11-13-1987

Rape: Medical Protocol

Senate Committee on Judiciary

Assembly Select Committee on Assistance to Victims of Sexual Assault

CALIFORNIA LEGISLATURE

SENATE COMMITTEE ON JUDICIARY

SENATOR BILL LOCKYER, CHAIRMAN

ASSEMBLY SELECT COMMITTEE ON ASSISTANCE TO VICTIMS OF SEXUAL ASSAULT

ASSEMBLYWOMAN LUCILLE ROYBAL-ALLARD, CHAIRWOMAN

Joint Hearing on

RAPE: MEDICAL PROTOCOL

November 13, 1987
9:30 a.m. - 12:30 p.m.
State Building Auditorium
Los Angeles, California

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CHAIRMAN: HONORABLE BILL LOCKYER

MEMBERS

Ed Davis, Vice Chairman
John Doolittle
Barry Keene
Milton Marks
Nicholas Petris
Robert Presley
H.L. Richardson
David Roberti
Art Torres
Diane Watson

STAFF

Patricia Wynne, Counsel
Joann Gergianakis, Secretary

88-3-27

CHAIRMAN BILL LOCKYER: I'd like to welcome the public and Members of the Senate Judiciary Committee and Members of the Assembly Select Committee on Sexual Assault Victims. We'll be listening to testimony and hopefully obtaining some enlightenment relative to the issue of medical examinations for sexual assault victims. There has been considerable controversy, as members of the committees and audience know, particularly in Southern California, as to the value and fiscal responsibility of the various agencies, public and private hospitals, and others relating to the medical exams required by state law as part of the forensic preparation to prosecute the perpetrators of these horrible crimes.

We have a long list of witnesses and because of that have suggested that people, oh, try to confine their remarks to ten minutes or so. Inevitably, we — some are a little shorter, some a little longer, and there are questions and so on. So it's that time of year when we like to let members interact and think through and mull over the options available to state government, so we encourage that sort of thoughtfulness.

Let me both introduce and ask any members of the respective committees if they have any introductory comments that they would wish to make.

I guess, as a function of senority, I should begin here on the audience's right and introduce Senator Marks, Senator Keene, and Senator Roberti and ask, gentlemen — Senator Roberti, did you wish to make a comment perhaps?

SENATOR DAVID ROBERTI: Thank you, Mr. Chairman.

I want to — I would like to make a statement on the question before us. And I would like to make note of the fact that this is a Joint Hearing of the Senate Judiciary Committee chaired by Senator Bill Lockyer and the Assembly Select Committee on Sexual Assault Victims Assistance chaired by Assemblywoman Lucille Roybal-Allard. And we find that this is a meeting of tremendous import on our constituencies where the problem is so very acute.

An average of ten women are raped each day in Los Angeles. In California last year, over 12,000 women reported to law enforcement authorities that they had been sexually abused. As many of you know, these numbers represent only the tip of the iceberg because many women don't report these sorts of crimes to the police.

I've strongly supported efforts over the years to ensure that law enforcement seriously investigate crimes of rape and that we prosecute rapes with tough and severe penalties. In addition, it's critically important that our criminal justice system show great compassion and sensitivity to victims of sexual abuse. It's inexcusable for a rape victim to be victimized a second time because of bureaucratic callousness and neglect.

During the past four months, it's apparent that our system of care for sexual abuse victims has broken down. In September, the Los Angeles Times reported that their survey of more than 40 area hospitals showed that about one-third of the privately owned facilities are sending victims away. These hospitals cite a variety of reasons for turning victims away, including the lack of adequate

reimbursement from local agencies and new examination regulations issued by the Office of Criminal Justice Planning. The problem was particularly acute in the City of Los Angeles where the L.A.P.D. provided only $17 for rape examinations that the hospitals claim cost upward of $400. The County of Los Angeles currently pays $50 for sexual abuse exams.

I'm happy to make note of the fact that there has been a verbal agreement, although also noting that no contracts have been signed between the hospitals and the service area of the City of Los Angeles and the City of Los Angeles, for a temporary agreement for six months so that the costs of these rape examinations be fixed at $200, a sort of midway ground between the two figures that are claimed. I think that's an encouraging first step. But I would note to the parties in the audience that frankly no contracts as of yet have been signed and that we are looking for some kind of speedy conclusion to this very serious problem within the city.

On September 22nd, when the problem came to our attention, the hospitals were asked, that if they were not examining rape victims or if they were about to curtail their care, that they should reinstate the service within 30 days. This was to allow the Southern California Hospital Council and city officials to reach a fee agreement without inconveniencing victims any further. Seven hospitals agreed to the request.

I'd like to publicly express my appreciation to the Queen of Angels Medical Center, the Beverly Hills Medical Center, the Bay Harbor Hospital, the Little Company of Mary, Northridge Hospital, Tarzana Regional Medical Center, and Holy Cross Hospital for demonstrating their concern in this area. An interim fee agreement, as you know, and as I had indicated, has now been reached between the city and area hospitals. But it's still unclear because of its tentativeness whether this has ameliorated the current problem.

It's my hope that this hearing will answer six critical questions on the care and treatment of sexual assault victims in Los Angeles: First, why are some hospitals referring rape victims to other hospitals to complete the medical protocol? How many hospitals are making referrals? Second, what impact does the medical protocol system in the practice of referrals to other hospitals have on victims of sexual assault? Are the proper law enforcement authorities and victims' rights groups being notified of referrals? Third, what rate of reimbursement is being provided to hospitals by law enforcement jursidictions? Fourth, what is the cost to hospitals for completing the medical protocol? Fifth, who should pay for the costs of performing the medical protocol for rape victims? Sixth, is the current requirement to provide one hospital per 1 million residents an adequate one?

I'd like to express my thanks to the members of the committee for being with us this morning on this -- for this very important hearing and also especially to Senator Lockyer and to Assemblywoman Roybal-Allard for bringing their committees to the state building to hear this important question.

CHAIRMAN LOCKYER: Thank you, Senator Roberti.

Let me acknowledge also Senator Watson who's joined us and ask if any of the senators wish to make any introductory comment at all, or shall I shift to this side and Lucille -- Assemblywoman ...

Also welcome, Lucille Roybal-Allard, go ahead. Assemblyman Roos.

ASSEMBLYWOMAN ROYBAL-ALLARD: Thank you.

I would like to take this opportunity to thank Chairman Lockyer for having this hearing and for having my committee and members participate.

As a woman and as chairman of the Assembly Select Committee on Sexual Assault Victims, this issue is of great concern to me. And hearings such as this are extremely important because they provide us with the kind of information that we need in order to truly help the victims of sexual assault. And I would like to take this opportunity to thank all of you for being here because it is the information and the expertise that you give us that enables us to deal with these issues from the standpoint of understanding and compassion. And I would just like to take advantage of the situation to let you know that I will be having some hearings myself on various issues dealing with sexual assault, and I would like to invite all of you to participate, although we don't have a date set at this time. But I look forward to your participation in providing my full committee with the information and with your expertise.

Thank you.

CHAIRMAN LOCKYER: Assemblyman Roos, any statement? No, okay. Well, we'll start with our witnesses.

Ms. Abarbanel. I didn't say that right; I left out a syllable.

MS. GAIL ABARBANEL: Good morning. My name is Gail Abarbanel and I'm the founder and director of the Rape Treatment Center at Santa Monica Hospital. The Rape Treatment Center was established in 1974 to provide comprehensive care for rape victims and we've treated over 8,000 victims. We also pioneered the development of what is now a nationally recognized treatment model for victims seen in emergency medical settings. And this model has been illustrated in a film produced by the National Institute of Mental Health that is now used to train hospitals and medical personnel throughout the United States.

I have served on several of the commissions appointed to develop medical protocols for rape victim examinations, including the committee selected by OCJP and the committee appointed by the National Institute of Justice to develop national standards and a national protocol which will be published in the next few months. I have also personally accompanied hundreds of rape victims through the evidentiary exams that we are here to discuss and I'm familiar with the procedures and the resources required to conduct these exams and the needs of rape victims.

I would like to address five issues in my remarks. The first, and since I'm first this morning (chuckle), I would like to make some comments about the impact of implementing the new protocol in Los Angeles County. When the new protocol went into effect, many hospitals that had previously provided care for rape victims closed their doors to these patients. They literally turned victims away and refused to give them care. And this is really not only what did happen; this is still happening today.

The women and the children who were turned away from these hospitals really experience this as another victimization. Since there is no one place to turn for information about which hospitals will help them, many of these victims had to drive around the city for hours looking for the care that they needed. In addition to the terrible sense of desperation and powerlessness this evokes in an

already severely traumatized person, it means that the evidence that is so crucial to successful prosecutions is lost.

In cases in which victims first turn to police departments for help, the same things happened. Police departments took these victims to the closest hospital and they were turned away. This meant that the police had to drive around the city looking for another hospital that would examine the victim. And in almost all cases, the police had to travel long distances and go outside of their own jurisdictions. This, in effect, took police officers off the street and out of their own communities, and in most cases, really doubled the time involved for the police department in investigating these rape cases.

One police agency had a developmentally disabled child who had been sexually assaulted on a field trip with her school. The police had to drive this child from Westlake to Santa Monica to get her examined. The impact of this maltreatment on rape victims, I think, is obvious to all of us. Turning these victims away attaches a stigma to being a rape victim and the victim again becomes a pariah.

These practices also have other consequences. They discourage victims from seeking the medical care they need and from reporting their assaults to authorities. After a decade of work in this country dedicated to encouraging rape victims to come forward, this is a very dangerous trend. We know from history that low victim reporting results in low apprehension rates, low conviction rates, and more rape. In a state that has led the nation in enlightened care for rape victims, this is a continuing horror story that should never have happened.

The second issue, why hospitals are refusing to provide sexual assault victim examinations, I think the answer is quite simply hospitals are turning away these victims because the reimbursement for providing the services required is really inadequate.

I have reviewed the protocols for rape exams for many other states, as well as the soon-to-be-published federal guidelines. And although there are variations across these protocols, and there are some differences in what's mandated for evidence collection procedures, there is a core set of steps and procedures that are common to all of these protocols and they really constitute a fairly time-consuming process in a busy emergency department. And I think we can all agree that the $20 to $50 reimbursement rates currently in effect in many jurisdictions are totally inadequate to cover the costs which come closer to $400 in exam.

And if anybody has questions, I'd be happy to answer them about the component parts of the $400.

ASSEMBLYMAN MIKE ROOS: Could I ask one quick question.

CHAIRMAN LOCKYER: Sure.

ASSEMBLYMAN ROOS: Yes. I wanted to ask in line with that, depending on where a rape geographically happens in Los Angeles County, are there designated hospitals like the Trauma Center network?

MS. ABARBANEL: No.

ASSEMBLYMAN ROOS: So they take them to the nearest hospital?

MS. ABARBANEL: Traditionally, what has happened in the past is the victim was taken to the closest hospital with which that police agency had a contract and they were always the closest hospitals in the jurisdiction.

ASSEMBLYMAN ROOS: And ...

MS. ABARBANEL: A part of the regulations now has, is a designation standard, which I'm going to address in a little bit, which I think is not adequate either but ...

ASSEMBLYMAN ROOS: Well, in terms of the reimbursement, though, how did that traditionally or historically take place?

MS. ABARBANEL: The way the law reads, the victim cannot be charged directly or indirectly for the costs.

ASSEMBLYMAN ROOS: Right.

MS. ABARBANEL: It's borne by the local jurisdiction which is the law enforcement agency and practice, or the city government.

ASSEMBLYMAN ROOS: Right. And so they have essentially refused to ...

MS. ABARBANEL: And they pay what they want to pay, not what the hospital bills, not what the costs, are.

ASSEMBLYMAN ROOS: Do they have their own schedule?

MS. ABARBANEL: They have — most of them have a flat fee that they pay which, in Los Angeles, the biggest payers, which are the ...

ASSEMBLYMAN ROOS: And the difference got bigger and bigger, and the hospitals finally said forget it?

MS. ABARBANEL: Yes.

ASSEMBLYMAN ROOS: You know, we just — okay.

SENATOR DIANE WATSON: Question.

MS. ABARBANEL: Yes.

SENATOR WATSON: Can all health care personnel in — or, say, the doctors — in these emergency rooms, or wherever they take them, perform this particular procedure — is it a highly skilled kind of procedure?

MS. ABARBANEL: It requires familiarity with the steps but it's not that complex. I mean most ER doctors are trained to do it, do it, yeah.

SENATOR WATSON: Could it be done in a different setting outside of the ER room?

MS. ABARBANEL: The problem with doing it in a different setting, I think, is that you really have to have this 24-hour capability for doing it. And every time we've tried to figure out how you could do it somewhere else, the costs seemed greater, you know, to build another system.

SENATOR WATSON: Than through the emergency room?

MS. ABARBANEL: To build another system for 24-hour availability, yeah, because in the emergency department, you already have this whole system of people and resources and equipment, you know, that's there 24 hours. And to buy that in another setting is very expensive. There is — there are a few places that have tried free-standing clinics with 24-hour staff, you know, but it's

expensive.

SENATOR WATSON: I was just wondering, could a nurse collect the evidence?

MS. ABARBANEL: Yes. And there is a program in California where they're using nurse practitioners to do the exams.

SENATOR WATSON: That could then be done outside of the ER room.

MS. ABARBANEL: Could it be done?

SENATOR WATSON: I'm thinking.

MS. ABARBANEL: I'm sorry.

SENATOR WATSON: That could be done somplace else outside of ER --

MS. ABARBANEL: Yes.

SENATOR WATSON: -- on a 24 -- okay.

MS. ABARBANEL: Yeah.

SENATOR WATSON: Thank you.

MS. ABARBANEL: But it's still the reimbursement issue, you know. And it requires that the District Attorney in that jurisdiction accepts nurse practitioners doing the exams.

SENATOR WATSON: I was just thinking, it might be a little cheaper if we could get someone else outside ER to do it because what you -- the expense inside that ER facility is the expense for the total operation of the emergency room that is factored in to that particular procedure. So I'm just thinking maybe a different kind of setting might be one option that we could look at.

MS. ABARBANEL: The other -- I think the other side of that coin is that an ER can absorb some victims, you know, under its existing structure, without additional costs. And in some ways, there is a cost saving to do it there. So ...

SENATOR ROBERTI: Before the most recent protocol was established, how much would you say the examinations cost?

MS. ABARBANEL: I really don't feel that the new protocol significantly increased the cost of the exams.

SENATOR ROBERTI: So you feel it's roughly $400 prior to the --

MS. ABARBANEL: Yes.

SENATOR ROBERTI: -- new regulations?

MS. ABARBANEL: Yes.

SENATOR ROBERTI: How is the -- do you have any idea how these lower figures were established? I know that's not your jurisdiction.

MS. ABARBANEL: You know, the $16 or $17 is so old. I've been doing this for 13 years and it's been there for 13 years and no one ever changed it. So I don't know what the rationale was originally, but no one ever changed it.

Okay. The third issue is -- that I want to address is separating medical care and evidentiary exams. Some hospitals have said that they would provide medical care for rape victims but not evidence exams. And I feel that it is not possible to separate the medical care victims' need from the evidence collection without doing a very serious disservice to the victim and the community. In

practice, this would mean that the victim would go to hospital A and be told we'll take care of your bruises maybe if they're serious enough to warrant emergency medical care, but then we'll send you to hospital B for a physical and a pelvic exam in evidence collection. So it would mean that the victim would go through two exams, two hospital systems, and it would really greatly delay the collection of evidence. So I think this would be a dangerous precedent.

The fourth issue is the reimbursement issue. I think we all agree that hospitals need to be paid for the costs of the services they provide. And the real question is: Who should pay? I've examined this reimbursement issue many times during the past 13 years from many perspectives. And at this point, I really believe that we have to ask you, our state representatives, for the solution because I can't see any way of resolving the reimbursement issue on a local level, especially in Los Angeles County, where there are 50 different government agencies with whom we would have to negotiate a reimbursement agreement. Although we've made signficant progress in recent weeks in Los Angeles in negotiating a higher rate from the city, the city only pays for half of the victims in our county. So we still have the county government and 48 or 49 other cities to deal with. And it would be very difficult, I think, to achieve a uniform adequate reimbursement rate across all of these jurisdictions. And who is going to do it?

Furthermore, as more and more police agencies and local governments are faced with these higher bills for rape victim exams, we may see another form of discriminatory treatment. In one hearing, it was stated, that in Northern California, one law enforcement agency said they would be more selective about which rape victims they decided to take to hospitals for exams in order to control their costs.

In searching for a solution to this difficult issue of who should pay, some have suggested that the state augment what the local jurisdiction pays. For example, that if L.A.P.D. is going to pay $200 an exam, that we find a way for the state to pay the other $200. And I think this is really an attempt to find a compromise or some shared responsibility/solution. But I feel that practically it's probably a difficult solution to implement. I mean if you can do it, that's great. But I think split billing could really be a problem for hospitals and it potentially could be another disincentive to hospitals to drop out of the system to have to deal with double billing.

So for all of these reasons, I believe that we must turn to the state to find funding for these exams. If the state assumes responsibility for the reimbursement issue, it will ensure equal treatment for rape victims throughout the state and uniformity across all jurisdictions. And at this point, it really seems like the only way to restore ready access to emergency medical care for rape victims.

The last issue is this requirement for a minimum standard of one hospital to do sexual assault examinations for each 1 million residents. I feel that this section of the Penal Code needs to be amended as soon as possible in the next legislative session. This standard is totally inadequate, particularly in Los Angeles County, for several reasons.

First, we have a population of 8 million people. This would give us eight hospitals to do all of the rape and child abuse exams in the entire county which equal half of the total number of these

exams in our state. And I can't think of any eight hospitals that could absorb this volume of patient care without a substantial increase in financial support and resources. And I think it's very important to understand that the difference between a hospital providing examinations for two to three victims a week and the same hospital providing care for two to three victims a day is really a step function. For most hospitals -- and this answers Senator Watson's question in a way -- a few victims a week can be absorbed by their existing staff resources. But if you bring in a constant influx of victims, like two or three a day, it's really a totally different situation because it requires additional special staffing and therefore a lot more dollars. So if you look to what has been, you know, viewed as an alternative of specialized or regional centers, I think that we're dealing with an entirely different financial burden.

The second reason for recommending a change in this Penal Code section is that Los Angeles County comprises 4,000 square miles. And if there were only eight hospitals doing these exams, or even 16 or 32 hospitals, some victims would be driving very great distances to obtain these services. And not only is that a hardship again for the victim, but the police would be going outside their jurisdiction, you know, for long hours and denying protective services to other citizens. So I feel that we need to do whatever is necessary to find a reimbursement system that encourages a large number of hospitals rather than a few throughout the state to provide these exams.

CHAIRMAN LOCKYER: Is the one hospital per one million in the OCJP regulations or ...

MS. ABARBANEL: It's in the Penal Code section.

CHAIRMAN LOCKYER: It's actually in the statutory ...

MS. ABARBANEL: It was enacted with the new regulations and it's Penal Code section 13823.9.

CHAIRMAN LOCKYER: Thank you.

Questions?

SENATOR BARRY KEENE: Yes.

CHAIRMAN LOCKYER: Senator Keene?

SENATOR KEENE: Yes. To what extent does a person's health insurance, under an ordinary basic policy, ever cover any portion of the costs of these procedures?

MS. ABARBANEL: Well, the law says that hospitals cannot bill victims directly or indirectly through insurance for any of the costs of the evidentiary exams. Now technically, they could bill insurance for treatment or injuries that weren't part of the evidence aspects of the exam. And there was a bill Senator Watson carried to change that procedure which was a bill by the insurance lobby. And I think that would provide some relief for hospitals.

SENATOR KEENE: I was just trying to link all of this in with a problem of uninsured working poor people --

MS. ABARBANEL: Right.

SENATOR KEENE: -- in California.

MS. ABARBANEL: But I think we do have to maintain some protection against charging the victims for these exams.

SENATOR KEENE: I agree.

ASSEMBLYMAN BILL FILANTE: A question, Mr. Chairman. Thank you.

You brought up the point that, in essence, L.A. County has a disproportionate share of rape assault victims. We have, and correct me, around 30 percent of the population in the state in L.A. County; is that correct or not?

MS. ABARBANEL: I believe we have more, don't we? Have about closer to 40 percent or ...

ASSEMBLYMAN FILANTE: Because if there is a disproportionate number, that is, population versus victims, then you're into the area like disproportionate share of Medi-Cal patients; only here, it isn't exactly things that just happen like illness and disease. It's something that's caused. And I wonder if we address it, first of all, in terms of disproportionate share, if that is significant, 35 or whatever versus 50 percent of the victims.

MS. ABARBANEL: Yeah. I think even if we had, in that way thinking, a higher number of victims, then our rate would be per population. I think the reason we have more victims reporting in Los Angeles County is because we have a lot of good services for victims which really has increased reporting. And in many of the places where there are low numbers for this crime, it really is that victims don't come forward and report.

ASSEMBLYMAN FILANTE: Okay. So then what you're saying is that you don't have additional causative factors here. You have just as many rapes throughout the state except that they're reported and taken care of better; is that correct?

MS. ABARBANEL: And we have -- we have -- don't we have half of the population in L.A. County?

SENATOR ROBERTI: About 35 percent.

MS. ABARBANEL: Is it 35 percent? So ...

ASSEMBLYMAN FILANTE: So then if you're at 50 percent of the victims and 35 percent of the population, it's at least a 40 percent discrepancy or disproportionate share; and that is significant. And I think it behooves us at the state level, medically or legally, or what have you, speaking, to know what that is. Is it reporting and care, which is fine, because that's what we want; or is it just some other causative factors? And we should try to determine that if we're looking at who's responsible and who should pay or looking at some kind of legislation, you know, because we're looking at victims, basically. And victims are our number one concern, that is, the rape or assault victims. But when it comes to cost, then you bring in other victims, whether it be other programs that are unfunded or taxpayers or whoever else has to pay. And I think then that it does behoove us to find out, you know, whether this is a ratio in terms of events and what the cause is to try to -- to try to focus on responsibility. I think our, you know, penal system simply doesn't do that. And I would like to know whether we really have that disproportionate share. And whoever is going to testify this morning, I hope that we will get that.

MS. ABARBANEL: I think everyone would like to see the people responsible pay, but rapists, I don't think, are going to pay for these exams.

ASSEMBLYMAN FILANTE: Well, obviously not.

CHAIRMAN LOCKYER: I might only insert this comment: In the prior hearing that we did,

there was sort of a broader list of issues under discussion. This is designed to be a little bit more focused, I suppose, in terms of the, the crisis in L.A. County relative to victims going without proper exam.

In that discussion, the differences in reporting requirements and the difference between urban and rural and suburban areas in terms of actually reporting was discussed at some length. I'd be delighted to get you some data from that.

ASSEMBLYMAN FILANTE: Please. Thank you. I don't want to waste more of the committee's time.

CHAIRMAN LOCKYER: Thank you.

MS. ABARBANEL: Thank you.

CHAIRMAN LOCKYER: I guess our next witness is plural, I believe. I have Priscilla Cruz and Patricia Giggans as -- are you together? Okay. Let me acknowledge on your way up Senator Art Torres from L.A. And Art, nice to have you with us.

MS. PATRICIA GIGGANS: Good morning. I'm Patricia Giggans. I'm the executive director at the Los Angeles Commission on Assaults Against Women. And this is Priscilla Cruz. And I have Priscilla here today because she is the hospital accompaniment coordinator at the Commission.

The Commission has been accompanying survivors of sexual assault to hospitals in L.A. County since 1971. And in 1985, LACAAW set up a 24-hour hospital emergency hotline which allows hospitals and directly links the hospitals to our agencies which puts them in immediate touch with the accompaniment advocates who are volunteers. And we we have 80 volunteers who are ready, willing, and able to go to any hospital in L.A. County on a 24-hour basis. We are part of a network of 11 rape crisis centers in L.A. County, all of whom try to work very closely together to ensure the service to survivors.

I want to mention that we call the victims of rape "rape survivors" for the reason of immediately trying to empower that individual to recover from the trauma. Although I want to say, after this more recent experience of what has gone on to survivors of rape, I almost feel we should go back and call them victims because I think that we are in jeopardy of them really not -- the surviving the assault but not surviving the system.

In 1985, LACAAW accompanied 65 women to emergency rooms and police departments providing rape survivors with information, comfort, advocacy, and support. In 1986, we accompanied 98 survivors of rape. Also last year, we provided hotline crisis intervention counseling to 2,267 survivors of sexual assault on our rape hotlines which, I think, is a real indication of the amount of reporting -- we talked about that earlier -- the amount of reporting that does not happen. And we provided follow-up services to over 1,300 survivors. Just the sheer numbers, I think, is an indication that the trauma of rape cannot be taken lightly.

The survivors' world immediately after a rape is controlled by hospital staff, law enforcement, rape crisis advocates, and significant others -- family, et cetera. We can't control the reactions of significant others, but we do have and need to have some control over the treatment given by professionals to survivors.

Survivors should not be treated as though society has no interest in their particular trauma that was inflicted upon them. The accessibility of medical care at a nearby hospital could be the determining factor in their decision to report the rape or not. This understandable reluctance to report can dramatically affect the number of assailants who are never apprehended and continue to find new victims. And as we know, rapists continue to rape until they are caught.

We have already spoken to women on our hotlines who have been turned away from one or more hospitals and were not given a referral to an appropriate hospital who would see them according to the medical protocol. We've also spoken with women who, after being turned away, felt that they did not want to go to another hospital because they feel like they've already been through it and they couldn't go in again and say, and repeat the words, "I was raped; can I get help here?" for that very fear of being turned away.

CHAIRMAN LOCKYER: Do you have any estimate of the percentage that either are turned away without an adequate referral or don't want to go on? How many, of all of the instances, how many don't get handled in some quick and successful, humane way?

MS. GIGGANS: I don't have a percentage. Priscilla, do have -- I don't think I have a number.

MS. PRISCILLA CRUZ: We don't have a percentage, but I work constantly with the hospital accompaniment advocates and our hotline counselors. And on a daily basis, we speak with the counselors who are on the line and who have gone to the hospitals. And also on a daily basis, we have heard at least one or more -- heard of at least one or more -- women who were turned away from hospitals, either given a referral or not given a referral even if the protocol mandates that. And they said, "I can't take it anymore. It's too much for me. I'm just going to go home; I'm going to wash; I'm going to clean; I'm going to forget it happened." So we don't have a percentage but we know it's happening too many times.

SENATOR ROBERTI: Did you also, in the course of your testimony, address at some point what your costs are?

MS. GIGGANS: Yes.

SENATOR ROBERTI: Bar edification and where you get reimbursement if ...

MS. GIGGANS: Yes, I would like to mention that. I know that is probably an issue that needs to be addressed somewhere else at another time. And I'm hoping to talk to your committee about that.

ASSEMBLYWOMAN ROYBAL-ALLARD: Yes. I'd just like a little bit of clarification. You're giving us numbers about the number of calls that you get. This is all adults that call you?

MS. GIGGANS: Yes.

ASSEMBLYWOMAN ROYBAL-ALLARD: What about the children that have also been sexually abused?

MS. GIGGANS: Well, no. What we're talking about ...

ASSEMBLYWOMAN ROYBAL-ALLARD: That is not included in your statistics at all?

MS. GIGGANS: Yes, in our numbers ...

ASSEMBLYWOMAN ROYBAL-ALLARD: Okay.

MS. GIGGANS: On our hotlines, we don't deal with very many child, young child victims. But

we do deal with adolescents and teenagers. So we are -- we are talking about adolescents, you know, say, from 12, 13 years, and above who will use our hotline services.

SENATOR MILTON MARKS: I'm from San Francisco so I don't know all the details of Los Angeles County except I know it's large.

If a person is raped, a woman is raped in, and pardon me if I'm wrong, in Burbank, can she go to a hospital in another part of Los Angeles? Or does she have to go to a hospital in the area where she lives?

MS. GIGGANS: It's preferable for her to go to a hospital in the area that she lives. And up to now ...

SENATOR MARKS: Even though the rape occurred in another area?

MS. GIGGANS: Well, no. Sometimes, if it does happen that she will go to a hospital, it depends on where she's picked up or how she gets to the hospital. Sometimes she will go to the hospital -- the police will take her to a hospital -- in the area where she is raped. It depends on when, at what point, she makes contact with law enforcement or gets to a hospital.

SENATOR MARKS: Is there any limitation on the right to go to any hospital in Los Angeles County? Can she go anywhere in Los Angeles County?

MS. GIGGANS: Lately, they have been going almost anywhere in L.A. County.

I want to talk about the medical protocol. We have reviewed the new forms and procedures. And, in fact, we're very aware of what was being put in them as they were being written.

And in addition to networking with local law enforcement, we feel that the new protocol provides for a much more accurate collection of evidence and are very much in agreement with what Gail said previously. We are very much concerned with the fact, that by being turned away from the emergency room, that is going to even make it harder for people to report. And the other concern is the idea of not having a much more community-based or a neighborhood access to the hospital.

We understand the need for hospitals to expect more than $16 reimbursement for the exam that they provide. And we are relieved at the agreement which has apparently been made by the city with medical facilities to increase that amount to $200. Still, this has not discouraged hospitals, such as Brotman and Centinela at the moment from continuing to turn away rape survivors. So we are still in the midst of this crisis.

We find the assignment of, or the possible assignment of, one hospital per one million residents to provide sexual assault evidence collection completely inadequate. This requirement is one that was made up, I think, for the entire State of California in its entirety and does in no way reflect the need of Los Angeles. FBI statistics show that 1 out of every 2.2 women over the age of 14 could be raped in L.A. County at least once in her lifetime. And in the State of California, there were 12, 118 reported sexual assaults in 1986. One-third of those, 4,400, were in L.A. County.

Recent studies indicate that still only 10 percent of all rape survivors do actually report to law enforcement which also goes in terms with our own personal statistics of the amount of calls that we get on the hotlines and the amount of times that we can actually go up and meet with people in the hospital. Therefore, we cannot assume that one hospital per one million residents is able to

adequately serve the needs of the true number of survivors in a community. Plus, there is that element of community in terms of the cultural aspects of community, also in terms — we are not necessarily addressing the needs, the different kinds of needs, of women in the disabled community or in the deaf community.

We urge the members of the State Judiciary Committee to seriously consider mandating service treatment and evidence collection for survivors of rape without this continuing of interruption of services. And again, I want to agree and reiterate what Gail said about trying to separate out the evidence collection from the actual medical treatment. Not only would it cost more but it would increase the trauma.

In terms of what I consider, and not only I but many people consider, inadequate funding in general of rape crisis centers — I mean the fact that the State may be looking at absorbing some of the costs that goes on in terms of evidence collection, I think that we need to look at the cost of serving rape survivors in the State of California in general and I would look very much forward to working with your Sexual Assault Committee in probing some of that, those issues.

We are currently funded through the Office of Criminal Justice Planning, as in the State of California, to serve rape survivors. And again, many of our agencies depend, really depend, on volunteers who are not paid — volunteers are not paid — to do much of the work. At the Commission, we have a staff of ten and we have over 250 volunteers that enables us to provide all the services that we do.

CHAIRMAN LOCKYER: We've heard repeatedly the desperate need there is for stable financing for the rape crisis centers. I know the staff of the committee has begun to try to collect hard information and various people's thoughts as to potential financing. At least with respect to the Senate, I think Senator Roberti is carrying that legislation next year but still remains for his final examination.

SENATOR ROBERTI: Could I ask you a question. My staff informs me that the protocols require the hospitals to notify local assistance groups that they're referring victims. Has the Commission on Assaults Against Women, your group, been notified that hospitals are referring other than to themselves and going elsewhere?

MS. GIGGANS: No.

SENATOR ROBERTI: So you have really never been notified? When a hospital cancels, they issue a press release or tell the police department; they don't tell you?

MS. GIGGANS: No, not at all. They just don't call us, period. And we are not told, while we are transferring this survivor to another hospital, would you like to send someone out there or would you like to contact that other hospital? No, we don't have ...

SENATOR ROBERTI: You really have no up-to-date list as to who's performing this treatment or isn't as far as some neighborhoods would be concerned?

MS. CRUZ: I'd like to, just real quickly, address that because I do work with the hospitals almost on a daily basis, the way I know.

CHAIRMAN LOCKYER: Priscilla, you might identify yourself.

MS. CRUZ: My name is Priscilla Cruz. I am the accompaniment coordinator at the L.A. Commission on Assaults Against Women.

And almost on a weekly basis, at the very least, I call the different hospitals to find out who's still doing accompaniment and where they are referring. Currently, I know of at least three hospitals that we used to go to regularly, one of them being Brotman and another being Centinela and Daniel Freeman, Inglewood, who did say that they would be starting in January because they don't have the equipment; but, I don't think that they need to wait until January, though. I think that they should be able to get the equipment sooner than that. That's my opinion.

But we do call these hospitals on a daily basis to find out where they refer them to. And many times, they don't even give a specific referral. They say, well, so and so and so and so and so and so -- they give like five or six still do them, we think; but they don't give a specific referral. And so when you give a survivor five or six hospital names and say, "We think they are doing it there," what kind of an option are you giving them?

SENATOR ROBERTI: And all three of those have canceled, I take it?

MS. CRUZ: They have not done it since at least August that I know of, maybe even before that.

CHAIRMAN LOCKYER: Okay. Patricia, had you concluded? Priscilla, do want to make any ...

MS. CRUZ: I just wanted to add one more thing. We did pass out the survivor booklets along with our service sheets to all of you. And that is something that we -- the survivor booklet, not the service sheet -- is something that we use in the hospitals. We give this to survivors of rape and go through that with her. It's basically an information guide so that she can understand what she needs to prepare herself for in this time after the rape. And that's just for your information so that you can see what services we offer to those women.

SENATOR MARKS: May I ask one more question, please? Maybe you can't answer this.

If a person goes to a hospital who's shot, not raped, is the hospital required to take that, give care to that person?

MS. CRUZ: Yes.

MS. GIGGANS: Yes.

SENATOR MARKS: Then how can the hospital get out of giving care to a rape victim?

MS. CRUZ: I think, from what I've seen, and I've also done a lot of hospital accompaniment in all ours of the day and night and all days in many different hospitals all over the city and the county, and many times rape survivors go into the hospital and are physically, seemingly unhurt because they are forced to permit what is happening to them by force of a gun or a knife or some threat of injury so that when they get to the hospital, these emergency room staff do not see any wound that is inflicted upon them and so don't feel many times that she needs the treatment when, in fact, she does. But the gun wound, they can see.

SENATOR MARKS: But they -- it would seem to me, that if a hospital is required to take somebody who's been shot --

MS. CRUZ: I agree.

SENATOR MARKS: -- they should likewise be required take people who have been raped.

MS. CRUZ: I agree. Being shot and being raped are both crimes. Right, absolutely.

SENATOR ROBERTI: Could I ask both of you also, based on your experience with these examinations, what your rough, your best estimate, is, as to what the costs --

MS. GIGGANS: The costs?

SENATOR ROBERTI: -- are pursuant to the current protocols.

MS. GIGGANS: Well, it's hard to say absolutely because also different hospitals have given us different informations, and doctors' fees sometimes are different. But I don't know. It just seems to me that $400 might be a little high.

SENATOR WATSON: Mr. Chairman.

CHAIRMAN LOCKYER: Did you want to estimate ...

MS. CRUZ: I can't estimate the cost, --

CHAIRMAN LOCKYER: Okay.

MS. CRUZ: -- of course, because I don't work at a hospital and don't bill; but just in working with survivors on an everyday basis and seeing hospitals being in all the various communities, I think that at some point, the hospital needs to start thinking about giving back to the community and assisting the law enforcement with providing these evidence collection exams and not bickering over the money. I think that the most important issue here is that this be settled without further interruption of good services to survivors.

CHAIRMAN LOCKYER: To just make sure to answer Senator Marks' question and then call on Senator Watson, when the new law was enacted three years ago, there was a specific permission granted for a hospital to opt out of doing this now. It's a valid point to debate and re-evaluate whether that was wisely granted or not; but in terms of whether their refusal is legal or not, that seems to be permitted under the statute that we adopted, Senator Seymour's legislation.

SENATOR MARKS: Well, we shouldn't have done it. (Laughter)

CHAIRMAN LOCKYER: Well, that's a good point and I think frankly, at the time that bill passed, that issue was not focused on or debated or discussed to my knowledge at all. It was -- it was regarded as an improvement in the prior law.

Senator Watson?

SENATOR WATSON: Yeah, I just wanted to follow up on that because I think we might have acted unconstitutionally under the equal protection clause because if you go in with symptoms of a heart attack, there are no obvious injuries and there's very little that would be able to indicate that there was a heart attack. You have to go through an examination.

Why is it we can discriminate against a person who is a survivor of rape? And I think some legal questions are raised here. I think maybe we acted maybe a little ahead of ourselves or inappropriately because can we give the providers of health care, emergency health care, a hole to go through? Can we give them the authority to opt out? This is a person that is a victim of any kind of crime or a person who's ill or a person who is the victim of some kind of trauma. Can we give them a loophole not to give service? So I think that's the question we might want to follow up on, Mr. Chairman, at a later time.

SENATOR ART TORRES: Mr. Chairman.

CHAIRMAN LOCKYER: Senator Torres.

SENATOR TORRES: Since you've been involved with the program, has there been an increase; has there been a dip and then an increase? What's been the pattern of rape and assaults against women in Los Angeles County, let's say?

MS. GIGGANS: I think that what we've -- on our hotlines, again, it's more of an informal ...

SENATOR TORRES: They've been operating for how long now?

MS. GIGGANS: Since 1971.

SENATOR TORRES: 1971.

MS. GIGGANS: 16 years.

SENATOR TORRES: 16 years.

MS. GIGGANS: We have seen an increase in the number of calls. Of course, we have also done a lot of community education to put that service out there to the public.

SENATOR TORRES: So the same phenomenon that may be working with child abuse, where we see a tremendous increase, may be simply due to the fact that we're becoming more refined in our reporting procedures, that it's been out there all along?

MS. GIGGANS: I personally think that it's a combination of refinement in reporting procedures, but again, not necessarily to law enforcement; to some of the agencies that deal --

SENATOR TORRES: Somebody else?

MS. GIGGANS: -- with somebody, somewhere along in other systems. But also, I think that -- I think it continues to be extremely dangerous for a woman on the streets and in their homes.

SENATOR TORRES: Because of the increased violence in motion picture, television, and all the societal factors that are changing?

MS GIGGANS: Possibly. Many, many, many factors go into causes of violence.

SENATOR TORRES: Things that we thought we achieved are not yet achieved?

MS. GIGGANS: Yeah, not at all.

SENATOR TORRES: Second important question for me is: Has there been more of an increase in black and Hispanic or minority women than there have with other women? Or have you been -- or is that able to be statistically determined?

MS. GIGGANS: In terms of the --

SENATOR TORRES: Rape and assaults, yes.

MS. GIGGANS: -- being victims of assault? I think that this is an area of reporting. I think that minority women, including black, Hispanic, Asian-Pacific --

SENATOR TORRES: Yes.

MS. GIGGANS: -- women, I think that they have been invisible in terms of the kinds of crimes that have always been perpetrated against them. I think what we're seeing more, when we talk about consciousness and of a knowledge of what is happening and a reporting, I think that, indeed, we're seeing much more of an intensification. I think they have always been victims. But I think the system is seeing more of them come forward.

SENATOR TORRES: Lastly, I think it's extremely important, and something you raised earlier and perhaps many of us didn't gain the impact of what you said, and it goes to a number of studies, one of which was done at Bates Hospital in Oakland and others across the board, and that is giving empowerment to a person who is confronted with that experience. By calling it something different can have a tremendous psychological impact in terms of therapy and thereafter. And giving a person that empowerment is extremely important, especially in those acts of violence that you are -- have jurisdiction over reporting. So I would encourage you to continue to use that type of label rather than the "victim" because I think that really adds to the fact that they survived and that puts them on the road to recovery.

MS. GIGGANS: Senator Torres, I'd just like to add that we at the Commission and in the rape crisis movement have really been ashamed of what has happened to rape survivors over the last four or five months, really ashamed what they have been put through again and again and again.

SENATOR TORRES: Thank you, Mr. Chairman.

MS. GIGGANS: Thank you.

CHAIRMAN LOCKYER: Okay. Thank you very much for your help.

I believe our next testifier is Betty Hannah Witherspoon. Good morning.

MS. BETTY HANNAH WITHERSPOON: Good morning to both committees. My name is Betty Hannah Witherspoon. I'm from the Rosa Parks Sexual Assault Crisis Center. I'm the project director for the center. Rosa Parks serves South Central Los Angeles, broadly the area that's served by L.A.P.D.'s south bureau, roughly the area from the Santa Monica Freeway to the city line going from north to south, from the Alameda to the city line and including parts of Inglewood if one were going from east to west.

Since 1984, the Rosa Parks Sexual Assault Crisis Center has been attempting to provide sensitive care to sexual assault survivors. Our target area is that part of Los Angeles that is heavily minority populated or populated by persons of color, both an increasing Asian population, a black population, and a Latina population.

The area has a sexual assault rate that is five times higher than in some other areas of the city. Despite this high reported rate of sexual assault, the south central community was one of the last areas to receive a state funded crisis center. Prior to that time, survivors traveled to centers outside the community or received no care. Most survivors received no care. And that has to do with a lot of issues that are important to the culture of those communities. It has to do with especially black women reporting and being received with graciousness by the law enforcement and by medical personnel.

Since its inception, the Center has been fighting an uphill battle against the myths that surrounds sexual assault and counseling. It has invested tremendous energy in letting assault survivors know that they are entitled to good care and to counseling. Center personnel were beginning to believe that they were making progress. More survivors were asking for the Center's aid; and as a result, more survivors were willing to go through the difficult judicial procedures for prosecution. Those procedures, going through that court process, requires many times the aid and

support of trained and/or paraprofessional counselors just to get through the process. Our being there has increased the willingness of women to go through that process.

The care and counseling that the Center provides starts at the time that a woman enters a medical facility for the evidential examination. Center personnel come to the hospital to be with her as she goes through the examination. They explain why the medical and legal procedures are necessary. They talk with her about her feelings, about herself, and help to prepare her for the response of family and friends to her after the attack. Then they offer her the opportunity to come to the Center for further counseling by trained professionals. That counseling, it has been shown, is very important if a woman is to resolve the internal conflicts about her assault.

Center experience has shown, that if survivors are not reached at this initial phase, that is, when they're in the hospital, they will often not come in for counseling. And this is very important because many hospitals will say they refer. They hand a woman a brochure and they say, "Call the Rape Crisis Center." Our experience has been in our community that is like no referral. Many, many times the women just will not call. Survivors may not see the connection between the assault and other emotional crises in their lives. Oftentimes, they're being urged by their families to just forget that this happened. Center personnel help them make the connections and go forward.

The new medical and legal procedures are jeopardizing all that we have been able to accomplish in that community in the last two years. We understand the reason for the implementation. We know that it's important that the protocol be implemented as it is, but at the same time we are highly aware that survivors are not being seen at hospitals by the Rosa Parks Center in the same numbers. And I'm going to say "Rosa Parks Center" because if you have a woman of color in a hospital, we feel it's important that she is seen by a counselor who comes out of the same culture who understands what she's going back to, who's a part of that community, so that she can make a trip to a closeby center as she should be served by a closeby hospital.

In June, Rosa Parks saw 25 survivors at hospitals. In July, Rosa Parks saw 5 survivors in the hospitals. That's a drop of 20 folks. Now we can't track whether those women were, in fact, seen by anybody else, whether they, in fact, received care. We don't know. And that is the real pain of it, not to know what's happening out there. We do know that sexual assaults were still happening. We're pretty sure of that. The L.A.P.D. can testify to that. But the confusion in the medical system about doing the new procedures as mandated by the state and the confusion about which hospitals were doing the examinations means the survivors are not being serviced. Now we're getting calls saying, "Where do we go to be seen?" They're not having the procedures explained to them by personnel trained in the trauma of rape. Survivors are not being prepared to deal with their own emotions or those of family and friends. They're not being helped to make contact with the counselors at our centers or other centers. Survivors in south central have been returned to the period prior to December 1984 when sexual assault was swept under the rug as too shameful to talk about.

We are pleased that King, Martin Luther King Hospital, continues to do the examination but those of you who know, know that Martin Luther King Hospital is the major trauma center for that area. If you're in the emergency room and triage is happening, and if a woman comes in who has been

raped, and you're also dealing with gunshot wounds and heart attacks and other things, she may end up waiting six to eight hours to be examined. By that time, she's ready to throw up her hands and say, "Forget it. I don't want to deal with you. You're as bad as the guy who raped me."

What can we do about this crass treatment of assault survivors? First, we can make sure that all county hospitals that do treat survivors immediately call the sexual assault crisis center when a survivor comes in for treatment. Second, we can insist that local and state governments -- and I think that means the governments that you all represent -- take responsibility for reimbursing all hospitals at a reasonable rate. And I do not know what a reasonable rate is, but I'm sure you have the resources to accomplish finding that out. Third, we can request the Legislature to close the loophole and the guidelines that allowed hospitals to opt out of serving assault survivors. Fifth, we can request police and hospitals that serve south central assault survivors to give priority to calling a crisis center so that survivors can start the healing process as quickly as possible and that is both those hospitals that are public and private.

CHAIRMAN LOCKYER: Thank you. Questions from members?

Ms. Witherspoon, I may just interject. One of the dilemmas that confronts us -- and I appreciate your comments and thoughts about what we might do -- with respect specifically to the reimbursement issue, we have conflicting instructions in the state constitution. The Gann Limit, which is beginning increasingly to be subjected to scrutiny for what seemed to be significant omissions or drafting errors, the Gann constitutional provision puts a limit on how much the State or local agencies can spend for all programs and we have basically been bumping into those expenditure ceilings. But the same constitutional provision enacted in that initiative in 1979 exempts from the state's requirement to pay for a mandate, anything involved in the criminal justice system, which is probably what we're talking about when we focus narrowly on the evidentiary, forensic aspect of this dispute. So we have kind of conflicting instructions in the basic document adopted by initiative. I guess it's one of those things we should try to sort out. But our flexibility is somewhat inhibited by the fact that we're talking about a constitutional amendment with two-thirds vote requirements in both houses of the Legislature and vote of the people and so on. But we're going to do it.

MS. WITHERSPOON: Thank you.

CHAIRMAN LOCKYER: Very, very severe problem that needs to be addressed. I appreciate your helping us today.

MS. WITHERSPOON: Thank you.

CHAIRMAN LOCKYER: Thank you.

Doctor?

ASSEMBLYMAN FILANTE: Mr. Chairman, could I just ask a brief question of Ms. Witherspoon.

You mentioned, as you began, some of the statistics that sort of answered the questions that we posed a few moments ago as to the relative frequency of rape and assault in the minority communities. I think you mentioned it was five times as frequent. Does that take into ...

MS. WITHERSPOON: Reported.

ASSEMBLYMAN FILANTE: Reported. All right. Does that take into consideration then the

recognized problems we have, especially with some societies where they simply cannot report various sexual problems, or in this case, assaults, so that you can come up with any kind of an answer in terms of the actual differential, in terms of incidence?

MS. WITHERSPOON: Okay. If I -- if I understand your question, let me put it in my words and see if I'm responding.

You're asking the question, if because of cultural differences there might be lesser rapes reported in certain communities; is that what you ...

ASSEMBLYMAN FILANTE: And we assume that's true.

MS. WITHERSPOON: We are assuming that's true. We believe that to be so in the rape community. Okay.

ASSEMBLYMAN FILANTE: With that, do your figures get us any closer to what the actual incidence is in, or comparison, in the various communities?

MS. WITHERSPOON: No. I would not say that because we know that under-reporting can run from two to eight times.

ASSEMBLYMAN FILANTE: Right.

MS. WITHERSPOON: We are clear, though, that if folks are reporting in an area, it probably means that there are others who are not. And if we are running five times higher than the rest of the city, then there are also those folks out there who are not reporting.

ASSEMBLYMAN FILANTE: And so your assumption is, and it would be logical for us to assume, that the ratio, say, for the minority communities, is five times or -- if we take into account what we believe to be under-reporting -- even more, maybe as much as ten times the rate in the other communities?

MS. WITHERSPOON: That is true.

ASSEMBLYMAN FILANTE: Okay.

MS. WITHERSPOON: And I think, when you run a correlation, if you were to run a multiple regression, factor analysis on it, and you look at the other things that are happening in the minority communities -- when you look at unemployment, when you look at poor health care, when you run all of those factors together -- it would be logical if we look at why people rape that we would have those high numbers.

ASSEMBLYMAN FILANTE: Another problem I have, Mr. Chairman, because we keep coming back and that's why we're here, talking about reimbursement, and I keep going back to the Medi-Cal problem, I don't have an answer, and I guess I'm supposed to. But when we talk about just mandating, which sounds great, in many cases, we do mandate, you know, life-and-death emergencies and so forth or Medi-Cal care. You can't not take care of someone because of ability to pay. And yet, we know in many cases, this mandate, along with a disproportionate share, actually has put hospitals out of business. And if we don't address that in terms of what the logical result will be, simply mandating may not be the answer because we may turn around and find that we don't have hospitals that opted out of the system in terms of treating rape victims. We find that hospitals are out of the system because they don't exist anymore. They cannot really provide any care. And if we haven't heard

them enough, we'll probably hear them this morning in terms of where that is. So I would like to hear that addressed more. We all agree, so it's hardly necessary to repeat the fact, that we want all the hospitals or most of them to do this. But we are going to have to talk about how would we do that and what the consequences would be if we simply mandated and didn't take care of the rest of the problem, as we did with things like Medi-Cal.

SENATOR MARKS: May I ask a question.

CHAIRMAN LOCKYER: Senator Marks.

SENATOR MARKS: I realize we're going to have witnesses here who speak from the police department or the District Attorney's department. They'll come. But I'm curious to know whether or not in the hospitals you discuss any of the legal problems involved in the rape cases. Do you discuss them or do you discuss medical problems?

MS. WITHERSPOON: We're basically there for emotional support. We explain the examination that she's going to go through. If many — in many instances, the officers are there with her, with the person who is being examined. They handle the evidence collection. And the officers in our area have been very careful to explain to us they don't want us tainting the testimony of the survivors. So we stay out of that area, let them tell their story. But we are there to get them through the process of telling the story.

SENATOR MARKS: But is there a person who cannot afford legal care? And there are undoubtedly people like that, many people. Is there anybody in the hospital who gives them any idea as to what the legal ...

MS. WITHERSPOON: Legal advice?

SENATOR MARKS: Legal ramifications of the ...

MS. WITHERSPOON: Oh, we can do that. Okay. We can tell them what their options are, that they can prosecute, that they can file a report. That piece, we do. I'm sorry. I didn't understand your question.

SENATOR MARKS: Thank you.

CHAIRMAN LOCKYER: Senator, perhaps I should provide you with this typical kit that's provided the hospitals. It has broken down each step in the exam and the appropriate procedures and so on for what seems to be rather specific and well thought out.

SENATOR MARKS: Okay.

CHAIRMAN LOCKYER: Okay. Our next witness, please. Miss Tilton? And clones or helpers?

MS. DEANNE TILTON: Yes, this is a very impressive panel and I'm very honored to be here. I'm Deanne Tilton, president of the California Consortium of Child Abuse Councils and director of the Los Angeles County Inter-Agency Council on Child Abuse and Neglect.

To my left is Dr. Astrid Heger who is director of the Child Sexual Assault Program at USC School of Medicine and chairperson for the Regional American Academy of Pediatrics Child Abuse Committee.

I also have with me two more state of the art physicians on child sexual assault here to answer your questions: Dr. Michael Durfee, the medical coordinator for the Child Abuse Prevention Project,

L.A. County Department of Health Services; and Dr. Elisa Nicholas who is the pediatrician in the Los Angeles County Child Sexual Abuse Crisis Center.

We have been listening to the testimony and have a great amount of compassion for adult victims of rape. We would like to take this ten minutes to focus you on a very, very critical crisis with child victims of sexual assaults. These are the tiniest victims, often infants. They cannot speak for themselves so we are here to speak for them. They are the most helpless; they lack communication skills.

The medical exam is a very different procedure. The same physicians who can perform an adequate medical evaluation on an adult rape victim are not the ones who can perform that exam on children. It takes longer; it requires different skills. If the child is under five, it will be the only evidence that will hold up in court. In terms of court time and the physicians' costs, we're not talking about one court system; we are talking about at least two court systems -- the dependency court and the criminal court. There are also a multitude of agencies that come into play within the child protection system, and it is not at all unusual for the child to be interviewed 23 times by different professionals.

Your questions, in terms of the protocols, I will answer in a very concise way; and I can answer specific questions later. The protocols are not the real issue. It is not the real issue at this point because they are a profound, excellent statement on behalf of victims of rape and child victims. But we should not cheapen that eloquent statement by assuming that these exams will be performed without providing for an adequate procedure for reimbursement.

To focus again on children, I want to give you a few statistics. In California, the Department of Justice, Bureau of Criminal Justice, statistics show that there were 12,118 adult rapes in 1986 in California. 4,428 of those were in Los Angeles. The State Department of Social Services' statistics for child sexual assault victims show 58,458 reported child victims, 17,421 of those in Los Angeles County alone.

This is not a new issue; it is not a new problem. The protocols have brought to light a chronic dilemma, particularly for those of us in the child protection system. We've seen this in 1983. We began to see a critical need for a comprehensive exam for these children. And a handful of physician heroes, including those with me today, began training physicians on the medical exam for children. And I will say, even before the protocols were promulgated, the procedures called for in those protocols were being followed by those physicians trained here and in some other counties including San Diego.

By 1985, private hospitals already were opting out of the child sexual assault exam. And in 1985 alone, five private hospitals in L.A. County reported a loss of $168,185 just on the child sexual assault exam. In 1986, L.A. County opened the Child Sexual Assault Crisis Center. And the highest level of multidisciplinary care was called for and is being provided. The cost of that is far over the $200; it is far over the $400.

We formed a committee to investigate funding issues. And for the last year and a half, we have been meeting to investigate and develop recommendations that would be most reasonable, most

feasible, and most expeditious in terms of funding an exam that was necessary and funding an exam that followed these protocols.

The result of our efforts was SB 180, authored by Senator Watson. And this bill -- I will bring to your attention today, in context of what we are talking about, it applies to both adult and child victims. And we are very pleased that this bill came before the Legislature. It has been held over for the next session. SB 180 would allow the hospital or physician or local agency, with the victim's consent, to apply for reimbursement for medical insurance carriers, health care providers, and may receive reimbursement from the Victims' Restitution Fund when the victim has so applied.

Now we have a process in gear that is developing a standard for forensic payment and I would suggest you consider as a tangible action. Once the forensic aspects of the exam are separated out from the medical aspects of the exam, through a committee now formed through OCJP, that that which is not forensic, mandated by protocol or mandated by law, that whatever is over and above that be billed to third party. Or if the victim or the victim's parents so choose, allow them to pay for it. It should be no different than the procedure for any other crime or assault, as mentioned earlier.

There are many other issues to consider with the child sexual assault exam, including the accountability of what the system does with the medical exam: How do we know it really helps? Do we have any feedback from that? How do we assure the victims get the exam? How do we deal with the child physical abuse that often accompanies the sexual abuse or may be separate? And how do we assure that any victim of any crime receives the care necessary and appropriate?

I would like now to allow Dr. Heger to make a statement and then Dr. Nicholas, if we have time, has a one-minute statement to read for you.

SENATOR TORRES: Mr. Chairman.

DR. ASTRID HEGER: At L.A. County USC Medical ...

CHAIRMAN LOCKYER: Senator. Pardon me.

DR. HEGER: Excuse me. I'm sorry.

SENATOR TORRES: Ms. Tilton, I laughed and chuckled a little bit when you mentioned the Victims of Crime Fund.

Yesterday, through the good graces of this chairman and the president of the Senate, we held almost a six-hour hearing in Sacramento dealing with the issue of the victims of violent crime. It is in shambles. And most of the cases that are needed to be reimbursed are those involving child sexual abuse. Whether it's for therapy, whether it's for medical attention, the program is in total disarray -- delays as long as 16 months in some cases; delays as long as ten months before even verification of a claim occurs.

I would urge you to use whatever Republican friends you have and supporters that you're involved with -- and I know there are a lot at USC, and other places -- to urge this Governor to get on top of this problem because enough is enough. This committee, the Senate Judiciary Committee, has been looking at this issue for well over two years and there has been no response. It's the first time that an agency has had such support from the Legislature. And from a law-and-order Governor, none. So anything you can do, if we're going to offer that as an alternative to whether it's adult rape

survivors or whether it's children survivors, it is meaningless unless there's some action from this Governor to get that program on line. They have the money; they have the terminals; they have the capacity; but they don't have the support of this administration. So anything you can do in that regard, would be most appreciated.

MS. TILTON: Yes, I can't speak for the Governor; but certainly, we would be willing to take any tangible action you recommend. Mia Baker will be speaking in more detail on that.

CHAIRMAN LOCKYER: If you find someone who does, will you let us know?

MS. TILTON: Pardon?

CHAIRMAN LOCKYER: If you find someone that does speak for him, would you put us in touch? (Laughter)

I want to acknowledge Senator Torres' very thorough work with respect to the Victims' Compensation Fund and express, I guess, my frustration. The rhetoric we hear is about fighting crime. The reality is building prisons.

SENATOR WATSON: Yeah.

CHAIRMAN LOCKYER: The rhetoric we hear is about helping victims. The reality is: Don't do anything for victims. Cut their budget, and build more prisons. It doesn't make sense.

MS. TILTON: Throughout the system, for children and adults, we always -- we chronically come in too late. And sooner or later, someone has to realize that the dollar we spend on early intervention and prevention is worth a $100,000 later. And in the case of child sexual assault victims, it's very clear. And I appreciate your comments.

CHAIRMAN LOCKYER: Okay. Doctor.

ASSEMBLYMAN FILANTE: Yes, Mr. Chairman. We have touched on a subject that bothers me tremendously, or has, namely, the Victims' Fund, and how to reimburse victims. And it may be, and you did the proper deductory comments for that, when you talked about building the prisons which we can't afford and so forth, and that is, at this time, when we're looking at alternatives to imprisonment, in prisons that we either can't afford or can't continue to have crowded, those alternatives may be more than just electronic; they may be financial. And it may be, that at this crisis time, and it isn't just rape crisis and so forth, that perhaps there will be enough of a joint effort to not only look at what we're doing right now but how we can pay for it and how we can pay for it from perhaps more those who caused it. And one of the things that's stopping it is obvious. And we don't catch many people; we don't imprison or make enough people pay. But those that do, at least, and those that are put in that position, instead of sitting in prison, perhaps they could be earning some money that, first and foremost, goes to the victims. And we have started that but in a very small way of having, you know, factories within fences and so forth. But I think that this issue today would help to light the fire under that because we have a different constituency opposing the progress in both areas. And it may be by confusing that we can get an alliance that would help.

I didn't mean to, you know, divert. But to me, if we don't have some significant funding, it ain't going to happen. And whether it's Gann or some other priorities like AIDS that we can't find enough money, we're stuck, but not to be partisan about this. We are financially stuck. And therefore, we've

got to look at something different and this could be.

And thank you, Mr. Chairman, for at least moving in that direction.

CHAIRMAN LOCKYER: Doctor?

MS. TILTON: May I make one quick point about the Victims' Restitution Fund. One of the problems is, that if, in fact, it's impacted by claims for the child's sexual assault medical evaluation, then there's a need for clarification because technically it is illegal because you cannot bill directly or indirectly. So, in fact, we have then some who are not following the current law, who are applying for funds that would disadvantage those who do not know they can do so. So there at least needs to be a clarification of what that fund is for and I would certainly hope it can be applied for these victims.

SENATOR KEENE: I'm not sure Senator Torres' message got through because afterward you began several sentences with "someone's got to realize," -- "someone's got to realize." That's really depersonalizing the difficulty. The someone who has to realize is named George Deukmejian. And you've got to start laying the problems on his doorstep because he is the one that is preventing adequate funding for all of these programs. And until you're ready to do battle with the Governor over this issue, nothing is going to happen. And it's nice to talk about someone has to realize. We're all sitting in this room. We all realize it that the funding is inadequate, and we all know why the funding is inadequate. That's where the blame belongs and we've got to acknowledge that at some point.

MS. TILTON: We're very happy to work with you in helping ...

SENATOR KEENE: Assemblyman Filante, I listened to you and you're right; we've got to come up with additional funds. But you know as well as I do that this administration is not prepared to come up with additional funds. There is no effort to do that. You may wish to do so; I may wish to do so. Until the administration gets behind it, we're not going to have it happen.

ASSEMBLYMAN FILANTE: Let me just repeat, Mr. Chairman, if I may, on the conclusion of that from my standpoint. I think it's a bipartisan problem when it comes to, for example, preventing prisoners from working and earning money. And I think we should have a bipartisan effort to change that and some of these other factors and maybe with that then we'll be able to get to the Governor who has to solve anything.

SENATOR ROBERTI: It is a bipartisan problem. But just because it's a bipartisan problem doesn't mean that both sides are equally wrong. Quite frankly, if somebody is a criminal, that doesn't mean that the penalty on society should be borne by someone who is in a job competing with what he may be doing in prison. And I think that's what the issue is. The butcher, the baker, the candlestick maker, he's not the one, or she's not the one, who committed the crime. And the usual Republican -- and I had to get partisan of this -- the proposal is that they should be able to do work that's in competition with these people. These people have jobs too. All of society has an obligation to remunerate the victim, the victim first, yes, and to the extent that the victim cannot -- rather, the perpetrator cannot -- remunerate the victim, then all of society. But to pick out any one group who just may be the poor unfortunates that have jobs that are competing with what the criminal may be

doing, that's not fair. And so, you know, put somebody out on a road gang or make furniture or whatever, well, what did the furniture maker have to do with the crime that he or she has to now find that their job is in competition with the criminal?

So yes, I agree with you, Assemblyman, that the perpetrator should be called upon to pay but not at the expense of an innocent person in society; and to the extent the perpetrator can't, then we all have an obligation to remunerate the victim and not just pick out somebody out there who may be a construction roadworker or a furniture maker and say, "You've got to pay the bill." We're a little bit afloat, I guess, from ...

DR. ASTRID HEGER: Well, I was sort of hoping I could speak for the Governor but I can't do that either. But as a Democrat, I can't anyway.

I want to speak, however, for perhaps the children in our society who exist within a very, very flawed component which is the legal system. And I want to just, just for a moment, address the fact that talking about reimbursement and forensics and all this, and we talk about child rape, really focuses on the wrong issue here and that children are unfortunately forced into the system for medical examinations. And there's a tremendous emphasis on the forensics in the medical examination where, in fact, for children, the emphasis needs to be more on a therapeutic, medical evaluation and this may be the key to seeking reimbursement for these children; that, in fact, the child exam is different and that it exists primarily for the child and not for the legal system. Therefore, we should be able to receive compensation from the private funding sources.

In addition, I'd like to really, really emphasize the fact that the adult exam is completely and totally different from the child exam and the emergency room and that you cannot mandate that these children be seen in emergency rooms. These children need to be seen by highly trained, well qualified physicians.

CHAIRMAN LOCKYER: Is the protocol meant to address the child abuse victim?

DR. HEGER: Yes, yes, yes.

CHAIRMAN LOCKYER: It's meant to be applicable to both?

DR. HEGER: There is a separate protocol just for the child.

CHAIRMAN LOCKYER: Okay.

DR. HEGER: All right. And I was involved in producing that protocol; therefore, I think it's an excellent protocol. However — and it does not add a tremendous amount of cost or time because we're in the county system so we have no essential ...

CHAIRMAN LOCKYER: The forensic work is similar —

DR. HEGER: The forensic work is similar.

CHAIRMAN LOCKYER: — but the psychological counseling and so on is significantly different?

DR. HEGER: Yeah, the protocol is different from the adult. But the evaluation of the child is different because you're asking for skills that the ER doctor does not have. So therefore, we need to, number one, you as our elected officials, need to mandate that there be tertiary centers, regional centers, for these children to be seen.

Secondly, we need to recognize the fact that the children require a more extensive, involved evaluation because they are not there acutely; they are not there most of the time as a rape victim for that type of forensic evaluation. They are there after the fact because they have delayed disclosure, ongoing abuse, over a long period of time. You all know this so I won't digress on it. So therefore, the child is there for a lengthy, involved psychosocial, multidisciplinary evaluation that is quite different than the adult evaluation. So I want to make sure that I mention that.

The other thing, maybe how to get some funding for this. And we're talking about how are we going to help out. I'd like to just address that briefly.

L.A.P.D. and the Sheriff's Department here is now going to pay more money for the exams. I think that's terrific and I think that's great. But you need to understand that they're going to spend that money to buy an exam for a child that's in the legal system that they want an expert exam on. So they're going to come to the centers in the county that they recognize that have experts like L.A. County, like Martin Luther King, like Harbor General; and that the other children who are not in the legal system, either too young or not in a situation that's going to be prosecuted, they are not going to buy an exam, and these kids are falling through the cracks. How do we fill these cracks up?

CHAIRMAN LOCKYER: Do they know that? I mean this is typically a report from a school teacher, neighbor, or whatever that comes to the police department?

DR. HEGER: That's right.

CHAIRMAN LOCKYER: No one's screened yet as to the likelihood of a prosecution in any of those?

DR. HEGER: That is correct. And many of those children will have an exam purchased by the police department for purposes of determining whether there, in fact, is a legal case. What I am speaking to is that the tremendous -- that most of the children don't fall into that category and they come in by DCS; they come in through parents; they come in through other private physicians.

CHAIRMAN LOCKYER: Oh, you mean to the hospital?

DR. HEGER: To the hospitals or to a doctor who's going to do the evaluation. So there is that wide group of kids who will fall through the cracks. I'm talking about filling in the cracks. I would like to just say we need to be able to seek remuneration from the private sector.

My caseload at L.A. County has doubled since the 1st of July, doubled. And so I'm seeing almost a 100 kids a month many times. That's too many kids for me to be seeing in one month in my center. And the reason for that is because private pediatricians are telling me in the community that they are being advocated by the people upstairs to not see child victims in the emergency room because, because the protocol says, "If you are unable to follow this protocol, refer it to a center." They finally have gotten an out. They now do not have to see this victim. They are now sending the victim into the county system. But the real reason that they are sending the child into the county system is that it is not a financially rewarding experience to see this child in their clinic or the emergency room.

So therefore, with the law, the way it states, that we can't seek reimbursement indirectly or directly from the victim ...

CHAIRMAN LOCKYER: So you would advocate the Senator Watson bill?

DR. HEGER: I would advocate we need Senator Watson's bill. That was a great bill and I applaud her for that bill. And we need that so that we can encourage private individuals to see them.

One last point — I know we're really running over time — and, that is, that if we have the private sector to go through to bill, those of us who are involved in teaching other doctors to do these exams and start centers have some other incentive to give to them saying, "We will teach you; we will help you; we'll support you. And, in fact, you can receive remuneration for the evaluations that you do." Therefore, in Bishop, California, in the northern part of the state, or Imperial Valley, where there is no USC or UCLA tertiary centers to send kids, we can get these centers established; but we can't do it if it's a freebie because doctors can't work without some kind of income. And the people who run their clinics say, "Don't do these exams because we lose money." So we can't have that. And so that would be just cutting, what I was going to say, down a little bit. That would be my solution. I'm an absolute advocate for us going into the, one, private sector to get money back, and two, the state has to take the responsibility for starting these great centers for kids. Kids do not survive in the legal system. We have got to figure out better places for them to be seen so that when they do enter the legal system, they can survive.

Thank you.

CHAIRMAN LOCKYER: Thank you. Did you wish to have someone else make a brief comment?

MS. TILTON: Yes, Dr. Elisa Nicholas, did you want to read your statement?

CHAIRMAN LOCKYER: Okay.

DR. ELISA NICHOLAS: I can read it or turn it in. I have that.

I'm here representing not only the Child Crisis Center at Harbor/UCLA but the entire medical center, the pediatric section of the medical center.

We at Harbor/UCLA have experienced a marked increase also in the number of children that are being refused medical care at the private institutions in the community. These children are therefore referred to our institution for their evaluations. In addition, we've been contacted by many of the community hospitals in the area. Because, because of the new law, they've opted not to see these children. Mostly, it's because of financial renumeration.

The emphasis on the OCJP design is for evidence gathering again and for potential criminal prosecution. And the medical community must address the clinical and psychosocial issues involved in these examinations as been stated already. We feel that we've reached a crisis situation in Los Angeles County. And the county-funded facilities cannot adequately care for these unfortunate children who are refused care.

We believe, that although the community hospitals complain about the complexity of the examination and paperwork, it is the issue of reimbursement that is key to solving the present crisis. We feel that the bill introduced by Congresswoman (sic) Diane Watson was a move in the right direction ...

SENATOR WATSON: I'm elevated.

SENATOR MARKS: I think she should have been.

DR. NICHOLAS: Pardon me?

SENATOR WATSON: Senator.

DR. NICHOLAS: Senator. In the right direction to assure that all these patients have access to appropriate care.

And we endorse the efforts of the Senate Committee on Judiciary to evaluate and rectify the unanticipated sequlae of this protocol.

This is also from Dr. Carol Berkowitz who's the director of Pediatric Clinics and Group Practice at Harbor/UCLA Medical Center, and Sandy Elvik who is our child abuse coordinator at Harbor/UCLA Medical Center.

CHAIRMAN LOCKYER: Thank you very much.

MS. TILTON: A big applause. Do we have one minute?

CHAIRMAN LOCKYER: Sure.

MS. TILTON: Dr. Durfee.

DR. MICHAEL DURFEE: Michael Durfee. I'm a child psychiatrist. I run this county health department's Child Abuse Program.

And let me just make two comments. One, it is fairly clear to me, that whatever information you gather, you're short of it. The dilemma is harder; and the more we uncover, the more we find. For example, even if you do figure out how to pay for the sex abuse exam, there's a problem of hospital overstays for children who get hospitalized and there's a lack of foster care. And we're talking about, I think, tens of millions. And I can run it up a whole lot higher than that. And we need to address the entire problem with a fair amount of sobriety.

I would just comment on my experience within the health system. I receive reports of reports. When a health professional in this county, public or private sector, reports child abuse, if they are connected to me, and most of them are, they send me a copy of that report and that gives us an enormous data base that does not exist anywhere else in this state that I know of. We get about 600 total reports a month.

The most common category is sexual abuse; it runs about 250 a month. Consistently, the most common age for sexual abuse reports that I receive is age 3, 4. And we are receiving reports in the first year of life. I could fault my data in a number of ways. Mostly, I would say my numbers are low. But with those children, a competent medical exam boasts as a medical psychosocial issue, as Dr. Heger pointed out, and as an evidentiary issue, is critical. There is almost no evidence that there is a system to predictably pick children up, screen them, pick the ones that need the most by evidence, by medical care, and then tie that to a system, either a legal system or a medical psychosocial system that follows up on that.

We are losing children in this county, preschool-age children, with gonorrhea. And the fact that we know that puts us ahead of the counties that the rest of you are from anyhow.

CHAIRMAN LOCKYER: Thank you.

DR. DURFEE: Have a nice day.

SENATOR WATSON: Mr. Chairman.

CHAIRMAN LOCKYER: Yes.

SENATOR WATSON: And in response, thank you for the elevation. (Chuckle)

But I intend to reintroduce SB 180, which is stalled in one of the committees. But I would like to use this vehicle to look at the protocol and also to look at another statute that we got on the books, oh, maybe eight years ago, that dealt with the DES examinations of women because not too many health providers knew how to, or were trained or skilled, to perform this examination. I'd like to use that as a model because we had certain centers throughout the state with the well-trained people to perform these particular procedures. So I'd like to offer this vehicle up to be used to add provisions that we think will clarify. And certainly, I hope that we can put a thrust behind to go into the private sector, to go into the third-party payer, and be able to fund these procedures.

CHAIRMAN LOCKYER: Okay. Thank you, Senator. Thank you very much for your ...

MS. TILTON: Thank you very much.

CHAIRMAN LOCKYER: Dorothy Jonas.

MS. DOROTHY JONAS: I'm Dorothy Jonas, chair of the Los Angeles Women's Leadership Network. I'm sorry. Thank you, thank you.

Frenzy, sense of shock and outrage swept through the women's community upon learning that the rape victim would once again be singled out for discriminatory treatment. But we are comforted in the knowledge that you, and you, Senator Roberti, and you, Senator Marks, Keene, Allard, Torres, Waters, all of you, are equally outraged with us. And we know that that's why these hearings have been convened. I know you're as determined as we are to guarantee that the clock won't turn back to other years, when following a sexual assault, the victim was made to suffer additional humiliation and trauma by an uncaring and unenlightened system.

Now I know that all of you have been listening very carefully to all the previous speakers, just as I have. So there's absolutely no reason for me to cover that ground one more time. But please let me get to the point that Senator Marks was making and let you know that we too do agree with you. To us, it is completely unacceptable. It's unthinkable that a hospital could ever turn away a victim in need. And yet, we have seen just that happen within the last three or four weeks. And we've seen other hospitals forced to accept an overload of victims simply because their doors were still open.

And we feel, that in an area the size of Los Angeles, the current rules, which allow hospitals to refuse rape victims or sexual assault victims, if a minimal number of others accept them is completely unrealistic. We feel the ratio of one hospital for every million residents is ridiculous to begin with. You can't do that in an area the size of -- the geographical size of Los Angeles. And evidently, since these present problems center around -- have focused to center around -- the financial considerations and the questions of which jurisdictions in our society are responsibile for actions as well as payments, we feel that the only thing that we can come to you now is to say to you there certainly has proven now to be a time that we need a uniformity of action.

On the local level, I think that you do understand that it's pretty impossible to conceive of how

people are going to negotiate with everyone of the 48 or 50 cities within the County of Los Angeles and then plus Los Angeles County. And so that what we've developed here as we've seen the chaos growing over the last three or four weeks is we wanted to say who's in charge.

Well, I suppose it might have been logical that the state agency, which instituted the new protocols, might have been expected to stay with it until proper procedures and if there could have been a smooth transition. But I don't know for what reason that that isn't being done. But I do know that right now we've come to a place where, no matter what wasn't done in the past, we need you now. And so what I came here to do today was not only to compliment you and all this committee but also to urge you to continue with the momentum that you've just started with these hearings, and to stay with this issue because it is our feeling, really, that no one is in charge. And through your offices, through the authority and the resources that you bring, I feel that we can solve this problem. But please, don't leave us until it is solved.

SENATOR ROBERTI: You're absolutely right. I think some kind of legislation mandating uniformity and permanency is in order, and I don't think that's what we have. What we're trying to find out right now is who's being candid with us on a number of issues, not the least of which is, how much do these examinations cost. Now I grant each hospital has a different, slightly different cost procedure but they're not radically different. And ...

MS. JONAS: We want just cost, don't we? I know that we have run such a cost at Santa Monica Hospital. I wonder how we can get enough of these costs together so that you and I and other people would know for sure that we've got the bottom-line costs.

SENATOR ROBERTI: All right. Because, see, I'm not positive. See, I'm sure many hospitals legitimately just want to be compensated for their expenses.

MS. JONAS: Yeah.

SENATOR ROBERTI: I'm a little suspicious that some hospitals, just to be honest, don't want to be bothered. And maybe a way of not being bothered --

MS. JONAS: Yes.

SENATOR ROBERTI: -- is by having a cost that is impossible to meet. I'm not going to make any accusations now. That's what this whole hearing is about. And other hospitals are doing the double and triple duty.

MS. JONAS: Yes, um-hmm.

SENATOR ROBERTI: So, you know, we just can't, we can't uniformally say, point the finger at any one hospital and say, you know, you are not complying with what really is your duty here. But we're going to try to find that out. But we need a uniform law; we need permanency in that law; and we have to try to find out what the costs are so we can come up with some kind of --

MS. JONAS: Realistic, yes.

SENATOR ROBERTI: -- realistic compensation.

MS. JONAS: Yes. Let me ask someone, have we turned in a cost list from Santa Monica hospital? Will we be doing that? Yes, we'll furnish that ...

SENATOR ROBERTI: Thank you very much.

SENATOR MARKS: Mr. Chairman.

CHAIRMAN LOCKYER: Thank you, Dorothy.

MS. JONAS: Yes.

CHAIRMAN LOCKYER: Senator Marks.

SENATOR MARKS: I wish you were still on the Commission on the Status of Women.

MS. JONAS: Thank you, Senator. That's very kind of you.

CHAIRMAN LOCKYER: Okay. Our next witness is Mr. Fisher from the Sheriff's Office.

Let me acknowledge Assemblymember Maxine Waters who's with us now also.

Mr. Fisher.

MR. ROY FISHER: Thank you, Mr. Chairman. My name is Roy Fisher. I'm the fiscal officer for the Los Angeles County Sheriff's Department. A number of questions have been raised as to the existing rate that the Sheriff's Department pays of $50.

A number of years ago, and go back into the '70s, early '70s, probably back into the '60s, our department was paying $16, same amount as the Los Angeles Police Department. In approximately 1978, there was a law revision which required victims of sexual assault to have pregnancy tests and VDRL tests. At that time, we conducted an analsis from billings which we had gotten, received from various hospitals, to try and determine a reasonable price that we could then pay. At that same time, we also implemented or prepared our rape evidence collection kit to help reduce some of the costs that hospitals were expending for miscellaneous supplies. We then determined what we felt was an equitable rate of $50. We then implemented that in somewhere in 1979. I don't recall the exact date.

Since that time, we've had very little actual complaints from hospitals to the Sheriff's Department as to the amount of reimbursement being too little. We've had a number of complaints concerning examinations for child abuse, not child sexual assault, but child abuse examinations. And that has been an issue I've previously raised here. We are prepared, and our office is starting to implement an increase of our reimbursement, to $200 for sexual evidence examinations effective January 1, 1988.

A number of the other comments that also have been raised concerning the number of hospitals that can be utilized, or if there can only be a few hospitals designated to provide the examinations necessary, it's our feeling we've used approximately, about 24, 30 hospitals in our jurisdiction. We have not had that many, as I mentioned, complaints of the amount of reimbursement. To my knowledge, we have not been turned away from any of those hospitals here in the last four months.

It's our position that hospitals should provide this service, that all hospitals should. We don't feel that it should just be restricted, that there's only one per million. Obviously, it would be much easier for any victim or survivor of a sexual assault to be able to go to the nearest hospital. In our situations, we would try and accommodate that. The laws that are on the books, I think, also allowed for private physicians to be utilized. I have not seen very many billings from private hospital or private physicians. Although I don't feel that our department would have the position of refusing a victim if they so desired to designate their own physician.

The payment of our $50 in the law enforcement community has been for physical evidence

collection. The confusion has existed for a number of years as to the examination portion and the physical collection of evidence portion of an examination.

Back in 1977, the Attorney General was asked to issue an opinion and distinguish about those particular costs. In the law, when it was located in the Government Code section, identified the fact that there be no cost charged to an individual, either directly or indirectly, but it also identified the treatment and services if they were performed at county hospitals or county charges, if they were performed at private hospitals where the responsibility of the law enforcement agencies. Back at that time, they made a footnote in their finding that there was this confusion, whether we're talking total cost, whether we're talking treatment, or just the examination portion as to who should be liable for all of the component costs.

We have traditionally held that we are paying for the collection of the physical evidence as evidence by the use of our evidence collection kit. And so that the examination portion where there are additional medical care rendered, we do not feel that that should be the cost of the law enforcement agency. We do not necessarily feel that it's strictly the responsibility of the victim, that there should be other avenues available to help that victim get reimbursement for those particular costs.

I have nothing else.

SENATOR ROBERTI: Thank you very much, Mr. Fisher.

Any questions? Assemblywoman Waters.

ASSEMBLYWOMAN MAXINE WATERS: I have a question, Senator. Perhaps it could be answered by any member of the panel. I'm just listening to the concern that's being raised about who pays what and how it's determined. And that work, I guess that's been done by the Attorney General in the past to determine, I suppose, what portion of that, the law enforcement agencies are responsible for.

Does anyone know the history of how this dual payment system has emerged?

SENATOR ROBERTI: Do we have anything on that?

ASSEMBLYWOMAN WATERS: What I gather from what I'm reading here, what I try to find out, why was the City of Los Angeles involved in reimbursement? And as I hear you testify, I understand that perhaps the thinking here historically is that the law enforcement agency would need information that goes above and beyond what would be considered an examination that insurance companies would pay for? Is that how we got to this point?

SENATOR WATSON: There is somebody from the Attorney General's Office that has some information on the protocol. Can you respond to the question? Yes.

MR. ED KERRY: I'm from the Attorney General's Office and I can't answer the question.

SENATOR ROBERTI: One of our, one of our earlier witnesses, I think, made the point, is the evidentiary portion is paid for by the law enforcement agency and is bifurcated. And the medical portion is paid for by the victim or the insurance company who, whichever is the ...

ASSEMBLYWOMAN WATERS: Does this create a problem in all of this?

MR. FISHER: In the sense of, when you get an invoice or when we get an invoice from a

hospital that is provided an evidentiary examination, there's nothing broken down to identify costs between an examination versus any treatment that may have been rendered. You'll normally see an emergency room charge; you may see a physician's charge in there. There may be ...

ASSEMBLYWOMAN WATERS: Does this cause a slowdown in reimburse — in payment while ...

MR. FISHER: Not necessarily in our department. We pay, I think, a little different than the city may pay. We actually issue checks directly from our office to the hospital. What we do, is when we get a billing in, we then verify from reports of various stations whether the individual who is being billed for was actually a case that was handled by the Sheriff's Department. So we normally get monthly reports from our stations as to those people they have sent in for evidentiary examinations. If we get a billing from a hospital, and we are unable to locate that individual's name, then we will go back to the hospital or we may go back to the stations within an area if we could not ascertain which station may have taken them in. And we may then, you know, to ensure that it is a Sheriff's Department charge ...

ASSEMBLYWOMAN WATERS: The hospitals are getting — the Sheriff's Department, the City Police Department, the Highway Patrol, whatever jurisdiction, is doing the reimbursement for the evidentiary portion of the examination; is that what goes on?

MR. FISHER: Well, the hospitals would bill primarily the agency that took the victim in because I must assume they would think that agency is the one conducting the investigation.

ASSEMBLYWOMAN WATERS: Okay. I understand. I understand. Do we have a problem here in slow payments because of the way that the hospitals have to bill for the payments, getting the correct agency; and the agency then taking a look to determine whether or not they're being billed properly, whether or not they're being overbilled or whether or not — do we have any discussions going on between the agencies and the insurance companies which would slow down payments?

SENATOR WATSON: Well, let me respond to that. Number one, the problem here, Maxine, is that the local health facility is not being reimbursed adequately to cover the cost of the procedures. The procedures are usually done in an emergency room. We're trying to determine today what would be the costs. It's been mentioned — it seems like it's somewhere around $400 per examination when the reimbursement goes from $20 to $50. It just doesn't cover the entire cost. Because it's bifurcated, because there's evidence and then there's, I guess, the continuation of the examination and maybe some treatment, that presents a problem. But I think what we have to ...

ASSEMBLYWOMAN WATERS: I think David Roberti is correct.

SENATOR WATSON: Yeah.

ASSEMBLYWOMAN WATERS: I think the problem is greater than that even. I think, when he raises a question about whether or not the cost are the only problems associated here, I think he raises a key question. I think it probably is cost. I think it's probably a lack of a willingness to want to do this work. And I think too, I'm gleaning here, that something else is going on in the system that might bog down speedy payment of the bills because of what I'm hearing. And that's what I'm asking, if there are some other factors here other than strictly the amount.

SENATOR WATSON: Well, you know that at the state level, we've had problems with the

speedy payment on those claims. That's one problem too. And the other problem is that the local providers have to bill the insurance company and that -- for a particular portion and that's presenting a problem too. So I think that whole mechanism has to be looked at.

ASSEMBLYWOMAN WATERS: Well, that's what I would suggest to all of you who are here today. I would suggest that victims should not be additional victims to the system; that, first of all, does not pay enough, most certainly the centerpiece of this hearing; but secondly, to the bureaucracies that have the responsibility for the payment and certainly should not be victims in a system where maybe payments are being slowed down because of people having to determine whether or not it's their rightful cost.

It seems to me, that as we look at this, there's a way to streamline all of this and to provide some way to make payments in a timely way; and certainly, the amounts should be increased. But also perhaps they should be very timely and perhaps not have to be concerned about whether or not the insurance company's going to get it back in a timely fashion or the law enforcement agency. I think there's a way to do that here. And I would hope that we would look at that too.

MR. FISHER: If I may just comment on the timeliness. We normally pay these type of billings once a month. For any billings that we get in, we process the check back to that hospital for whatever number of claims we received that month. We don't pay one at a time.

ASSEMBLYWOMAN WATERS: Except if you got a wrong billing and it belonged to L.A.P.D. instead of the county, then you'd have to do something else, wouldn't you?

MR. FISHER: Well, we would refer it back to the hospital to bill the other agency.

ASSEMBLYWOMAN WATERS: That's what I figured.

MR. FISHER: If we knew that agency's name, we'd notify 'em. If we didn't, we would just say that this was a case not handled by the Sheriff's Department.

Now with the increase to the $200, because of the manner in which we pay through a petty cash type of operation, we will be paying, in essence, basically on a weekly basis so that we have -- we're going back to the auditor to replenish our fund. So we're going to have to be processing those more or less on a weekly or perhaps a biweekly basis. So that, that would expedite it as it applies to us. We haven't had the complaints, though, of, you know, delayed payments in that regard.

ASSEMBLYWOMAN WATERS: Okay.

ASSEMBLYWOMAN ROYBAL-ALLARD: Mr. Fisher. Okay. Did I understand you to say in your opening statements that you have not experienced, or your department has not experienced, having anyone turned way?

MR. FISHER: I have not heard of any. As I became aware of the protocols -- and remember, I'm dealing in the finance office. And when there's issues like this where I'm expecting some impact to the budget, I get concerned about it. And as these headlines started coming in the paper -- and I would ask back to the divisions, "Have you experienced any problem with any of the hospitals of turning you away or has any of them raised any questions to you that they would not be taking them?" And, you know, the information I was getting back was, you know, was nothing.

ASSEMBLYWOMAN ROYBAL-ALLARD: Okay. Now do you think that is because those

hospitals that are no longer providing the service are reporting that to your department so you're not going to those same hospitals? Or is it because the hospitals that you traditionally use are continuing to service these surviviors?

MR. FISHER: I probably couldn't answer that exactly. It'd probably be some combination. Over the years, most of the relationships we've had with the hospitals has been a very personal relationship. We haven't dealt with contracts with hospitals. It's more a relationship between the station commander and the hospital administrator. And when we raised our rates back in '79 to the $50, the station commanders were directed to go out and talk with the hospital administrators, you know, meet them, deal with them, you know, and get a relationship going. And we've never had a contract with any of the hospitals that have provided us service.

ASSEMBLYWOMAN ROYBAL-ALLARD: Okay. And how many hospitals are we talking about in your jurisdiction?

MR. FISHER: Well, I don't know how many are in the jurisdiction. We utilize between about 20 and 30.

ASSEMBLYWOMAN ROYBAL-ALLARD: 20 and 30.

MR. FISHER: I had a listing. I regrettably didn't bring it. But last year, there were about 20 to 30 hospitals that we utilized.

ASSEMBLYWOMAN ROYBAL-ALLARD: And to the best of your knowledge, they haven't turned anyone away?

MR. FISHER: To the best of my knowledge, yes.

ASSEMBLYWOMAN WATERS: Excuse me, Ms. Roybal. Does that include Daniel Freeman and Centinela, your jurisdiction?

MR. FISHER: I believe we do use those. We're not, you know, that frequent users of them. But to my knowledge, you know, nobody's told me that they've been turned away from any of the hospitals.

ASSEMBLYWOMAN WATERS: Well, it says right here that Daniel Freeman Memorial Hospital and Centinela Hospital Medical Center are not performing rape exams at all. You wouldn't know that? You're L.A. County?

MR. FISHER: That's correct. I pay the bills. You know, I don't know where the officers will take the victims.

ASSEMBLYWOMAN WATERS: Well, where — let me ask you — in the L.A. County area, in that south portion, where do you take your rape victims if you're not taking them to Daniel Freeman and Centinela? Where do you go; where would you go?

MR. FISHER: I do not have the list of those hospitals ...

ASSEMBLYWOMAN WATERS: Well, I know, I know which ones are out there. I mean that's a whole area there that they cover, that whole south kind of west area.

MR. FISHER: That's correct.

ASSEMBLYWOMAN WATERS: Where do you take your rape victims? I mean where do they go?

MR. FISHER: I do not have that list of hospitals available. I personally don't direct them to go

anywhere.

SENATOR ROBERTI: They're supposed to notify you when they close, the Sheriff.

MR. FISHER: The Sheriff. They would not necessarily notify me in the finance office. A station may have received notification if they, you know, will not accept ...

ASSEMBLYWOMAN WATERS: Well, who are you paying a lot?

MR. FISHER: St. Francis, I believe, was one that we used quite frequently. But I just can't remember ...

ASSEMBLYWOMAN WATERS: Are you using Martin Luther King?

MR. FISHER: Yes, we are.

ASSEMBLYWOMAN WATERS: Backed up in the waiting rooms, they wouldn't be able to do them. I mean people sit there all night.

MR. FISHER: I do not believe we use -- because they are a county hospital, their whole billing mechanism is entirely different. And it's, it's the most confused -- and I don't even want to get into the Health Services' billing the Sheriff's Department for services. But it's -- we have a number of problems with trying to determine what we're being billed for in that area.

ASSEMBLYWOMAN WATERS: Well, I just ...

MR. FISHER: Not only sexual examinations but also just treatment.

ASSEMBLYWOMAN WATERS: Well, let me just say this to you: It is interesting that you or somebody wouldn't know that Daniel Freeman and Centinela are not doing the exams. They cover a big area out there. And between those two hospitals on the southwest end, Martin Luther King all the way back over to St. Francis, I mean that's all you have. And if you don't know that they're closed, I mean I don't know what to say. As a finance officer, you know who you pay.

MR. FISHER: I don't know how to comment. The stations tell me that they don't have a problem. I don't look -- I have not looked at individual billings going out as to who is being paid.

ASSEMBLYWOMAN WATERS: Well, let me tell you ...

MR. FISHER: I don't normally do that.

ASSEMBLYWOMAN WATERS: You have a problem. If Daniel Freeman and Centinela, both, on that corridor, on that end, are not doing them, you have a problem.

MR. FISHER: That well may be.

ASSEMBLYWOMAN WATERS: Yeah, you have a big problem.

MR. FISHER: It has not been related to me from a financial standpoint.

ASSEMBLYWOMAN WATERS: (Sigh) Thank you, bureaucracy.

SENATOR ROBERTI: Thank you, Mr. Fisher. Your testimony is very enlightening. (Laughter)

Mia Baker, special assistant, I guess, and as well, Lauren Weis, deputy in-charge, Los Angeles District Attorney's Office.

MS. LAUREN WEIS: Not quite. The Sexual Crimes and Child Abuse Unit.

SENATOR ROBERTI: Sexual Crimes and Child Abuse.

MS. WEIS: Of the District Attorney's Office.

SENATOR ROBERTI: Of the DA's office. Who wants to go first?

MS. WEIS: I think I will.

SENATOR ROBERTI: Okay. And you ...

MS. WEIS: I'm Lauren Weis.

First of all, I'd like to say, as a prosecutor, I think that we gained a very, very beneficial gift by the promulgation of this medical protocol. I have talked with lots of prosecutors and I know that they all feel the same.

In the past -- well, I've been prosecuting sex crimes for about five and a half years now. And I've looked at medical reports in the past that were totally illegible. You couldn't even tell who the doctor was. I've seen such cursory examinations that the victim should -- why bother going to the hospital? So I really believe that the medical protocol, although it gave us this gift, on the other hand, with the problems that are created now, it's almost as if it's being taken away because I think that the negative publicity that has been generated by this has really had an effect on the victims. And contrary to what the last gentleman said, I have heard from law enforcement that they are being turned away from hospitals, that they are having to take victims all the way across the county, that they have taken victims to hospitals where they'll only -- they'll treat their injuries, their bruises or whatever; and then for the rest of the exam, they have to drive all the way across maybe to the Rape Treatment Center, to Santa Monica Hospital, to have something done. And we then are in the same boat that we were in before; we are losing evidence. So I do want to say that it's really a problem we have to address.

The new forms, the new protocol, I think, presupposes that a doctor should perform all of the examination. It allows the nurse to take the history of the victim. And I think that that saves some time as far as the doctor's time.

There was testimony before about a nurse practioner. I think Senator Watson asked that question. Now I happen to know that there are some very, very competent nurse practioners. Sandy Elvik's name was mentioned. She works at Harbor General with Dr. Carol Berkowitz. And she performs a lot of examinations on the children. She has testified in court before.

I think, that if there were some kind of training program established for nurse practioners, they could qualify as experts in court. I don't think it would really hurt a case from a prosecution's standpoint if they were well qualified and experienced and they had done this over a period of time, worked with a doctor, you know, over a long period of time, learned how to do these things. They are just as capable in most cases if they could do that because the exams are not that intricate. It's more a matter of procedure, how it's done, if it's done in the proper way. And then, of course, we have the expert, the laboratory, the criminalist, who really is the expert and then can really delineate what the, the evidence shows. So I think that that could save some time, some cost if maybe something could happen in that sense.

Speaking towards the referrals and the notice that's been given, I think that the -- it's very unclear how that notice is to be given. We receive letters sometimes; sometimes phone calls. So we really don't know which hospitals are providing these exams and which aren't. And I know that some are back into the system because of you, Senator Roberti, your requesting that. And so it's, it really

changes all the time so we're really not aware of which are and which aren't. And I think that it should be, it should delineate more. It should really speak to who exactly should be notified and I don't think that that's really complete enough.

The differentiation between evidence collection and treatment, I think that's really a major issue. I think that perhaps maybe the Legislature can set some kind of an arbitrary guide so that there won't be a problem in payment and, you know, and the billing, like which, which -- how much are we going to bill for treatment; how much are we going to bill for the actual evidence, evidence collection? I think that there can be an arbitrary standard since this is a required mandate by the State. I think that that has to be done also.

And I also think that there are some things that go for evidence and for treatment. You have to provide the emergency room, the time, the electricity, whatever. The equipment is there used for both purposes. So I think that's it's very hard to separate the two. And I think that maybe we can have some kind of arbitrary figure, like law enforcement pays so much of a percentage and the State picks up the other percent. I think, that since it's a state mandated program, the State should pay for this. It should do this for victims.

So basically, I'm here to answer some legal questions, if you have any of those.

SENATOR ROBERTI: Thank you very much, Ms. Weis.

MS. WEIS: It's Weis.

SENATOR ROBERTI: Please excuse me. Well, it was wise testimony. So I think Ms. Baker.

MS. MIA BAKER: Thank you, Senator Roberti. My name is Mia Baker. I'm the special assistant district attorney for victims of crime. And I'm the program administrator of Los Angeles County's Victim-Witness Assistance Program.

Our Victim-Witness Assistance Program sees approximately 30,000 victims per year. 4,800 of them last year were sexual assault victims of whom a rising percentage are children, approaching 45 percent in our county. We work closely with the rape crisis centers, the sexual assault service programs, the hospitals that you've heard from today in order to assure that victims of sexual assault receive optimum services through health care, psychological counseling, and court accompaniment.

I'm one of the drafters of Senate Bill 180, and I particularly want to thank Senator Watson for her assurances that this remains a viable vehicle. We have heard a great deal of testimony. I served recently as chair of the legislation and funding subcommittee of Los Angeles County's Task Force on Rape and Abuse Treatment. And the committee heard a great deal of testimony regarding that bill and possible ways in which it can be amended to make it a more viable vehicle, to provide reimbursement for the cost of sexual assault exams.

I must agree with previous speakers that the delineation between treatment and evidence collection remains unclear. At the time that Senate Bill 180 was drafted over a year ago, we -- the Restitution Fund did not have its current problems that it's experiencing today and we did not yet have the promulgation of the protocols. We were hopeful at the time we drafted the bill that the protocols would clearly delineate evidence collection from medical treatment. That did not occur in the protocol. The committee has asked the Office of Criminal Justice Planning to reconvene its

protocol committee to determine whether or not that decision can be made. We've heard testimony from doctors that that need, that cannot be a clinical decision; it needs to be a legal mandate in the protocol. And we have asked OCJP to look into that. So we do suggest that we continue to work with Senate Bill 180 as a vehicle for possible legislative change.

It's our strong feeling in the District Attorney's office, that because this is a state mandated program, there needs to be a state source of funding to pay for these exams. This is not just a local issue. It may well have surfaced in Los Angeles first. But I've been doing this for 10 years and I can tell you that most victim issues surface first in Los Angeles County. If it's a local issue here today, it will be a statewide issue very shortly.

Much like the mandated evidence collection for blood alcohol exams where a state source of reimbursement is available, we feel that this needs to be the case. You shouldn't be able to get a terrific rape exam in Beverly Hills and a shoddy one in East Fresno if you're a migrant worker. I think we can make a Serrano-type argument here that the funding needs to be available statewide to make sure that sexual assault victims are not re-victimized wherever they may come from.

We've also suggested a possible amendment to Government Code section 13967(a) and Penal Code section 1203.04(e) which establish mandatory restitution fines on conviction of a felony or a misdemeanor. And we're suggesting, that as a possible addition to Senate Bill 180, those fines, those mandatory fines, upon conviction could be increased and perhaps with a portion specified to go either to the restitution fund or to be retained locally in the jurisdiction for the payment of sexual assault exams because I think we need to look to a non-General Fund source. If we can find a way to cause offenders to pay for these exams, I think that is far preferable than going to the General Fund.

Again, we've asked that the rape protocol be revised because, under current law, the cost of treatment can be billed to third parties. We have had problems recently with the State Board of Control because they indicate, that because the statute says evidence collection cannot be billed directly or indirectly, and since the protocol doesn't delineate which cost is evidence and which is treatment, they're considering the entire bill to be evidence collection and rejecting those claims.

I think, particularly with child sexual assault victims, this argument is very specious. Once we can prove that a child or an adult has been sexually assaulted, that opens the door for them to qualify for state reimbursement, up to $46,000 for their loss of income and their medical expenses. But if we don't have a good solid evidence collection -- and particularly you heard from Deanne and Dr. Heger about the extensive exams needed for children -- unless we have that exam, we can't open the door to have that victim's psychological care reimbursed. And it seems ridiculous, that if a pot of $46,000 is indeed available to a crime victim, that the cost of getting them into that system, that $200 or $400, $600, whatever it is, that's not an additional cost to the Restitution Fund because the victim will max out at $46,000 anyway. So why not allow that? If the Restitution Fund can be used for such purposes as rewards for people who give information to locate missing children, it could surely be used to reimburse the cost of these exams.

Finally, we would suggest that a test claimant, or SB 90, the state mandate's claims fund, be prepared. We understand the difficulties in this. It's a lengthy process. It's possible, that since the

statute only mandates that there be eight hospitals in Los Angeles County, that either those eight hospitals or perhaps the local jurisdictions who are providing the cost of treatment could make a claim. But the hospitals tell us that even that small gesture, even if it were simply to purchase the equipment, the new equipment that's necessary to perform the exams -- the Wood's lamps, the culposcope, which isn't mandated but is necessary for child sexual assault exams -- that that small gesture would keep hospitals within the network. We're concerned that hospitals not have to bear the cost of evidence collection, that children and adults continue to receive quality care in our county.

I do want to clarify one statement that was made earlier. It does not matter which law enforcement agency brings a patient to a county facility. That is a county cost. It is only where law enforcement takes the victim to a private hospital or private physician that the cost becomes the burden of local law enforcement. And I think what we're seeing in our county -- and we will see in other counties -- is that a number of private police agencies, small municipalities, large municipalities, will dump their patients on our county facilities which are already overloaded because it relieves them of the responsibility for reimbursement.

I'd be happy to answer any questions you might have.

ASSEMBLYWOMAN WATERS: I have a question.

SENATOR ROBERTI: Yes. Assemblywoman Waters.

ASSEMBLYWOMAN WATERS: Yes, I would like you, very quickly, to go over that part of your testimony where you spoke to the interpretation of the State Board of Control relative to the cost of exams. Would you please tell us again?

MS. BAKER: Our experience has been, in the past, up to a year or so ago, we would ask, "What did local law enforcement pay?" The statute has changed in that regard. There was a greater burden on local law enforcement prior to the change in the statute last year. So let's say where L.A.P.D. paid $16 for the sexual assault exam, we would ask the hospital, "Did L.A.P.D. -- did you bill them for the $16?" The hospital says, "Yes, the bill was $240." The additional portion was billed to the Restitution Fund as the cost of medical treatment because the only way we had to define what was treatment and what was evidence collection was by what amount is law enforcement paying for the collection of evidence. Admittedly, that was arbitrary, but it was the only basis we had. And the State Board of Control would then reimburse whatever was the difference between the cost of evidence collection as defined by law enforcement and the total cost of the victim's hospital bill. Admittedly, that's hedging the statute a little bit because there was no clear definition. But we felt it was not fair for victims, many of whom had been told by the officers who took them to the hospital that they would not be billed for the cost of the exam. And I think that was a good-faith belief on the part of law enforcement because they knew that the victim couldn't be billed and they knew that law enforcement was supposed to pay. What they didn't know was the great discrepancy between the amounts law enforcement actually paid and what the victim would be billed. And so we would, in turn, submit those bills to the State Board of Control. Recently, they have been rejecting all of those claims and stating, that under the Penal Code, it is not legal to bill the victim directly or indirectly. And they're claiming that that entire cost is evidence collection.

As Lauren indicated, how do you bill the cost of the hospital room, the emergency room? Suppose your victim comes in and two heart attack victims or earthquake victims come in and your rape victim has to wait? Who do you bill the cost of that two-hour wait in that room? What about the VDRL? Some of the other exams that are of the high-dose penicillin, the morning-after contraceptive? Well, they're not technically evidence. It may turn up something we might be able to use in the prosecution. Generally not. It's for the health of the victim.

We heard testimony from doctors who said the entire cost of the exam in their opinion was treatment, with perhaps the exception of three swabs and three slides. But they would do the same treatment for any victim brought to them.

We heard testimony from others who said there's no bright-line test; we wish there were; and others who said they had always regarded it as all evidence collection. And that's why we've asked OCJP to reconvene the protocol committee to try to give us a bright-line test, even if only a legal definition, not a clinical one, so that we could at least bring some relief to our health care providers in billing available sources.

ASSEMBLYWOMAN WATERS: Thank you.

SENATOR ROBERTI: Thank you. Senator Keene.

SENATOR KEENE: Ms. Baker, would it be possible, because these exams -- because the breakout of treatment versus examination for purposes of evidence occurs in all of these cases, wouldn't it be possible to establish some fairly uniform percentage and say that X percent is examination for purposes of evidence gathering; Y percent is treatment for ...

MS. BAKER: I believe it would be. And that certainly is our understanding from the health care providers. Again, they don't want to make that determination on a clinical basis in determining, okay, her wounds need to be cleaned; you know, this wound needs to be cleaned for purposes of treatment and this for purposes of evidence collection, whatever. They don't wish to make it as a clinical judgment; but they're suggesting, that as a legal matter, it could be divided, whether through percent, whether through a baseline figure. But I think your suggestion is an excellent one.

SENATOR KEENE: And should that be done statutorily in your judgment?

MS. BAKER: I believe that, and we did look at this, that simply by delineating that in the protocol -- because the statute itself, Penal Code section 13823.9, speaks to both treatment and evidence collection. And at the time we drafted Senate Bill 180, we only had that statute. We didn't yet have the protocol. And so we were of the belief that the protocol would clearly delineate, okay, now you're treating and now you're collecting evidence. But the protocol doesn't do that. And so I think, that simply by amending the protocol without further legislative action, we would have a guideline for billing that would hold up.

SENATOR KEENE: Okay. Thank you. My other question is of Ms. Weis. A lot of the shortcomings in the response procedure that you discussed seemed to be based on anecdotal evidence rather than any empirical evidence. Isn't there a way of cataloging these things so that you know which hospitals are responding, which ones aren't?

The statute, section 1281, seems to impose a very direct duty on hospitals, either as individual

hospitals to receive and respond or to develop a protocol that involves referral to other hospitals. So it seems to me that all of this knowable and yet we don't seem to know.

MS. WEIS: Right. I think the problem is that it doesn't really tell you how to notify. It tells you who basically, in general terms, to notify that you're going to refer. But it doesn't tell you in writing; it doesn't tell you to which particular person of that organization or whatever.

Also, I think that, on our committee, we have a task force committee, the L.A. County Task Force Committee, on this. There is a person on that committee -- I think it's from the Hospital Council. They're trying to get a list together of those hospitals that are and are not. But the problem is that it keeps changing daily, weekly. And so you really don't know because some hospitals are back in the system.

I also wanted to bring up the point, though ...

SENATOR KEENE: You're jumping around a little bit, at least that I'm not understanding you maybe.

There is no list of hospitals to whom rape victims can be taken for an appropriate response?

MS. WEIS: Well, I think ...

SENATOR KEENE: Does it exist at this late date?

MS. WEIS: I don't think that there is a centralized list, no. Do you know of any?

MS. BAKER: It was my understanding at the last meeting of the Task Force that the Hospital Council was going to be the repository of that information since they had the most direct contact with hospitals.

Again, we have -- I received five letters from all of L.A. County's hospitals indicating that they were going to refer to the local county facility. We know that many more have opted out in the interim. Some have come back in. But I only received five letters and I was one of the persons that was supposed to be notified in case of referral.

MS. WEIS: Right. In my unit, I think we received six. And I know that there are many more that are referring also.

SENATOR KEENE: But as I read the statute, you don't get to opt out unless you've arranged for a referral.

MS. BAKER: Well ...

SENATOR KEENE: So each hospital individually should be responsible. And if they say, "We're not on the list to receive," then they have to have some protocol for referral to some other hospital. Who's got the list?

MS. BAKER: I believe that it's Hospital Council of Southern California. I believe they will be testifying.

SENATOR KEENE: Okay. Thank you.

SENATOR ROBERTI: Thank you very much.

Next is Commander L.C. Cramer and Lieutenant Don Foster of the Los Angeles Police Department.

MR. L. C. CRAMER: My name is Commander Loren Cramer and I'm also Don Foster this

morning who's not going to be here.

SENATOR ROBERTI: Okay. Very good. I can see both of you.

MR. CRAMER: What I'll try to, for the sake of brevity, and not be redundant, I will try to respond to some of the questions that the committee had from my department's perspective, specifically, first of all, concerning why some hospitals are referring rape victims to other hospitals. I think a lot has been said already about costs. And I certainly think that that is, as our officers and our detectives are being told, is one of the primary reasons why those referrals are taking place.

I think there's also another issue and that is that some of the hospital staff is saying that training -- the requirement of the protocol to train medical staff to perform the medical exams, and not only the training itself but the time to do the training and the staff resources to do that, and also the funds for the training, is also another aspect.

Several other speakers have commented on the protocol clearly giving a hospital the prerogative of not doing rape-type examinations and referring them to some other hospital that does. Some of the impact of that has been that some of the smaller community hospitals that, that we interact with are experiencing an overload of rape victims because of those referrals. And this is causing additional, long delays in their emergency rooms and continuing, or an ongoing, reduce service of the community.

Concerning the, how many hospitals are making these referrals, in 1986, our department dealt with 18, what we call contract hospitals, not like the Sheriff's Department. The City of Los Angeles does contract with certain hospitals to provide medical treatment, and those contracts then in turn bill either the victim, or, in the case of rape examinations, the city. Currently, there are only 11 hospitals. So 7 have opted not to participate in providing those type of rape examinations. One of those hospitals that is not is Daniel Freeman. And that was mentioned earlier during another speaker. Three of those hospitals were hospitals such as Beverly Hills, Daniel Freeman, and Serra Memorial that our department, our field officers, deal very heavily with, have ceased taking victims of sexual assaults.

Concerning the impact of the medical protocol system and the practice of referrals on the victims, I think that it's pretty clear. Other speakers have commented on the victims being taken to hospitals. They have already experienced a very traumatic episode. They're being referred to another hospital because those emergency rooms will not take the victim. That tends to protract the trauma because now the officers have to transport that victim to another hospital that they know will accept the victim. Generally in a rape type of investigation, the victim is physically injured and so this perpetuates the trauma because the injuries are not being dealt with in a timely way. It's another frightening experience for the victim to be really -- I guess "shunned" may be an improper word -- but being rejected by that hospital and told they have to go somewhere else.

In fact, we have even had some horror stories where victims have, because of the referral and then being told how much more time it's going to take, refusing medical treatment and refusing to sign crime reports because they have become extremely frustrated. In my opinion, I believe, that absent any other severe medical emergencies in an emergency room, that a rape victim should be

given some kind of priority for treatment and placed very high on the list.

Concerning the rate of reimbursement, there are other speakers, I believe, that have already testified and will after me that are much more qualified to talk about the method of determining reimbursement. But I really do believe that and concur with the remarks of some of the prior speakers that it really comes down to a matter of treatment versus evidence collection and medical examination. I think that whatever is a reasonable amount and whatever is reasonably determined should be reimbursed to the hospital and their staff for performing those examinations.

Our department and the Chief of Police specifically has taken the position that something concerning the reimbursement needs to be done. In his opinion, since the protocol is a state mandated system, that the State should reimburse to some degree the level of funding for rape examinations.

SENATOR WATSON: Mr. Chairman.

SENATOR ROBERTI: Thank you. Senator Watson.

SENATOR WATSON: We dealt with this kind of problem when we set up CMAC under the prior funding of hospitals to receive Medi-Cal. And what we did, we divided the State up into regions and we commissioned CMAC to go out and negotiate on an individual basis with every hospital that wanted to provide services to Medi-Cal. And I suggest, that as we go back and we look at the commission that handles the funding, that we also look at setting up a way of negotiating because different areas are going to require different levels of cost relative to providing services in that area. And we need to look at the whole state in terms of regions so we can be sure that there is no region going unserved or under-served.

Centinela Valley and Daniel Freeman are in the same area. They don't take Medi-Cal. Daniel Freeman has closed down its trauma center. And it is indeed an embarrassment; it's indeed frustrating and indeed really puts a black eye on the system of Medi-Cal when we don't even provide these services, let alone we don't provide the trauma services. And I do know Daniel Freeman next week will go into renegotiating with the state to provide those services. And I think we ought to hook these services up to the availability of Medi-Cal services because we're talking about not only indigents but, you know, other people too, anyone. And I think that we're going to have to come up with some kind of organized statewide system just like we're doing under Medi-Cal to deal with this.

After saying that, I just want to throw something else out. It's related but indirectly. Several years ago, I proposed to put rape crisis centers in every police precinct. It was just before the Olympics and because of some reactions of the Russians and so on that bill was put on the shelf. But it appears to me, if we had within every police precinct the Rape Crisis Center and people within the centers that can do the counseling, this might work hand in hand with police personnel, working with victims and with the hospitals, to have a better understanding, more sensitivity, and maybe some organized way of handling the problems.

Once we get the problem, reimbursement, settled, what would your response be?

MR. CRAMER: My response would be that whatever we can do to expand the availability of counseling people available to -- and referral services would be constructive.

SENATOR WATSON: Good. So this would not be a new responsibility that would be opposed? I'm talking about each police precinct.

MR. CRAMER: Yes.

SENATOR WATSON: Okay.

ASSEMBLYWOMAN WATERS: Mr. Chairman, I have one caution before I leave, and that is, I'd like the testimony that leads us to the -- down the path of trying to determine how much we are going to pay and just setting some arbitrary amounts for, you know 50/50, 70/30, whatever, for medical evidentiary portion of the exam. And I think we should really look at that. I think that's very good. And I think the State, absolutely, has to accept its responsibility. I'm a little bit worried, and I would say certainly, we should look at it. But I would look at it with a lot of care and caution, contracting with hospitals in various areas to perform these services. The same hospitals, Daniel Freeman, and I think Centinela also, that we contracted with for Medi-Cal services couldn't perform on the Medi-Cal contract and they just stopped doing it. They stopped taking women for prenatal care; they stopped delivering babies; and they simply just said, "We can't do it for the cost that we contracted with you. The cost is much higher and I'm sorry. We just can't do it." And they quit doing it.

So I'm suspect of our contracting Medi-Cal reform in the State of California, period, and our czar and all that business. I think we just sort of pay people for the work that they do and so I would just really approach that with a lot of caution and a lot of care and would certainly advise us to do everything that we possibly can do to get the State doing what it should do and get us out of this area where we may have some problems about which is medical and which is evidence in the exam and just pay for it, whatever it is, and assign the proportions in some way that we consider would be fair.

SENATOR ROBERTI: Yeah, I tend to agree with you. I tend to see some bill coming along the line in which we all sort of agree on some kind of figure and that's going to be it.

ASSEMBLYWOMAN WATERS: And just do it.

SENATOR ROBERTI: Thank you very much, Commander.

Next witnesses will be testifying together -- Anthony Abbate, Senior Vice-President of the Hospital Council of Southern California; James Barber, administrator for Daniel Freeman Hospital.

ASSEMBLYWOMAN WATERS: They're here.

SENATOR ROBERTI: They're waiting for you. Dr. Donald Kurth, Queen of the Valley Hospital.

Mr. Abbate.

MR. ANTHONY J. ABBATE: Thank you, Mr. Chairman. We have a substitution. Unfortunately, Mr. Barber of Daniel Freeman had to return to the hospital.

ASSEMBLYWOMAN WATERS: Ah, I wanted so much to hear from him. (Laughter)

MS. BELKHAM: We have his testimony.

MR. ABBATE: Kathleen Belkham of the Hospital Council staff will read his testimony, and we will respond to inquiries concerning Daniel Freeman at that point. I'll lead off.

I'm Anthony J. Abbate. I'm Senior Vice-President of the Hospital Council of Southern California, and I'm speaking also this afternoon in behalf of the California Association of Hospitals

and Health Systems.

The Hospital Council of Southern California operates in an area in which there are 159 different law enforcement jurisdictions. And according to our data, there are presently 65 member hospitals routinely providing rape and sexual abuse treatment, including the evidence gathering in communities encompassing a population of approximately 14 million people.

At the outset of this discussion, I want to emphasize that no Southern California hospital has refused necessary medical or surgical emergency care to a victim of rape or sexual abuse. The hospitals are committed, and historically we have led the way in both calling for and initiating comprehensive humane treatment for survivors of rape.

In mid-July of this year, shortly after the release of the sexual abuse treatment protocol, a number of hospitals began notifying law enforcement agencies that they would no longer be able to serve those agencies as treatment facilities. Approximately 11 of the then 55 hospitals serving as treatment facilities opted out over that period of time. Again, it's important to state that in all cases these were painful actions taken after thoughtful consultation with care providers at various levels in the hospital -- physicians, nurses, other professional personnel -- formally and informally shared in the deliberations. These are people who have committed their lives' work to caring for others. They are professional and they are involved. The decision to refer a rape and sexual assault survivor did not come easy.

Looking back over the period as to what caused these decisions, we conclude from our discussions with our hospitals that there were a number of issues -- confusion over the new protocols, concern with the hospitals' ability to continue to meet routine needs of its community for emergency care, requirements that other in-custody services must be provided, funding, as we've heard a great deal about, costs, the overall atmosphere of the government's treatment of health care providers in 1987.

When the sexual abuse protocol was first released, there appeared to be a great deal of concern -- the protocol's format, the potential for future demands for court time as medical witnesses, training requirements, particularly in low-volume situations, costs of additional staff time, costs of additional equipment, and the uncertainty with the numbers of hospitals needed to assure adequate geographic coverage. We heard variously that all hospitals in the community must be prepared to meet the protocol and at the same time that only one hospital per one million persons was needed. Neither of these makes any sense in Southern California. This is a very serious situation. The care must be given expertly and in a humane way. This requires teams of doctors, nurses, social work professionals, counselors, and technicians. These people need specific training; they need specialized skill; they must be acutely sensitized individuals. They must be sensitive to the situation that they're facing. We need space; we need equipment. And all of this must be absolutely unqualifiedly available 24 hours a day, trained, and ready to go. Essentially, we need a network similar but much larger than -- similiar to the trauma system but obviously much larger. We're talking 60 or so hospitals across the board, maybe 40 to 50 in Los Angeles County.

Other concerns -- hospitals feared that they would become unofficial regional treatment

centers straining their limited emergency treatment capacity and again their ability to meet the mission for their own local community. Several law enforcement jurisdictions have insisted that rape and sexual abuse treatment is simply a subset of other in-custody treatment. Providers are faced with a take-it-or-leave-it situation. Now most community emergency departments are not designed and not operated in a way in order to accommodate a shackled, belligerent, or unruly prisoner.

Also in the recent past, many jurisdictions paid the hospitals and doctors little or nothing for in-custody services, including the treatment of rape and sexual assault. The example, primary example, of course, is the City of Los Angeles. That's in terms of the volume that we deal with here. Their payment was $16 to $23, and effectively it took up to a year to get paid. Other communities have recently made major changes. The City of San Diego is up to $400; San Luis Obispo to $550; Contra Costa County to $500.

A review of the costs associated with the treatment of rape and sexual abuse indicates some variation from facility to facility, no doubt. However, hospital costs seem to typically fall between $250 and $315. This is for emergency department services, clinical testing, cultures, sexually transmitted disease tests, pregnancy tests, treatments for medical and surgical supplies, social services counseling and so on. These are costs. Physicians' fees run somewhere between $175 and $250 for their time involved in the initial medical screening, interview, the physicians' role in the collection of evidence and in the processing and the developing of the record that is so absolutely essential and part of this treatment of protocol.

We're not attempting to include here any comment on in-court time. That's considerable and needs to be taken into consideration. But the numbers that I mentioned to you -- the hospital numbers of $250 to $315 and the physician numbers of $175 to $250 -- are strictly in that emergency setting.

Our final comment focuses on the crushing burden of uncompensated care, its impact on routine essential health care services, and the inaction in dealing with this. Uncompensated care will cost California hospitals over $1.8 billion this year alone. I get a little tongue-tied when I get near a number that large. That's up from $1.6 (billion) last year and $1.3 (billion) a year before.

There appears to be no help in sight. To expect hospitals to take on additional uncompensated service simply stretches credibility beyond reason. Continued demands for services for which there is to be no payment or very little payment seems to many providers to have become a standard business practice in this state. It should be noted that in Los Angeles County, during the last year and a half, five trauma centers have closed and nine hospitals have canceled their contracts with Medi-Cal. This is a disaster.

Several activities are in progress in Los Angeles County. First since June, the hospitals have involved, in discussions with the City of Los Angeles regarding the provision of payment for sexual abuse treatment services. Our work, aided immeasurably by the help of Senator Roberti, Mayor Bradley, and Councilman Yaroslavsky has resulted in an interim agreement which hopefully will resolve many of the current acute problems. Additionally, the Council, in coordination with the Los Angeles County Department of Health Services, is staffing a board of supervisors authorized task

force to look to solutions to this problem.

With the prospect of some increased funding and improvements by the City and the administration of the program, the Council has identified 36 hospitals which form the basis of the Los Angeles treatment network, an initial basis. We expect both the city's contract and the new Los Angeles County Agreement to be fully implemented by Thanksgiving, and we can proceed in the implementation of the network. This is, at best, a short-term solution. The local jurisdictions must seriously address their responsibilities and the legitimate needs of the hospitals and the doctors providing these treatments. We have continuing serious concerns.

In addition, they're having a great deal of work ahead of us. The hospitals have a number of points we would like the panel to hear. If the rape and sexual treatment program is to avoid problems we have now, in the future, we urge the Committee's consideration and solutions of the following recommendations: That the Assembly and Senate members of the Interim Hearing use their influence to expedite a conclusion of the protracted processes for finally -- finalizing -- working agreements between local government and the networks of hospitals.

Three weeks ago, we had an agreement; we have yet to see a contract. We hear rumor that it's sometime after the first of the year. Before we'll see that contract, that's the basis, not just of payment; that's the basis of the network; that's the basis of determining who is formally in and who is formally out. It takes away this day to day. We must see that before Thanksgiving.

Secondly, that agreements with law enforcement jurisdictions be designed in such a way as to allow flexibility between the requirements to provide rape and sexual abuse treatment and other forms of in-custody services. We can't hold the rape and sexual abuse treatment system hostage to other needs. They're important needs; no question. But we have to address this issue first. And believe me, it can stop the solution.

Thirdly, that compensation be provided for physician witnesses for court time or the development of alternative methods for gathering evidence and presenting it.

Fourthly, that funding sources be developed to relieve the local jurisdictions of heavy financial obligations necessiated by law, permit local retention of fines to obtain dedicated doctors -- dollars, access to state mandates claim fund, consider utilization of the Victims' Compensation Fund.

Fifth, remove the prohibition that counties and districts cannot bill law enforcement jurisdictions for the exams. It's a technicality and it's not fair.

The California Association of Health and Hospitals and the hospital -- hospitals and health systems and the Hospital Councils of Southern California want to thank the members of this interim hearing. We're extremely impressed with your involvement ...

ASSEMBLYWOMAN ROYBAL-ALLARD: Mr. Chairman.

SENATOR ROBERTI: Yes.

MR. ABBATE: I'm sorry.

ASSEMBLYWOMAN ROYBAL-ALLARD: Okay. Mr. Abbate, you mentioned in your --beginning of your statement that no hospital has turned away anyone who is in need of necessary care.

MR. ABBATE: That's right.

ASSEMBLYWOMAN ROYBAL-ALLARD: Now we're talking about someone that has come to a hospital that has been traumatized, that has been both physically and sexually assaulted, that is in pain and suffering, both emotionally and physically.

I would just like to hear from you as to what your definition is of necessary care.

MR. ABBATE: What my statement referred to was the necessary emergency and surgical care. That includes emotional support. The Hospital Council -- the hospitals of Southern California were given the award of the Los Angeles Council on -- the Commission, rather -- on Assaults Against Women for developing a protocol throughout our hospitals for that primary type of -- for that level of care in 1985.

What we're concerned about here is extending that necessarily to this evidence gathering, and that is the point at which hospitals are saying yes, I can meet what we've been doing but we cannot or do not or whatever wish to go the next step.

ASSEMBLYWOMAN ROYBAL-ALLARD: But there are hospitals that are turning away these survivors?

MR. ABBATE: There are hospitals that quite honestly didn't ever routinely do this work.

ASSEMBLYWOMAN ROYBAL-ALLARD: No, all I'm asking is that you made a statement that no one -- no hospital has turned away anyone with need of necessary care. And I'm asking for what your definition is of necessary care because we know, in fact, hospitals have turned away survivors of sexual assault and that these people are, as I described or I've been -- they have been traumatized; they are in pain, both physically and sexually; and they are in pain emotionally. So I'm trying to understand how you can make a statement saying that no one has been turned away in necessary care when, in fact, anyone that goes to you is suffering in this way.

MR. ABBATE: Essentially what we say when we say that is that the individual requiring -- if the individual requires surgical or medical care, life -- to address life-threatening or life, limb, immediate future threatening situations, those treatments are provided. They're not turned away. They're not turned down ...

ASSEMBLYWOMAN ROYBAL-ALLARD: So the term's not necessary.

MR. ABBATE: Now wait a minute.

ASSEMBLYWOMAN ROYBAL-ALLARD: It's just medical or it's the surgical.

MR. ABBATE: Absolutely necessary.

ASSEMBLYWOMAN ROYBAL-ALLARD: Okay. Okay.

MR. ABBATE: Now if they require specialized care, it's almost the situation of a trauma center, as in trauma centers. If there is highly specialized care required, then the referral -- "turned away" is a term; "referral" is a term; and between the two, there's probably truth -- referral is made to points where there can be more appropriate care given. That's the system that we have to put in place.

SENATOR WATSON: Let me just follow-up on that. If a woman comes into Daniel Freeman Hospital as a victim of rape, what would happen to that woman?

MR. ABBATE: If she is -- if she has a broken bone, if she has other, --

SENATOR WATSON: No, no, no. She has ...

MR. ABBATE: -- other major medical problems, they're treated immediately. Then --

SENATOR WATSON: She has ...

MR. ABBATE: -- they will refer her to a ...

SENATOR WATSON: She has no visible factors that can be identified. She says, "I have been raped."

MR. ABBATE: Yes.

SENATOR WATSON: What happens to that particular patient?

MR. ABBATE: She will be referred to a hospital that can properly ...

SENATOR WATSON: Then they are turning away people who have emergent needs. She is traumatized; she's emotionally suffering; she is feeling pain; and she is being turned away.

MR. ABBATE: Well, it's similar to a patient with a critical heart condition requiring immediate open-heart surgery going into a facility that's not capable of providing open-heart surgery. Transfers ...

ASSEMBLYWOMAN WATERS: Protocol.

SENATOR WATSON: Well, I come to you and I tell you I have a pain in my chest or a pain in my head.

ASSEMBLYWOMAN WATERS: That's double talk.

ASSEMBLYWOMAN ROYBAL-ALLARD: We're not interested in the reasons why someone is being turned away. We're just asking whether or not sexual assault victims are being turned away, and the answer is yes.

MR. ABBATE: But I think you need to look at the reasons. If ...

ASSEMBLYWOMAN ROYBAL-ALLARD: No, we weren't asking the reasons. We just wanted a yes or no answer because you made the statement that they were not being turned away. So, in fact, these sexual assault victims are being turned away for whatever reasons --

MR. ABBATE: Okay.

ASSEMBLYWOMAN ROYBAL-ALLARD: -- your hospital has. I think we need to make that clear.

MR. ABBATE: Yeah. I agree with you. The statement specifically addressed medical and surgical emergencies, in other words, life-threatening situations which always have to be addressed first. And once addressed, the other emergencies then can be addressed. It's a simple triage situation that our people face day in and day out. We watched it on M.A.S.H. for many years. It is -- you deal with life first; you deal with limb; and then you deal with other absolutely important, unquestionably important, situations, once you're sure the patient is going to live.

ASSEMBLYWOMAN WATERS: But let me just ask a question 'cause I really don't understand that.

How does one make that determination? I didn't watch M.A.S.H. I don't quite understand the triage situation perhaps as well as some other people in this room. For example, a woman comes in, "I've been raped." Do you give a physical examination at that point, or do you kind of look at me and

decide that I don't have any broken bones so you'll send me someplace else?

MR. ABBATE: We have a physician on the panel, and I -- we're touching on physician testimony now. And if you don't mind, I'm going to ask him to respond.

ASSEMBLYWOMAN WATERS: Sure. I thought you knew it all. Physician?

MR. ABBATE: Thank you very much.

DR. DONALD J. KURTH: My name is ...

MR. ABBATE: I just got promoted.

DR. KURTH: My name is Donald Kurth. I'm an emergency physician at Queen of the Valley Hospital in West Covina.

And to try to answer your question, really, that patient should be evaluated medically, whether or not -- I can't tell you what goes on at all hospitals. But the patient should be evaluated medically; they should be -- a chart should be generated. The patient should be seen by a physician and should be examined. Now whether all the patient's medical needs are going to be taken care of at that moment, that may not occur. And if the physician or the facility doesn't feel that they can do the evidence collection exam ...

ASSEMBLYWOMAN WATERS: But see, that's not the point and that's what I, you know, basically was trying to find out because it sounded as if -- we were being told that referrals are being made based on an assessment that may be done that does not include an examination of any kind but an assessment that this person does not appear to have broken bones or they do not appear to have a torn limb or whatever. And, you know, if you know anything about these rape cases, anything could be the case in searching of objects and all kinds of things could have taken place. There could be internal bleeding going on, all kinds of problems that, that ...

DR. KURTH: Absolutely. Even if those things didn't occur, I think the patient needs to be evaluated psychologically. I mean somebody needs to ...

ASSEMBLYWOMAN WATERS: I agree with you. So I think -- the question that was being asked was, you know, are you turning away patients? And you are attempting to say no and cloud it with a new definition of some kind. And the answer is yes, you are. And they are not patients who need specialized care that's unable to be given at the particular facility necessary where they're being turned away because you don't really know that, for those people who are turning them away without some kind of examination. That's number one.

Number two, let me just tell you to be very careful when you talk about rape and you relegate it to something less than importance in terms of what the community perceives as its emergency concerns. (Applause) That's very important for you to understand, particularly when you're talking to women. What you have said today is that the community wants us to be about the business of real emergencies. That's really what you have said to us and that just does not sit well. And I would just like to caution you, when you talk to about this to -- for you don't understand that some of us believe, the community believes, that rape is a real emergency. And that's important for you to know, just in your language that you use.

MR. ABBATE: I apologize if I said that and I'm sure ...

ASSEMBLYWOMAN WATERS: Yeah, you did, and I accept your apology.

MR. ABBATE: Because that was not our intention. There's no question of the emergent nature and the importance. The question is doing the job right.

ASSEMBLYWOMAN WATERS: And I understand that. But we all know how emergency rooms operate. We have people, unfortunately, that use emergency rooms in the way the clinics should be used. You have people who come in and sit in those emergency rooms and they may have a low-grade temperature because they have the flu or they have the cold. You treat them when you get to them; you treat them. That's what you do. And that's not, in my estimation, and perhaps in anybody's estimation, the proper use of the emergency room. So when you begin to define what your emergency room is used for, please don't tell us, for any reason, that perhaps it is not the proper place to treat ordinary rape victims because that's really what you're saying to us.

MR. ABBATE: As has been addressed in testimony earlier today, there's quite a bit involved in meeting the protocol if we're going to do it right. There's quite a bit involved in providing the counseling and psychological support. And we insist that it be done right. And that is the essence of our request, our planning, our working towards this network that will assure this community what you want, Assemblywoman Waters.

ASSEMBLYWOMAN WATERS: And that's what I think we want, we want to know. And Senator Roberti again raised what I think is the significant question of this hearing. If you have the money, would you do it?

MR. ABBATE: Every hospital in every community, no.

ASSEMBLYWOMAN WATERS: I beg your pardon. I didn't hear you.

MR. ABBATE: Every hospital in every community, no.

ASSEMBLYWOMAN WATERS: Well, I think, again, you guys had better be honest as we talk about this situation. Either you want the money to do it or you just don't like doing it and you don't want to go to court; because if you don't, let me go and work on a bill where women can start taking care of women and we'll just start setting up a network of clinics by which to do these examinations if you don't want to do it. And that's what it sounds like. And nobody has answered Senator Roberti's question, and maybe Senator Keene's question.

MR. ABBATE: We want a network of hospitals with round-the-clock staffs trained and ready to go sufficient to meet the needs of every community in California, hopefully reimbursed properly, but most importantly, capable of conducting treatments that are humane, that are effective, and that assure that evidence gathering is done in a proper manner. That's ...

SENATOR ROBERTI: Let me ask you a question. The current law indicates that the hospitals have to notify both the rape, various rape, counseling centers, the Sheriff — and there's a list of groups that have to be notified. And so far, the indications are as unclear if anybody gets notified at all.

In the case of Queen of the Valley, if you notify that you are conducting rape examinations, do you notify referrals or are referrals — and do you notify the Sheriff; do you notify the local rape counseling centers? Or those who may refer to you, do they do that?

DR. KURTH: We do our own examinations at Queen of the Valley and we're committed to that. We do get referrals from other hospitals. I don't know if they've, if they've notified the Sheriff's Department or anyone else.

SENATOR ROBERTI: How about Mr. Abbate? Do you know what the procedure is?

DR. KURTH: The procedure is that they are supposed to notify the DA's office, the local law enforcement agency, and the local rape crisis intervention, community group. I don't -- I personally don't know of anyone that's done that, but then that's not really my field of expertise.

SENATOR ROBERTI: Do you know?

MR. ABBATE: As I mentioned earlier in the testimony, there is a great deal of confusion out there on these protocols. I would say as many haven't as had, and that's just right off the top of my head.

SENATOR ROBERTI: Are you speaking for Daniel Freeman or ...

MS. KATHLEEN BELKHAM: I'm prepared to read his testimony.

SENATOR ROBERTI: But you're not prepared to ...

MS. BELKHAM: I can speak to some of the issues that Mr. Abbate is talking about.

SENATOR ROBERTI: Can you tell us whether it is customary at Daniel Freeman or at a hospital that you may be acquainted with other than that to notify rape counseling treatment centers, the Sheriff as to whether rape victims are going to be referred?

MS. BELKHAM: It is stated that way in the protocol. Each hospital has received a copy of the protocol. Whether or not they've actually done the paper work, I don't know.

In a survey that was sent out by the Hospital Council four to six weeks ago asking questions about who you refer to if you do not treat, we have received indications, yes, they do have these referrals in place at least within their own emergency rooms. Whether or not they have followed through and written to the DA and to the law jurisdictions, I do not know. We did not ask that question, however.

SENATOR ROBERTI: Well, I'm a little concerned because nobody seems to know. And somewhere between the humane and caring personnel at the emergency room level itself, which I think exists, and the administration of some of the hospitals, we're getting lost in the bureaucracy where this is just sort of being treated as paper work or bureaucratic legalisms; and somehow the humanity of the victim involved is kind of getting lost.

MS. BELKHAM: I think this has been ...

SENATOR ROBERTI: It concerns me a little bit. And I don't want to cast aspersions at every hospital. Some hospitals are doing a very, very good job in this area and actually picking up the slack of other hospitals. But other hospitals really just seem to, well, it's none of my business this week. We don't even have to notify based on what the law requires.

MS. BELKHAM: Well, Senator, the confusion has been noted. And in the Board of Supervisors' appointed Task Force that Mr. Abbate mentioned, one of the items that we did discuss was communications was notification of inappropriate agencies. The Hospital Council is prepared to assist in this, as is the County Criminal Justice Coordinating Committee. They have agreed to be the

coordinating agency letting the various jurisdictions know who is doing what. This task force has not yet concluded its deliberations, although a report to the Board of Supervisors will be given by the end of this month. We feel that by the end of the year we will have this in place county wide.

SENATOR ROBERTI: Frankly, since this whole thing has come to my attention -- I'm sure some of my colleagues -- I think Assemblywoman Waters has hit on the point. We'd frankly be a lot more comfortable if somebody would just come in and say listen, Senator, listen Assemblywoman, or whoever, we just don't want to do it and there is nothing in this world that'll make us want to do it. We wouldn't like that, but at least it would be a candid response that we could work from. But we tend to feel like we're, you know, running around in circles. Nobody wants to really admit that the reason is nobody wants to do this. They don't want to be bothered. They don't want to go to court. They don't want to have to testify, the whole reason none of us ever want to go to court even if we're innocent bystanders. Now I don't think that's performing the hospital's duty. But still, at least, it helps us a little bit in formulating public policy. But I think a lot of hospitals really are too chicken to tell us the real reason. And hence, we hear it's the $400 cost; it's a whole bunch of reasons that sound plausible to a policy maker but aren't really necessarily the case. Now I don't want to say this about every hospital because that is not true of every hospital. And if I'm wrong, please tell me.

MS. BELKHAM: I do have some candid information from hospitals.

SENATOR ROBERTI: Okay. Good.

MS. BELKHAM: They have said I am perfectly willing to provide the protocol and medical treatment to victims within my community. Brotman is a case in point. Brotman was mentioned earlier.

SENATOR ROBERTI: Yes, absolutely.

MS. BELKHAM: But they do not want to be considered a treatment center, a referral center, because they couldn't handle the volume and if every -- if the Task Force recommendation is that every jurisdiction have resources. And Culver City's will be Brotman's.

SENATOR ROBERTI: Well, in the formulation of the latest protocol, it's my understanding that the hospitals did participate, in the formulation of the protocols. And at that time, the Hospital Councils involved did not indicate that there was going to be a problem as far as the protocols are concerned. And now suddenly, we find that there's this problem.

MS. BELKHAM: The protocols themselves are not a problem. It's the volume.

SENATOR ROBERTI: Well, I had -- I had a meeting in my office not so very long ago -- and I think it was followed by a press conference or something; I can't remember. But at that point, the indication to me was the protocols were a problem. And today, I'm very happy to find out the protocols aren't a problem. But you have to understand how this is coming, how this -- the impression that I'm getting is that some people just don't want to do it.

ASSEMBLYWOMAN WATERS: Me too.

SENATOR WATSON: Senator Roberti ...

ASSEMBLYWOMAN WATERS: That's what I ...

SENATOR WATSON: You're absolutely right. We really have to get down to brass tacks.

ASSEMBLYWOMAN WATERS: That's right.

SENATOR WATSON: Centinela Valley did not want to take care of poor people. They don't want to take care of the rape victims and they have made that very clear. And Mr. Abbate said, that if they had adequate amount of money, they would still not want all hospitals to take care of these victims. And I know they go hand in hand. That's why I suggested that we need to look at this whole state. And if we have a mandate that you will provide services based on the protocol, we need to mandate that hospitals in certain areas have to provide these services. I think that's what we're going to have to do.

Who knows where people get raped? They get raped any place at any time. And I think it's very arrogant to think that well, it's all right over here but we don't want the high volume. Well, we don't know where people are going to be raped this week. And I think the arrogance of a hospital to say I can't take the volume is unrealistic. We've got to be able to provide health care services where they are needed. I think it's unconscionable. And I'm really incensed about this because both of the hospitals we're talking about are in my district. And if you are a pregnant woman and you're poor, you've got to go 40 miles away, either down to Harbor or you've got to go over to Martin Luther King. And that's not the kind of treatment that we have guaranteed the people in the State of California. So I think the hospitals are going to have to be cooperating in this effort. And I think for you to say, no, you're not going to do it, is unrealistic.

We need hospitals to cooperate. We also need to reimburse you. I am concerned about uncompensated health care just like you are. We've been debating this; we've had hearings; we've been meeting. And we're going to have to address that issue. We also have given you a mandate. And when we do a mandate, we're supposed to have the dollars follow that mandate. That is one of the issues that we're going to be dealing with. But I think you've got to pick up your responsibility, carry your load, and you've got to help us on this.

SENATOR ROBERTI: Senator Keene.

SENATOR KEENE: I'd like to focus quickly on a related responsibility of hospitals. It seems to me that you constantly bring to our attention, as I guess properly you should, that the State is somewhat hypocritical in not providing the financial resources for you to do the kind of job that you want to do. And then, of course, it's hard for us to examine motivations about whether you really want to do the job or whether you're saying you can't do the job.

You made the point that uncompensated care is a tremendous problem for hospitals in California, as we all realize that it is, and that this whole situation is part of the problem of uncompensated care, and that it's costing hospitals $1.8 billion this year alone, which is sort of California's version of the federal deficit or at least a portion of it.

We know exactly who's responsible. The Governor vetoed the trauma centers. And in his veto message, he said we can't spend the money because it might be misspent; we can't spend the money for trauma centers because the money might be misspent. So that's how much understanding of the uncompensated care issue he has and his political sympathizers in the Legislature who prevent us from adequately funding this uncompensated care situation in responding to it.

Now my point is simply this: That you can't -- you've got to stop talking about the State not doing it, and you have to hold those who are politically accountable and responsible for what they do or don't do in this particular situation. All the very good establishment Republicans sit on your boards of directors of your hospitals. Why aren't they knocking down the Governor's door? Why aren't they sitting on his doorstep and demanding an answer to this uncompensated care situation? Because that's where the roadblock is; that's exactly where it is. It's the Governor and the people who are sympathetic to his position in the Legislature. And we know who they are; they're all Republicans. The doctors of the State of California are predominantly Republican. Why aren't they knocking on the Governor's door about this issue of uncompensated care in which you say this is a subset?

The hospitals have -- the hospitals have organized and mobilized very successfully politically in the past over other issues. If you don't mobilize over this one, what can we assume, other than it just isn't a high enough political priority for you?

MR. ABBATE: It's very high. That's a tough door, as we all know. The doctors, our trustees, the hospitals have tried through it, over it, under it, to draw historically the little bit of micro-history a line from his decision on the 10 percent cut effecting physician and outpatient fees to the collapse of the trauma center network in Los Angeles County. It is a very simple transition. Senator Roberti heroically attempted to turn that around. We're grateful. Our trustees tried every way possible, and we will continue to do so. We appreciate your comments, Senator.

SENATOR KEENE: If the highway lobby can move this Governor, which they are, and they're finding a way to punch a whole in the Gann Limitation, if the business community can move the Governor, as they've been successful in doing, it seems to me that your directors and the doctors of the State of California can certainly get out and beat the political drums and get the uncompensated care issue resolved in some fashion.

SENATOR ROBERTI: I think we have a -- yes, Dr. Kurth.

DR. KURTH: Yeah, I'm really not a politician and, although I'm here with the Hospital Council, I really represent myself and my hospital. And I can perhaps give you some understanding of what occurs at a very local level.

Queen of the Valley is a community hospital in West Covina. I'm the program director of the Sexual Assault Program there. I'd like to just introduce Peggy O'Neil who's our nurse coordinator of the program and I may need her help. I'd like to go through some of the evidence collection kits in just a minute.

I'm proud to say that Queen of the Valley's board of directors, administration, and physicians are committed to this program. We've been doing these examinations since 1979, and we try to do a good job. We feel that the changes in the protocol are good and helpful. I agree with Gail Abarbanel -- I don't think it's added all that much. It has added some. It's more detailed. But I don't think that's really the issue here.

I would like to talk about just a few things. One of them is the medical care and the psychosocial support, which has to go along with taking care of these patients, the training to ensure

that the physicians and nurses know how to do the exam, access to hospitals, comprehensive and timely service, and reimbursement.

The protocol itself is good. It's basically a check sheet and I've included that. I'll go over it in just a second for you. But you can't — you can't just fill out that check sheet in a vacuum. You have to spend time with the patient and it can be very time consuming. You have to develop a rapport with these people. If you're dealing with a three year old who's been raped by her father and told that she'll be mutilated or killed if she tells the doctors — I mean they tell them, "Don't tell the doctors or the nurses what I did to you." It can take hours, and maybe not just of the physician's time; you need to involve these rape crisis people that we've heard from earlier and social workers and nurses. It's a very time consuming process. There's a lot of skill involved with this.

Access to, access to facilities which will do these examinations — I think most hospitals would like to do them if they felt they could. But they — I think most of them feel burdened — they feel that they're being asked to shoulder a disproportionate share of the burden of doing these. It's, as I said, it's time consuming. You have to train your personnel. The State course is a two-day course. And you have to have the commitment to make sure your staff — well enough to be able to do them without letting the rest of the department fall apart.

Many physicians are willing to go the extra mile to take care of these women and children subjected to sexual violence. But I think there's a lot of financial pressure on all of us not to do these exams, not to see these exams in our hospitals. Training, as I mentioned before, it's a two-day course put on by the State right now. Hospital Council is working on some other courses. The course really is, is a little bit too long. It needs to be shortened; it needs to be more intense. And everybody needs to take it. And somehow, these people need to be compensated. The hospitals don't want to — you know, our emergency staff is nurses and physicians, probably 60 or 80 people or more. And that's a lot of people to pay two days' salary to go take this course, plus the cost of the course. It's a lot of money for something that the hospitals feel that they're not going to be reimbursed for anyway.

Comprehensive and timely service — Queen of the Valley is committed to the care of rape survivors. Our written policy is such that these patients receive priority care over all but life-threatening trauma or cardiac emergencies. But even with the written policy, sometimes it's difficult to make sure this gets done. You can spend hours and hours just finding out which police department is responsible to take care of this patient. Maybe the patient was picked up in West Covina but they were taken to a house in El Monte and then they were driven to L.A. to someplace they're not even sure where they were, and that's where they were raped, and then dropped off in Pasadena and somehow they make their way back to, well, all these different police departments. It's very, very time consuming.

I mean these are people that need to be taken care of. But the attitude of the emergency staff in the middle of the night, when it's Saturday night, and you've got lots of other patients you have to take care of — I mean it may not be right but they just — they don't want to get involved with it. They'd rather not bother.

Painting an accurate history can be extremely time consuming. You have to talk to the police,

the crisis intervention workers, the nurses who are dealing with the case, the family, the friends before you even find out where you're going to focus your exam, what acts have occurred or what do you need to look at, what do you need to check -- not just for evidence collection but also to make sure that the patient is taken care of medically and psychologically.

SENATOR ROBERTI: How long does the -- how long do the protocols take?

DR. KURTH: Absolute minimum is probably two hours, and that's a rare case that you can do in two hours. I think generally it takes around four hours, and sometimes even longer than that.

Let me, let me give you an example. I've put two kits up there. This is the -- if you have -- if you're working with people who are trained, it's not too bad. But most of the people right now are really not trained on the new protocols. And it's very time consuming if they're not trained.

This is the clothing bag for collecting any clothing, underwear. The clothing needs to be dried before it's put in the bag. And ultimately, all the other packets go into this bag. And this is labeled with the medical record number, hospital, collected by who, and date and military time.

We have five envelopes which have to be completed, including debris, dried secretions, including oral and rectal samples, pubic combings, vaginal aspirate, and a vaginal sample.

Now these are the forms that we get from the -- these are the kits that we get from the State. These really aren't complete to do all that they want you to do on the basis of the form.

SENATOR ROBERTI: I take it, you supervise the testing at Queen of the Valley. How many other people are there who have your expertise in your ...

DR. KURTH: In doing the exams, all the physicians there have done the exams. We have one designated physician. At Queen of the Valley, historically, it's a busy place. It's not the busiest in town, but it's a busy place. And we've had trouble in the past with exams not getting done in a timely manner. And because of this, we've gone out and solicited other physicians from the community and designated them as sexual assault examination physicians. It's hard to keep -- we subsidize them. The emergency group pays them $250 a case; this is just the physician fee. We pay $250 a case for every case and we still can't get people to do it. Some of the doctors will tell you, "Look, I won't do those exams no matter what you pay me."

SENATOR ROBERTI: Excuse me for a layman's questions, but of all these packets and evidence that you have to gather, is any of that ever, in your estimation, for medical purposes, or is that entirely, entirely different? Is this totally forensic?

DR. KURTH: There could be some crossover. But this -- but you really need to do a medical exam in addition to all this, in addition to this. I mean these patients may have been beaten up; they may be stabbed. You know, who know, who knows what could have happened to 'em. They need to be examined.

SENATOR KEENE: Why do these procedures have to be done by doctors, the forensic portion?

DR. KURTH: I don't know that they have to be done by doctors. It's --

SENATOR KEENE: But you said you had difficulty finding doctors. And my question is: Why can't you use a nurse practioner, nurses, or other allied ...

DR. KURTH: I don't believe -- I'm not certain of this -- but I don't believe we were allowed to

before. I think that we can use them now under the changes in the law.

In Northern California, there's a nurse named Sherry Arnt who's developed a nurse examiner program. She uses some RNs and some nurse practioners. But they've all gone through a 40-hour course. And they're the ones that collect the evidence in her county. I think it's a great program. We don't happen to have that where we are. This is the system that we use and this is -- this is how we do it. We try to do it the best way we can.

SENATOR KEENE: Why? You say you don't have the system, and why don't you have it; why can't you have it?

DR. KURTH: We have a task force at Queen of the Valley right now in the process of looking at her program as well as other programs. There's a Houston model which has a similar system. We're not -- we're not close to utilizing a system like that. But still, these people need to be reimbursed. I mean they don't -- they don't do this for free.

How much detail do you want on these? Do you want to know what's in them?

SENATOR ROBERTI: Yeah.

DR. KURTH: Debris. Collect all debris -- grass, sand, loose hair -- found in gross examination of the patient. Place it on a sheet of paper that comes inside. Put it inside here. Fingernail scrapings need to be collected using a wooden applicator, toothpick, et cetera.

Step 2, rectal and oral secretions. The swabs inside need to be moistened. Any dry secretions need to be rubbed so you can pick up the material. Slides are included. These are often not adequate. We add other slides as needed to make sure that the examination is done appropriately. All this stuff, by the way, has to be dried. You need a special -- under the old system, it didn't. Under the new system, under the new protocol, it needs to be dried there, a special -- you know, companies, of course, catch right up to this and they come out with special drying machines. They don't cost a lot but it's 250 bucks that the hospital would prefer not to spend if they don't have to. But you need to have it.

There's a chain of evidence now which needs to be protected throughout this examination, and somebody has to stay in the room or this evidence, until it's dried, until it's bagged, until it's handed over to the police. If you can get the police to do it, great. But you can't always do that. They have other things to do. They're busy; they're off; they're gone. So one of our nurses has to stay there. On Saturday, that's very dear cost; it's a very dear price to pay. There's lots of other things that nurse needs to be doing. And, of course, every slide has to be labeled with the patient's name, hospital number, medical record number, date and military time, sample location, and collected by who. All these things need to be initialed. Every label needs to be initialed by the nurse, the doctor, and the police officer involved with the case. It takes a lot of time to do it.

Pubic combings, there's a piece of paper and a comb they give you. This goes under the patient's buttocks. Pubic hair is combed for debris, for pubic hair, possibly of the assailant. Vaginal swabs are used of standard pelvic examination, absolutely has to be done.

Most facilities now are using culposcopes. A culposcope -- I don't know if you know what that is. It's a binocular microscope on a stand with an attachment for taking pictures. They cost about

$20,000 or a little bit more. It's not required by the protocol but you really have to have it. At Queen of the Valley, we don't have it. It's in the budget. The budget's been approved; but just due to normal bureauacracy, when we'll get it, I don't know. We really should have it, though. We know we need to have it. We feel inadequate doing the exam without it because most of the -- most of the places have them now, or the places who are doing a good job have them. But it's 20 grand. It's a lot of money for the hospital to shell out for a program that they don't get paid for or get paid minimally for.

Three swabs together into the vaginal pool. We do a wet-mount slide that has to go to the laboratory for sperm motility. This goes to our own laboratory because the sperm will die if you leave it.

We also do dry slides which are put into the drying machine and sent back with the police department to their forensic laboratory. And, of course, all this stuff has to be labeled. All the -- all the swabs that we use go back into the containers once they're dried. And they go to the police department as well.

Vaginal aspirate, they give us a test tube. One of the part of Peggy's job is to beef up this kit to make sure that we have what we need when we do the exam. You can't go looking for this stuff. Everything has to be there. Vaginal aspirate means basically, while you're doing the pelvic exam, you need to take a syringe and put some saline into the vaginal area, aspirate the fluid, and send that for sperm motility as well.

The paper work involved is significant. You should have a packet like this up there. On the right-hand side, you'll find a typical chart. This is -- I couldn't get enough copies of the original so I Xeroxed it.

The first -- now some of this is medical record, but this needs to be generated on every patient. If somebody presents and says, "I've been raped, I need help," this is what we have to do even if we elect -- and we don't -- but even if we elected to not do the evidence collection exam, you still have to do the medical examination. I mean any ER that's not doing that is wrong. I mean they really need to be doing that. Any patient that presents in an emergency room needs to be evaluated. They need to be seen by a doctor.

The first pages are medical record. This is where we put the chief complaint, the triage sheet, the blood pressure, the chief complaint. And this will be the doctor's medical record, separate and distinct from -- even though you may do these exams together and they're interrelated, this is where we put our medical exam, separate from the forensic exam.

The next page is a nursing record. And this all has to be completed.

Next is the business office chart and this is filled out by the secretaries out front.

And on Page 4, we begin the OCJP 923 form. This is the Adult Suspected Sexual Assault form. This is a six-page form. The first couple of pages are Authorization and Patient Consent, general information.

On Page 5, which is the second page, you can see some of the detail under Number 4, close to the top, Acts Described by Patient. And if you have an adult who you can speak to and communicate

easily with, it's not so difficult. But with a kid or even a baby, I mean it's really hard to get some of this information. Penetration of Vagina by Penis, Finger, Foreign Object, Describe the Object, Penetration of Rectum -- kids don't know what a rectum is. I mean it takes time to develop the rapport so that the child will even speak to you about these things. Or sometimes an adult. Adults don't like to discuss this either. And then to get them to describe these objects? Oral Copulation of Genitals of Victim by Assailant, of Assailant by Victim. Going down to Number 6, Methods Employed by Perpetrator, Weapons, Weapon-inflicted Injuries, Type of Weapons, Physical Blows, Grabbing, Grasping, Holding, Physical Restraints, Bites, Choking, Burns. On to Number 5, Lapse of Consciousness, Vomiting, Preexisting Injuries, Last Menstrual Period.

The next page is recording some of the physical injuries -- I mean as opposed to purely vaginal penetration injuries. Do they have bruises; do they have gunshot wounds; do they have stabbings?

Page 7 goes on to a more detailed examination. This is where some of this material is covered, the evidence examination, but there's even more detail listed here: Obtain a Pregnancy Test, Obtain Specimens Described Above, Aspirate Washings to Detect Sperm. This is where you check them with the Wood's lamp, the black light, to see if there's any dried semen anywhere that might not be apparent just under normal light. And, of course, there's an area to graphically illustrate these injuries. This chart goes on.

The first 17 pages of what you have would be what we would use for any adult patient that presented and said, "I've been raped. I need to be checked." That's 17 pages of paper work that has to be filled out. It's just a lot of stuff.

The next seven pages would be what we'd use in a case of a suspected sexual abuse on a child. The first page -- on Page 18 -- is the reporting form that we send in. And the next six pages are the OCJP 925 form which is similar to the adult form but geared more toward a child. And, I mean I know that you understand that it's ludicrous to expect the hospital and physician to split the $16 (laughter) for doing all this. I mean it takes a lot of time. It's a big -- it's a big project to do and it's a hard thing to do.

SENATOR ROBERTI: Yeah, I think we all agree that $16 is unrealistic.

DR. KURTH: Yeah. Now this all should be done, if you can, within the first six hours. I mean it really needs to be done. You can't delay it a great length of time.

SENATOR ROBERTI: Well, which is one reason why we have to know who's doing it and who's not doing it, I think.

DR. KURTH: Yes. The reimbursement, I really should just touch on that.

ASSEMBLYWOMAN ROYBAL-ALLARD: Excuse me for just one second.

DR. KURTH: Sure.

ASSEMBLYWOMAN ROYBAL-ALLARD: Out of this, what, 25 pages, how much is actually required by the protocol?

DR. KURTH: Well, for an adult, it's six pages. For an adult, there's six pages -- excuse me. For an adult, there's five pages. For a child, there's six plus the reporting form, so seven pages. But in a hospital emergency room, I mean as a physician, I can't just do that. I mean I have to evaluate

this patient medically. It's really -- I mean it's unfair to ask me to just collect evidence and not check this patient. We wouldn't do it for anybody else.

If somebody came in with any other injury, they're going to be evaluated. They're going to have their blood pressure taken; they're going to be checked. And if they have complaints, they need to be taken care of. You can't -- I'd just -- I wouldn't not examine them. I mean they have to be examined. They have to be taken care of medically. Now that might be a very brief exam if the patient says, "I don't have any other injuries. He jumped on top of me and entered me and then left and I'm not hurt in any other way, and I don't want to talk to a counselor and I just want this evidence collected." Well, then it would be very brief. You still need to check 'em. But on the other hand, these patients may be battered beyond recognition. I mean you could spend two or three hours getting X-rays on them. It's hard to say for each, you know, what's fair reimbursement? I don't know.

Neither the physicians nor the hospitals expect to make a profit from the care of these women and children. Everybody, though, really wants to cover their expenses. Key fiscal issues need to be resolved. Community standards dictate that reimbursement to physicians be linked to the RVS code system and separated from the hospital reimbursement. I mean this is traditionally how we get paid. For a more extensive exam, you get paid more; for a less extensive exam, you get paid less. And this is throughout emergency services, not just in California but in the country. That's how we're reimbursed.

Evidence collection is a separate service from the medical care and it really should be reimbursed separately, whatever system is decided upon. This is all consistent with the community standard. The vehicle is the RVS code system. I don't know if -- do you know what I mean by that? The relative value system.

If you look on Page 14, this is our feed sheet. These are computer numbers that you're seeing. These are computer numbers in the left-hand margin. But they are --they correlate with RVS code numbers. The RVS code book is a relative value scale that gives the number of medical units or surgical units to each exam or procedure. And the way you get the charge is you multiply it by the conversion factor. For instance, I think at our hospital, the medical conversion factor is about $5 or $6 per unit. And a brief exam, which would be the second one at the top, a brief exam might be four medical units. So if it's $5 a unit and it's four medical units, then a brief exam is $20. If it's an extended exam, which would be -- and there are definitions, multi-system, length of time, intensity of exam. A brief exam is -- just as an example, somebody comes in with a sore throat; they have no other complaints. You check 'em, give them a prescription, and they're gone. That's a brief exam. If somebody comes in and they're having a heart attack, a myocardial infarction, and you spend a lot of time examining this patient -- getting tests, interpreting the tests -- well, that might be an extended exam. And it's still the same $5 medical units but there might be 20 medical units for an extended exam. So it's a hundred dollars for that charge. But it's an easy system, depending on the amount of time. And it's a very -- and there are definitions that go with all these. There's a book published that tells you. Everything on this page has a definition in the RVS code book, and it has a number of either medical or surgical units. And you multiply it out and you calculate it, whatever the charge is.

Physicians -- the probability of a physician doing these exams, the probability of him being subpoenaed to court is very high, higher than a physican doing family practice in the community. And if these people are going to get called to go to court, they really ought to be reimbursed. I mean that's only fair. I think when I've been subpoenaed I've never even gone to collect the money. I think it's $15 or $18 that they pay you. But you've got to go stand around and fill out forms. And I have really a lot of other things that I have to do. I mean it's hard to even go there and spend the time waiting to testify, and then you have to get up on the stand and get grilled by lawyers too. And to not get anything for it, it's hard. I mean not -- people don't want to do these. It's a good thing to do but it's not a fun exam. There's a lot that goes into it. Reimbursement for the hospitals in their defense, you know, they need to be reimbursed adequately for their costs, at least.

What I see now -- at Queen of the Valley, our board and our administration and our docs are committed to this program and I'm happy; I'm proud that they are. But we're afraid that we're becoming a referral center, a community referral center, if not a tertiary referral center. We don't want to do the exams for everybody from everywhere. I mean we have limited staff and they tend to come in at peak times. They're there Friday night and Saturday; we're busy and we're understaffed as it is; and there's a nursing shortage, and lots of times, we're working two or three nurses short. And you might get two or three of these cases at once. It's just very hard to do. Maybe we should say, yeah, we'll do all of them for everybody but you just can't do that. I mean -- and if we're going to have to be doing more and more of these cases, somehow, the hospital needs to be paid so they can justify assigning more staff to the emergency department so that we don't get behind, so that we're not overburdened by the cases that are coming in.

My recommendations -- I'll tell you honestly, I learned a lot today listening to some of the other people. I thought I had this all figured out earlier this morning. And listening to the other people speak, I realize I don't have all the answers. But let me just give you my recommendations and I'll sort of temper them with some of the things I've learned from other people.

I think we do need to have a briefer but more intense training course. And I think somehow these people need to be compensated. You can't expect the hospital to pay all these, all these people's salaries, you know, a hundred people's salaries for going and taking this course for a day or two days and then not pay them for doing the exams. I mean somehow, it has to be fair to them.

I was going to recommend that all full-service emergency departments be -- provide the evidence collection service. The trouble is they can't all do it, you know. I think the Hospital Council is probably right, but I don't have the solution to it. You know, places like Queen of the Valley and Santa Monica Hospital, Gail Abarbanel's program, we're happy to do the exams and we're happy to do whatever we can to help. But I don't think -- I honestly don't think we can do all of them. I mean it needs to be spread out somehow. And I think the only way to do that is make sure people are compensated enough so that they're willing to do the exam, so that they don't feel overburdened. I'd like to see somebody help out with the equipment, whether it's local law enforcement agencies or the State, or maybe just through reimbursement for the exams. The hospitals are reluctant to invest 20 grand on these culposcopes but that's what they cost; that's what they cost. And you really need

to have it if you want to do a good job, and nobody doesn't want to do a good job. We want to do a good job.

Physician reimbursement needs to be separated from hospital reimbursement. To say you're going to pay even a flat fee of $200 is -- that's against the way things have always been done, not that they can't be changed, but it makes it difficult for us to work within that system. Link physician reimbursement to the established RVS code system. It's a good system. It's worked well. It's not perfect and there's hitches to it. But it's a system that we all understand. All physicians know the RVS code system. And it gives you a chance to have a sliding scale. If the rape survivor has a scratch on her hand, that's a very different, very different examination from somebody that also comes in with a gunshot wound. It's far less time consuming and it should be reimbursed appropriately less. But if somebody does have major injuries or if the exam is particularly difficult or time consuming or long, then they should be reimbursed more. It seems to me that it would be fair to have local law enforcement agencies reimburse the physicians for evidence collection.

Some of the people have presented -- for instance, Gail Abarbanel said that you can't negotiate contracts separately with all these different police departments. And she's probably right. You know, I guess I'm kind of parochial in thinking about Queen of the Valley and just the police departments that we deal with in our little area. And it's probably not unreasonable for us to work it out with the three or four agencies that use us, but for other hospitals I'm sure they couldn't do it because there's lots of different agencies that come there. Maybe it needs to be the State or maybe the State needs to reimburse the local people.

Allow physicians to bill patients or third-party payers when appropriate for medical services. What about the patients that need to be admitted? You know, you can't expect the evidence collection to be enough to pay for that. Somebody may have to have their spleen taken out because they've got internal injuries.

Compensate physicians adequately when they're subpoenaed to court, mandate either local law enforcement or state agencies to pay the hospitals adequately to make sure that they can staff the emergency departments to keep up with the demand for these cases, and ensure that reimbursement is received in a timely manner. One of the problems is that it takes months and months and months to get the $50 out of the police department. I mean that doesn't even cover the billing costs. I think you understand much of that.

In summary, I think that the new protocol is a good protocol. I think it streamlines the system. There's less subjective material, but it still is time consuming to fill out all this paper work, to gather the information, to do the evidence collection exam, to do the medical exam, which you have to do, and to interact on a psychosocial level with this patient, whatever agency you're using, whether it's your nurses or your social work department or a rape crisis intervention team.

I'm glad that -- I'm happy to see that somebody's finally paying attention to this. I think the new protocol really has initiated a lot more interest in problems that have been problems for a long, long time. At Queen of the Valley, I feel the commitment of our board of directors and of our administration and I'm sure that we'll continue to do the best job that we can. But I think we need to

turn to you to help set up a system so that it's not just isolated little hospitals that are trying to stand alone. Everybody needs to be helping to take care of these victims and everybody needs to be paid for the work that they do.

SENATOR ROBERTI: Yeah, we agree with you, Dr. Kurth. Thank you for your testimony. It's been helpful.

The statement from Daniel Freeman, we'll be happy to submit it into the record. I think that'd be helpful and to give it the sergeant; we will make sure all the members see it.

Next witness is Dr. David Chadwick, Director of Medicine of Children's Hospital.

DR. DAVID CHADWICK: Good afternoon.

SENATOR ROBERTI: Doctor.

DR. CHADWICK: Good to see you. I'm not the Director of Medicine at Children's Hospital. I'm the Director of the Center for Child Protection at the Children's Hospital in San Diego. Along with the handout that you're receiving now, you should find a copy of my business card which is included so that you can call me before you come to see our program, which I now invite you to do, and bring your assistants and bring your accountants so that you can see that I'm also here to say that there are people in California living outside of Los Angeles, despite the concentrated concern for most of this hearing about the Los Angeles situation. It is a big state and I represent a chunk of it with a couple of million people in it and a program that deals with child sexual abuse in that area. And I'm speaking only to the issue of child sexual abuse because that's all I know. I'm a pediatrician. I've worked all my life in children's hospitals. I spent some time at the Los Angeles one, and then I saw the light and went down to San Diego where I've been for the last 20 years. I had been the medical director at that children's hospital but I now am full time in child abuse work for the last two years.

Our center sees a thousand sexual abuse victims a year and about 500 physical abuse victims a year. We have a dedicated facility which was constructed for the purpose. That cost a million dollars to the Children's Hospital in San Diego to build that building. But it is dedicated to the purpose. And we have three culposcopes, all of which were donated. In other words, we have a facility; we have good equipment; we have good people; and we have excellent training. We have a large volume, which you must have, in order to do this. We do operate a 7-day, 24-hour program. However, as you know, child sexual abuse is much more likely to be chronic and it is less likely to be rape. However, children are defined, as from infancy to 18 years; and at the upper end of the age scale, we do see rape of young women up to the age of 18 and we do scramble a team at night and use our dedicated facility for all of those exams.

The big difference in children's work, or a big piece of the big difference, is the interview phase of it, is trying to find out what happened, is getting a history because you're dealing with a person who may be as young as two years of age and barely articulate. And so we spend a lot of time at that. We have — our facility includes two dedicated interview rooms just for children with a — and they flank a viewing room. I've brought slides of all of this. But this projector in the State Building was probably built by Galileo (laughter) and no one here, including myself, knows how to work it. So,

but we have very excellent interviewing rooms. We use videotape, and we videotape virtually 100 percent of our interviews. And if anybody has any questions about the details of that, I'll answer them later. But that's -- that has worked very well in San Diego for us.

The evaluation takes a lot of time. The children are generally in and out in about three hours, sometimes four -- interview, physical examinations, some laboratory work, the rape kit that's already been described to you, in certain cases but not all, and then the preparation of reports, conferencing, and so forth. We have -- we have two full-time physicians, including myself, doing this work. We have six additional part-time physicians that help us out on nights and weekends on a, on an on-call basis.

The first, on the top of your pile of handouts, there is a, is a copy of the form 925, which you've already seen. That's redundant because you got that from the preceding speaker. The second thing in the pile should be a price list. It's a -- it's a list of the services we provide and the charges that we are currently making for those services and sometimes getting. The principal payer in San Diego County is law enforcement and we have eight law enforcement jurisdictions that we deal with, and they all pay us the same. However, they must have prior authorization. We usually have to talk to the lieutenant somewhere to see if we're going to be able to do this for law enforcement or not. And we also do examinations for Child Protective Services that's very under-budgeted. We do examinations for families at their request, using their own resources, whether they be insurance or otherwise. We do occasional evaluations for Medi-Cal. We will use any source that we can get in order to get paid for our work.

Addressing the questions in the letter that was sent out ahead of time by Chairman Lockyer -- why do hospitals refer? In our own area, we do. We are not quite the sole provider but we're almost a sole provider. There's another hospital that does a little of this work for Escondido. But we do most of this work and we have two offices. We have a North County office simply because of the geography so that, so that 99 percent of our population is within 45 minutes of one of our places. And if we had an East County setup, which we should probably, we could make that close to 100 percent. The -- but I don't think most hospitals should do child sexual, at least the evaluations. If anybody else in San Diego tried to duplicate what we've got, they'd have to put in the same investment, the same training, the same staffing, and it's going to be hard for them to do. So many do refer and many should refer. That, that doesn't mean that the service should not be available; and when you look at California and all of its differing kinds of areas then you begin to look at rural areas that obviously in some places has to be a regionalized, staged process of service whereby some hospitals can give an immediate response because nobody should have to wait more than 15 or 20 minutes in an acute situation. But other hospitals can do backup, and particularly in this child sexual abuse work, where you have to have extremely skilled interviewing or the case goes to pot.

What's the impact of this? Well, I think, if you have a concentrated, excellent service, such as the one we attempt to offer, I think that the impact is quite beneficial to the victim. It's more humane; it's more competent. The forensic errors are minimized and yet there is not undue delay in getting at the service.

What about costs and charges? I think, as I say, the handout that I've given you is our charges; those are not our costs. We're still losing money. The loss is absorbed by the Children's Hospital and Health Center in San Diego and by the Board of Trustees. And they, they regain that loss by fund raising and by supporting us out of other operations. Tonsils are wonderful. You can make money on tonsils. You lose money on child abuse. That's the way it is and that's life in the Children's Hospital. But that kind of cost shifting is becoming increasingly criticized.

The question's asked: How do you -- what's the process of arriving at the charges? How did we get law enforcement to pay us $400? The answer to that is with extreme difficulty. And if I tried to raise the cost, raise the price, to what is actually our cost, as my accountant tells me, the only effect that that will have is to reduce the number of children that law enforcement will bring because our law enforcement agencies deal on fixed budgets. And unless they have planned ahead to increase those budgets, they will not be able to increase the number of victims that are brought in for examinations. I'll add parenthetically at that point that our thousand exams or evaluations represents one out of eight child sexual abuse reports in our county. There's about 8,000 or 9,000 reports per year of child sexual abuse to our Child Protective Services. We're seeing about a thousand of those kids. We could deal more with how many go onto court and so forth, but that tells you that a lot are not being evaluated in this way and probably at least twice as many should be.

Who should pay? Well, that's, you know, at the moral or justice level, it's easy to say that the responsible adult should pay. You often don't know who it is. To prove who it is takes years. In the meantime, there's the payroll to meet. So even if you can put some of the charges into the responsible adult, if that person has resources, it still is a very slow system. I am clearly in favor of a state payment mechanism or at least a state subsidization mechanism to subsidize the local jurisdictions. I think to put this all into the cities, which is the way it kind of is in our area, is burdensome, particularly since the State is now setting up the, the criteria and the standards for service in the form of protocols and forms.

As long as we're talking about the costs, I would like to talk about benefits. The principal benefit of doing a good child sex abuse evaluation is that it stops the abuse. If you can prove that abuse has occurred, you can stop it. If you can't prove that it's going on, you often can't stop it; and it goes on and on and on. And if you want a method -- let me tell you a method to produce a rapist. You take a boy, at the age of about six or so, and you begin to sexually abuse him and you put him in a kind of a hopeless situation where he can't escape from it; no matter what he says, he's not believed; and it goes on or it continues over a period of seven or eight years. And you will have an abuser by the time he's 12. And we see that transition from victim to perpetrator in males. Astonishing -- not so astonishingly -- it's perfectly logical that that would happen when you stop and think about it. But that's the way you can produce abusers. That's one way to produce abusers. There are probably others. The effects, of course, on female victims are quite different but still, but nonetheless, debilitating, nonetheless tragic when sexual abuse of children is allowed to continue indefinitely. And a good evaluation can bring it to an end, and that's the principal social value of it.

How valuable is that? Well, you know, I can't do cost benefit ratios on that precisely. I --

instinctively, I know it's a good buy. I know it's worthwhile spending $500 to stop a child from being continually sexually abused.

The conviction, how important is that? Well, that's pretty important too. Often the conviction of the abuser is the mechanism by which the abuse is actually stopped because that is a clear indicator that the -- that something has to happen. As you know, we intervene through Child Protective Services and remove children from abusive homes. Generally, that's temporary. Generally, the child returns. And unless, unless there's -- and then abuse can resume sometimes. So that isn't always totally the answer.

We certainly favor the Watson bill. I think it's a real step in the right direction. I think it's a partial step. My own personal policy recommendation about the mechanism for dealing with this for children is to use not the Medi-Cal analogy but the California Children's Services analogy. California Children's Services designates centers. They inspect them; they make sure that the quality is there; they make sure that there are enough of them to deal with the population; and they set the rates of compensation relative to costs after a thorough analysis of it and I believe -- Florida has, incidentally, has adopted that model for its child abuse services and I think that California could well take a look at that Florida model and do the same in the way that CCS does it.

I'll answer any questions, Mr. Chairman.

SENATOR ROBERTI: Thank you very much, Dr. Chadwick. I think your testimony is very helpful. We don't have any questions, but we will hopefully come see your facility.

DR. CHADWICK: Please do.

SENATOR ROBERTI: The next witness is Mr. Ray Allen, assistant general manager of Los Angeles Personnel Department.

MR. RAY ALLEN: Good afternoon. I have to admit, as Dr. Kurth did before me, that I came here this morning thinking I had some answers and really understood the problem fairly well from my limited perspective. Clearly not the case. I've learned a whole lot here today.

It's important to us in the City of Los Angeles because we've clearly been part of the problem. I think we're still part of the problem. I think we've made a giant step in addressing the difficulties that rape victims and child abuse victims have, have faced over the past few months and probably for years. But we've got a long way to go. It becomes very clear as you become more studied in this subject.

We are the jursidiction that has gotten away with paying $16 since 1971, I can't defend that. I won't even attempt to. We are somewhat embarrassed by that and we would not disagree that there was never any anticipation that the $16 was covering the costs of performing these examinations. Recognize this as a contract that was struck in 1971 under a different set of circumstances, not only when the costs were different but also when there were Federal funds and other sources of funds to help cover the cost of these examinations.

I think, as you hear the testimony unfold today, what you begin to hear is there still needs to be a sharing of the cost. There needs to be an identification of what is evidence; what's treatment; who ought to cover what. We certainly would agree with that.

Let me also say, that with two exceptions to our 20 hospital list of contracting hospitals, no hospital ever came to the City of Los Angeles and said, "We have a problem with your $16. We'd like to negotiate something more reasonable; and if we don't, we're going to walk away from this." That never happened; that hasn't happened to date, with two exceptions. And the two exceptions, interestingly, elected to withdraw from the program indicating that cost really wasn't the issue. They just didn't want to do this anymore. And even if we did negotiate a contract, which we were in the process of doing in 1985, that they wouldn't be very interested in returning to our system.

We did, at one point, have a contract agreed upon with the Hospital Council of Southern California who's been very helpful throughout this process. We actually talked with them before the two hospitals came to us in 1985. We continued to talk with them. We had a completed contract in late 1985. Before that was finally consummated in 1986, the Hospital Council had to pull out of the agreement. As a result, there's some changes in their programs with the County of Los Angeles.

With regard to why hospitals are referring people elsewhere -- as best I can ascertain, there's no one answer to that. I think, as the Committee identified earlier today, some hospitals just don't want to do it. Others are concerned about the costs; others are concerned about the workload. The L.A. police commander who testified earlier indicated that 7 of the 18 hospitals that we have on contract are referring patients elsewhere. Well, that's sort of a moving target, as you've also heard earlier today. Some of those hospitals have started referring and then stopped referring, probably as a result of Mr. Roberti's assistance in that regard. They come in and out, and it seems to be less a function of the decision made by the hospital administration oftentimes than a decision made on an emergency room physician, based on the workload at the time. It's a moving target. We have the names of the hospitals that are on the list that have been in or out, but I can't tell you minute to minute whether they're in or out. We depend on the police officer. We would still refer a police officer to those facilities if they called and said, "Where can I take this person?" because it's a good chance they'll be accepted there. I think it is very clear that this is not just a cost problem.

You've heard testimony about cost shifting; you've heard testimony about indigent care; you've heard testimony about insurance coverage; you've heard testimony about identifying evidence versus treatment; you've heard testimony about the time they have to spend in court once they get involved in these kinds of cases. Serious issue. You haven't heard, but I think we observe, that there is an issue of emergency room workload that sometimes influences an emergency room physician's decision on a given day as to whether or not to accept the patient. You've heard about training; you've heard about protocol. Most importantly, you've heard about the traumatized victims. And the impact this has on them is unacceptable.

I tried to ask myself this morning before I came here two questions that I thought would be germane to what I understood the goal of this committee. Firstly, what can we as the City of Los Angeles do to make it better beyond what we've done? And what we've done is we've negotiated with the Hospital Council and the emergency room physicians. And as you heard from the testimony from the doctor from Queen of the Valley, it really is two sets of folks we're talking to. You don't negotiate with the hospitals anymore. Most hospitals contract their emergency room services. The

hospitals and the physicians, in fact, want to bill separately now. They want it understood up front -- this much for the doctor, this much for the hospital. What we can do is continue to attempt to expand the system of hospitals who would be willing to accept rape victims.

Another issue that has come up is we have talked to hospitals individually as we surveyed some of them upon reaching a $200 agreement was "Yeah, we would -- we'd be more than happy to continue doing this but not just us. There has to be a number of hospitals or we end up carrying the entire load for the area. We can't do that. We'll carry our share of the load." We need to work on that.

We need to continue to work toward a longer term solution, whether that's cost analysis, cost sharing, determining what insurance companies will and won't pay; and we've done some surveying on that briefly, and in a shallow way, and have some sense of that. We need to continue to work with the Hospital Council and the hospitals and the emergency room physicians, which is, in our view, a new group that we've talked to. This is a new process for us, an interesting process.

Importantly, I also asked myself, "What can the State do?" because as a jurisdiction, the local jurisdiction recognize our role is essentially to fight crime, to gather evidence, to find the perpetrator, and then turn it over to the DA for prosecution. There's a bunch we can do primarily because of our size. We can speak very loudly as compared to a number of other local jurisdictions in this area. And believe me, they were concerned while we were going as we negotiated. They knew that. They knew we were going to set the floor. They knew that whatever we went for, in the way of a negotiated agreement, they were pretty much going to have to go along with that. Most of them are well below that right now. They're not at $16, but they're nowhere near $200 either.

At any rate, I think, as several of the other people have said today, that we need to look to the State for some assistance here. We need to look at the State perhaps to pick up part of the cost, and I don't know whether that's most appropriate under SB 90 or under the Victim Assistance Fund or both. Maybe there's a logical rationale. It seems to me there is in saying, "This much is appropriate in Victims' Assistance; this much ..." Maybe it's arbitrary. Maybe that's the way to do it. That was suggested earlier -- let's do it arbitrarily. Say this much is evidence -- 25 percent, 30 percent. The rest is examination and treatment. The evidence goes to local jurisdiction. Examination and treatment goes to the insurance company. It's not unreasonable. But the State needs to be involved in that. It's clearer and clearer as I listen to the experts talk about this.

I think there is a need, not for purposes of treating a victim, nothing that the victim ever needs to know about; but there is a need to clearly identify and define treatment, examination, and evidence gathering. It ties in very much with the cost sharing to avoid cost shifting.

I think it is inappropriate to at least consider it -- I had said before I came here this morning, "Let's remove the clause that allows hospitals to refer rape victims elsewhere." That just seems ludicrous to me to allow hospitals to do that. As I listen today, I'm not so sure. I've heard experts talk, just in the last few minutes, about the fact that some hospitals probably ought not be doing this. I don't know. That may well be true. If they're improperly equipped or improperly trained, I'm not sure that can't be dealt with. But perhaps not all hospitals should be required to perform this. We need to identify that problem.

Finally, and very much a part of that, I think clearly what you've heard is that one hospital for one million population is just unacceptable. That would mean three or four hospitals for the City of Los Angeles. The 17 that we still have on our role are insufficient. We need more than that. I think the hospitals would agree with that. Every hospital, or representative of the hospital, community today has told you, "We can't do them all. We can't become a regional center. We'll do our part, but don't send us everyone from everywhere. We can't handle it."

That's about as much as I can say to you. I'm not nearly the expert that many of these former people were. I do have a broader view and I have been involved most specifically in the City of Los Angeles difficulty. I hope I've been of some assistance. I'd be happy to try to answer any questions that you have.

SENATOR ROBERTI: Thank you very much, Mr. Allen. We appreciate your testimony.

Finally, Mr. Kenneth Kobrin, counsel for the Office of Criminal Justice Planning.

MR. KENNETH KOBRIN: Thank you, Mr. Chairman. I realize that the Committee's pressed for time. I've taken the liberty of providing a prepared statement to the Committee's staff. And unless the Committee wants me to, I'd submit that for the record.

SENATOR ROBERTI: Very good. We will submit that to the other members of the Committee along with the statement of a couple of the other witnesses who've proceeded this way.

MR. KOBRIN: Thank you, Mr. Chairman. There are a couple matters I would like to comment on.

SENATOR ROBERTI: Please.

MR. KOBRIN: Thank you. First of all, OCJP has participated in the Task Force that was started by the Los Angeles County Board of Supervisors. We did participate in all meetings to date and intend to continue to do so. We are, in light of the comments about additional training being requested, providing, in association with the Southern California Hospital Council, three additional training seminars that we anticipate will take place in January of 1988. Those seminars are anticipated to be approximately one day in length, not two days. The two days that the court heard about -- or excuse me -- the Committee heard about -- earlier are from the original training that was done as an introduction to prepare the medical community to the new protocol. In addition, we are near completion of a video training tape that will be available to all hospitals in the state. And finally, in response to comments about distinguishing between evidence collection and the treatment of victims, we are reconvening the State Advisory Committee on December 3rd to address that very issue.

We've heard a couple of things about hospitals opting out and maybe changing the statute that -- to prevent that. I'd point out, that under the old law, there was nothing that prevented hospitals from opting out. They always had the power and authority not to do these exams. What the statute did was provide a method of notification so if someone with authority would be aware of which hospitals were and were not performing the examinations and therefore victims would not be shuffled between hospitals. The law requires, as it currently is written, that victim-witness centers, the District Attorney, and local law enforcement be notified of the referral protocol.

TESTIMONY OF

CAPTAIN D. CLAYTON MAYES

COMMANDING OFFICER, JUVENILE DIVISION

LOS ANGELES POLICE DEPARTMENT

FOR

THE SENATE JUDICIARY COMMITTEE

REGARDING

THE NEED FOR SEXUAL ASSAULT MEDICAL EXAMINATIONS

FOR CHILDREN IN LOS ANGELES COUNTY

NOVEMBER 13, 1987

LOS ANGELES, CALIFORNIA

MEMBERS OF THE SENATE JUDICIARY COMMITTEE

THANK YOU VERY MUCH FOR THE OPPORTUNITY TO PRESENT TO YOU THE CONCERNS OF THE LOS ANGELES POLICE DEPARTMENT FOR THE PROVISION OF SEXUAL ASSAULT MEDICAL EXAMINATIONS FOR CHILDREN IN LOS ANGELES COUNTY.

THERE IS LITTLE DOUBT THAT INCIDENTS OF CHILD ABUSE AND SUSPECTED CHILD ABUSE CONTINUE TO RISE AT ALARMING RATES. RESOURCES OF PUBLIC AND PRIVATE AGENCIES, RESPONSIBLE FOR INVESTIGATING AND TREATING CASES OF CHILD ABUSE ARE STRETCHED TO THE LIMIT. THIS VERY PROBLEM LED TO THE ESTABLISHMENT OF THE LOS ANGELES POLICE DEPARTMENT'S ABUSED CHILD UNIT IN 1974.

SINCE ITS INCEPTION, THE ABUSED CHILD UNIT HAS EXPERIENCED A STEADY, LONG TERM RISE IN REPORTED CASES. IN 1974, THE ABUSED CHILD UNIT INVESTIGATED 927 CASES. IN 1986, THE UNIT INVESTIGATED 4788 CASES AND THE PROJECTED NUMBER FOR 1987 IS 5000.

THE INCREASE IN SEXUAL ABUSE INVESTIGATIONS IS PARTICULARLY ALARMING. IN 1974, THERE WERE 69 INVESTIGATIONS. IN 1986, 786 INVESTIGATIONS. THE PROJECTED NUMBER FOR 1987 IS 800, WHICH REPRESENTS A 1,059 PERCENT INCREASE SINCE 1974.

THE CHILD SEXUAL ABUSER IS TYPICALLY A RECIDIVIST AND AN ESCALATOR AND THE FREQUENCY AND SEVERITY OF THE SEXUAL ABUSE TENDS TO INCREASE. BECAUSE OF THESE TYPICAL CHARACTERISTICS, EARLY IDENTIFICATION, REPORTING, AND PROSECUTION ARE ESSENTIAL.

THE MAIN AREA OF CONCERN INVOLVES THE MEDICAL TREATMENT OF CHILDREN SUSPECTED OF BEING SEXUALLY ABUSED. IN A LETTER TO MR. ROBERT CHAFFEE, DIRECTOR, DEPARTMENT OF CHILDREN'S SERVICES DATED MAY 1, 1986, I ENUMERATED INCIDENTS OF CONFLICTING MEDICAL EXAMINATIONS, SOME OF THEM INVOLVING LOCAL EMERGENCY ROOM PHYSICIANS. I WOULD LIKE TO SHARE A FEW OF THESE CASES WITH YOU:

SISTERS, AGES 12 AND 11 ALLEGED THEIR STEPFATHER HAD SEXUAL INTERCOURSE WITH THEM. THE CHILDREN WERE EXAMINED BY AN EMERGENCY ROOM DOCTOR, WHO FOUND NO EVIDENCE OF SEXUAL ABUSE. THE SUSPECT ADMITTED INTERCOURSE WITH BOTH VICTIMS AND WAS CONVICTED.

A 14 YEAR OLD GIRL ALLEGED SHE WAS RAPED BY HER MOTHER'S COMMON-LAW HUSBAND. THE CHILD WAS EXAMINED BY AN EMERGENCY ROOM DOCTOR. NO EVIDENCE OF TRAUMA WAS FOUND. A REEXAMINATION BY AN EXPERT FOUND EXCESSIVE TRAUMA.

A 6 YEAR OLD VICTIM ALLEGED DIGITAL PENETRATION BY HER NATURAL FATHER. THE FIRST EXAM WAS NOT COMPLETED. MEDICAL RECORDS STATED, "UNABLE TO COMPLETE DUE TO CHILD'S AGE." THE CHILD WAS REEXAMINED WITH A FINDING OF A LACERATED HYMEN RESULTING FROM SEXUAL ABUSE.

ONE 15-YEAR OLD VICTIM ADMITTED SEXUAL INTERCOURSE OVER AN EIGHT YEAR PERIOD WITH HER FATHER AND FOUR OTHER FAMILY MEMBERS. THE INITIAL DIAGNOSIS STATED, "NO RECENT HYMEN TRAUMA + HYMEN PRESENT." IT WAS LATER DISCOVERED THE VICTIM WAS PREGNANT.

THESE EXAMPLES ILLUSTRATE HOW AN EXAMINATION GIVEN BY A DOCTOR WHO IS UNTRAINED IN SEXUAL ABUSE DETECTION IS WORSE THAN NO EXAMINATION. REPEATED EXAMINATIONS FURTHER VICTIMIZE THE CHILD BY THE VERY PEOPLE WHO ARE SUPPOSED TO HELP THEM.

THE STATE-MANDATED REGULATIONS THAT WENT INTO EFFECT JULY 1 HAVE MADE THE EXAMINATIONS MORE TIME-CONSUMING AND COSTLY. HOWEVER, THE PROTOCOL WAS ESTABLISHED TO ENSURE THAT VICTIMS RECEIVE A STANDARDIZED EXAMINATION WHICH WOULD ALLOW FOR THE COLLECTION OF MEDICAL EVIDENCE, THE TIMELY RECOVERY OF WHICH IS CRITICAL IN THE PROSECUTION OF CHILD SEXUAL ABUSE CASES.

IT IS EXTREMELY IMPORTANT THAT DOCTORS PERFORMING SEXUAL ABUSE EXAMINATIONS BE THOROUGHLY FAMILIAR WITH THE PROTOCOL AND RECEIVE ADEQUATE TRAINING TO ENABLE THEM TO PERFORM THE EXAMINATION IN A MANNER WHICH WOULD ERADICATE INACCURATE EXAMINATIONS SUCH AS THE ONES THAT I ALLUDED TO EARLIER. SINCE THE STATE OF CALIFORNIA DEVELOPED THE PROTOCOL, I SUGGEST THAT THEY ASSUME THE RESPONSIBILITY FOR MONITORING OR PROVIDING THE TRAINING NECESSARY TO ENSURE TOTAL COMPLIANCE.

A SECOND COMPONENT OF THIS PROBLEM IS THE DECREASING NUMBER OF DOCTORS AND HOSPITALS WILLING TO PERFORM THESE CRITICAL EXAMINATIONS. A RECENT MEETING OF LOS ANGELES POLICE DEPARTMENT AREA JUVENILE COORDINATORS REVEALED THAT A NUMBER OF CITY CONTRACT HOSPITALS HAVE DISCONTINUED PERFORMING MEDICAL EXAMINATIONS OF RAPE AND CHILD MOLEST VICTIMS. THIS REDUCTION IN SERVICE HAS CAUSED SERIOUS DELAYS IN OBTAINING EVIDENCE NECESSARY FOR SUCCESSFUL PROSECUTIONS.

THE TWO REASONS CITED FOR THE DISCONTINUATION ARE: INSUFFICIENT REIMBURSEMENT TO COVER THE ACTUAL COST OF THE EXAMINATIONS AND THE RECENTLY ENACTED STATE LAW WHICH REQUIRES STRINGENT STANDARDS AND TRAINING FOR HOSPITAL STAFF INVOLVED IN THE EXAMINATIONS. RATHER THAN ABSORB THE UN-REIMBURSED COSTS,

OR EXPEND TIME AND FUNDS FOR TRAINING, SOME HOSPITALS HAVE CHOSEN TO REFER THESE VICTIMS TO OTHER HOSPITALS. AT THE END OF 1986, 18 HOSPITALS STILL CONDUCTED SEXUAL ASSAULT EXAMINATIONS. IN 1987, THE NUMBER DROPPED TO 11.

ON OCTOBER 27, 1987 THE LOS ANGELES TIMES REPORTED THAT THE SOUTHERN CALIFORNIA HOSPITAL COUNCIL, WHICH INCLUDES 160 HOSPITALS COUNTY-WIDE, HAD ACCEPTED THE CITY OF LOS ANGELES' OFFER TO INCREASE REIMBURSEMENT RATES FOR RAPE AND SEXUAL ABUSE EXAMINATIONS FROM $16 TO $200. IT IS HOPED THAT THE INCREASE IN PAYMENT WILL BE SUFFICIENT TO ENSURE THAT AN ADEQUATE NUMBER OF HOSPITALS WILL PROVIDE THE SERVICE. A PRELIMINARY INQUIRY BY THE LOS ANGELES POLICE DEPARTMENT SHOWS THAT THE INCREASE HAS IN FACT SERVED TO RESTORE THE SERVICES IN ONLY A COUPLE OF THE HOSPITALS THAT HAD CHOSEN TO DISCONTINUE THE SERVICE.

AS PROFESSIONAL LAW ENFORCEMENT OFFICERS, IT IS OUR RESPONSIBILITY TO ENSURE THAT ANY AND ALL EVIDENCE WHICH COULD HAVE A BEARING ON THE OUTCOME OF A CRIMINAL PROSECUTION IS PROPERLY RECOVERED IN A TIMELY MANNER. WE ARE PREPARED TO DO OUR PART. WE ARE REQUESTING THAT THE STATE OF CALIFORNIA MONITOR THIS SITUATION CAREFULLY, PROVIDE AND ENFORCE PROPER PROTOCOL, AND ENSURE THAT SUCH A SEVERE SHORTAGE OF QUALIFIED DOCTORS AND ADEQUATE FACILITIES NEVER AGAIN OCCURS. THE CHILDREN OF NOT ONLY LOS ANGELES COUNTY BUT THE ENTIRE STATE OF CALIFORNIA, AND ACROSS THIS NATION DESERVE TO BE PROTECTED FROM THOSE WHO SEXUALLY ABUSE THEM.

Queen of Angels Medical Center
2301 Bellevue Avenue, P. O. Box 26916
Los Angeles, CA 90026, (213) 413-3000

NOV 20 1987

November 16, 1987

Senator Bill Lockyer
California Legislature
Room 2187
State Capitol
Sacramento, CA 95814

Re: Medical Protocal for Victims of rape

Dear Senator Lockyer:

My sincere apologies to you for not attending your hearing last Friday. The issue you were hearing is of definite importance to our hospital, and I had planned to be present. However, in managing a hospital there are events which sometimes occur which alter your plans for the entire day, and last Friday was certainly one of those days.

The emergency department at Queen of Angels has continuously provided medical care to victims of sexual assault. When the new statutory medical protocol became effective, we continued to provide such medical care. When many other hospitals, because of the increased cost of meeting the new statutory requirements relative to the minimal reimbursement, started to decline to provide these services we saw our case load double. We were evaluating whether we could then continue to provide this care to so many victims, when Senator Roberti asked me to continue to provide the services. Because of this hospital's basic mission and my respect for the Senator, we are still providing medical care to these victims.

We do recognize our moral commitments. In order to continue to fulfill these moral commitments, we must also recognize economic reality. Over 80% of our patients are either Medicare or MediCal patients. We do not have any major source of outside funding. Our hospital must be concerned with its survival.

Our hospital wants to continue to provide medical care to those who need it. If the State is to require that we provide the services of law enforcement agencies, the State should also require that we be reimbursed for the costs of providing such non-medical services.

Senator Bill Lockyer
State Capitol
November 16, 1987

We want to work with you, we want to cooperate with the law enforcement agencies -- but most of all we want to survive so that we can continue our mission of providing quality hospital care to our community.

Very truly yours,

Richard F. Smith
President/CEO

RFS:jmt

cc: Senator David Roberti

Testimony of James D. Barber
State Judiciary Commission - Sexual Assault Evidence Collection Protocol
November 13, 1987

SENATOR LOCKYER, SENATOR ROBERTI, AND OTHER MEMBERS OF THE PANEL, MY NAME IS JIM BARBER AND I AM ADMINISTRATOR OF DANIEL FREEMAN MEMORIAL HOSPITAL. WE ARE A CATHOLIC, 403 BED ACUTE CARE HOSPITAL SERVING THE SOUTHWEST SECTION OF LOS ANGELES AND WE OPERATE NUMEROUS SPECIAL SERVICES INCLUDING A VERY BUSY EMERGENCY DEPARTMENT.

WE SEE OVER 3,000 PATIENTS PER MONTH IN OUR EMERGENCY DEPARTMENT. MOST OF THESE PATIENTS ARE SERVED IN THE EVENING AND NIGHT TIME HOURS. WE CURRENTLY SEE UP TO 30 OR 40 RAPE AND SEXUALLY ASSAULTED SURVIVORS PER MONTH. THE TREATMENT OF RAPE SURVIVORS IS SOMETHING WE HAVE ALWAYS DONE AND ALWAYS WOULD DO REGARDLESS OF A PATIENT'S ABILITY TO PAY. HOWEVER, TAKING ON WHAT IS IN ESSENCE A LAW ENFORCEMENT AGENCY RESPONSIBILITY, AS WELL AS MAINTAINING OUR MEDICAL RESPONSIBILITY, IS SOMETHING WE NEED YOUR HELP IN DOING. WE FULLY SUPPORT THE INTENT OF THE NEW EVIDENCE COLLECTION PROTOCOLS, BUT I AM NOT SURE THE PANEL REALIZES JUST WHAT IT IS YOU ARE ASKING HEALTH CARE ORGANIZATIONS TO DO.

I AM HERE TODAY TO TELL YOU THE REASONS THAT DANIEL FREEMAN MEDICAL CENTER IS NOT AT THE PRESENT TIME PARTICIPATING IN THE PROTOCOL FOR EXAMINATION OF SEXUAL

ASSAULT SURVIVORS. WHEN THE NEW PROTOCOLS WERE PUT INTO EFFECT THIS PAST JULY, WE CALCULATED THAT IN ORDER TO PROVIDE STAFF TRAINED IN THE NEW EVIDENCE COLLECTION PROCEDURE, IT WOULD TAKE THE TRAINING OF MOST OF OUR 30 NURSES AND 12 PHYSICIANS. THIS IS NECESSARY TO PROVIDE 7 DAYS PER WEEK, 24 HOURS PER DAY COVERAGE. NOT ONLY ARE THE TRAINING CLASSES TIME CONSUMING, THEY ARE EXPENSIVE BOTH IN TERMS OF OVERALL HOSPITAL STAFFING AS WELL AS IN ACTUAL DOLLARS.

THE COST OF ADDITIONAL EQUIPMENT WAS LESS CRITICAL, BUT STILL AN IMPORTANT FACTOR. OUR ESTIMATED EXPENSE FOR START-UP EQUIPMENT WAS $8,000. THIS FIGURE DOES NOT INCLUDE ONGOING COSTS FOR DISPOSABLE ITEMS USED IN THE EXAMINATIONS.

ADDITIONALLY, WE WOULD HAVE TO HIRE NEW NURSING AND SOCIAL SERVICES STAFF TO HANDLE THE LARGE VOLUME OF WOMEN WE WOULD EXPECT TO SEE. IF WE WERE THE ONLY HOSPITAL IN OUR AREA TO PARTICIPATE IN THE PROGRAM, WE ESTIMATED OUR VOLUME WOULD HAVE INCREASED 2 OR 3 TIMES THE CURRENT LEVELS OVERNIGHT. I WANT TO REPEAT; MEDICAL SERVICES HAVE NOT BEEN REDUCED OR COMPROMISED IN ANY WAY. IT'S THE LENGTHY EVIDENCE COLLECTION PROCESS THAT STOPPED US IN OUR TRACKS.

WE MUST PUT THE MEDICAL NEEDS OF OUR EMERGENCY PATIENTS AS OUR HIGHEST PRIORITY. BEING A MEDICAL FACILITY THAT IS OUR CLEAR MISSION. THIS QUITE OFTEN WOULD PUT US IN A VERY UNDESIRABLE POSITION RELATIVE TO INDIVIDUALS WAITING FOR EVIDENCE COLLECTION. PROMPT EXAMINATION IS KEY TO EVIDENCE

GATHERING. THERE ARE LESS THAN 4 HOURS BEFORE KEY ELEMENTS OF EVIDENCE DETERIORATE AND ARE NO LONGER IDENTIFIABLE. PROMPT EXAMINATION ALSO PROVIDES THE SURVIVOR WITH THE EMOTIONAL SUPPORT SHE SO DESPERATELY NEEDS IN THIS TIME OF CRISIS. THIS PROMPTNESS IS NOT ALWAYS AVAILABLE IN A BUSY EMERGENCY ROOM, AS MEDICAL AND NURSING PERSONNEL MUST RESPOND TO LIFE-THREATENING CASES FIRST.

ONCE THE EXAMINATION BEGINS, IT IS ESTIMATED THAT 3 TO 4 HOURS ARE REQUIRED TO COMPLETE THE EVIDENCE COLLECTION. THIS PROCESS MUST BE UNINTERRUPTED TIME IN ORDER TO PROVIDE A QUALITY AND EXPEDITIOUS SERVICE. THE EXTENSIVE TIME COMMITMENT PUTS A HUGE STRAIN ON THE EMERGENCY DEPARTMENT'S ABILITY TO PROVIDE OTHER, MEDICALLY URGENT PATIENT CARE.

COUPLED WITH ALL THIS, OF COURSE, IS THE ISSUE OF REIMBURSEMENT FOR SERVICES RENDERED. MOST OF YOU ARE WELL AWARE OF THE EXTREMELY LOW OR NONEXISTENT PAYMENT THAT HAS BEEN RECEIVED BY HOSPITALS AND PHYSICIANS PROVIDING THESE SERVICES. WHILE CERTAIN NEGOTIATIONS ARE CURRENTLY UNDERWAY TO REIMBURSE PROVIDERS, EVEN THE $200 PAYMENT PROPOSED BY THE CITY OF LOS ANGELES REPRESENTS LESS THAN HALF OF WHAT THE ACTUAL COSTS ARE. ADDITIONAL TIME AND EXPENSES ARE EXPERIENCED BY THOSE PHYSICIANS AND NURSES WHO ARE REQUIRED TO TESTIFY IN COURT - NOT AS EXPERT WITNESSES, WHO ARE PAID - BUT AS PERCIPIENT WITNESSES - THOSE WHO ACTUALLY DO THE EXAMINATIONS.

AS I SEE IT, SEVERAL THINGS NEED TO HAPPEN FOR THIS

PROTOCOL AND ACCOMPANYING SYSTEM TO FUNCTION OPTIMALLY OVER TIME. WE NEED TO FIND A WAY TO:

1. PROVIDE ADDITIONAL LOW-COST TRAINING FOR MEDICAL AND NURSING STAFF AT THE LOCAL LEVEL.
2. ORGANIZE REGIONALIZED RAPE TREATMENT CENTERS WHICH WOULD PROVIDE THE FOLLOW-UP CARE AND SPECIALIZED COUNSELING NECESSARY TO PROPERLY DEAL WITH THE RAPE SURVIVORS' NEEDS.
3. PROVIDE A CENTRAL CONTROL POST WHICH IS AWARE OF ALL HOSPITALS PROVIDING THE EXAMINATIONS, AS WELL AS A ROUTING MECHANISM ALLOWING LAW ENFORCEMENT OFFICERS TO BYPASS THOSE FACILITIES WHICH ARE TEMPORARILY TOO BUSY TO DO PROPER EXAMINATIONS.
4. ENACT LEGISLATION TO PROVIDE ADEQUATE FUNDING TO ALL MUNICIPALITIES THAT WILL ENABLE THEM TO REIMBURSE HOSPITALS FOR ACTUAL COSTS.
5. REDUCE THE POTENTIALLY UNPRODUCTIVE WAITING TIME FOR OUR NURSES AND PHYSICIANS IN THE COURTS.

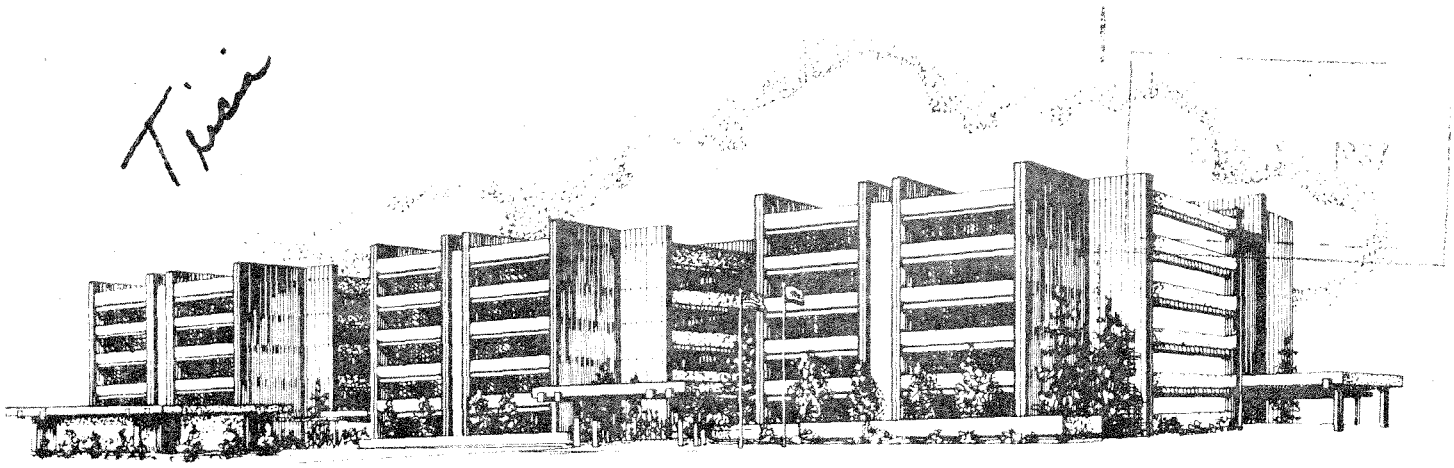
IN SUMMARY, IT SHOULD BE POINTED OUT THAT DANIEL FREEMAN MEMORIAL HOSPITAL IS OPEN TO REEXAMINING ITS POSITION ON COLLECTING EVIDENCE FOR SURVIVORS OF SEXUAL ABUSE. WE FEEL STRONGLY THAT THERE IS AN UNMET NEED TO PROVIDE A FULL RANGE OF SERVICES TO OUR LOCAL COMMUNITY AND WE WOULD LIKE TO MEET THAT NEED. WE ARE SUPPORTIVE OF THE STATE'S EFFORT TO PROVIDE A MECHANISM FOR IMPROVED EVIDENCE

COLLECTION FOR SURVIVORS OF RAPE. THIS IS AN ISSUE OF UTMOST IMPORTANCE IN OUR SOCIETY.

WE WOULD SINCERELY LIKE TO CONTINUE PROVIDING THIS NECESSARY SERVICE TO OUR COMMUNITY MEMBERS AND LOOK TO THE STATE AND LOCAL GOVERNMENT FOR HELP TO DO IT. HOWEVER, WE DO NOT THINK IT IS UNREASONABLE TO ASK FOR EQUAL DISTRIBUTION OF PATIENTS AMONG PARTICIPATING HOSPITALS TO CONTROL WORK LOAD AND ENSURE HIGH STANDARDS OF CARE AND ASSURE TIMELY REIMBURSEMENT OF ACTUAL COSTS.

IF THESE AREAS OF CONCERN COULD BE RESOLVED, WE FEEL SERVICE COULD BE CONTINUED UNINTERRUPTED AND THE COMMUNITY NEEDS WOULD BE BETTER MET.

C3/025



MARTIN LUTHER KING, JR./CHARLES R. DREW MEDICAL CENTER 12021 South Wilmington Avenue Los Angeles, CA 90059 213/603-4321

WILLIAM A. DELGARDO, Administrator JAMES G. HAUGHTON, M.D., Medical Director EMMA DELL FOLEY, R.N., Director of Nursing

November 16, 1987

Senator Bill Lockyer, Chairman
Senate Committee on the Judiciary
California Legislature, Room 2187
State Capitol
Sacramento, CA 95814

Dear Senator Lockyer:

Enclosed you will find a copy of the testimony I had planned to make before your committee on November 13th here in Los Angeles. Unfortunately, though my name was on the initial list, the final list of individuals and their respective times did not include me. If amplification of my review or knowledge in this area would be of help to either yourself or other members of the committee, please do not hesitate to call me at (213) 603-4872.

Sincerely yours,

Kerry L. English, M.D.
Associate Professor of Pediatrics

KLE:sb

Enclosure

The Context of the Medical Evaluation in Child Sexual Abuse

I recently attended a meeting of pediatricians focused on the physician role in relationship to the evaluation and treatment of child sexual abuse. At the meeting one of the pediatricians suggested that we need to change our thinking about child abuse and consider it as a disease process rather than a crime. Driving home from the meeting I weighed the pros and cons of such an approach. In so doing it became obvious to me both that he is correct in principle, yet there is no way our society at this point in its history is willing to allocate the resources required to adopt this point of view. The criminal model is cheaper and cleaner for us despite the fact that it does not seem to be holding up well to scrutiny as to long term outcomes. At least it gets the offenders off the streets in some cases.

While it might make sense for a society to triage social failures and disease processes in adults by calling them crimes and removing involved individuals from the wider society, such an approach with child victims does not make sense. Please think for a moment what the child victims and their siblings face under our present system. If a child is suspected of having been sexually abused, she or he will be interviewed by one or more law enforcement officers, often a protective services worker as well and a number of health care professionals which may include social workers, psychologists and physicians. Ideally a medical exam will also be done by a physician with particular training in the genital and anal exam of young children. These assessments are generally done at different times and in different places and are finally focused on the legal aspects of the problem. Even the therapists and health care professionals in the system serve the legal process and finally serve the conceptualization of child abuse as a crime.

Many of us will argue that this is necessary in order to protect the child, but from what and at what cost? If we were able to analyze the simple dollars allotted to therapy and intervention in children compared to those spent on "protecting them" with our legal system, does anyone imagine that the therapeutic expenses exceed one tenth of the total?
Far from decriminalizing child abuse for adults (all of whom were formerly abused as children), we have criminalized a deeply personal and problematic disease in children and their families. Virtually any difficult disease process is better defined and treated by multidisciplinary teams of professionals with good coordination working in close proximity to diagnose and treat the problem in question. Diagnosis and treatment are both best served by consistent professional contact over time. Why have we given these difficult

tasks over to judges and blindfolded them with both legal and logistic limitations on their access to information? Why finally are judges making these decisions at all and why are we collecting evidence to facilitate that end? While it is true that some would have AIDS diagnosed and treated with a similar legal model, when viewed in this context, our actions around child abuse at this point in our history would seem well-intentioned, maybe even noble by turns, but finally quite mad.

I do not mean to trash the protocol work of OCJP and the many professionals who worked on it. I believe the form and the protocols provide helpful guidelines for the physical evluation of suspected child sexual abuse. We have simply gone terribly astray in attempting to implement these helpful guidelines and have brought into sharp relief the failure of the overall context in which we are attempting to find a place for them. We must stop today attempting to find a way to pay for medical exams in some hope that they will improve outcomes for sexually abused children and ask whether we are willing to pay for diagnostic and treatment centers that offer more than a series of caring strangers to troubled children and their parents. The medical exam must be done and it must be done well, but it should be done in the context of competent, ongoing child interviews and the therapist should be available to the child during the examination itself if indicated and helpful. This should not be a rare event but a common expectation. We should not be preserving objectivity for the court by failing to communicate. We should attempt to relate all areas of information collection to one another from the beginning and at all points in the process. We should finally be acting as physicians, therapists and social workers and funding should be provided that pays us to do our jobs in the service of this illness that we all care so deeply about changing. We are only paid now by courts (730 evaluations) or the police -- if we are paid anything at all.

A number of years ago a movie producer whose name I have forgotten (she produced the T.V. movie Adam) came up to me after a presentation and asked me a question she said she had never had a professional working in the field of child sexual abuse answer appropriately. The question was simply, "If something happened to your own child, would you trust the system you work in to handle it?" My honest answer (apart from fudging by personal selections within the system) was a resounding no. That was five years ago and my answer has not changed. I decided then to oppose any change in our system that did not move me in the direction of a yes answer to that question. I do not feel that any of the discussions we are currently having move us an inch in that direction except as they relate to requiring third party payers to pay for medical services to their clients in child abuse and neglect cases. Such a move would be a tiny one.

It would be amplified a good deal, however, if psychological services were mandated as well and that all payment for human services for abuse and neglected children be: 1) massively increased of course, but 2) also totally removed from the legal origins it currently has. It is truly saddening to know that we fund one of the major social and public health problems of children in our society almost exclusively because it is a crime. How a lobbyist for any provider in the area of health care can fix his or her mouth or pen to oppose paying for clients suffering from such problems is the question I will leave you with and charge us all with helping to change.

Kerry L. English, M.D.
November 13, 1987

STATEMENT

SENATE JUDICIARY COMMITTEE

ASSEMBLY SELECT COMMITTEE ON SEXUAL ASSAULT
VICTIMS ASSISTANCE

J O I N T I N T E R I M H E A R I N G

RAPE AND CHILD SEXUAL ABUSE MEDICAL PROTOCOLS

NOVEMBER 13, 1987

LOS ANGELES, CALIFORNIA

SUBMITTED BY:

ROBERT L. CHAFFEE, DIRECTOR
LOS ANGELES COUNTY
DEPARTMENT OF CHILDREN'S SERVICES

Although the focus of concerns expressed in the media is on rape victims, it is important to note that the medical evidentiary exam problem applies equally to children who are victims of sexual abuse. An effective response to cases of suspected child sexual abuse requires a sensitive and comprehensive medical examination of the child that will accurately diagnose physical evidence of recent or past sexual assault, and will provide documentation for the protection of the child and prosecutorial action.

Some figures demonstrate both the increased numbers of cases in the child protective system and also the growth of allegations of sexual molestation. For example, the number of sexual abuse calls to our Child Abuse Hotline increased from 686 in 1982 to 5342 in 1986, a 679% increase! Referrals of physically abused children increased 195% in the same time period. A review of the 1981-1985 data on petition requests to declare a child a dependent of the Juvenile Court shows that victims of sexual molestation increased by 238%. This growth reflects the public's heightened awareness and ongoing concern for abused and neglected children. It also reflects a higher proportion of calls from mandated child abuse reporters. The ongoing emphasis in the professional community on identifying and reporting abuse and neglect has produced increased reports from schools, hospitals, day care centers and mental health agencies.

The higher number of reports, along with the increased severity of cases coming into the child protection system, has exacerbated the problem of obtaining medical examinations of victims. As a result, health care providers have been inundated with requests from law enforcement agencies for specialized and costly medical evaluations needed to facilitate appropriate follow-up care on behalf of the child and for possible prosecution of the offender.

The lack of medical facilities willing to perform physical examinations for child victims of sexual abuse, and the lack of qualified sexual assault examination clinics is a very real concern for service oriented agencies throughout our County.

The crime of sexual assault cuts across all socio-economic levels of society, with those children referred to the Department of Children's Services representing only a small portion of that total. To best serve all children and help them to grow into healthy, productive adults, the public and private sectors must come together to insure that the best prevention, protection and treatment systems are developed and utilized.

The Los Angeles County Board of Supervisors has long recognized that an effective response to cases of suspected child sexual abuse requires a sensitive and comprehensive medical examination that will accurately diagnose physical evidence. The Board also recognized that the increased reports of child sexual abuse to law enforcement and the Department of Children's Services has stretched the capacity of our existing systems to provide comprehensive medical examinations. In addition, the lack of appropriate funding sources for hospital and physical examinations had become apparent.

In response to these concerns, last year the Board sponsored a legislative proposal that was adopted by the County Supervisors' Association of California (CSAC) to increase the availability of medical examinations by expanding the reimbursement alternatives to include insurance companies and the Crime Victim Witness Restitution Fund.

SB 180, authored by Senator Diane Watson, addresses many of the issues for victims of child sexual abuse. When the bill was introduced, concerns were raised by the California Medical Association, other health care providers and insurance companies. Efforts are necessary to bring together the parties to work out the concerns. SB 180 still represents the most viable alternative to respond to the issues discussed in this Interim Hearing today.

The Department of Children's Services is committed to providing the highest possible level of care to abused and neglected children. Resolution of the concerns presented in this Interim Hearing requires the joint action of law enforcement, health services, children's services, health care providers and insurance companies.

SB 180 would allow local governments, with the victim's consent, to apply for reimbursement from the victim's medical insurance carrier or health care provider. The absence of a cost recovery mechanism that would adequately reimburse the medical evaluation provider has limited the number of private facilities willing to provide this essential service. SB 180 would help remedy this situation by providing alternatives for adequate cost recovery assistance that would enable both public and private facilities to provide needed medical examinations.

We urge your consideration and support of SB 180.

Thank you for the opportunity of presenting our statements.

CHILD ABUSE HOT LINE

Five-Year Comparison Summary

1982 - 1986

	1982	1983	1984	1985	1986
Total Calls	23,830	28,530	42,287	49,671	60,639
Accepted Referrals	7,257	9,333	16,434	20,646	27,525
Sexual Abuse	686	1,007	2,923	3,926	5,342
Physical Abuse	3,247	3,886	5,845	7,340	9,565
Neglect	2,396	3,039	5,151	5,622	8,588
Emotional Abuse	357	411	762	898	877
Other*	571	990	1,753	2,860	3,153

	Rate of Increase	
	1985 - 1986	1982 - 1986
Total Calls	22%	155%
Accepted Referrals	33%	279%
Sexual Abuse	36%	679%
Physical Abuse	30%	195%
Neglect	52%	258%
Emotional Abuse	2%	145%
Other*	10%	452%

*Other includes out-of-county inquiries abandonment, adolescent suicide attempt, exploitation of a child (other than sexual), caretaker absence or incapacity, infants born addicted to heroin or PCP, etc.

County of Los Angeles
Department of Children's Services

SENATE JUDICIARY COMMITTEE
November 13, 1987

Statement of
Kenneth Kobrin
Office of Criminal Justice Planning

Thank you Mr. Chairman and members of the committee.

The medical protocol for the examination of sexual assault victims was originally established pursuant to Chapter 750, Statutes of 1976, which required the Department of Health, later the Department of Health Services (DHS), to establish the protocol by regulation. It also required the Department of Justice (DOJ) to adopt, by regulation, a form for the recording of data disclosed during the medical examination of sexual assault victims.

Unfortunately, the procedures and methods for the collection of evidence under these regulations varied from hospital to hospital or did not exist at all. The form for recording the data was so general that necessary procedures were not performed or not recorded. What was recorded was often not legible.

In 1982, AB 3172 (Waters) directed an advisory committee of the Office of Criminal Justice Planning to standardize these procedures. In 1985, SB 892 (Seymour), which was supported by both DHS and DOJ, ended the duplication of effort and conflicting responsibilities by shifting primary responsibility for both the protocol and forms to OCJP. Instead of requiring OCJP to adopt the protocol by regulation, however, SB 892 itself codified the minimum requirements for the protocol and forms by incorporating a number of regulations that had previously been in Title 22 (Sections 40301-40317).

At the request of the California Hospital Association, SB 892 required hospitals that were not in compliance with the new protocol to adopt a referral protocol and notify local law enforcement of this fact. Previously,

such notification was not necessary even though hospitals were not legally required to perform the examinations.

OCJP established an advisory committee composed of prosecutors, law enforcement personnel, physicians, criminalists, a clinical social worker, a child psychologist, rape crisis center directors, and representatives from the California Department of Health Services, the California Department of Emergency Medicine, the California Medical Association, the California Hospital Association and the Southern California Hospital Association.

As the protocol and forms were developed, draft copies were widely circulated for review to representatives of affected professional disciplines and to major hospitals throughout the state. Public meetings were held at which public comment was solicited. All suggestions received were evaluated and many were incorporated. The check-box format and placement of instructions on the form, which lengthened the form, were requested by physicians and criminalists.

To assist professionals with the transition to the new protocol, OCJP conducted 12 two-day seminars throughout the state. Three of these were in Los Angeles County. Approximately 1500 medical professionals attended representing 372 hospitals and clinics, including 107 hospitals and clinics in Los Angeles.

Historically, forensic examinations, investigations and case prosecution have been a local cost. This principle was reinforced with respect to the examination of sexual assault victims by specific legislation when it was learned that hospitals were attempting to bill victims after local agencies failed to adequately compensate them for the examinations (i.e., former Government Code Section 13961.5, now Penal Code Section 13823.95).

During the development of the protocol, OCJP learned from committee

members from Los Angeles that inadequate compensation to hospitals was an issue under the old protocol. A reimbursement subcommittee was established to explore the issue. The subcommittee deferred to legislation proposed by Los Angeles County (SB 180 (Watson), a two-year bill pending in the Senate Judiciary Committee).

The requirements of the new protocol are in reality not that different from the old protocol. Hospitals that were doing thorough and complete examinations under the old protocol, such as UCLA/Harbor Medical Center, have found that the new protocol really does not impose any substantial change in their procedure other than the format in which they record their findings.

OCJP is an active member of the Task Force established by the Los Angeles County Board of Supervisors to examine the problems that have occurred in Los Angeles. The discussions held during the meetings of the Task Force and its various committees have convinced us that the protocol itself is not the cause of the problem. We continue to work with the other members of the task force, however, and have agreed to conduct three additional training sessions in Los Angeles County in association with the Southern California Hospital Council.

The new protocol is the first ever to include protocols for both child and male sexual abuse victims. They provide for clearer medical reports to prosecutors and more complete documentation with consequent benefits to subsequent courtroom testimony by medical professionals. Trauma to the victim by the court process may be reduced due to better medical corroboration of the victim's statement. More cases may result in convictions based upon more reliable medical findings due to the improved and proper collection and preservation of evidence. One law enforcement official from Los Angeles, at a meeting of the Advisory Committee held on October 22, 1987, described the new protocol and forms as "a godsend".

OCJP remains convinced that the protocol is an outstanding model for the collection of evidence in sexual assault cases. It is also our firm intention to continue as a member of the Task Force and work with local officials to resolve the problem that Los Angeles has experienced.