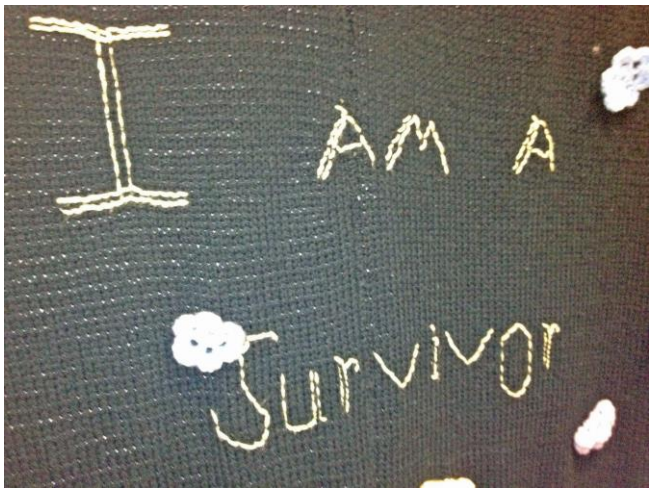

THE FEASIBILITY OF CREATING A RAPE CRISIS CENTER IN AMERICAN SAMOA

"Never depend upon institutions or government to solve any problem. All social movements are founded by, guided by, motivated and seen through by the passion of individuals." - Margaret Mead

Funded by OVW Grant Award 2017-MU-AX-0002

Table of Contents

Executive Summary

This document provides an overview of the existing Territorial response to sexual assault in American Samoa, and discusses the feasibility of creating a Rape Crisis Center (RCC) as the primary coordinator of timely, effective, streamlined assistance to victims and survivors. Studies have shown that Rape Crisis Center's produce better outcomes for victims and survivors as a result of their holistic and comprehensive array of services, and coordinated delivery and referral system[4, 19, 20].

Currently, service providers in American Samoa work in silos. There are no policies, protocols, or laws to enable interagency collaboration of service delivery. While attempts have been made over the years by government agencies, the lack of political will and high turnover in leadership created insurmountable barriers according to key informants within the Social Services department. The result is a critical need for crime and service data, ineffective use of federally funded program resources, unevaluated initiatives, and lack of qualified service providers.

The lack of data is the most concerning issue. Without valid data, prevalence and need cannot be determined. The following overview attempts to illustrate need using alternative resources and will be followed up with an analysis of felony case studies. The first recommendation is to fund the review of court records to establish a baseline and hiring of a qualified researcher to monitor court records to ensure that proper case information is released to the public.

The second recommendation is to analyze the back stories of each felony conviction to identify sociocultural enablers and develop effective educational, i.e. warning, messages for children. There is no cohesive, community-based and culturally normed education campaign on sexual assault in the Territory.

The third recommendation is to establish the key attribute of any coordinated response to sexual assault: networking. The development of responsive interorganizational protocols is necessary for the timely and effective delivery of services. Regardless of the funding levels amongst providers, if they are each approaching their client's situation as being one piece of a multi-disciplinary team effort, and in so doing make trustworthy, accurate referrals, the client (victim/survivor) will most likely receive the best possible service in that system[19, 24].

Is creating a Rape Crisis Center in American Samoa feasible?

While there is a definite need for a coordinated community response to sexual assault, feasibility depends upon who will emerge as the lead agency/organization to move the effort forward, and how strong their long-term commitment to the effort will be. While there are no uniform national or international standards governing the development of an RCC, the minimal services needed to be an effective RCC are available in the Territory, albeit uncoordinated. The development of the RCC should reflect the diversity and complexity of the community it serves. For this reason, a community-based non-profit may be best suited to be the lead agency.

The Feasibility Study Process

Background

The **American Samoa Alliance Against Domestic Violence and Sexual Assault** (aka Alliance) is one of 56 national Coalitions recognized by the federal Office for Victims of Crime – Victims of Crime Act (VOCA), and the Office on Violence Against Women – Violence Against Women Act (OVW). The Coalitions are exclusively funded membership organizations for local service providers and advocates for improvements in laws, services and resources for victims of domestic and sexual crimes[4]. As such, they have a fiduciary duty to address their partners' issues concerning the territory's response to domestic violence and sexual assault (DVSA).

In 2017, representatives from the territorial Department of Justice (CJPA) communicated to Technical Assistance facilitators at a Resource Sharing Project training that the best use of funding would be the establishment of a Rape Crisis Center (RCC) in American Samoa. In response, the Alliance coordinated a feasibility study to determine whether or not an RCC is warranted in American Samoa, and if so, ascertain the minimum standards of service provision for an RCC, and whether or not the territory has sufficient resources to comply with these standards.

Community Context

The Alliance is conducting an ongoing assessment of DVSA service provision levels and standards, and the coordinated response of service providers. Preliminary research shows that to date there is no intent to develop a 'State Plan' which includes an organized response to DVSA, there are no Coordinated Community Response (CCR) teams, or Sexual Assault Response Teams (SART); nor is there a Sexual Assault Crisis Center or any semblance of an organized network of service providers other than the leadership provided by the Alliance for its member organizations. A minimal level of service i.e. Child Protective Services, Rape Kits, one emergency shelter, are provided through federally funded local agencies such as the local Department of Human and Social Services. However, interviews with service providers reveal that all of them operate in 'silos' without protocols for referral, transfer, or inter-agency case management.

Preliminary data from the assessment reveal that core services for victims of sexual assault are not available in American Samoa (N=54). Exhibits B and C reflect a lack of understanding of what the core services provide victims/survivors, and that there are few services available for some of the most vulnerable individuals in our population including children, females, the disabled and elderly.

Due to the paucity of prevalence and incidence data on sexual assault in American Samoa, no one can factually state that sexual assault is ubiquitously problematic in the territory. However, sexual assault may be considered prevalent in this small community based on several alternative resources:

i. The newly established Sex Offender Registry of American Samoa (https://americansamoa.nsopw.gov/) which as of this writing is still being populated with prior offenders
ii. A review of court reports listed in the single local Samoa Newspaper

Exhibit D contains the complete legal designation of the Registry established by the American Samoa Sex Offender Registration and Notification Act or SORNA of 2017. According to the AS Attorney General in October 2017, Talauega Ale, there were "more than 100 sex offenders in the local sex offender registry"[1] however as of July 30, 2018 only 54 felons were registered on the website https://americansamoa.nsopw.gov/. Exhibit A presents a profile of the Registrants as well as 17 felons who were identified through court reports printed in the Samoa News. The Alliance was able to find background stories for 35 of the 71 felons identified so that victim ages and other data could be assessed below.

Exhibit A:

DATA SOURCE*	**#**	**%**
REGISTRY	18	0.2535
MEDIA	18	0.2535
BOTH	35	0.493
	71	1

GENDER	**#**	**%**
MALE	70	0.9859
FEMALE	1	0.0141
	71	1

NATIONALITY	**#**	**%**
U.S. NATL/CITIZEN	7	0.0986
NON-U.S.	17	0.2394
UNKNOWN	47	0.662
	71	1

PLEA AGMTS.	**#**	**%**
YES	42	0.592
NO	5	0.0704
UNKNOWN	24	0.338
	71	1

FELONS IN REGISTRY	**#**	**%**
INCLUDED	54	0.7465
EXCLUDED	17	0.2535
	71	1

INCARCERATED AS OF 7/27/18	**#**	**%**
YES	36	0.507
UNKNOWN	10	0.1408
		0.6478

AVERAGE AGE OF FELON @ TIME OF INCIDENT N=71	33.51 YEARS
AVERAGE AGE OF VICTIM(s) N=35	14.86 YEARS
AVERAGE JAIL TIME SERVED N=71	55.07 MONTHS

*Note: The assaults in Exhibit A occurred between 2008 and 2018, with the majority occurring in 2015. They include only those cases which are in the Sex Offender's Registry as of July 2018, and cases for which convictions were confirmed through publication in Samoa News. The Alliance was unable to access the official court records to conduct a thorough search for all sexual assault convictions before this report was due.

The underreporting by victims, undocumented recidivism, ineffective immigration protocols, and erratic statistics are major barriers to accurately assessing the extent to which sexual assault occurs in American Samoa. However, based on its experience in the community the Alliance endorses the community's concerns that sexual assault is prevalent and that traditional living conditions (i.e. multi-family households, transient family members) as well as cultural norms of propriety and sexual taboos, perpetuate environments in which sexual assault is proliferated and unreported.

A survey conducted by members of the Psychology Club at the American Samoa Community College in 2016 found that 25% of respondents (N=140) had "experienced some kind of sexual assault."[2] Half of them did not report their experiences citing fear or not knowing who to tell, and only 34% said they felt comfortable talking to parents about their sexual encounters. While the reported results excluded demographics and research methodology it is clear that sexual assault is prevalent amongst the group of college students. The assessment of the Offender Registry data also validated prevalence, and more importantly the background stories describe a culture which shames the victim and the victim's family more so than the perpetrator.

Amongst key informants in American Samoa chosen for their experience in the field of DVSA and/or high frequency of interaction with the community, the Alliance discovered that there is no single facility or agency committed to assisting victims/survivors of DVSA. In American Samoa, victims go from incident to status quo, or haphazardly through the system i.e. disclosure, investigation and treatment. There is no dedicated, coordinated center of support for SA victims. There are no metrics for assessing victim outcomes, number of victims served, number and type of services used and to what extent, or the reach of those services.

While traditional statistics are unavailable to validate the prevalence of SA, there is a clear need for a coordinated response to SA which could be fulfilled by an RCC or adapted form of a Crisis Center.

Methodology

Without valid incidence and prevalence of sexual assault in the territory, this study is not reliant on a baseline to assess the need for an RCC according to the number of assaults recorded.

This study utilizes a community based participatory-action model of qualitative research with the goal of determining the feasibility of developing an RCC that is responsive to the unique needs of local SA victims in the multiple contexts of service delivery in American Samoa including culture, place, literacy and economics.

The Alliance conducted interviews with 19 community leaders, and 10 SA survivors. They also surveyed 42 individuals from member organizations, 19 community leaders and 10 SA survivors. In addition to identifying the strengths, limitations, and gaps in the existing service delivery protocols the Alliance aimed to define the needs of member organizations and the community to effectively serve victims/survivors of SA. Interview questions and surveys were reviewed by a group of Samoans familiar with the Samoan language and culture, and pre-tested before interviews and surveys were completed on July 30th, 2018.

A literature review was conducted using references linked to websites and publications relevant to RCCs and sexual assault to identify minimum standards for service provision and operation in the U.S. and

abroad. An internet search was conducted to identify models currently utilized to serve victims, and published research specific to the concept of coordinated response to SA and advocacy philosophies. This study includes a thorough review of the local code annotated concerning the registration of sexual offenders, sexual assault offenses (Exhibit E): http://asbar.org/.

Defining a Rape Crisis Center

The first RCCs were established in the 1970s, side products of the wave of feminism and 'consciousness raising' during which women were more openly speaking about their SA experiences and demanding better services and support from government agencies[6]. Today there are 1300 RCCs in the U.S. funded primarily by federal agencies tasked with monitoring adherence to the Violence Against Women Act of 1994 (VAWA), Victims of Crime Act of 1984 (VOCA) and the Preventive Health & Health Services Block Grant (PHHSBG) administered by the CDC. The commonly accepted definition of an RCC is a ***community-based not-for-profit agency whose major purpose is providing advocacy and support services to victims and survivors of sexual assault***, and may be included in a dual service (DV and SA) agency[4].

In the 1980s the National Organization for Women identified rape as a priority focus which grew their organizational base and support for the criminalization of marital rape, repeal of the requirement for corroboration in rape cases, elimination of the requirement that survivors must have physically resisted their attackers as prerequisite to prosecution, and expansion of the legal definition of rape to include forced oral and anal sex, and other deviant sexual acts[6]. The redefinition of rape between 1927 and 2013 also changed the ways in which people viewed sexual assault. Today, the official definition of rape by the U.S. Federal Bureau of Investigations is "penetration, no matter how slight, of the vagina or anus, with any body part or object, or oral penetration by a sex organ of another person without consent of the victim[7]." This definition is not gender based, removes any religious references, and eliminates the premise that the act of rape must include physical force (as if the violation of one's body isn't enough). Compare it to the original definition to understand the narrow focus and presumption of the male dominated society in the 1920s: 'Carnal knowledge of a female forcibly against her will.' The definition of rape in the code annotated of American Samoa is: 'a person commits the crime of rape if he has sexual intercourse with another person without that person's consent by the use of forcible compulsion or he has sexual intercourse with another person who is 16 years of age or less.' Rape is defined in terms of gender, requires proof of force, and limits the act to intercourse without a concise definition. The legal age of consent is 17 years.

RCCs specifically serve victims of rape, however many also serve victims/survivors of sexual assault in general as many incidents tend to overlap, especially if there are repeat violations. Forms of SA include sexual harassment, threats and intimidation, attempted rape, incest, et cetera. No RCC in the U.S. will ask for evidence or corroboration of SA at intake – all victims are treated as credible. Many RCCs refer to primary and secondary (family, spouse, etc.) victims. Typically, an RCC will not discourage serving 'significant others' or secondary victims. A qualified RCC client is an 'individual who is a victim of SA, who requests services from the RCC', and provides sufficient information to establish a case file[8].

The RCCs' prime objective is to provide 'emotional support and assistance' which distinguishes them from doctors whose main concern is the physical welfare of the victim, and the police whose concern is the investigation and prosecution of the perpetrator[6]. Therefore networking – developing responsive

interorganizational protocols – is a fundamental attribute of the RCC. RCCs that are integrated into a network of mainstream organizations are the most responsive to rape victims/survivors[6]. Likewise, the most effective networks for fostering community response to SA are those coordinated by an RCC in seamless partnership with local police and healthcare providers. RCCs also manage a community's response to rape by ensuring that victims/survivors are protected by confidentiality, linkages between organizational services are streamlined to eliminate repetition, and that anonymous reporting is available.

Minimum Service Provision

International standards recommend that one Rape Crisis Center be available for every 200,000 females[8]. Additionally, the RCC should house at least one Specialist in sexual violence and the minimum services should include: an anonymous phone helpline, individual counseling, accompaniment to other services, and advocacy. Also, each staff member should complete a minimum of 30 hours training in all areas of DVSA. As a gold standard, the RCC could be integrated with assigned physicians, law enforcement and forensic specialists. Advocacy, protocols for suicide and crises, legal advice and financial assistance are also highly recommended.

Each RCC is unique in that it must reflect the specific needs of the community it serves.

In the U.S., 1300 RCCs provide an array of services that could be considered 'minimum' or standard provision of services. Most are guided by the requirements of their primary funding sources. To be eligible for federal funding, each RCC must demonstrate that it has support from its community, organizational stability, and sustainability beyond funding. Other funding sources include the National Institute of Mental Health's Center for the Prevention of Rape, Law Enforcement Assistance Administration, Department of Justice, and the United Way. Many of these funders also focus on community service provision which includes education and prevention programs, training of service providers to create standards for collaboration, writing legislation/advocacy, and outreach.

A review of the 'core characteristics' of 28 RCCs in the U.S., conducted by the Resource Sharing Project[4,9], identifies core services as opposed to supplemental services. An online review of the services provided by RCCs (through their websites) excluded from the Project reflect the same minimal menu of services offered primarily to individuals. **Without these essential services the agency would not be considered an RCC**:

RCC Core Services for Individuals *(presumes the victim 'presents' him/herself to RCC for assistance)*
a) **24-hour Crisis Intervention**: timely response to an individual presenting a crisis related to SA
b) **Support Groups**: foster sense of regaining control, promote understanding of SA, assist with finding resolution
c) **Advocacy & Navigation**: Medical, legal, and general advocacy; supporting and assisting a client to define needs, explore options, ensure rights are respected
d) **Counseling & Therapy**: supporting victim's recovery process
e) **Institutional Advocacy/Systems Change**: RCC advocates for social change by addressing community conditions which adversely affect SA victims
f) **Prevention & Awareness**: each RCC is an active community resource (engaged in community)
g) **Information & Referral**: each RCC is an active source for info and referral for victims, families and community

The only State which listed a specific metric to qualify as an RCC is California: at minimum, the RCC must serve the same number of SA victims as number of forcible rapes reported in the RCC's service area[8]. As a community-based networking agent, the RCC should also provide a minimum level of core services for the population it serves. There are no uniformly defined standards amongst the 1300 RCCs in the U.S., however a review of their websites and the literature from international SA advocacy groups offer the following prescription:

RCC Core Services for Communities

a) **Community Presence**: the RCC is engaged in the community society and culture
b) **Information & Referral**: provide TA in the development of protocols to facilitate inter-agency referrals and data sharing
c) **Prevention Education**: presentations, trainings, outreach, materials to increase community awareness and understanding of SA
d) **Professional Training**: normally directed at law enforcement, medical personnel and social services, RCCs can provide SA training that these service providers may not have funding for
e) **Institutional Advocacy**: advocating for change in system responses to victims, developing networking agreements to partner, establishing SARTs, being active participants in local service networks

Several States have established Penal Codes or legislation that define the minimum standard of service provision by RCCs within their borders. (*They are provided as examples for consideration here.)* In **Texas** the core services are defined by law, funders and the State Coalitions. There are 84 cities in Texas who have community-based SA programs (SAP) who manage the RCCs. The current statutory requirements identify five minimum services to be provided by the SAP/RCC: 24-hour crisis hotline, crisis intervention, advocacy, accompaniment to services, and public education. Until 2014 there was no consensus on the basic components of the five services but the SAP/RCCs intended to develop standards to ensure that every survivor has access to a minimum level of consistent services, and to provide a framework for describing and developing service components[10]. They developed detailed criteria for each service, which includes risk management protocols to ensure victim/survivor confidentiality and safety, training requirements, QA/QI metrics, performance and evaluation metrics. It is a simple, 8-page document but detailed in a straightforward list format that mirrors the majority of service descriptions used by the RCCs[10]. See Exhibit F.

The State Advisory Committee on SA Victim Services was established pursuant to **California** Penal Code to set minimal level of operational standards for Rape Crisis Program grant recipients in the State. The goal of their service provision standards is to 'reduce the level of trauma experienced by SA survivors through provision of comprehensive and supportive services' to improve coordination of multi-disciplinary response systems[11]. Of 28 State standards reviewed, California comprises the most detailed standards for operations, administration and coordination. All RCC program services must be provided by a SA Victim Counselor who completes 40 hours of SA training before meeting with clients, and eight hours of continuing education annually. The Counselor's application and the RCC training curriculum must be certified by the State Agency. The RCC must provide training to partner agencies, participate in quarterly multi-disciplinary meetings to coordinate comprehensive response systems for SA survivors, and directly assist/refer clients to victim/witness projects or private attorneys for assistance.

The Council of **Europe** defines an RCC as an 'NGO that provides some combination of helpline, counseling, advocacy and self-help in supporting women and girls who have been assaulted recently or in the past.'[12] As standalone entities outside of the socialist health care system, these RCCs are unique in that reporting incidents to government agencies is the victim's choice. The Council identified the following minimum service provision: anonymous phone helpline, one to one support and counseling, accompaniment to other services, group support, and advocacy. These mirror the standard of RCCs in the U.S., with the addition of a minimum training requirement of 30 hours in DVSA[13]. They also recommend a national crisis hotline which would be followed up with a 'live' response in 48 hours.

A thorough review of the RCC standards available online and the Resource Sharing Project studies provides a consensus that the five core services defined by the RCCs in Texas are the most universal amongst SA programs and RCCs in the United States. Exhibit F provides the criteria list for the five core services used by the RCCs in Texas as an example.

***How* one provides may be more important than *what* one provides when assessing sexual assault services**

Minimum Standards of Practice

The services provided by the RCC are its defining attributes, however the ways in which the services are provided – foundational philosophy, methodology, values – are equally important.

The RCC philosophy is grounded in social justice: 'the social justice-based model of intervention holds that clients are inherently whole, strong people who are not at fault, but who might benefit from support after sexual violence'[4]. All service standards examined by the Research Sharing Project contain sections on philosophy, approach, guiding principle or ethics that used terms like empowerment, victim-centered, without blame, and trauma-informed. They also viewed social change as necessary to eliminate SA, and self-determination as necessary to establish autonomy and achieve healing.

Trauma Informed Services and Women-Centered Care were also common approaches to service delivery. Trauma-informed services are rooted in the understanding of the effects of trauma on survivors and their families[17]. These services support growth and autonomy, and actively work to build victim/survivor resiliency throughout the treatment and healing processes. The World Health Organization (WHO) advocates for 'women-centered care' in the response to IPV and sexual violence. This approach entails immediate first-line support provided by a healthcare provider to any woman who discloses any form of SA[18]. Consultation is non-judgmental, validating, expeditious, and confidential. Any intervention must be guided by the principle 'to do no harm'. WHO guidelines also state that 'women who have spent at least one night in a shelter or safe house should be offered a structured program of advocacy, support and empowerment'. Finally, WHO promotes one service that is not as commonly mentioned in the U.S.: emergency contraception and early term abortion for a rape induced preganancy[18].

Other common philosophies or guiding values are: confidentiality, accountability, specifically trained workers, free/no fee collected, supporting survivors' choices, providing services to all/diverse survivors, 24-hour access, and expedient response time. RCCs should also ensure the safety of both service users and providers. There should be protocols for suicide calls, and other crises which include transportation and third-party anonymous reporting[8]. Additionally, all services should be provided in private

environments and include access to legal advice and advocacy, practical support like shelter and access to a phone or computer, information and referral.

The Australian National Standards of Practice for Services Against Sexual Violence (NASAV) provides best practices for each standard. Exhibit G is a snapshot of these, founded upon the UN Declaration of the Rights of Indigenous Peoples: the central Right of Self-Determination. As standard practice service organizations, including RCCs, must be willing to address issues of difference arising out of race and culture[14]. Thus, achieving cultural competency is a primary goal. The NASAV promotes 'culture-infused counseling' which places culture in the center of every interaction between victim/survivor and provider. From client intake to treatment or resolution, the policies and procedures recognize and value diversity and the rights of all people.

All RCCs reviewed state that accountability is an essential feature of an RCC, developed in a client centered, survivor driven and transparent way. For example, a crisis line should be tested quarterly and results reported to the community[4]. Most RCCs require a live person answer the crisis phone. Also, protocols should be in place for every service provided and for the hiring and training of all providers, including volunteers to ensure the safety and confidentiality of clients. Training should include gendered analysis of violence against women, diversity, impact and meaning of SA trauma, active listening, assessing risk, and empowerment[8].

Ethical codes of conduct should be guiding principles for the intake, documentation, allowable disclosures, expectations for Board, staff and volunteers. Clients should be informed about the scope, limitations, and independence of the services provided[16]. To ensure that providers are supported to make ethical choices in dealing with victims/survivors, they should be trained to be aware of their own personal beliefs and prejudices and how to put these aside in order to respond to the victim/survivor in a respectful and nonjudgmental way.

The U.S. White House Task Force to Protect Students from Sexual Assault found that Crisis Centers, including RCCs 'make a difference': victims received better treatment in the medical system, survivors reported that contact with the RCC was beneficial, advocates increased victims' knowledge and understanding of options[17]. The critical components which differentiated RCCs from other sexual assault programs are the coordinated responses in the community which allowed for service flexibility by collaborating between different services. This attribute, the core feature of an RCC – networking – is directly related to better victim outcomes[17]. To establish an effective RCC in American Samoa, the service providers will have to emerge from their working silos and begin to collaboratively address sexual assault issues in the territory.

American Samoa's Current Response to Sexual Assault

Service providers from 22 communities in the U.S. with coordinated SA programs were interviewed for a study which aimed to determine how and why these programs are helpful to rape victims. Results showed that the 'high coordination' communities shared three types of services in common: coordinated service programs, interagency training programs, and community-level reform groups[19]. They essentially created a community culture that is more responsive to victims' needs. The researchers hypothesized that coordinated programs reflect the complexity of needs that victims of SA experience and are able to meet those needs through coordinated response and referral.

Organizational Assessment

An interview with the Branch Manager of the American Samoa Child Welfare and Family Advocacy Branch, **Department of Human and Social Services** (DHSS), who is also the State Administrator for the Family Violence Prevention and Services Program which administers the Family Violence Prevention and Services Act (FVPSA), revealed that during her 18-year career in the Department there has never been a coordinated community or inter-agency response to DVSA. She cited several attempts to establish MOUs with the Department of Safety (police) but due to changes in leadership, politics, and what she termed 'a lack of understanding' of DVSA, to date there are no protocols to collaborate with the police, and no legislation to mandate referrals.

According to the Chief of **Emergency Medical Services** (EMS), domestic and sexual assault are common in the local community. "We receive at least one call a week", he stated to the Alliance in 2017. When asked what the protocol was for handling victims during an emergency call the procedures he described were not consistent: "if they want to go to the hospital then we take them, but many times they don't want to go". When asked if EMS procedures required them to report the incident to Social Services he replied, "no". He also shared that there are no written agreements or formal procedures that initiate or require inter-agency collaboration between EMS and DPS or the hospital. It appears that the extent of their response to a call is to do what they can to "stabilize the person", and move him/her to the ER at the hospital or transport the patient to a safe space at the patient's request.

The Alliance has made several, well documented attempts to establish a working relationship with the **Department of Public Safety** (DPS). They have offered to send officers off-island for DVSA training, provide on-site technical assistance, and simply interview representatives to find out how the Alliance can develop collaboration between the department and other service providers. Unfortunately, the department's leadership has been unresponsive which validates similar experiences shared by service providers.

The **Attorney General's Office** has provided several insights to the local **court system** from the perspective and experience of individual attorneys. Unfortunately, the judges and other court employees have declined to speak with the Alliance or collaborate with service providers outside of the parameters set forth in legislation regarding public records. Requests to participate in surveys, interviews and community activities have been politely denied.

The **Department of Education** (DOE) has the most regular contact with minor children. As such, it is reasonable to hope that teachers and administrators would follow an established protocol to identify, report, and manage victims of SA found in their student populations. It would also be prudent to have established working relationships with DHSS, DPS and the hospital. A review of the American Samoa Compilation of School Discipline Laws and Regulations (2018) prepared by the U.S. Dept. of Education, shows that there are no protocols other than paragraph 52 in the Personnel Policy Handbook regarding "mandated reports on abuse, neglect and trafficking (of a child or minor)". Specifically, the regulation states that 'anyone' who has reasonable cause to suspect that a child/student has been subject to abuse or neglect shall immediately report such incident to the School Principal who shall then report the incident to the 'appropriate legal authorities'. One is led to believe that the 'legal authority' would be the DPS however this is not defined in the Policy. The report found no laws specific to the handling of sexual assault in the DOE system.

The **American Samoa Community College** (ASCC) Governance Manual addresses 'acts of threats or violence' on campus. With regards to sexual violence there is a section entitled 'New Requirements to Educate Students and Employees on Sexual Violence', but to date the only information is a simple statement: "1. Must have training programs in place"[21]. A review of the college's media show that the administration does support the education and awareness of sexual assault amongst students. In 2015, the Alliance participated in an outreach with students from the ASCC Psychology Department who conducted a well-attended workshop on violence.

The laws concerning **reporting requirements** help to ensure that victims of violence are identified and assisted, especially when they are not incapable of accessing help themselves. In the report, "Mandatory Reporters of Child Abuse and Neglect" (2018)[22], the AS Code Annotated 45.2002 requires the following persons to report child abuse:

- Physicians or surgeons, including physicians in training, osteopaths, optometrists, chiropractors, podiatrists, child health associates, medical examiners or coroners, dentists, nurses, or hospital personnel
- Christian Science practitioners
- School officials or employees
- Social workers or workers in family care homes or child care centers
- Mental Health professionals

And 'all other persons are urged and authorized to report.' Institutional Responsibility to report is not addressed in the Code. According to Code 45.2010, the name, address, and occupation of the reporter must be included in the report. The identity of the reporter is not released to the subject of the report if that release would be 'detrimental to the safety or interests of the reporter'. According to the Code, reports must be made to the DPS or Child Protection Agency (DHSS), and if the Agency is called first, and feels that abuse had occurred, it must then report to DPS.

The Code also establishes a '**Central Registry**' within DHSS to monitor "child abuse, sexual abuse, or neglect" as well as a 'Telephone Number for Reporting Cases'. According to Code 45.2021, oral telephone reports are to be "immediately transmitted by the central registry to the Director of Health together with any previous report concerning the subject of the report or any other pertinent information." The Central Registry should contain all information in the written report, record of the final disposition of the report including services offered and rendered, the plan for rehabilitative treatment, names and identifying dates and circumstances of any persons requesting or receiving information from the Registry. DHSS does manage an in-house database but is not considered a 'Central Registry'.

Code 45.2031 establishes a '**Child Abuse Commission'** comprised of six members appointed by the Governor for the purpose of reviewing appeals from parents whose child(ren) have been removed by authorities in response to charges of child abuse or neglect. This Commission should cooperate with the Child Protection Agency (CPS) in developing education and training for the public to establish awareness of medical and social problems of child abuse. According to the CPS Branch Manager, there has never been such a Commission.

Service Assessment

The Alliance conducted written, self-administered surveys with member organizations between May and June of 2018. Fifty-four surveys were returned. Question 12 asked respondents to cite whether or not five core services needed by SA victims are available in American Samoa for eight types of victims of SA (Exhibit C):

- Adult females
- Adult males
- Children
- LGBTQs
- Elderly
- Disabled
- Alcohol/Substance Abusers
- Adult survivors of child SA

In every category the majority of respondents had no answer/didn't know if the service existed. It is roughly a 35/65 split on whether they knew if the service is unavailable, or don't know.

When asked in Question 10 if a Crisis Line, Support Group, Shelter, Court Advocacy, Hospital Escort and Outreach are available in the Territory, the majority listed a resource. Most of those who stated that the service exists cited DHSS as the main provider. Many respondents listed the DHSS shelter as the source of 'shelter'. An overwhelming number commented that there is no mental health counseling available. Legal Aid is the primary source for 'Court Advocacy', and the Alliance was listed as the main source of 'Outreach', and 'Support Group'.

Unfortunately, there were also several groups or entities listed as providers who don't actually provide the service referenced, or don't do so in a consistent and organized way. These include individual advocates, church groups, and culturally based groups such as the village women's group. While they may offer support, they do not have the training or resources to provide services in a coordinated and effective manner. However, they should definitely be recruited to join any territory-level, agency led coordinated community response.

Limitations & Gaps in the Current Response

Integration of services is a key principle of trauma-informed care and the defining attribute of a Rape Crisis Center. The survey results, interviews, data reviews and analysis clearly show that the current use of the minimal resources available to coordinate a response to sexual assault in American Samoa undermines the quality of care that victims and survivors receive from the agencies and departments legally responsible to help them.

The lack of policies and protocols to sustain effective collaboration between service providers is a critical gap in the infrastructure. Legislation, policies and protocols withstand changes in leadership, funding, and political will. Advocates must coordinate their efforts to promote the development of clearly written policies and procedures. Additionally, existing laws must be reviewed for relevance and follow-through, i.e. does a Child Abuse Commission actually exist.

The law clearly places all responsibility for the reporting, investigating, and treatment of perpetrators and victims on the Departments of Safety, and Human and Social Services. The hospital, Department of Education, Department of Health, and non-profit groups in general are not recognized as available resources. There are also no laws to support or encourage collaboration between service providers.

As mentioned earlier, providers in American Samoa operate in silos. To coordinate their efforts a lead advocate will have to emerge as 'friend', supporter, empathizer for all providers. While education and technical assistance are always helpful, simply getting providers on common ground to discuss a State Plan, a Coordinated Community Response, is the first and most critical task.

A prime example of the lack of service integration was cited by the DHSS Branch Manager. She shared that her department receives funding to provide rape kits to LBJTMC, and pay for exams. She or her colleague carry a phone purposed for crisis calls from DPS and the hospital so that they can respond in person immediately. Unfortunately, most SA cases are sent to the hospital without their knowledge. Either DPS or the hospital do not inform them of the victim. Here is a case where, for the benefit of the victim, services can be provided free of charge by DHSS through the hospital, and the victim will also receive access to other resources through DHSS such as shelter, counseling, filing a police report. Without the proper referral, the victim must independently locate these services and navigate the legal system alone.

A second critical issue is the lack of trained SA service providers. It appears that all of the pieces of a minimally resourced SA response system exist, albeit uncoordinated, but the number of providers and level of expertise may be inadequate. As of March, 2018, DHSS CPS had only six employees in the department which includes Child Protective Services, the single crisis Shelter, and all other DVSA services. The Manager stated that there are two Shelter buildings but she only has enough manpower to staff one building which accommodates up to 20 individuals.

DHSS does not have a Ph.D. level counselor/therapist with experience in DVSA. There are no clinicians assigned to the Department to provide trauma-related interventions. Currently, the various service providers could not collectively provide 'comprehensive services' which include the minimal essential services plus opportunities for victim/survivor healing, education, and community prevention[23]. However, the survey responses suggest that there are sufficient resources combined with non-traditional grassroots programs at the community level. Together, the government departments and agencies could embrace the community-based advocates to create a 'trauma-informed culture':

Core Principles of a Trauma-Informed Culture	
Safety	Ensuring physical and emotional safety; 'do no harm'
Trust	Maximizing trustworthiness, making tasks clear, maintaining appropriate boundaries
Choice	Prioritizing survivor choice & decision making; supporting self management
Collaboration	Maximizing collaboration and sharing power with survivors
Empowerment	Identifying strengths, prioritizing building skills that promote survivor healing
Cultural Competence	Ensuring cultural applicability of services and options; sensitivity to the role of culture in lived experience and decision making

Growing such an environment would create a collaborative atmosphere, provide better services to victims/survivors, create a sustainable agent for organizational change, and reduce the distress and suffering experienced by victims and their families. Such an environment may encourage better data collection and sharing as well. This is the third major gap and limitation in the status quo: lack of valid data.

Proposing a Feasible Crisis Organization

Required Organization Collaboration

The three service phases of a coordinated response include the disclosure (reporting) phase, investigation and treatment. A coordinated interagency response streamlines the victims' progression through each phase[24]. Coordination requires a multi-agency/provider response in a systematic manner. At the very least the agencies/providers involved include police, prosecutors, crisis services, medical/clinical professionals, SA Counselors, legal/court advocates, child protection workers. All of these agencies/providers are functional in American Samoa.

To be considered an RCC the organization must have written agreements with services providers (MOUs) delineating the provisions of their collaboration. The agreements must align with local laws and federal mandates, as well as requirements by funders. They should also consider cultural norms. The context of the service delivery should consider culture, place, literacy and economics. An effective MOU will address all of these aspects. Exhibit H provides a straightforward MOU templated from the State of California.

The RCC must also have an established community presence and demonstrate community engagement that recognizes diversity. Working with community-based organizations as mentioned above will grow trust between the parties, enough to encourage referrals, and risk higher levels of involvement as time goes on.

The **main collaborators** are:

Department of Safety (Police)
LBJTMC (Hospital)
Attorney General's Office
Community-based Service Providers
Department of Human & Social Services
FQCHCs (Community Health Centers)
Fono (Senate & House of Representatives)
Department of Education

There are five essential attributes of an effective collaboration:

- Availability of resources in the community which highlights the community's commitment to victims
- Accessibility to services at any time of day
- Quantity in terms of number of services, diversity of services, and adequate staffing
- Quality of services in terms of approach being victim-centered and trauma informed
- Legitimacy of the RCC or trust in its worth by its partners

Required Systems Collaboration

Effective coordinated inter-agency response requires targeted, victim-centered, trauma-informed approaches to victim intake, investigation, management and treatment. Unlike most clinical protocols, the final resolution will not be in the form of a prescribed medication or procedure. Addressing SA requires long-term commitment to the healing and recovery of the victim throughout survivorship.

As such, systems collaboration will follow the lifetime continuum of social service and physical needs. Required systems could include services for the elderly, Social Security Administration, Medicare; services for the disabled and mentally challenged, daycare, adult education; services for those victimized for their gender identity or sexual preferences. An effective RCC will provide a 'comprehensive' array of services, if not in-house, then by referral to a trustworthy resource.

Many survivors feel revictimized during the process of disclosing their situation, prosecuting and accessing help[24]. They may be involved in several systems at once: social services for WIC, Food Stamps, etc.; in the healthcare system receiving treatment; in the judicial system prosecuting the perpetrator. Every time the victim must repeat his/her SA assault or explain its effects as the reason for something, it could potentially trigger a relapse into fear, anxiety, depression, even anger. This type of revictimization, feeling the stresses of the original assault, is not survivor-centered or trauma-informed. By ensuring that the various systems are included in the coordinated community response implemented by the RCC, revictimization is minimized and service access is streamlined.

Funding Issues and Resources

When considering 'who' could coordinate the development of an RCC, or at the very least, a Coordinated Community Response to SA, the Alliance emerges as the prime candidate. As the officially recognized State Agency by the Office of Violence Against Women and recipient of the Family Violence Prevention and Services Discretionary Grant, the Alliance is mandated and funded to coordinate services and provide technical assistance to service providers (their member organizations).

Also, as a non-profit entity it is not bound by the politics of local government administration and has the ability to leverage its resources without interference. With additional funding from the federal government, it is possible that the Alliance could take on the task of first – coaxing the various providers out of their silos to collaborate. They would need to identify tangible incentives for the initial roundtable discussions and move quickly towards the execution of MOUs. The Alliance's long experience in the community, and reputation for compassion and empathy will strengthen their credibility.

EXHIBIT B: Survey Responses to Q10 - What services are available to victims of SA in American Samoa?

Code 3 indicates that the respondent feels the service is available and he/she 'listed' a resource that provides the service; however, the majority of the providers listed do not provide the service as defined by VOCA and OVW. Some respondents 'listed' multiple resources which equal a higher response rate.

Crisis Line

Code	Response	Frequency	%
1	don't know	20	0.3704
3	no response	6	0.1111
2	list response	28	0.5185
		54	1

Support Group

Code	Response	Frequency	%
1	don't know	17	0.3148
3	no response	10	0.1852
2	list response	27	0.5
		54	1

Shelter

Code	Response	Frequency	%
1	don't know	12	0.2222
3	no response	9	0.1667
2	list response	33	0.6111
		54	1

Court Advocacy

Code	Response	Frequency	%
1	don't know	21	0.3889
3	no response	13	0.2407
2	list response	20	0.3704
		54	1

Hospital Escort

Code	Response	Frequency	%
1	don't know	16	0.2963
3	no response	11	0.2037
2	list response	27	0.5
		54	1

Outreach/Education

Code	Response	Frequency	%
1	don't know	17	0.3148
3	no response	11	0.2037
2	list response	26	0.4815
		54	1

EXHIBIT C: Survey Responses to Q12 - What SA services are lacking for specific demographic groups?

		Un = un available NA = No Answer	a. Housing	%	b. Free Legal	%	c. MH Counseling	%	d. Crisis Intervention	%	e. Support Group	%
Q12-1	**Adult**	Un	22	0.41	18	0.33	14	0.26	20	0.37	16	0.3
	Female	NA	32		36		40		34		38	
	Victims	Total	54		54		54		54		54	
Q12-2	**Adult**	Un	24	0.44	17	0.315	18	0.333	22	0.41	18	0.33
	Male	NA	30		37		36		32		36	
	Victims	Total	54		54		54		54		54	
Q12-3	**Child**	Un	19	0.35	19	0.35	18	0.33	22	0.41	15	0.28
	Victims	NA	35		35		36		32		39	
		Total	54		54		54		54		54	
Q12-4	**LGBTQ**	Un	26	0.48	22	0.41	25	0.46	24	0.44	20	0.37
	Victims	NA	28		32		29		30		34	
		Total	54		54		54		54		54	
Q12-5	**Elderly**	Un	22	0.41	20	0.37	23	0.43	21	0.39	18	0.33
	Victims	NA	32		34		31		33		36	
		Total	54		54		54		54		54	
Q12-6	**Disabled**	Un	21	0.39	19	0.35	20	0.37	19	0.35	16	0.3
	Victims	NA	33		35		34		35		38	
		Total	54		54		54		54		54	
Q12-7	**Substance**	Un	22	0.41	18	0.33	17	0.31	23	0.43	18	0.33
	Abusers	NA	32		36		37		31		36	
		Total	54		54		54		54		54	
Q12-8	**Adult Surv**	Un	22	0.41	20	0.37	20	0.37	19	0.35	18	0.33
	of Child SA	NA	32		34		34		35		36	
		Total	54		54		54		54		54	

EXHIBIT D: Chapter 28 - Registration of Offenders

http://asbar.org/index.php?option=com_content&view=category&id=744&Itemid=172

46.2801 Registration of persons convicted of offenses against a victim who is a child.

(a) Any person convicted of the following offenses, when the act was committed upon a victim who was a minor, or person under the age of 18 years at the time of commission, is required to register their name, identifying information, current residential address, and provide fingerprint, photograph, and any requested body fluids to the Department of Public Safety, corrections division warden:

46.3531 Kidnapping
46.3532 Felonious restraint
46.3533 False imprisonment
46.3534 Interference with custody
46.3604 Rape
46.3610 Sexual Assault
46.3611 Sodomy
46.3612 Deviate sexual assault
46.3615 Sexual abuse in the first degree
46.3616 Sexual abuse in the second degree
46.3617 Child molesting
46.3703 Patronizing Prostitution
46.3706 Promoting prostitution in the first degree
46.3707 Promoting prostitution in the second degree
46.3401 Attempt, when committed with the purpose of attempting the above offenses

(b) Persons convicted of these offenses, when the victim is a minor, or person under 18 years of age, shall for a period of ten (10) years from the date of release from prison, being placed on parole, supervised release, or probation, be required to notify the Department of Public Safety, correction division, of any change of residence within ten (10) days of the change of address. This requirement includes being out of the territory for a period of over six (6) months, or for any period of time where he/she is employed, or is a student.

Any person convicted of the above offenses who fails to register, or who fails to notify the Department of Public Safety, corrections division warden within ten (10) days of any change in residence, including being out of the Territory of American Samoa, is guilty of a crime, and upon convictions may be sentenced as for a class A misdemeanor.

(c) Any person who is required to register under subsection (a) above is also required to notify the Department of Public Safety, corrections division warden, within ten days of the registrant's commencement, termination or current enrollment or employment at any institution of higher learning within the territory. Any person who fails to provide timely notification in compliance with this subsection is guilty of a crime, and upon conviction may be sentenced as for a class A misdemeanor.

(d) Upon the conviction for any of the offenses set forth in subparagraph (a), the Court shall document through the judgment and sentencing record that prior to release from prison, being placed on parole, supervised release, or probation, that the warden of the Department of Public Safety, corrections division, will inform and explain to the convicted person his/her requirement to registered and obtain verification of notification through the signature of the offender.

The corrections division warden is responsible for the maintenance of the registry, which at a minimum,

shall contain the following:
(1) notification to the offender of the offender's duty to register, maintaining a copy of this notification, signed by the offender and the Warden of the corrections division, and to obtain the information, fingerprints, photographs, and samples required for such registration;
(2) notification to the offender of the offender's duty to notify the Department of Public Safety, correction division warden of any change in their residential address within ten (10) days of changing addresses;
(3) notification to the offender of the offender's duty to contact the state agency responsible for registering offenders in any other state, territory, or jurisdiction of the United States in which they intend to reside, move or relocate;
(4) The Department of Public Safety, corrections division warden is responsible for maintaining a registry of offenders which include at a minimum the offender's photograph, fingerprints, criminal history, and identifying information, which includes information on current residential address, spouse, and family matai;
(5) The Department of Public Safety, correction division warden shall be responsible for verifying the addresses of each offender in American Samoa through a physical verification of the residential address every three months;
(6) The Department of Public Safety, corrections division warden shall be responsible for maintaining a registry of those offenders' records which are referred from other states or jurisdictions of the United States, including those military or former military personnel and federal employees under federal judgments;
(7) The Department of Public Safety, corrections division warden shall be responsible for transmitting all registry information, including photographs and fingerprints, criminal history, and identifying information to the U.S. Department of Justice, Federal Bureau of Investigation repository, National Sex Offender Registry (NSOR) and Department of Human and Social Services within ten (10) days of release, placement on parole, supervised release, or probation.
(8) The Department of Public Safety, corrections division warden shall be responsible for maintaining registry records of non-resident offenders who reside in American Samoa for school or employment for more than 14 days or for an aggregate period exceeding 30 days in a calendar year;
(9) The Department of Public Safety, corrections division warden shall be responsible for transmitting all registry information on offenders who change their residence to another state or territory or who work or attend school in other jurisdictions, including photographs, fingerprints, criminal history, and identifying information for those offenders who notify the corrections division of a change of address to another jurisdiction, or upon determining that the offender has moved to another jurisdiction and has failed to notify the corrections division.

46.2802 Heightened registration of sexually violent predators; recidivists and aggravated offenders.

(a) Any person who is convicted for a second time for any of the offenses listed in 46.2801, regardless of when the prior qualifying conviction occurred and regardless of whether the prior conviction for an offense covered by this chapter resulted in registration in the jurisdiction of conviction or who is convicted a first time of any of the following offenses involving a victim of any age:

46.3604(b) Rape, inflicting serious physical injury or utilizing or displaying a deadly weapon in a threatening manner;

46.3610(b) Sexual assault inflicting serious physical injury on any person or while displaying a

deadly weapon in a threatening manner;
46.3611(b) Sodomy, inflicting serious physical injury on any person or while displaying a deadly weapon in a threatening manner;
46.3612(b) Deviate sexual assault inflicting serious physical injury on any person or while displaying a deadly weapon in a threatening manner;
46.3616(b) Sexual abuse in the first degree, inflicting serious physical harm or displaying a deadly weapon in a threatening manner; or
46.3618 Child molesting (victim is minor of twelve years or under) is considered a sexually violent predator, and is required for the remainder of their life upon release from prison, being placed on parole, supervised release, or probation, to notify the Department of Public Safety, corrections division warden, of any change of residence within ten (10) days of the change of address. This requirement includes being out of the Territory for a period of over six (6) months.

Any person convicted of the offenses set forth above who fails to register, or fails to notify the Department of Public Safety, corrections division warden within ten (10) days of any change in residence, including being out of the Territory of American Samoa, is guilty of a crime, and upon conviction may be sentenced as for a class C felony.

(b) Any person who is required to register under subsection (a) above is also required to notify the Department of Public Safety, corrections division warden, within 10 days of the registrant's commencement, termination or current enrollment or employment at any institution of higher learning within the territory. Any person who fails to provide timely notification in compliance with this subsection is guilty of a crime, and upon conviction may be sentenced as for a class A misdemeanor.

(c) The lifetime registration of sexually violent predators shall be administered in accordance with the provisions of 46.2801(c) (1-9), and the registry file shall include any record of psychological treatment.

(d) The High Court may designate and judge any person convicted of any of the offenses in 46.2801 as sexually violent predator or aggravated offender without the necessity of a second offense, and require the offender to register on a lifetime basis in consideration of the offender's criminal history, treatment received, and expert testimony of psychiatric, law enforcement or victim advocacy witnesses.

46.2803 Continued registration not required when underlying conviction is reversed, vacated, or set aside.

When the underlying conviction requiring a person to register under this act is reversed, vacated, or set aside, or if the registrant is pardoned, continuing registration is not required.

46.2804 Release of information contained in the registry of 46.2801 by the Department of Public Safety.

(a) The Commissioner of Public Safety shall release offender registry information as necessary to protect the public of American Samoa. The Commissioner of Public Safety is responsible for developing and implementing a policy on the release of relevant offender information to the public of American Samoa, with the following limitations:

(1) All relevant registry information shall be released to the Department of Human and Social Services and, upon written request, to legitimate law enforcement agencies, Courts, prosecutors and defense counsel, and health care treatment officials which have been approved by the High Court of American Samoa;

(2) All relevant registry information, excluding the identity and location of any victims involved in the registry offenses, to members of the public who provide a written request demonstrating a need to

examine offender registry files that is necessary for the protection of themselves and/or their families; and

(3) All relevant registry information, excluding the identity and location of victims involved in the registry offenses, to prospective employers and employers who provide a written request demonstrating need to examine offender registry files in any field that has contact with minors, including but not limited to schools, child care agencies, counseling and social services groups or agencies, churches, and the hotel industry.

46.2805 Resident offenders convicted in other states or territories.

The provisions and standards of this act pertaining to registration and the penalties for failure to comply with registration requirements apply to residents of the Territory who are convicted in other states or territories of any of the covered offenses against victims who are minors or of sexually violent offenses upon their return to this Territory.

EXHIBIT E: American Samoa Code Annotated[5]

CRIME	ACT	FORCE	FACTORS	MAXIMUM PENALTY
46.3604 Rape Class B Felony	He has sexual intercourse with another person w/o that person's consent by use of forcible compulsion; or he has sexual intercourse with another person aged 16 or less	Force or threat of force	na	imprisonment 5-15 years
46.3604 Rape Class A Felony	Class B Felony offense PLUS actor inflicts serious physical injury on any person or displays a deadly weapon in a threatening manner	Force - element of force is 'sufficient force to overbear the protests of the woman'	element of force = 'sufficient force to overbear the protests of the woman'	death, life imprisonment or more than 1 year
46.3610 Sexual Assault Class C Felony	He has sexual intercourse w/another person who is incapacitated or 16 years old or less	Force	na	imprisonment 7 years
46.3610 Sexual Assault Class B Felony	Class C Felony offense PLUS in the course of the assault the 'actor inflicts serious physical injury on any person or displays a deadly weapon in a threatening manner'	Force or threat of force	na	imprisonment 5-15 years
46.3611 Sodomy Class B Felony	He has deviate sexual intercourse with another person w/o that person's consent or by use of forcible compulsion OR he has deviate sexual intercourse with another person who 16 years old or less	Force or threat of force	na	imprisonment 5-15 years
46.3611 Sodomy Class A Felony	Class B Felony offense PLUS in the course of the assault the 'actor inflicts serious physical injury on any person or displays a deadly weapon'	Force or threat of force	na	death, life imprisonment or more than 1 year
46.3612 Deviate Sexual Assault Class C Felony	He has deviate sexual intercourse with another person without consent or who is incapacitated or who is 16 years old or less	Force or threat of force	does not require proof that defendant committed the act with the purpose of arousing or gratifying sexual desire	imprisonment 7 years
46.3612 Deviate Sexual Assault Class B Felony	Class C Felony offense PLUS in the course of the assault the 'actor inflicts serious physical injury on any person or displays a deadly weapon in a threatening manner'	Force	na	imprisonment 5-15 years

CRIME	ACT	FORCE	FACTORS	MAXIMUM PENALTY
46.3615 Sexual abuse First Degree Class D Felony	He subjects another person to sexual contact w/o that person's consent or by use of forcible compulsion OR he subjects another person who is 16 years old or less to sexual contact	Force or threat of force	na	imprisonment less than 5 years
46.3615 Sexual abuse First Degree Class C Felony	Class D Felony offense PLUS in the course of the assault the 'actor inflicts serious physical injury on any person or displays a deadly weapon in a threatening manner'	Force	na	imprisonment 7 years
46.3616 Sexual abuse Second Degree Class B Misdemeanor	He subjects another person to sexual contact without that person's consent	Force or threat of force	na	imprisonment > 15 days but less than 6 months
46.3616 Sexual abuse Second Degree Class A Misdemeanor	Class B Offense PLUS in the course of the assault the 'actor inflicts serious physical injury on any person or displays a deadly weapon in a threatening manner'	Force	"element of sexual contact of 'purpose of arousing or gratifying sexual desire' may be inferred from defendant's conduct"	imprisonment 6 months
46.3617 Indecent Exposure Class A Misdemeanor	he' knowingly exposes his genitals under the circumstances in which he knows that his conduct is likely to cause affront or alarm	No Force	na	imprisonment 6 months
46.3618 Child Molesting Class A Felony	he engages in sexual intercourse or deviate sexual intercourse with a minor of age 12 or younger		na	minimum: prison term of 10 years without probation or parole
46.319 Mandatory HIV testing			na	adult or juvenile offenders undergo HIV testing within 30 days as condition of sentence
46.2801 Registration of Offenders and 46.2802 Heightened registration of sexually violent predators: recidivists and aggravated offenders	Persons convicted of any offense in Title 46 chapters 3401 - 3707 when the victim is a "minor, or under 18 years of age"		those classified under 46.2802 involving a victim of any age is required to register on a 'lifetime basis'	provide residential address, fingerprint, photo, requested body fluids to DPS Corrections Division Warden for a period of 10 years from date of prison release, parole, or probation including anytime person is out of territory, employed or a student

EXHIBIT F: Minimum Service Standards for Sexual Assault Programs in Texas[10]

24 HOUR CRISIS HOTLINE

• The SAP must maintain a 24-Hour Crisis Hotline for survivors of sexual violence to provide immediate, confidential, non-judgmental support, crisis intervention, information and referrals.
• A 24-Hour Crisis Hotline means a telephone line answered 24 hours a day, 7 days a week by trained Sexual Assault Program (SAP) staff/volunteers.
• The Hotline number must be accessible to the public via the SAP's website and in public directories that cover the SAP's service area, if available.
• Where advertised, the Hotline indicates 24-hour availability and specifies 'sexual assault'
• SAPs must ensure employees/volunteers provide 24-Hour Crisis Hotline services subject to confidential communication requirements in the Texas Government Code, Chapter 420, Subchapter D.
• Hotline calls must be answered immediately either by an SAP employee/volunteer or a 3rd party answering service and connected to a trained SAP employee/volunteer within 5 minutes. Hotlines must have at least one bypass feature in place to accommodate more than one call at a time (busy signal and call-waiting features do not satisfy the bypass feature). Bypass calls must be answered or returned by a trained SAP employee/volunteer within 15 minutes.
• SAP employees/volunteers providing 24 Hour Crisis Hotline services shall complete training that meets the OAG's Sexual Assault Training Program Certification Requirements contained in the OAG's Sexual Assault Training Program Certification Guide.
• SAP employees/volunteers providing 24 Hour Crisis Hotline services must be supervised by a SAP staff member with at least one year experience providing direct services to survivors of sexual violence.
• Hotlines must be equipped to respond to callers who are deaf, hearing impaired or with limited English proficiency.
• SAPs must maintain a current resource/referral list responsive to individuals affected by sexual violence.
• SAP employees/volunteers answering the Hotline must have the current resource/referral list in their possession.
• The SAP must regularly evaluate the 24-Hour Crisis Hotline and, as needed, make adjustments based on the findings.

CRISIS INTERVENTION

• SAPs must provide Crisis Intervention to survivors of sexual violence.
• Crisis Intervention means an immediate, supportive response in order to reduce acute distress, to begin stabilization, and to assist in determining next steps.
• Crisis Intervention must be provided by trained SAP employees/volunteers.
• The SAP must provide Crisis Intervention 24 hours/day, 7 days/week via the 24-Hour Crisis Hotline and via Accompaniment to Hospitals, Law Enforcement Offices, Prosecutor's Offices and Courts.
• SAPs must ensure employees/volunteers provide Crisis Intervention subject to confidential communication requirements in the Texas Government Code, Chapter 420, Subchapter D.
• The SAP must provide Crisis Intervention on a walk-in basis during the SAP's regular hours of operation.
• The SAP employee/volunteer providing Crisis Intervention must complete training that meets the OAG's Sexual Assault Training Program Certification Requirements contained in the OAG's Sexual Assault Training Program Certification Guide.
• SAP employees/volunteers providing Crisis Intervention must be supervised by an SAP staff member with at least one year of experience providing direct services to survivors of sexual violence.

• SAPs must maintain a current resource/referral list responsive to individuals affected by sexual violence.
• SAP employees/volunteers providing Crisis Intervention must have the current resource/referral list in their possession.
• The SAP must regularly evaluate Crisis Intervention services and, make adjustments based on the findings.

ACCOMPANIMENT to HOSPITALS, LAW ENFORCEMENT OFFICES, PROSECUTORS' OFFICES, and COURTS

• Sexual Assault Programs (SAPs) must provide Accompaniment to Hospitals, Law, Enforcement Offices, Prosecutors' Offices and Courts.
• Accompaniment to Hospitals, Law Enforcement Offices, Prosecutors' Offices and Courts means in-person support, assistance and provision of information about crime victims' rights during the survivor's interaction with medical or criminal justice professionals at hospitals, law enforcement offices, prosecutors' offices, and courts. To qualify as an Accompaniment to a Hospital a minimum of 45 minutes must be spent with the survivor.
• Accompaniment to Hospitals, Law Enforcement Offices, Prosecutors' Offices and Courts must be provided by trained SAP employees/volunteers.
• The SAP must provide hospital Accompaniment services for survivors of sexual violence for a sexual assault medical forensic exam 24/hours day, 7 days/week.
• SAPs must ensure employees/volunteers provide Accompaniment subject to confidential communication requirements in the Texas Government Code, Chapter 420.
• SAP employees/volunteers must provide Accompaniment services until they are no longer needed by the survivor.
• The SAP must dispatch an employee/volunteer to provide Accompaniment to a hospital within 15 minutes of receiving a request.
• The SAP must have a system in a place to accommodate multiple or overlapping requests for Accompaniment to a hospital.
• SAPs shall initiate, lead or be a key participant in a sexual assault response team. A sexual assault response team includes, at a minimum, the following core members who are first responders as identified in the Office for Victims Crime SART Toolkit: community-based advocates, law enforcement, and forensic medical examiners including sexual assault nurse examiners.
• SAP employees/volunteers providing Accompaniment must complete training that meets the OAG's Sexual Assault Training Program Certification Requirements contained in the OAG's Sexual Assault Training Program Certification Guide.
• SAP employees/volunteers providing Accompaniment must be supervised by a SAP staff member with at least one year experience providing direct services to survivors of sexual violence.
• The SAP must regularly evaluate Accompaniment services and, as needed, make adjustments based on the findings.

ADVOCACY

• Sexual Assault Programs (SAPs) must provide Advocacy to survivors of sexual violence.
• Advocacy means working with third parties on behalf of a survivor of sexual violence (e.g., schools, employers, law enforcement agencies, housing authorities, healthcare professionals, prosecutor's offices, CVC).
• Advocacy must be provided by trained SAP employees/volunteers.

• The SAP must provide Advocacy 24 hours/day, 7 days/week via the 24 Hour Crisis Hotline and via Accompaniment to Hospitals, Law Enforcement Offices, Prosecutor's Offices and Courts.
• The SAP must provide Advocacy on a walk-in basis during the SAP's regular hours of operation.
• SAP employees/volunteers must orient survivors of sexual violence to their constitutional and statutory rights and assist survivors in securing those rights.
• SAPs must ensure employees/volunteers provide Advocacy subject to confidential communication requirements in the Texas Government Code, Chapter 420, Subchapter D.
• SAPs shall initiate, lead or be a key participant in a sexual assault response team. A sexual assault response team includes at a minimum, the following core members, who are first responders as identified in the Office for Victims Crime SART Toolkit: community-based advocates, law enforcement, and forensic medical examiners including sexual assault nurse examiners.
• SAP employees/volunteers providing Advocacy must complete training that meets the OAG's Sexual Assault Training Program Certification Requirements contained in the OAG's Sexual Assault Training Program Certification Guide.
• SAP employees/volunteers providing Advocacy must be supervised by a SAP staff member with at least one year experience providing direct services to survivors of sexualviolence.
• The SAP must regularly evaluate Advocacy services and, as needed, make adjustments based on the findings.

PUBLIC EDUCATION

• The Sexual Assault Program (SAP) must provide Public Education to increase knowledge of the dynamics of sexual violence, its causes and consequences, and of services available through the sexual assault program.
• Public Education means workshops, speaking engagements, and distribution of printed materials.
• SAP employees/volunteers must provide Crisis Intervention, information and referral to individuals making a sexual assault related outcry at Public Education events.
• SAP Public Education must use accurate information and statistics with citations.
• SAP Public Education must include efforts to identify survivors of sexual violence that might not otherwise be reached (i.e., underserved or marginalized populations) and refer them to services.
• Public Education must be culturally and developmentally appropriate to the audience.
• Public Education must be intentionally inclusive of underserved and marginalized populations.
• SAP employees/volunteers providing Public Education must complete training that meets the OAG's Sexual Assault Training Program Certification Requirements contained in the OAG's Sexual Assault Training Program Certification Guide.
• SAP employees/volunteers providing Public Education must be supervised by a SAP staff member with at least one year experience providing direct services to survivors of sexual violence or providing Public Education.
• The SAP must regularly evaluate Public Education and, as needed, adjustment based on the findings.

EXHIBIT G: Australia's Natl. Standards of Practice for Services Against Sexual Violence (2015)[14]

Standard	Minimum Practice	Best Practice
Cultural Competency	Providers must be willing to address issues of difference arising out of race and culture; recognize that addressing diversity is a continuous learning effort; modify services to resonate w/the perspective of each client so that each is served effectively	Makes a clear statement that recognizes and values diversity; commits resources to improve cultural competency of employees; engages in networking with diverse and minority cultural groups; has strategies to improve access to its services by diverse groups
Increasing Access	Organization can articulate its capacity for service delivery; is committed to improving access to services; is actively engaged in trying to reduce access barriers; can measure the effectiveness of any access strategy implemented	Organization commits resources to systems and client advocacy; consults with marginalized groups to identify needs and barriers to services
24-hour Services	Organization has systems in place to facilitate 24-hour on call access to SA counselors when recent SA has occurred; has systems ins place to redirect after hours calls	Organization provides 24-hour on call services with sufficient protocols to ensure service quality, client confidentiality, and staff safety
Outreach	All aspects of outreach are evaluated; outreach is planned with risk assessment and safety procedures in place	The organization's work health safety policies have provisions covering outreach service provision
Referral	Resources are updated and enable high quality referrals; organizations build relationship as part of systemic and individual advocacy; have a wide range of relevant info accessible to victims; consent should be verbal/written and recorded; level of client info sharing should be approved by client in writing	Personalized referrals are prioritized over cold referrals; client have option recontact Referer; protocols exist to enable follow up contact
Client Advocacy	Organization has knowledge of advocacy services that may benefit its client; informs clients of their rights to, and availability of, advocacy; ensures written client consent as a pre-requisite for advocacy work	Should have protocols to support providers; provide opportunity for professional development of advocacy; be able to quantify and describe its advocacy work
Client Engagement	Organization recognizes that a victim may be in crisis at any point in their journey to recovery, at recurring points, when triggered by events; operates using client-centered model of care; every employee is trained in SA	Intake protocols are detailed enough to match client with appropriate service and provider; data collection systems are in place; 'acute care' is the general level of responsiveness for every client
Consent	Informed consent forms part of establishing therapeutic goals and is ongoing throughout the process; receiving written consent is a condition of receiving services	Provider reads any consent related documents in appropriate language of client and explains in detail

EXHIBIT H: MOU Template

SAMPLE MEMORANDUM OF UNDERSTANDING–CA

This Operational Agreement stands as evidence of the commitment of the agencies listed below to implement a Sexual Assault Response Team (SART) in this county.

It is hereby recognized that SARTs are an effective intervention method for ensuring competent, coordinated, and effective intervention for victims of sexual assault. SARTs organize interagency, multidisciplinary responses for the benefit of the victim and the community. Each agency indicates their commitment to implementing and maintaining the SART in the following ways:

- Participating in SART planning and implementation activities;
- Training patrol officers and detectives in the SART approach and implementing first responder training;
- Training Deputy District Attorneys in the SART approach;
- Establishing and obtaining training for sexual assault forensic medical examiners;
- Ensuring victim advocacy and continuity of care for survivors of sexual assault by involving rape crisis center advocates;
- Involving the local crime laboratory in training sexual assault forensic medical examiners;
- Ensuring coordination with the Victim/Witness Assistance Center to facilitate access to the Victim Compensation Fund, and other services;
- Participating in a monthly SART meeting to ensure smooth operations, problem solving, and case review;
- Developing and maintaining an agency database;
- Developing and maintaining a SART database;
- Making a commitment to positive, constructive problem solving for the benefit of the sexual assault victim and the community;
- Making a commitment to effective case review to identify trends, themes, and system problems; and
- Ensuring a culturally competent system of care, including the planning and availability of interpreters.

Rape Crisis Center	Hospital or Sexual Assault Forensic Medical Team
City Police Department	Crime Laboratory
County Sheriff's Department	Victim/Witness Assistance Center
County District Attorney's Office	

References

1. Samoa News Staff, (2017, October 17). Lolo Signs Bill That Puts Sex Offender Registry in Compliance. *Samoa News*. Retrieved from http://www.samoanews.com/local-news/community-news-briefs-14
2. High Rates of Sexual Assault in American Samoa (2016, April 27). Retrieved from https://www.radionz.co.nz/international/pacific-news/302430/high-rates-of-sexual-assault-in-american-samoa.
3. About Sexual Assault (2018, July 25). Retrieved from https://www.rainn.org/about-sexual-assault.
4. Bein, Kris. (2018, June 10). Core Characteristics of a Rape Crisis Center: A review of state service standards 2nd edition. Retrieved from http://www.resourcesharingproject.org/sites/resourcesharingproject.org/files/Core_Services_and_Characteristics_of_RCCs_0.pdf.
5. American Samoa Code Annotated. (2018, July 10). Chapter 36 – Sexual Offenses. Retrieved from http://asbar.org/index.php?option=com_content&view=category&id=750&Itemid=172
6. Rape Crisis Centers. (2018, July 6). Retrieved from https://en.wikipedia.org/wiki/Rape_crisis_center.
7. UCR Definition of Rape. (2018, July 2, 2018). Retrieved from https://ucr.fbi.gov/recent-program-updates/
8. Council of Europe Directorate of Human Rights and Legal Affairs. (2008). Combating violence against women: minimum standards for support services. Retrieved from https://www.coe.int/t/dg2/equality/domesticviolencecampaign/Source/EG-VAW-CONF(2007)Study%20rev.en.pdf
9. Core Services and Characteristics of Rape Crisis Centers: A Review of State Service Standards. (2011). National Sexual Violence Resource Center. Retrieved from https://www.nsvrc.org/publications/core-services-and-characteristics-rape-crisis-centers-review-state-service-standards
10. Texas Association Against Sexual Assault. (2014). Development of RCC Standards. Retrieved from taasa.org/wp-content/uploads/2015/04/RCC-Standards
11. Service Standards for the Operations of Rape Crisis Centers Attachment B. (2017). 2017-18RC Attachment B – Cal OES. Retrieved from www.caloes.ca.gov.
12. UN Women. (2018, July20). Virtual Knowledge Centre to End Violence Against Women and Girls. Retrieved from www.endvawnow.org/en/articles/print/684/
13. Council of Europe, Kelly, L. 2008a. *Combating Violence Against Women. Strasbourg: Council of Europe, pg. 50.*
14. Standards of Practice Manual for Services Against Sexual Violence 2nd edition. (2015). National Association of Services Against Sexual Violence, Australia. Retrieved from http://www.sahealth.sa.gov.au/wps/wcm/connect/5d2180804ae23ff8ab07ff0b65544981/NASASV_Standards_2nd_Edition_2015.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-5d2180804ae23ff8ab07ff0b65544981-lztq7ke
15. Rape Crisis National Standards. (2018, July). Retrieved from https://rapecrisis.org.uk/userfiles/PDFs/RCNSS.pdf
16. Key Components of Sexual Assault Crisis Intervention/Victim Service Resources. (2014, April). Retrieved from https://www.justice.gov/ovw/page/file/910266

17. Sexual Assault Demonstration Initiative – Enhancing Sexual Assault Services. (2018). Retrieved from www.nsvrc.org/sites/default/files/publications_nsvrc_reports_sadi-final-report.pdf
18. Responding to IPV and Sexual Violence Against Women: WHO Clinical & Policy Guidelines. (2013, June 20). BMJ 2013;346:f3100.
19. Campbell, R. & Ahrens, CE. (1998). Innovative community services for rape victims: an application of multiple case study methodology. *Am J Community Psychology.* 26(4):537-71.
20. Battered Women's Justice Project. (2017, June 6). Webinar Resource Retrieved from: *http://www.bwjp.org/resource-center/resource-results/interagency-planning-engage-your-partners-in-goal-setting-to-address-dangerousness-and-gaps-in-case-processing.html*
21. American Samoa Community College. (2018). Violence Against Women Act (VAWA). Retrieved from http://www.amsamoa.edu/policies/vawa.html.
22. Mandatory Reporters of Child Abuse and Neglect. (2018). Child Welfare Information Gateway. Retrieved from https://www.childwelfare.gov
23. Building Cultures of Care: a Guide for Sexual Assault Services Programs. (2018). Retrieved from https://www.nsvrc.org/.../building-cultures-care-guide-sexual-assault-services-program
24. Campbell, R. (2006). Rape survivors' experiences with the legal and medical systems: Do rape victim advocates make a difference? Violence Against Women, 12, 30-45. doi:10.1177/1077801205277539