# National Strategy Session on Sustaining Services During the COVID-19 Pandemic: Session 3

CHARITY HOPE: All righty. Good morning again. This is Charity Hope with the Vera Institute of Justice at the Center on Victimization Safety and the National Resource Center for Reaching Victims. And we are happy to have you all join us today for our National Strategy Session on Sustaining Services for Victims and Survivors during the COVID-19 pandemic.

We have just a few quick logistical items that we need to cover before we turn you over to all of our esteemed colleagues and panelists today. To begin with if you would like to turn your closed captions on, you'll need to do so both by going to the very bottom of your Zoom Room. You're going to see a little box down there that has a CC in it and it says closed caption underneath it. To the right of that box there is a little arrow, a little carrot. If you click on that arrow you're going to have a couple of options to show your closed captions. You can either show subtitle, which will put your captions right at the bottom of your screen. Or you can view the full transcript, which will populate the captions in real time over to the right of your screen. So you can use either of those options.

If you're having any challenges with getting those closed captions going on your screen today, you can reach out to our staff who are waiting to assist you in the Q&A pod. Again, down at the bottom of the Zoom Room you'll see a little Q&A and a couple of little cartoon bubbles. And if you click there you will be able to reach out to our staff and ask any questions you might have or get any assistance.

Once we open this up for questions later, that's also going to be one of the mechanisms we're using. So go ahead and take a look and see if you can see that Q&A pod down at the bottom of your room. Your Zoom Room, not your physical room.

You should also be able to see our interpreter, our American Sign Language interpreter, as well as all the panelists. If you're having any challenges in seeing our interpreter, again please reach out to us and our staff via the Q&A pod and we can assist you.

And with that we can turn it over to our panelists.

NANCY SMITH: Thank you, charity. Good morning, everyone. My name is Nancy Smith. I am with the National Resource Center for Reaching Victims at the Bureau Institute of Justice. And we are here together in recognition of a number of things. First and foremost, we recognize the extraordinary impact that COVID-19 is having on survivors of crime. Their access to victims services, hospitals, police, courts and many other vital systems of support.

We also recognize the new and unprecedented set of challenges facing organizations that serve survivors. And at the same time, we recognize that we as a movement are strong. We are resilient, creative, and innovative. We have created this time for us to come together to tap into our collective creativity to solve these unprecedented challenges together.

We are excited to be joined today by a number of panelists who I will have introduce themselves in a moment. We will be taking notes of this call, and we will also be recording this call, which we will make available after the call is over.

We hope to do a few things during today's session. We want to share what we know. We want to surface the challenges and issues that are facing us now. And we want to provide any guidance that is available. And at the start, we want to acknowledge that we likely will raise many more questions than answers, and we are committed to finding the answers to those questions that remain unanswered. So we will be, in addition to providing the recording and the notes from today's call, we will be sending out additional information that hopefully answers the questions that we're unable to answer today, or we're unable to get to due to time.

As I said, I'm really happy to be joined by a panel of my colleagues who are here today to answer a number of your questions. And we are also joined by representatives from the US

Department of Justice's Office for Victims of Crime and the Office on Violence Against Women. They are here in listen mode. They are here to learn. They are here to track your questions. And they, too, are committed--

If you could tell us where you're writing from, it'll just help us be able to tailor our answers to your questions and also to get to know a little bit better what is happening around the country, which is quite different depending on where we are and where we find ourselves in relation to this fast changing situation.

And then you can raise your hand-- so if you click on the participant box, there is an option there to raise your hand. When we open it up for Q&A if you have a hand raised, we have someone on our team who will be able to un-mute your line and you will be able to share your question directly. So again, a couple of ways to participate.

For now, I'd like to ask our panelists to introduce themselves and then we'll get started with your questions. Kim, would you be able to get us started and tell us who you are?

KIM DAY: Sure. Thanks, Nancy. I'm Kim Day from the International Association of Forensic Nurses. So I work with sexual assault nurse examiners and multidisciplinary teams around the country. I'm currently sitting in Hilton Head Island,

South Carolina, which is my home office. And I'm really happy to be here. Thank you.

NANCY SMITH: We are delighted to have you, Kim. Lisa?

LISA FLEMING: Hi. I'm Lisa Fleming I'm with Rose Brooks Center. We're here in Kansas City, Missouri. We serve adult and child and pet survivors of domestic violence, with a 100-bed emergency shelter, therapy services, non-residential and residential advocacy services, and violence prevention program.

NANCY SMITH: Lisa, thank you. And thank you so much for taking time out of your day to be with us today.

LISA FLEMING: Thanks.

NANCY SMITH: Erica?

ERICA OLSEN: Hi, everyone. My name is Erica Olsen. I'm the director of the Safety Net Project at the National Network to End Domestic Violence. Our work looks at the intersection of technology and abuse, which always has a focus on technology safety, privacy, and confidentiality. And those pieces are extremely common and relevant right about now. So we are a technical assistance provider. We have projects to answer your questions about anything-- anything that can be related to technology safety, relocation, and confidentiality. So you can find

more information at techsafety.org and we'll make sure that's in the chat. Thank you.

NANCY SMITH: Thank you, Erica. Olga?

OLGA TRUJILLO: Hi, everyone. I'm Olga Trujillo, and I'm with Latinos United for Peace and Equity. We're a national training and technical assistance organization that's part of Caminar Latino, which is a local Latino community service provider on anti-violence issues in Atlanta, Georgia. I am in Star Prairie, Wisconsin, which is a town of 500 people, and I have satellite internet. So just in case it's a little bit slow, I'll be chopping in and out. But just as a demonstration of what rural communities have to deal with.

NANCY SMITH: Thanks, Olga. And welcome to you as well. We're going to return to you in a minute, because we do have some questions about rural advocacy programs and what that means in a time in which we're going to remote. But first, I'd like to take our first question and ask if Kim you could respond to it. We've got a number of questions that really center around trying to get a handle of what it means that our hospitals are ramping up to respond to people who have COVID-19. What does that mean for survivors who are accessing forensic exams at hospitals? What does it mean for advocates who are accompanying those survivors?

KIM DAY: Sure. This is a really good one, because our members actually have been communicating a lot about this. There's a couple of different things that are impacting them. One is most sexual assault nurse examiners are not working solely in that area of facilities or hospitals. Most of them are emergency nurses or critical care nurses, which as you all know are really highly in demand. So they're being taxed just kind of physically and their time. They're being pulled into emergency responses. So that's one area.

The other is as the hospitals themselves are responding to the crisis, they are commandeering rooms that may have been used for sexual assault forensic exams. So that's one other area.

The other is that critical in our responses to sexual assault patients is kind of co-working with advocacy. And hospitals are restricting visitors, and they include advocacy in the visitors. So some programs are not even allowed to come into the hospital to have accompaniment. And we're seeing a variety of different ways that advocacy programs or and SANEs are working together to still provide services, including doing some tele-support support using phones, or even tele-medicine type responses.

And we also are seeing as their rooms are commandeered-- we also have the other issue that I didn't even mention, is what do you do if you have a patient that has the virus and comes in to have the exam? Where do you take them? So I'm seeing some

programs that have gotten permission to do medical forensic exams not in the emergency department, but away in another area of the facility. And then if they have a patient that has the virus, or even is symptomatic, they have to go to another room.

One program actually is currently using, in a rural program, they are using a surgical procedure room to do exams if the patient is positive for COVID or even has symptoms. And that way they're isolated and a lot of elective procedures are canceled now. In fact, most hospitals have canceled elective procedures so that surgical suite is available. And that's what they're doing for positive patients. So those are just three examples of what they're facing.

NANCY SMITH: Thank you, Kim. We'll probably return to some of those themes that you've raised. One of them that we've already started talking about that we've gotten a lot of questions about is around shifting or expanding our strategies to support survivors using tele or mobile approaches.

So Erica, I'm wondering if you could respond to some of the questions we've gotten around what are the most important considerations for programs to be taking now as they may be moving into mobile advocacy for the first time, or they're expanding what they've been doing?

ERICA OLSEN: Thank you. There's a lot of content to be addressed here, so I want to first point out that we did create some resources on this. They're available at techsafety.org and will be put in the chat. So we created some pieces on communicating with survivors using technology and also resources for working remotely.

The biggest considerations are going to be the same considerations we've always had, just having to make decisions pretty quickly. And we want to, again, be here as much as possible to help programs through that to navigate those things. But we want to be looking at privacy and confidentiality considerations, which usually comes down to first and foremost access. Does the third party company-- any service that we will be using, whether it be video conferencing, a text chat line, an online chat, whatever the service might be-- it is going to be hosted and ran probably by a third party company. And we need to first look at what that third party company has access to.

Unfortunately a lot of services that are out there, the third party has access to a lot of information. They might be able to collect all of the user identifying information for anyone who's logging in, where they're logging in from. They might even be able to see and retain on their servers the entire back and forth of a chat, which obviously if we're talking with survivors could include significant personal and sensitive information and would violate

privacy and confidentiality. So that's something that we absolutely really want to look at and make sure that we're not using any platforms that would give a third party on agency access to that kind of information.

I'm not even going into the fact that they might not even own their own server. So not only just that one company, but other companies that they are working with might also have access. So that access point is really important.

Beyond that, even when we decide on certain types of technologies for ourselves, we also want to be looking at access internally when it comes to working remote. We have to think about access levels and making decisions about who access as what kind of information from where. If we can ensure that people are using agency devices, that's going to be really important. My five-year-old watched me, you know, put my pin in my phone and learned it so quickly. I was not prepared for that. But that's a reality. If we're using our personal devices to communicate with survivors, anybody else that's in our home that could have access to our devices could have that.

When I connect my backup, when I back up my phone, all of that survivor information could go there. So we are big advocates for making sure that agencies find resources and ways to get agency owned devices in advocates hands so that advocates are using that. And that protects the advocates for privacy as well, and

that's also a really big important piece. We want to make sure the agency remains in control of all technology and all data that's being exchanged. So those are a couple important pieces.

NANCY SMITH: Thanks, Erica. I'm wondering if I could turn things over to you, Olga, as we are talking about mobile advocacy. And you know, I have noticed just in the past couple days so much of that conversation is centering around platforms that require high speed internet. And we want to make sure that isolated and rural communities that may not have that high speed broadband internet are also receiving support and strategies for how they can maintain their services. I'm wondering if you can talk a little bit from your perspective about what those programs may be considering?

OLGA TRUJILLO: Sure. Yeah, so there's a couple of different things. So first let mean say, living in a rural community totally has its benefits and its downsides. And for sure, internet access, and in some places cell phone service, is the biggest challenge. So in that situation, what folks can do-- so first of all, not everyone has high speed internet. So video conferencing might not work. Now if folks have satellite internet, that's usually fast enough to be able to do Zoom, in particular, because that platform is really stable and works really well on slower internet.

But then if folks don't have internet or don't have fast internet-- meaning that they have something closer to dial up-- then if you

have cell service you can up your-- so if the programs can change the subscription to cell service to add unlimited service so that people can use their cell phones as hotspots to do video conferencing, to use Zoom, that would be helpful. That would be a lot faster than internet access.

Or you might be like me where you have limited internet and limited cell service where you live. So in that situation, you can go old school, quite honestly. You can go back to having phone conversations with folks. And again, that's somewhat limited, but that's a good connection for folks. But let me kind of take a step back. Despite the fact that there are quite a few confidentiality issues, a lot of times what you're doing with survivors right now-- I think the way you think about your work right now is kind of redefining how it is that you're helping survivors get through this period.

So for example, I do a lot of peer support with people with dissociative identity disorder. They're survivors of childhood sexual abuse, and some of them are survivors of sexual abuse now, or sexual assault. And so I stay in contact with folks. And so right now I'm texting people, if they've texted me, to check in with them to see how they're doing. If they've Facebook messaged me the past, I Facebook message them to do the same. I'll email them if they've e-mailed me in the past. And if

someone's struggling, I'll set up a phone call with them or a video conference with them.

And the idea isn't to like do anything other than kind of check in with them, see how they're doing, and help remind them about how they can manage the anxiety that all of this is kicking up. And that's a really powerful thing to do for folks, and that might be all you're doing right now. And that might be all they can handle right now.

The other piece of it is there is, in rural areas, you're not going to be-- it's less likely that you're going to be in crowds. So if you do need to work with someone or get someone to sign a form or anything like that, you can actually-- unless you're in a jurisdiction where you've been asked to shelter in place-- you can actually drop something off and pick it back up, or meet at the grocery store, at the pharmacy, any of those places to get that.

In Wisconsin, we've been asked to keep connections below 50, and I know the federal government's asked below 10. That's really easy to do in a rural area when you're serving survivors. The point, though, is it's going to take more time, because you're going to be driving longer distances than you're used to when people come to you. So just those kind of those suggestions.

NANCY SMITH: Thank you, Olga. And also I want to thank Caitlin, who in our Q&A box just shared that in many places we are

seeing some of the internet service providers either offer free internet service for several months. They are also opening up their hotspots, Wi-Fi hotspots, to be available to the public in different areas. And I think those are great resources also for us to tap into. So thank you Caitlin for raising that.

I also want to remind everyone to continue to use the Q&A box to type in your questions. Also raise your hand if you'd like us to un-mute your line. We do have several questions that have come in about the availability of American Sign Language interpreters for deaf survivors. I know this is something that we have been thinking quite a bit about prior to the circumstances in which we find ourselves in. We know that there has been a real lack of qualified interpreters to be able to support survivors-- that's both interpreters who have a deep fluency in American Sign Language who are really skilled in interpretation, and then also who have the vocabulary and all of the skills required to support survivors of domestic and sexual violence.

And we anticipate that there will be even greater challenges, currently and as the days and weeks unfold, as survivors are being asked to use more phone based systems. So as we're hearing courts say, don't come in for protection orders, call us first. And also as we're seeing a more critical need for deaf survivors to engage with hearing systems, whether that be hospitals or whether that be testing facilities.

We have been cultivating a pool of healing informed, trauma informed interpreters, and we have been talking to interpreters this week. And one of the things that we are seeing, also, is that with the cancellation of so many in-person engagements, we are hoping that we will see a greater availability of qualified remote interpreters to be able to interpret for survivors in these different engagements that we're talking about.

I would encourage anyone who wants more information on accessing qualified remote interpreters to contact us at Vera. We have a number of networks there and we would be happy to share those resources more broadly.

We have a couple other questions that are coming in. Lisa, there's been a number of questions from residential programs, domestic violence shelters, who are really grappling in the moment with how to ensure the health and well-being of their staff, of the survivors that they're serving, and also maintain what is a vital service in terms of enhancing safety for survivors. I'm wondering if you could share a little bit about what the team at Rose Brooks has been doing.

LISA FLEMING: You know, it is that dilemma of being able to think about that community living in the majority of our shelters is in complete contrast to social distancing. So when we began making our preparations for these plans, it was like, yes, we can figure out how to use technology and how to be able to reach out

to our non-residential survivors, but it was focused on shelter. And so I think that we took a pretty ambitious course of action with our shelter setting. And I've seen that other domestic violence programs are using a variation of this.

Really what we wanted to be able to do was, first and foremost, was to implement that social distancing and to be able to use different community resources. We're so dependent upon shelter as the only option, but for this temporary period-- and in Kansas City, you know, state of emergency the mayor declared for the next 21 days. So we made the decision to look at what would be alternative placements to emergency shelter?

And really triage that to be able to first find out diversion, which we are seeing this is a strategy that's used in our continuum cares when we're thinking about persons who are homeless. Is there a place that the survivors can go to temporarily, and then glad to be able to come back after the 21 day period? So we have-- and balancing that out, you know, certainly we were worried about safety. But at this point we have this added dilemma about social distancing and the spread of infection.

So our advocates and case managers and our Paws Place pet shelter manager met with each of our families to figure out what is that alternative placement? So some were able to go with family and friends. We have used our general funds to be able to place families in regular hotels and extended stay. And then we

have expedited, really expedited, rapid rehousing model. And I think that this is really a great strategy and something that we have been working towards is a housing first model, of how do we have survivors who are fleeing domestic violence-- they're wanting to flee the domestic violence and the safety risks that they're experiencing. They're not fleeing wanting to come to a shelter. And as wonderful as we can make our shelters, really people want to be able to have the privacy and safety of their own home.

So that's really where we've put our focus on is how can we expedite and be agile and to be able to have those funds, much like you would have in any type of natural disaster, is that you're going to be able to get the emergency funds to survivors that need it in the moment. So we have expedited getting those housing plans, of being able to, as many families as possible, working with our continuum care to get people rapidly placed into permanent housing. And I would say that we have probably about 10 families-- 10 households-- that in less than a week's time that we've been able to move into housing, by being able to provide back utilities, payments, first month's rent, deposits-- just getting them out the door into homes where they want to be able to be.

Working with some of those survivors where it may not be safe for them to be able to do any of those placements, and because

of safety issues they may go ahead and need to stay in shelter. But we really want to be able to have that safe distancing.

Our plan is to, after the 21 day period, with our shelter census would have decreased, because we have those households that have moved into permanent housing, that we can then change how we go about structuring shelter, at least for the time being. And I think that that's the open ended question of how long will this last?

And so as we go into our phase 2, we're planning on, as we bring families and individuals and their companion animals back to shelter, that we will have families in their own room. We will not go back to doubling up, tripling up families in one room. Having individuals-- no more than two individuals per room, so that we can have that social distancing. And then we will continue to re-evaluate how long will we go about doing this.

And at the same time, continuing to focus on the fact that any given day the majority of survivors are served in our non-residential programs. And so we will continue to provide those services. We're still meeting people out in the community. So our housing team is continuing to work with families to get them placed into housing. Continuing to figure out safe ways to be able to meet with survivors to provide advocacy and care coordination.

The same thing with our therapy services. We've taken the guidance of the NNEDV's tech safety team, because we are in-person, one on one, or group setting, we have not adopted many of the technology to be able to do web based services and internet services. so the guidance is, it's like in a crisis this is not the time to try and figure that out. So in our phase 1, like Olga said-- I love it-- let's stay old school. That we're going to do what we've always done, we're doing follow up calls when we have consent and we have a safe number to be able to call, making those arrangements.

And then in our phase 2, then really looking at what are going to be the safest ways for us to be able to use more advanced technology as we anticipate that this may go on for many, many more months.

NANCY SMITH: All right. We're going to pause for one second just to transition interpreters.

All right. We are ready. Lisa, thank you so much. I really appreciate so much of what you shared, especially at the end, just this idea that we still want to be intentional and we want to make sure that in our rapid response we are still holding true to the principles of our work. And it's really staying with me, the question sort of in a crisis, is now the time and how can we phase out our responses? So I really appreciate that.

LISA FLEMING: Can I say the other thing is, too, is that I mentioned in the other session is this is the time that we really need to be intentional about recognizing the signs of our own trauma exposure. And so survivors and our own workforce have the duo where we have trauma exposure and vicarious trauma. And so this is the time that as organizations, as organizational leaders, we're being able to figure out how direct service staff are working with survivors to be able to manage their trauma symptoms, build resiliency. That as organizations, that it's our responsibility as leaders as well to help with our own workforce and managing workloads, managing stress, all of those different things and helping to be able to support that.

NANCY SMITH: And Lisa, I'm so glad you brought that up it's a great segue into another set of questions that we received. One of them that I'm hoping, as a panel, we can collectively respond to, especially since so many of us have been working from home for many years. But for so much of our country and advocacy programs, many people are moving to working from home for the first time. What does it mean to leave work at work when work is now your home? And you don't have that kind of pre-set physical boundary, if you will, between work and home. What are some of the ways, especially for those of you who have worked from home, that you've navigated that? And for those of you who are entering into this for new, how are you thinking about that?

OLGA TRUJILLO: So I've been working from home for about 20 years now. Wow. That makes me feel old. And I've done a variety of things. And I think it depends on each person and how much they need a structured difference. So one of the things that I've done in the past is I would only do my work in a specific room in the house, and then I would leave that room and then be in the rest of the house when I'm not working. And then only come into the room when I am working. It's not always workable for people who don't have that many rooms in their house.

So in those situations, I would recommend that you kind of set times that you're going to work and times that you're not going to work. And it's not going to-- if you have kids, it's not going to be as neat as I'm going to work 9:00 to 5:00. Because your kids are home and now you've got to address the issue of either homeschooling them or caring for them one way or another. And so what you could do is take chunks of time-- like I'm going to work for these two hours, and then I'm going to work with my kids for these two hours, and then I'm going to go back to work for these two hours. That kind of breaking it up. And if you keep it structured that way, you're going to have a better balance.

But then the other thing is asking people to not congregate does not mean that people can't go outside. And so I mean, I live in Wisconsin. There's still snow on the ground. It's actually raining today. But you know what? That rain feels good right now, I have

to say. Because it's like, oh yeah, it's still raining. I know it sounds silly, but thinking about-- like I have dogs, so I walk the dogs every day. I try to walk around outside each day, which is really helpful for breaking the balance. So doing things that aren't associated with work when you're not working is a really nice way to differentiate the boundaries.

And then one last thing I wanted to say is each person has a different need for boundaries. So it's not a one size fits all. I am one person that doesn't need a lot of boundaries now. And it's actually more important to me to be there for the people that I provide peer support for in a text or an email or a quick Zoom meeting than it is for me to watch TV at night. Or what sometimes I'll do is like what I'm doing a lot more now is coloring, because that's a way of for me to relax and kind of be more mindful. So then I might do a Zoom call while I'm coloring. So just like different things that you can try to set apart the work part from the home part.

NANCY SMITH: Thank you, Olga. Would anyone else care to add to that? Kim?

KIM DAY: Yeah, sure. I've worked at home for quite a while now, too. And one of the things I find that for me I have to have a routine. I still get up in the morning, get dressed like I'm going to work. Because we do a lot of videos, so I want to be prepared for that. And then I love when Olga said have a space. I have to

have a space that I go to, and this space is my workspace. And I don't play here and I don't-- so I can leave it. I can't close the door, so I can't have it behind that much of a restriction. But I try to do that. Some things spill over, but I like being kind of regimented in some ways to be able to know this is work time and this is not.

NANCY SMITH: Thanks.

LISA FLEMING: Those that are-- those that are new to work from home-- because it's new. And it's so different for people who are site based and direct service workers, and just some of our initial lessons learned and we will continue to learn. Out of sight, out of mind does not mean that the person is not available. And so we are so dependent upon being able to see the person and pop over to their office. And so it's figuring out different ways of making sure that everyone knows that we're still connected. So that our shelter advocates who are still here at shelter know that the case managers around the community and our therapists, who are home based now, can still work together. So it's figuring out different ways of care coordination.

And so that may mean daily check-ins, just to kind of do a debriefing. We've also noticed that for those that are working at home for the first time, it's the rapid fire emails. And so I can very much tell the persons who are site based and those that are

working from home. So being mindful of that. We're not sending emails every time that we think of something, have a question.

One of the things that's been working well for us with our director of residential services and for myself is that I'm sending out to program directors, and she's sending to me, a daily recap of what's gone on for the day or what's going to be planned for the next day, so that we can limit the amount of correspondence that we were having with one another.

And then I would reiterate-- I mean, we've taken the cues and heard that to be able to have the-- know what your work hours are and that we are communicating that. So one of the things the therapists have communicated and put onto their Google Calendar what their work hours are, when they would be available, so that their advocates, when they're talking to survivors, we'll be able to share that information so that we can allow staff to be able to have those that work life balance.

NANCY SMITH: Thank you. I too have had the opportunity to work from home for more than 10 years now. I would just echo many of those strategies that have been shared. I would also say that it's so important for us to continue to be intentional about sustaining our culture and our community as we work remotely. I think the physical space is a really strong way to define and continue culture, but you can do it remotely. I think some of the

things that have been shared already really supports sustaining our culture.

I think that we cannot underestimate how important it is to reach out and to communicate with one another. We have been having much more frequent check-ins, one on one also with the team. And some of those check-ins are just for us to come together and see how each other are doing. We did that this morning before this call, and it's been a great source of strength and resilience.

And then also for us to really understand what are the dynamics that we're bringing to work today? Because this is disrupting so many parts of our lives. So many of us are homeschooling our kids. We've become teachers overnight. So just creating space for people to be real about what's happening in their lives. And you know, I really think the culture where one person steps forward as one person needs to step back. And so I think those check-ins have been important.

We've created an open door sort of virtual policy and practice. So we use Zoom a lot, and Zoom has a chat feature where you can tell when I'm in a meeting and when I'm not in a meeting. When I'm not in the meeting, chat me up. You know, I'm here to be a resource and I have an open door. And I also think getting creative about how we can maintain the sense of community that we have always had. And I think we all have our own cultures for how we celebrate as a team and how we have fun as a team. And

I think we can't lose sight of that, and I think there's lots of things that can be done remotely.

We do a pet of the month contest, for example. We do virtual hours of happiness. I think there's many things that we can do and now they are even more important, and we need to make sure that we have time for those.

A few other questions. I know, Erica, you have been answering some questions that have come in on the chat. They are questions that I think are on many people's minds, so I'm wondering if I can have you answer them to the larger group. One of those questions being what strategies can we use as we're supporting survivors remotely to sign consent forms and other documents?

ERICA OLSEN: Yeah. This is a question that's coming up a lot, as we all can imagine. But it's not a new question either, so we've been looking at this for quite a few years. And I'm sure everyone knows that the confidentiality language of VAWA, VOCA, FVPSA does require written consent, but it doesn't actually define how we obtain written consent and what written consent is.

So written can be electronic, and we can be really flexible. And I encourage us to be really flexible with how we figure out what electronic looks like for different people as we are remote from them and communicating with survivors not in person. Because

what might be safe for one person and what might be an option for one person with the type of technology or bandwidth that they have might not be an option for another. So it's not a one size fits all solution in terms of identifying what your program would do for electronic signatures, but rather thinking kind of creatively about how we would ensure that.

The things that are going to be really important to that process is going to be, one, ensuring that we are still thinking of first and foremost about informed consent. So even though we're not in person with the survivor how do we have conversations and provide information so that we can ensure that the survivor has all the information that they need to make an informed consent. So are we comfortable with the information that we've provided, whether it's over the phone or whatever?

We also want to think through about are we sure that we're talking to that person? Is this the same person that we know? Because impersonation is something that abusive individuals, is a tactic that they do misuse, and something we have seen. So are we sure that this is the person we're communicating with? And depending on the technology that the person relies on regularly, this is something we might want to be prepared for.

And we've been talking about this for a long time, especially around working with survivors who might be deaf, who use technologies all the time, where you might not be hearing

somebody's voice and recognizing them in that way, but typing back and forth. This is a conversation we've had for a long time around that about identifying ahead of time. Maybe code words or anything, or code phrases that you might say back and forth to the person. A question you might ask and they always give the same answer. And then just to make sure that you are comfortable that that is the person that you are talking to. So that's an important step and a thing that we want to think about.

But once we've established that and we're certain that we have informed consent and we're certain we know who we're talking to, depending on what they have access to, what's comfortable for them, what's safe for the person. People could write down on a piece of paper, I want you to release this information to x, y, and z and sign it. They could take a photo of that and send it via text message. They could send it via email. People could do a number of things. We could send our informed consent information, the notice of rights, whatever it is that we want to share, if that is a safe option.

So it's really about assessing safety, accessibility of the technology, things like that. And then looking for ways of ensuring informed consent, and then talking with people about how we might be able to get something in writing from them. So those are some things that immediately come to mind in the way that we're answering them.

NANCY SMITH: Thanks, Erica. Kim, do you have anything to add?

KIM DAY: I did want to add onto that. Thanks, Nancy. Because I think that one of the things that we do, if a patient comes in for an exam we definitely-- the nurses-- are used to getting informed consent. And we can get informed consent, also, for that participation with the advocacy program to notify them to have them come in. And I think that there's ways that we can collaborate together with our advocacy programs to create the new process that we're going to have to use. And to give the nurse the language that she needs to be able to get that informed consent, and then have that patient sign at the point of service. Because at the point of service, they're always signing consent forms. And I think this is one other way to get that in.

NANCY SMITH: Do any of our other panelists have anything to add to that question? Erica?

ERICA OLSEN: Yeah, I was just going to add and piggyback off what she was just saying. The one thing with point of service I want to make sure is very clear, too, is that what we've often seen, especially when the written time limited and informed piece became-- so 13 years ago or some 14 years ago-- when that first came in, especially, we really started seeing a lot of people really pushing consent forms right at the point of service. And as you all know, too, though, consent cannot be mandated as a provision of

service. So we do have to make sure that people are having really informed conversations with people about those things.

And especially in a time of crisis it can get really hard to not just kind of default to a bunch of things that people are not really understanding. And so taking that moment to really slow down, even in that space and that point of contact is still going to be really important, too. Because that is exactly where a lot of those exchanges are happening.

NANCY SMITH: Thank you. I want to be mindful of our time. We only have about five minutes left. And I'm wondering if I can ask each of the panelists just to share a closing remark, something that you'd like us to carry forward with us after this call.

Olga, would you mind starting us?

OLGA TRUJILLO: Yeah. So one of the things that I kind of just want to focus on is that it's possible that some of the survivors that we work with or some of our friends that might experience trauma, or family members, are going to need hospital care in the next few months. And so it's a hard thing to do when you've experienced trauma, especially sexual abuse and sexual assault. And then there's a lot of people that have trauma associated with medical procedures that they've had growing up. I think that's the case with some people with disabilities.

So it's a good time to start talking with survivors and family members and friends about a plan for what if you need hospital services, and how would that go? Recognizing that if someone does come down with COVID-19 that they're going to be isolated in the hospital. So kind of talking through what would that look like? What do you need, and can we get that? Just kind of preparing yourself.

I'll just say I have dissociative identity disorder, trauma is a big part of my past. And this is something I'm doing with my partner around, OK, so if this happens, this is what I need to do. And recognizing that I may not have control over the care that I get at this point.

NANCY SMITH: Thanks, Olga. Erica?

ERICA OLSEN: Thank you. Again, I just want to say thank you so much to Vera for creating this space. I think it's so important. It's wonderful to see other people and hear so many people that I've connected with over the years in this field, and just to be reminded of the strength that we have here. And we can rely on each other. There's so much knowledge in this space, and so much compassion. And so I really just want to lift that up. And say we need to lean into that at this time.

I also want to point out, like I did in the other ones, too, that I fully understand how overwhelming technology can be. And

again, as a TA provider we are here to help people navigate those things. All the terms of services and the privacy policies and the instructions can get so overwhelming, and we're definitely here to help read those for you and try to figure things out and answer your questions. So don't feel too alone on that.

And I agree with what has already been said about leaning in on some of the old school technologies as well. I failed to mention Resource Connect is a great service, if people are not familiar, for secure online chat and text. So everything doesn't have to be video. And in fact, for some survivors video is not going to be a safe option. You know, you have to have ear-buds so that a potential abusive partner may not hear what's happening. So thinking through other options is going to be important, too. But please let us know how we can help and thank you for everything you're doing.

NANCY SMITH: Thanks, Erica. Lisa?

LISA FLEMING: I think that giving ourselves grace, that we are trying new strategies of being able to do this. And that as we go along we are keeping in mind finding out from survivors and finding out from our own workforce, our front-line staff, what is working well, what's not working as well. What's not working as planned. And then to focus in on how are we organized to do our work. To be very mindful of not jumping to pointing fingers at particular individuals or organizations that are not doing what we

think that they should be doing. Again, but looking at how are we organized?

And then learning from that and applying it to the future.

NANCY SMITH: Thanks, Lisa. Kim?

KIM DAY: Hi. One of the messages that I want to get out is that we need to collaborate together. We're not alone. We have each other. We have some people that have a lot more experience and some people that have less, and we need to rely upon each other to be able to create a process by which we can still provide services.

The message I want to make sure that we get out there to our clients, to our patients, is that we are still here. We are open for service. And it may not run like it always ran, but we are there to take care of them. And that is just really the most important thing that it boils down to is people need to know that we're still here. It may look different today, but it doesn't mean that we're not going to be able to deliver the services.

NANCY SMITH: Well thank you all so much. I have such deep gratitude for each of you to take the time out of what I know is just incredibly busy schedules, being pulled in many different directions. And I really appreciate you taking the time to be with us. I appreciate everyone who is on this call for taking the time to

come together. We know that this is an unbelievably stressful time, and I think that this is such a great reflection.

We have always been a movement of collective action, and we are renewing our commitment to collective action and collaboration. And we are not in this alone. We are here together, and we are here to support you. So please reach out in the days and weeks ahead. We are happy to support the work that you're doing, and to learn from what you are doing and share that with others.

So again, thank you all so much. Look forward to us posting this recording and the notes on our website, reachingvictims.org.

LISA FLEMING: Thank you.