminal justice system. A SANE nurse is a registered nurse who has been specially trained to provide comprehensive care to the sexual patient and demonstrates competency conducting a medical forensic exam. They also have the ability to be an expert witness. SANE nurses receive 40 hours of classroom training and another 60 hours of clinical training on issues of sexual assault and how to perform a medical forensic examination. They standardize the care these victims/patients are receiving, and in addition, have been trained on how to properly collect forensic evidence.

SANE programs can either be established located within a hospital (usually with the emergency department) or can be a community based program which runs independently. Depending on the program make up, some programs are available to provide a variety of services other than just sexual assault examinations. Several programs can offer other services such as suspect examinations, which are often performed in the local jail where a suspected perpetrator is being held. The perpetrator is known forensically as a second crime scene and has the potential to have trace evidence on him/her, which

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## *Forensic Nurses Assist Law Enforcement continued...*

means that they are in need also for having a rape kit performed on them to collect forensic evidence.

In addition, the forensic nurses are also available to photograph and medically document physical injuries in cases where injury documentation is crucial, such as child abuse cases. "I had the nurses do an exam on an abused child; the documentation was unbelievable that I received. The documentation from the hospital was only a written paragraph. From the forensic nurses I have four pages of injury documentation along with photographs taken correctly so they could be used in court. It really helped my case," said Detective Kevin Woods from the Warren Police Department.

Turning Point's Forensic Nurse Examiner Program, located in Macomb County, was fortunate to have tremendous support from the late David Woodford, a scientist with the Michigan State Police Forensic Science Division located in Sterling Heights. He supported and educated this team to provide a service that's unique to Macomb County. Working in conjunction with the Macomb County Medical Examiner's Office, this group of nurses responds to crime scenes and takes trace evidence from the body before it is moved to the morgue. "It just makes sense to have nurses looking over the body at a crime scene. They are very familiar with the human body. It's what they do every-day," Woodford would explain to detec-

tives convincing them it was acceptable to let civilians on their scene. "They know what they are doing. They are not there to take over your scene. They are only there to look over the body," Woodford would add.

"The forensic nurses have been a valuable asset to the MSP crime lab ever since its inception. There have been crime scenes that have been successful because of their professional/excellent work and assistance the program has provided not only to the laboratory, but to many local law enforcement agencies throughout Macomb County," said S/Sgt. Steven Nowicki, Latent Print Division of the Sterling Heights Forensic Science Division.

In the old days someone would have to die in order to get a detailed forensic examination by a medical examiner. Now forensic nurses can provide this service to the living population. They are not just available for sexual assault anymore. Any case that involves a body has a potential where a forensic nurse can be of assistance.

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# VOCA Grantees Making A Difference

*"Many volunteers have been with River House as unpaid staff nearly since its inception."*

## River House, Inc. Appreciates Volunteers

■ By Marey Jurkovich

Volunteers at River House are essential to daily operations. They provide strong support to both clients and staff. It takes a very special person to volunteer, and River House volunteers are extraordinary!

Volunteers assist River House in a wide variety of ways. Some volunteers assist paid staff as part of the on-call team. These volunteers carry a pager when on-call, and they are ready to respond when needed to support a victim of domestic or sexual violence. Other volunteers offer childcare or a listening ear to women staying in the shelter. These dedicated people have completed extensive training, and they continue with their education as updated information becomes available. There are also volunteers who are ready to help around the building, by putting up shelves or repairing a chair, for example. Clerical duties, phone calls, bulk mailings, and sorting donations are all tasks supported by volunteers.

In addition to our regular volunteers, we have volunteers who support special events. Each October on Make a Difference Day, a crew of volunteers comes together to upgrade and clean the shelter. Providing a safe and clean environment for women and children during their transition is reward enough for these volunteers.



*In observance of National Volunteer Appreciation Week, the paid staff at River House cooked lunch for volunteers on April 21, 2006. Shown here are Helen Scheer, Sr. Jean Umlor, RSM, Catherine Bergum, Deborah Smith, Barbara Mrozinski, and Marey Jurkovich, RH Volunteer Coordinator (back row); and Mert Brushaber, Jeanne Cardinal, Rhoda Hacker, RH Director, and Pat Ecola (front row).*

Volunteers for River House come from many different walks of life. People's interest is often piqued when our staff and volunteers visit and talk with members of the community about the services we provide. There are many areas of need, and therefore potential volunteers have the freedom to choose their level of involvement.

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## *River House, Inc. Appreciates Volunteers continued...*

Perhaps the River House Board of Directors does not think of themselves as volunteers, but they are by definition. According to Webster, volunteers are those who, of their own free will, offer themselves for service. The Board spends countless hours in meetings assuring River House will be faithful to our mission now and in the future.

Many volunteers have been with River House as unpaid staff nearly since its inception. These long-time volunteers have a strong commitment to the Mission of River House, and they will continue to support paid staff and survivors of domestic and sexual violence and homelessness long into the future. Retaining volunteers is an important part of the work of River House staff, and we have come up with several strategies that seem to encourage volunteers to make a long term commitment to our organization. For example:

- Staff support our volunteers' personal situations. For example, if one of our volunteers is ill, we send a get well card.
- We address any issues promptly and respectfully through open and honest communication.

- We recognize the strengths and limitations of our volunteers, and use this information to match volunteers to particular responsibilities.
- Staff recognize volunteers on a regular basis. We tell volunteers things like "nice job," and "good to see you." We also have an annual volunteer appreciation luncheon.
- We always remember that our volunteers are not getting paid. They are choosing to do this job.
- We don't ask anything of our volunteers that we wouldn't do ourselves.
- We provide extensive volunteer training and invite volunteers to in-service trainings. We also ask older volunteers to mentor new volunteers.
- We provide a quarterly newsletter for our volunteers to keep them informed.

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*Marey Jurkovich is the River House Volunteer Coordinator.*

## Therapeutic and Empowerment Philosophies: Can't we all just get along?

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■ By Gloria Woods & Linda Lucchesi

When we were invited to author this article, we were asked to compare the philosophies of the therapeutic and empowerment models of responding to survivors of domestic violence. The hope was that the result would discuss each model's strengths. Coming from an empowerment perspective ourselves, we did not look for an "either/or" solution; instead we looked at how empowerment can be incorporated into (some) therapeutic models.

It is important to note that many battered women do not need counseling or outside help in healing. Moreover, women (and some men) are not trapped in violent relationships because of low self-esteem or some other mental health condition, but rather because our culture creates and reinforces the power of batterers. Our experience shows us that most battered women are strong people who live through brutal conditions and can come through the trauma of those conditions without the need for extensive counseling. However, there are battered women who benefit from therapy. In our view, there are helpful and unhelpful models of therapy and empowerment for women who need this type of assistance.

The language we use in this article reflects our political and philosophical stance. We use the word "survivor" or the term "battered woman" to describe a person who was/is the victim of domestic violence. Our use of the term "battered women's movement" is an acknowledgment of our political and philosophical perspective as feminists on the causes of violence against women and our identi-

fication with the women who created a political movement to end it. When referring to survivors, we use the pronoun "she," not to ignore male victims, but because 90-95% of victims are women (BJS/USDOD, 1994), and because domestic violence is rooted in our culture's gender-based power structure, which gives men more power than women to determine what behaviors are rewarded, allowed, ignored, and punished in our society.

The good news is that therapy and empowerment are not mutually exclusive. In fact, a therapist can find that he/she is most effective when working with survivors when he/she has a sound understanding of domestic violence and utilizes a model that incorporates empowerment.

### So, Where is the Conflict?

Ellen Pence (1987) wrote "We must constantly be aware of the tremendous pressures to view women's oppression as a sickness rather than as a political, social, and cultural condition." Similarly, Worell and Remer (1992) explained "Psychotherapy traditionally applied to medical or illness models locate problems within the person and aim to remediate pathology in patients." Therapeutic models become problematic when providers view an individual's behaviors as caused by a mental state that is outside of the norm, i.e. pathological, without recognizing the context in which the behavior takes place.

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## *Therapeutic and Empowerment Philosophies: Can't we all just get along? continued...*

However, an empowerment perspective can be problematic as well, if applied without a social change component. It was early on in the battered women's movement that the concept of empowerment was criticized. Author Bonnie Mann, as quoted by Pence (1987), says,

The word "empowerment" individualizes and psychologizes the issue. The issue is one of women's power (as a group) getting systematically ... destroyed by male violence and by an ideology of male supremacy, yet the solution that is offered traps us in a search for a transformation that takes place inside of us, not a transformation of the conditions of our oppression.

Using the word empowerment is not sufficient because it can imply different meanings. The battered women's experience must be seen and addressed as a social problem. If a survivor's experience is individualized or pathologized, whatever counseling method is used will be ineffective at best and victim-blaming at worst.

### **Empowerment-based Therapy**

Empowerment can be described as a process for developing change. One author has described three levels of empowerment: personal, intrapersonal, and political. Personal empowerment involves acknowledging the power one already has, while intrapersonal empowerment comes when one has the ability to affect or increase one's influence over others. Political empowerment usually comes through group support and coalition-building around social action and change. All three levels of empowerment are necessary, and they must be informed by the multiple barriers a survivor may experience. For instance, the experiences

of women of color, lesbians, and people with disabilities will be impacted by racism, ethnocentrism, heterosexism, and able-ism (Gutierrez & Lewis, 1999).

Effective therapeutic models hold to several truths, beginning with the understanding that domestic violence is a complex social problem rather than a personal or private matter. Factors such as gender inequality, patriarchy, and social disenfranchisement create a climate where violence against women flourishes. Therapeutic models can challenge the practice of laying blame and responsibility on women for their experiences of violence (Resick, 1983). In other words, therapeutic models that incorporate both the personal and the political sensibilities of empowerment work.

Effective therapeutic models are also sensitive to the impact of trauma past and present on the physical, mental, and spiritual well-being of a woman. These models normalize a survivor's symptoms and behaviors rather than pathologizing them (Sundberg, 1977). Without recognizing that a survivor's symptoms are a normal response to trauma, a survivor's batterer may be able to effectively use her "diagnosis" as proof that she is an unfit mother within the court system. Such a "diagnosis" could cause her to lose custody of her children or, at the very least, cause her voice to go unheard.

A therapist who does not understand these complex issues may misunderstand the experiences and behaviors of his/her client, asking "Why does she stay?" when the real question is "Why is he allowed to batter without accountability?" Effective therapeutic models involve working cooperatively with survivors to understand and change the systems in which we all oper-

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## *Therapeutic and Empowerment Philosophies: Can't we all just get along? continued...*

ate, rather than focusing on helping them to fit into its oppression.

### **From Our Perspective as Advocates**

At the Underground Railroad, Inc., we interact with thousands of survivors and their children each year. Most survivors use our advocacy within the courts or other systems to gain safety for themselves and for their children, as well as some accountability for their batterers. Many hundreds of these survivors find that working with an advocate who supports her or by attending peer support groups with other survivors is sufficient to help her start to feel whole again. It is a powerful thing to be in a room with a dozen angry survivors who realize that their experience is not only personal—it is shared by every woman in the room. "Why isn't something done about this?" is a question we hear, and our role is to help survivors discover ways that, working together, we can change how things are done.

Of the survivors we connect with each year, some also have mental health issues or may be experiencing the effects of multiple traumas. Others may realize that one or more of their coping strategies is no longer helpful. These survivors deserve to find therapists who understand the dynamics of domestic violence, acknowledge their survival strengths, and empower them with the knowledge that battering is not their fault, they are not crazy, and they do have options.

### **References**

- Bureau of Justice Statistics. (1994). *Violence Between Intimates*, USDOJ.
- Gutierrez, L.M., & Lewis, A. E. (1999). *Empowering Women of Color*. New York, NY: Columbia University Press.
- Pence, E. (1987). *Our Best Interest: A Process for Personal and Social Change*. Duluth, MN: Minnesota Program Development Inc.
- Resick, P.A. (1983). Sex-role stereotypes and violence against women. In V. Franks & E.D. Rothblum (Eds), *The Stereotyping of Women: Its Effects on Mental Health*, (pp. 230-256), New York, NY: Springer.
- Sundberg, N.S. (1977). *Assessment of Persons*. Englewood Cliffs, NJ: Prentice-Hall.
- Worell, J. & Remer, P. (1992). *Feminist Perspectives in Therapy*. New York, NY: John Wiley & Sons.

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## Communicating with Policymakers: A New [www.michiganadvocate.org](http://www.michiganadvocate.org) Tool

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■ By Julia Heany

All of us have a stake in local, State, and federal policymaking processes. As citizens in a democracy and as individuals concerned for victims of crime, it is our right and our responsibility to be involved in the decisions that impact our lives and the lives of those we serve. However, it is not always clear how to become involved with the policymaking process, or how to be most effective in our advocacy efforts. As such, a self-guided presentation has been added to the 'Resources' section of [www.michiganadvocate.org](http://www.michiganadvocate.org), which is designed to help professionals in crime victim services understand the policymaking process and advocate effectively.

This presentation, titled 'Communicating with Policymakers: Advocacy Tips for Agencies Serving Crime Victims,' begins with a basic explanation of the policymaking process. For most of us, it has been several years since high school civics class, and it may be somewhat difficult to remember exactly how a bill becomes a law. This section of the presentation describes how issues come to the attention of public figures, how issues are translated into bills, how bills move through the legislature, how policies are implemented, and how policies are evaluated. Keeping in mind the many steps in this process can help advocates identify multiple opportunities for becoming involved and different strategies that may be more effective at different stages.

The next section of the presentation offers specific advocacy tips and specifies the point at which advocacy becomes lobbying. It is important to recognize that nonprofits have some special considerations

when it comes to lobbying, and that various funding streams place limitations on using funds for lobbying efforts,

*Pursuant to direction to the Crime Victim Services Commission from the Legislature, grant funds received under the Victims of Crime Act Victim Assistance Grant Program shall not be used for lobbying and shall not be used to attempt to influence the decisions of the legislature, the governor, or any state agency.*

including VOCA. However, organizations like the Michigan Nonprofit Association ([www.mnaonline.org](http://www.mnaonline.org)) can help your agency understand restrictions that may impact your lobbying activities, and these restrictions should not preclude your agency from becoming involved in the policy process. The majority of this section describes ideas for pulling together background information on your issue, working with others who have similar interests, and taking action. The presentation concludes with the following 10 quick advocacy tips:

1. Expand dialogue among your agency partners regarding creating a shared agenda for advocacy – a shared vision communicated by several agencies is particularly persuasive.
2. Use your agency's email system or website to share information about State and national policy issues (e.g., opportunities to testify, excit-

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## *Communicating with Policymakers: A New [www.michiganadvocate.org](http://www.michiganadvocate.org) Tool continued...*

ing/troubling developments, upcoming votes, etc.).

3. Write letters to policymakers that are endorsed by your agency on agency letterhead.
4. Include policymakers in your work to help them see the importance of what you do and the challenges facing the clients you serve. Invite policymakers to meetings, presentations, events, or to tour your facility.
5. Send policymakers resource materials produced by your agency to help them become familiar with your work.
6. Include the policy implications of your work in presentations and in resource materials.
7. Build ongoing, trusting relationships

with legislators and legislative staff - relationships are the key to successful advocacy.

8. Encourage public dialogue regarding the tangible effects of policy choices on crime victims.
9. Send a member of your staff to testify at legislative hearings.
10. Prepare and submit proactive legislation.

If you have questions about this resource or suggestions that you would like to share, please contact Julia Heany at [jheany@mphi.org](mailto:jheany@mphi.org). Happy advocating!

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*Julia Heany, Ph.D., is the Project Leader at the Michigan Public Health Institute for the Crime Victim Services Commission Technical Assistance Project and co-editor of The Michigan Advocate.*