**Sexual Assault Survivors with Mental Illness**

**(SAMI) Project**

A statewide collaborative change project between

the Iowa Coalition Against Sexual Assault (IowaCASA) and

the National Alliance on Mental Illness, Iowa Chapter (NAMI Iowa)





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# **Introduction**

## **Vision:**

*Survivors of sexual violence living with mental illness will have access to holistic services wherever they seek support.*

## **Mission:**

The SAMI Project will ensure that survivors of sexual violence living with mental illness have access to holistic services by:

1. Fostering and cultivating the capacity of sexual assault and mental health advocates to better respond to survivors living with mental illness through training, education, and resources.
2. Improving institutional policy and evaluation criteria, supporting organizational growth and transformation through on-going learning communities.

## **Values:**

As a collaboration we value the following:

* As a collaborative we will make sure our work comes from an Equitable, Inclusive, and Liberating model.
* Respect and mutual understanding that each person and organization in the collaborative brings their own identities, lived experiences, and expertise which influence the work of the collaborative.
* The collaborative pledges to approach our work with a willingness to learn, unlearn, and relearn.
* We value “calling in” rather than “calling out” our partners: Holding each other accountable by taking time to discuss problematic behaviors or ideas in a thoughtful, intentional way to provide context and understanding.
* We value holding in confidence our personal and organizational experiences that may be shared during our collaborative.

**Values held regarding services**

* Self-Defined Family Advocacy
  + We recognize that connection to family and the ability for families to define what advocacy means for them can be key to an individual's healing process
* Accessibility of holistic services for survivors of sexual violence living with mental illness
  + For the purpose of this collaboration, we define holistic services as a focus on the individual’s whole self, as opposed to their diagnosis, experience, or a specific identity
* Trauma-informed victim and mental health services
  + We understand that trauma can uniquely affect an individual’s life in a variety of ways that influence access and delivery of victim services and mental health care
* Individual experiences will be the guide in all aspects of their healing, because each survivor knows their own needs and advocates are helpers, not experts
  + Peer support and peer advocacy are valid, evidence-based models of empowerment and recovery
  + Peer support and peer advocacy based on shared experiences are effective in creating connections between survivors and peers
* “Nothing about us without us”
  + The individual has the right to self-determination and the centering of their own needs in healing and recovery
* Every person has the right to recovery, resiliency, and wellness
  + This encompasses the holistic model of an individual’s healing

## **Our Working Assumptions:**

* Collaborative partners will share deeply of their knowledge and expertise while respecting and supporting the wisdom of their co-collaborators.
* IowaCASA is an expert in the field of services for sexual violence survivors, trauma informed care, victim centered services, and supporting comprehensive sexual abuse and emergency sheltering program.
  + Including advocating on behalf of programs and survivors in policy and legislative arenas, implementation of training and service standards for advocates and programs, and supporting efforts to address oppression faced by survivors.
* NAMI Iowa is an expert in the field of mental illness, the impact of mental health on communities and family, the peer support model of services, and supporting affiliates.
  + Including advocating on behalf of people living with mental illness in policy and legislative arenas, implementation of training and service standards for affiliates, and supporting efforts to expand NAMI affiliates to unserved areas.

# **Collaborative Structure**

## **Member Agencies**

**Lead Agency**:Iowa Coalition Against Sexual Assault (IowaCASA)

3030 Merle Hay Road

Des Moines, IA 50310

**Description**: IowaCASA is a statewide organization. Our mission is to end sexual violence and improve support available to survivors of sexual assault. We advocate on behalf of survivors and victim advocates. IowaCASA provides a bridge between advocates at sexual assault service programs, statewide policy makers, and federal responses to sexual violence and violence against women. Advocates are trained professionals whose jobs are to support sexual assault survivors.

**Partner Agency**:National Alliance on Mental Illness - Iowa (NAMI Iowa)

3839 Merle Hay Rd. Suite #229

Des Moines, IA 50310

**Description**: NAMI Iowa is the statewide organization of the National Alliance on Mental Illness. We envision a world in which all people affected by mental illness experience resiliency, recovery, and wellness. NAMI Iowa works to achieve this by providing education, support, and advocacy to people with mental illness and their families. As the statewide advocacy organization, we provide legislative and public advocacy as well as technical assistance and NAMI Signature Program training to local and regional NAMI Affiliates across the state of Iowa. NAMI Program leaders are either peers living in recovery or family members or loved one’s of people living with a mental illness. They are trained and certified to deliver NAMI’s nine evidence-based programs for education, recovery, and support.

## **Collaboration History**

During the State Fiscal Year 2014, Iowa restructured victim services to modernize the model and address a funding deficit in order to serve the entire state, with the state administrator dividing the funding into six victim services regions.  Due to this regionalization, sexual assault programs are serving much larger areas, with one rural program serving 19 counties using mobile advocacy and outreach offices spread across the region. For four consecutive state fiscal years, victim services programs have faced a continuing reduction in state and federal funding, causing programs to reduce staffing patterns, limit travel, and reduce overall availability of services.  This is part of a larger trend within the state that is reducing access to many community services that Iowans have depended on to care for themselves, their families, and their communities.

In the late 1980s and early 1990s, a number of the local publicly supported mental health agencies began to close. Those agencies had provided ongoing therapy and long-term supportive services for many of the survivors who came to sexual assault programs. For those families and individuals involved in NAMI Iowa, these services had been important community supports for individuals struggling with serious mental illness.  These closures followed a national pattern of closing institutions that had housed people with serious mental illness, often providing poor treatment and usually without any efforts to move them back into the community. As is well-known, these closures left many without supports and family members struggling to address the needs of their loved ones. Closure of the community mental health programs meant even fewer resources were available.  As communities struggled with reduced resources, sexual assault programs often found themselves addressing issues of those with serious mental illness without appropriate training. Sexual assault programs turned to NAMI Iowa affiliates as a resource for families, and to help those with serious mental illness learn self-advocacy skills.

Iowa is facing a growing mental health crisis. Iowa is last in the country in the number of psychiatric beds per capita, with less than five state psychiatric beds available per 100,000 residents. It is not unusual for those in a mental health crisis to wait hours or even days in hospital emergency rooms to be admitted for psychiatric hospitalization. As sexual assault programs attempt to make referrals, and NAMI Iowa supports families and individuals with serious mental illness, this is a daunting reality.  Of Iowa’s 99 counties, 11 are without community mental health centers. One of these is Sioux County in Northwest Iowa, where the statewide victim services call center is housed. In addition, in 2018, 89 out of 99 Iowa counties were classified as Health Professional Shortage Areas (HPSAs) for Mental Health by the Health Resources and Services Administration (HRSA).

## **Collaborative Structure & Commitments**

The SAMI collaborative is composed of two organizations that are committed to the vision of this project.  Each organization represents both a stakeholder and expert in this project. Working as a dyad, the collaborative possesses both strengths and challenges unique to this composition.

Inherent in the strengths of the dyad is that there is a high level of engagement from the partners.  As each represents a core subject matter expert, both must be engaged in order to meet the goals of the project.  Similarly, both partners are statewide organizations rooted in the core belief that the individual person is the expert in their own life and experiences.  This allows for greater philosophical alignment from the outset of the project and reduces barriers.

Through this partnership and shared vision, both organizations have pledged to share authority through committing to a co-director relationship for the project.  The project co-directorship will be comprised of one staff member from IowaCASA and one staff member from NAMI Iowa, with co-equal decision-making power. This will help ensure balance is brought in all steps of the process.

With the acknowledgement of these strengths must come an acknowledgement of the challenges that are inherent with this structure.  The dyad reduces the number of people available to contribute to the work, as both organizations are investing significant staff resources through the core collaborative members.  Additionally, each member does not have equal ability to allocate time for the Co-Project Director and collaborative members, which means that responsibilities will need to be recognized and assigned accordingly.  Finally, as IowaCASA is the recipient of the grant funds directly and subcontracts a portion of those funds to NAMI Iowa, there is a power imbalance and challenge implicit in this arrangement. This is partially mitigated by co-directorship but will continue to be an underlying challenge through the life of the collaborative.

**Structural Commitments**

In order to bolster these strengths and mitigate these challenges, IowaCASA and NAMI Iowa will abide by the following commitments related to the structure and composition of the collaborative.

* IowaCASA commits to recognizing and respecting that NAMI Iowa is the subject matter expert in the areas of mental illness, peer support for those living with mental illness, and in policy and practices that support those living with mental illness.
* NAMI Iowa commits to recognizing and respecting that IowaCASA is the subject matter expert in the areas of sexual violence, advocacy and services for survivors of sexual violence, policies and best practices for victim services programs, and sexual violence prevention.
* Both organizations agree and commit to following a clear plan for decision-making, communication, conflict resolution, and confidentiality as laid out in this collaborative charter.
* Both organizations agree to provide staffing at a level to ensure the success of the collaboration, including providing one staff member to serve as a Co-Project Director from each organization.
* New or additional members of the collaborative team will be approved via consensus by both IowaCASA and NAMI Iowa prior to the addition.

**Collaboration Change and Turnover Process:**

The collaborative nature and dyad structure of this project creates the need for our two organizations to be especially sensitive to the ways staff changes can affect both organizations and the completion and success of this project. Due to this, we recognize the need to create a process to address potential staff adjustments.

Because we understand that the nature of leaves of absence and staff capacity can be unpredictable, especially regarding health or family circumstances, our collaborative must maintain flexibility in our plans to deal with the possible changes. Such changes will necessitate discussions between collaborative members and organizational leadership to determine the most effective use of staff time and resources to maintain co-equal decision making and equitably decide on roles and responsibilities.

Therefor in the event of a major staff change, these are the steps we will take:

1. The individual requiring a change in status will notify their direct supervisor from their organization
2. They will then request a meeting with SAMI co-director(s) and the leadership of the organizations to notify, discuss, and create a plan to address the needs; including roles, responsibilities and status of project
3. During this meeting, they will engage in a discussion regarding staff of both organizations and how best to delegate current and upcoming responsibilities
4. Once the plan is finalized, the SAMI co-director(s) will coordinate an additional meeting with the entire SAMI collaborative to provide notification of changes; explaining project planning, with the goal of offering space to strategize and best execute existing plan
5. Post strategy meeting will be held with SAMI co-director(s) and organizational leadership for final project approval reflective of necessary changes

**Collaboration Teams**  
The project co-directors will meet weekly for a minimum of two hours. As necessary, other staff from each organization will be included to provide subject-matter expertise. During this time, we will work on building the charter, learning communities, strategic planning, and implementation phases of the grant. Throughout the duration of this project, we expect to add individuals to our Core Team.

On a quarterly schedule, the leadership of each agency will come to the table for a meeting with the Core Team to discuss progress phase of grant status. At this time, each quarter, we will share updates with key decision makers regarding the status of policy and procedure, and discuss which policies will need to be strengthened, enhanced and created.

### **Project Co-Directors:**

* **Nadia LaFontant**, Underserved Advocacy & Training Specialist at IowaCASA, has been involved and employed in the anti-violence movement since 2012, including working in a comprehensive sexual assault program and an emergency sheltering program.  She joined IowaCASA’s staff in December of 2015. She provides support to a statewide group of women and men of color working in comprehensive sexual assault programs. She also assesses the needs of marginalized and other underserved communities; provides training and coordinates victim services efforts to work with correctional institutions, detention facilities, and jails as they come into compliance with the Prison Rape Elimination Act (PREA) standards; and provides consultation and support to member programs in these areas.
* **Heather Strachan,** Grants Administrator at NAMI Iowa serves on the SAMI collaborative, and through 2018 was responsible for oversight of NAMI Signature Program trainings, management of NAMI Iowa’s grant projects, and NAMI Affiliate formation and standards across the state of Iowa. Through this work, Heather advocates for peer- and family-based mental health services at the system and state level, working with health systems, medical schools, and insurance companies to provide evidence-based education and support that are based on recovery principles. Heather’s professional background spans 15 years of organization, outreach, communications, public policy and program development before becoming a mental health professional in 2014. In that capacity she served as a resource expert and utilizing her own experience in recovery and as a survivor of violence, specialized in care coordination for survivors who live with mental illness. Heather holds Iowa and International certifications as a Recovery Specialist and has served as a curriculum reviewer for the University of Iowa Peer Support Training Collaborative. She has served as subject matter expert to the DHS Commitment Review workgroup, FTA Coordinating Council on Access and Mobility, and currently serves on the Iowa Maternal and Child Health Advisory Council.

### **Leadership Team Members**

* **Elizabeth (Beth) Barnhill**,Executive Director, has been with IowaCASA since 1990.  Prior to the coalition, she worked in a variety of direct service and victim services settings.  In her role, Beth supervises both the Iowa state-wide training and technical assistance to member programs and the National Sexual Assault Coalitions’ Resource Sharing Project.  During her time with IowaCASA, Beth has been instrumental in the creation and modernization of sexual assault comprehensive services across the state of Iowa. She is a founding member and past president of the Iowa Board for the Treatment of Sexual Abusers and was a founding member of the National Alliance to End Sexual Violence.
* **Peggy Huppert**, Executive Director of NAMI Iowa has served in this capacity since March 2016. Peggy has a long history of service to nonprofits in central Iowa. She’s a Drake journalism graduate who started her professional life as a reporter and editor, then moved to the nonprofit world as a communications director. In addition to communications, she’s served as a development, government relations, and Executive Director for such varied groups as the Chrysalis Foundation, the Iowa Hospice Organization, the Des Moines Playhouse, and the American Cancer Society. She counts as her proudest professional achievements helping to raise $2.3 million to build the Kate Goldman Children’s Theater in Des Moines and passing the Iowa Smokefree Air Act.  Peggy has lived experience with mental illness over nearly 20 years through several close family members who have experienced addiction, hospitalization, and incarceration as a result of their illness.
* **Shundrea Trotty:** With over 20 years of nonprofit experience, Shundrea Trotty provides training, resources, support, and in-depth capacity building for standalone rape crisis centers, assisting them with organizational sustainability. With an extensive background in both community organizing and self-sufficiency programming, she directs the flow of technical assistance and training to member programs and community allies in her role as the Director of Iowa Services and Projects with the Iowa Coalition Against Sexual Assault. She is dedicated to educating all who will listen on the various intersections of sexual violence; including; racism, class, generational and historical trauma. Shundrea works with individuals and organizations to rethink violence, its impact on society and how we can work to interrupt the normalization of rape culture.Mrs. Trotty holds her Bachelors in Business Administration from William Penn University, Masters in Public Administration with a Nonprofit Emphasis from Drake University, and is currently attending Drake University earning her Doctorate of Education in Leadership.

*Since beginning work on this grant, we have experienced some staff changes. We want to acknowledge the work put into securing this grant as well the early stages of planning and development. We are grateful for the visions that Kerri True-Funk and Emily Berry brought to this project and will continue to work with those intentions in mind.*

# **Decision-Making Protocol**

*A commitment to open and shared decision-making is inherent to our collaborative model, including Co-Project Directors having equal responsibility in advancing the activities of the collaborative team and completing the deliverables of the project.*

## **Decision-Making Process**

The members of the SAMI Project believe that the process of making decisions provides an opportunity to empower people to voice their unique perspectives and create greater understanding among the collaborative partners.  All members of the collaborative will have an equal voice in the decision-making process; our goal is to create an environment where all members feel they are being represented equally and fairly and have the opportunity to share their own experiences and expertise. No major decisions will be made without the input of all members of the collaborative team; examples include any decision subject to OVW approval, project deliverables or scope, and collaborative team composition.  The SAMI Project will also seek input from stakeholders identified as subject matter experts on specific issues.

### **Gradient Decision-Making**

To reach decisions we are using a gradient consensus model which facilitates listening, participation and creative decision-making.  A consensus process using gradients of support will help to ensure that all team members feel ownership of the work of the collaborative.  Any collaborative member can request the use of this process for any decision the collaborative may consider. If agreement is not immediately achieved, we will use a consensus decision-making model based on the following 5-point scale.

1. The proposal has my full support.
2. I have reservations but support a majority of the proposal.
3. I’m undecided and need more information, discussion, or time to think about the proposal.
4. I do not support the current proposal but am willing to continue discussion. It’s possible to revise the proposal or include more information to make it acceptable to me.
5. I will not support the proposal; further discussion is unlikely to change my perspective.

In order for the collaborative team to move forward with a decision, all group members must be at the first or second level of agreement.  If any member of the team polls at level 3, 4 or 5, the team will continue discussing the topic, continue gathering information on the proposal, or propose a new idea. If 50% or more of the collaborative team are at a 4 or 5 on this scale, revisions should be proposed, or a new idea presented. The Project Directors will initiate polls as needed until a final decision is made.

As a collaborative, we acknowledge and understand that information processing and communication styles among team members vary. Because we value all perspectives on this project and validate all communication styles, when brainstorming new ideas, lists of concerns, or discussion points, team members will be encouraged to request time to process and write down their own ideas.

The decision-making process for the collaborative team will proceed according to the following steps:

1. Project Directors will check in with each member of the collaborative team.  The individual will share their position on the scale, perspective and concerns, and what needs to be done to move toward full support.
2. The Project Directors will create a list of concerns that must be addressed for consensus to be achieved.
3. The floor will then be opened for discussion of the concerns brought up by team members.
4. After sufficient discussion of all concerns listed, each team member will be asked for their gradient scale score.  If all team members identify a 1 or 2 on the scale, consensus is considered to be achieved.
5. If a team member identifies a 3, they will identify any issues requiring more information, discussion, or time.  Depending on their concerns, the collaborative may:
   1. Continue discussion, providing a few minutes for individual reflection and processing of ideas, as well as the opportunity to write one’s ideas down.
   2. Table the issue until a later time.
   3. Gather more information or bring other stakeholders or experts to the discussion.
6. If a team member identifies a 4 or 5, they will provide a recommendation, revision, or alternative course of action.  The group will then discuss the proposal(s) and vote on which they prefer. Each individual will then rate the winning proposal on the gradient scale.  Any team members who identify their position as 3-5 will be asked to share their concerns. Depending on the issues faced, the collaborative may:
   1. Continue discussion, providing a few minutes for individual reflection and processing of ideas, as well as the opportunity to write one’s ideas down.
   2. Adapt the proposal.
   3. Table the issue until a later time.
   4. Gather more information or bring other stakeholders to the discussion.
7. If the project team determines that we have reached an impasse, the Executive Directors of IowaCASA and NAMI Iowa may meet with the collaborative team to try to come to a resolution.
   1. If sensitive organizational information is involved, the Executive Directors may request to meet privately, with or without the Project Directors, then meet with the collaborative team to discuss resolution and get approval from the entire team.
8. If consensus cannot be reached at this point, the Project Directors will contact Vera Institute for technical assistance and mediation.
9. Once a decision is reached, it will be honored by all members of the collaborative team.

We understand that this process may not always work.  As we navigate the process of collaborative decision-making in our work, we will center our commitment to open, honest communication and the validity of all voices.  If a team member’s perspective changes, or if new information arises, the collaborative team may revisit decisions and surrounding issues. However, we will publicly honor and commit to all decisions reached in our work.

We also understand that the collaborative team may not have final decision-making authority in many of the organizational changes identified as necessary.  To address these changes, the team will seek to break down the barriers to systems change and create the systems within and among our organizations that will best support survivors living with mental illness, aid them in recovery efforts, and empower them to heal from experiences of violence.  We will do this by:

* Discussing proposed organizational policy changes with the IowaCASA and NAMI Iowa Executive Directors and requesting final approval of these changes.
* Providing learning opportunities for staff, advisors, and board members of both organizations on why proposed changes reflect best practices in serving survivors living with mental illness.
* Consulting with the national organizations on changes that impact national policies and programs.
* Continuous learning about the needs of survivors living with mental illness through the establishment of learning communities.

We recognize that the SAMI Project Core Team may not have final decision-making authority in many of the systemic changes we identify as necessary.  We will work with decision makers such as Boards of Directors and staff to create the systems within and among our organizations that will best support survivors with disabilities and empower them to heal from experiences of violence.  All team members are committed to advocating for the SAMI Project within the collaborating organizations and among associated stakeholder groups. 

## **Decision-Making Authority**

As a collaborative, the SAMI Project partners are committed to consensus decision-making and equity in the decision-making authority.  As we navigate the process of decision-making in our work, we will remember our commitment to open, honest communication and the validity of all voices.

Certain collaboration members are empowered to make decisions on specific issues, as listed in the roles and responsibilities below.  We also recognize that IowaCASA and NAMI Iowa’s individual organizational policies must work with the SAMI collaborative process in order to enact systems change.

### **Core Team:**

The Core Team is the core operating group for the SAMI Project.  As such, this group has the authority to:

* Set the direction of the collaboration, including the philosophy, values, and other issues which impact the mission or trajectory of our work.
* Develop the focus of the learning communities and exchanges.
* Set the geographic area and approve participating member programs and affiliates.
* Develop grant deliverables, budget, and other products of our work.
* Develop timelines for deliverables and plans for program implementation.
* Internally approve final products and deliverables prior to being distributed or sent to OVW for approval.
* Designate priority areas of concern for our work.
* Approve any changes to the project focus and scope.
* Approve weekly meeting agendas and notes.
* Request additional meetings.
* Request meetings with Executive Director Team.
* Determine when other stakeholders should be consulted.
* Initiate contact with Vera/OVW when needed.

### **Co-Project Directors:**

The SAMI co-directors have the authority to:

* Manage the day to day operational decisions of the project with feedback from the Core Team as necessary. These decisions include but are not limited to:
  + Scheduling grant activities.
  + Venue identification for grant activities.
  + Meeting locations for collaboration meetings.
  + Scheduling technical assistance.
* Delegate tasks to Core Team members as needed.
* Contact Vera.
* Collaborative agencies leadership will contact OVW.
* Determine meeting logistics and agenda items.
* Develop and submit OVW progress reports.
* Advocate for team members to have the resources and time required to meet the commitments of the SAMI Project.
* Determine when, with the input of the Core Team, to implement decision-making and conflict resolution protocols.  This includes contacting Vera for mediation.

### **Executive Director Team:**

As leaders of the collaborating organizations, the Executive Directors have special authority to implement systems change within IowaCASA and NAMI Iowa. Their authority, regarding the collaboration’s work is:

* Determine when an issue should be brought to the attention of an organization’s Board of Directors, or to the organization’s staff for discussion or approval.
* Request regular progress reports from the Core Team.
* Review and approve any program activities which may impact their organization’s budget.
* Review and approve any policy or programming changes that may result from our work.
* Meet when the Core Team has reached a stalemate in the decision-making process to discuss organizational perspectives related to the issue.

### **Individual Team Members:**

The collaboration recognizes that each individual team member is a subject-matter expert, and as such may respond to requests for technical assistance or refer the request on to the appropriate team member or stakeholder.

### **IowaCASA:**

* Commits to managing the contracts and funds of the Disabilities Grant.
* Decides how to provide staffing on the project to meet the commitments to partner organization(s).
* Acts as fiscal agent for the project, submitting grant adjustments;
  + Include NAMI Iowa’s input on grant adjustments as it affects their budget and staffing levels.

### **NAMI Iowa:**

* Decides how to provide staffing on the project to meet the commitments to the partner organization(s).
* Provides feedback to grant adjustments as affects organization budget and staffing levels.

# **Conflict Resolution Process**

As statewide collaboration of organizations committed to reducing silos, developing an empowerment and recovery-informed model, and learning from one another’s experiences and expertise, we value and encourage multiple perspectives and a diversity of opinion in our collaboration. We recognize that our collaboration members will be challenging long-held beliefs and systems, and they are committed to giving these conversations and the learning process the time they need to be properly heard.

We also recognize that conflict is a natural part of any collaboration that truly values diverse perspectives. The SAMI Project collaborators are committed to moving the work forward and resolving conflict through open, honest communication and consensus building.

If conflict arises, we remain committed to the values of the collaborators and agree to:

* Engage in open, respectful communication.
* Remain open to learning from each other.
* Normalize and respect the preferred communication method of each member.
* Create space for members to understand issues through their own perspective during challenging conversations.
* Focus on the issues, not the individual (“Call-in” not “call-out”).
* Actively listen and try to understand others’ perspectives.
* Commit to identifying the source of the problem and solving it.
* Keep conflict discussions confidential and not discuss beyond the collaborative partners and technical assistance provider.

In addition, due to the dyad structure of the collaborative, we find the following commitments vital to open communication:

* All team members have equal authority to address members’ accountability to the project.
* Team members should work with the Co-Directors when difficult conversations arise.
* Each team member should clearly communicate when their workload is overwhelming.
* As a team we will check in regularly to determine the time availability and capacity of each member of the team.
* We provide a mechanism for team members to hold the Co-Directors accountable for meeting commitments of the project.
* When an accountability measure is invoked, we will allow time for self-reflection and acknowledgement.

With these commitments in mind, we will use the following steps to resolve conflicts within our collaboration.  These steps stem from our consensus model of decision-making. The previously outlined 5-point gradient scale will be used to check in with all individuals involved:

1. Meet as a Core Team, and with other involved stakeholders if necessary, to discuss the issue.  If an individual feels that they cannot bring a conflict to the entire group, they may consult with one or both Co-Project Directors or their supervisors.
2. Identify and define the issue(s). All individuals will be given the opportunity to voice their perspective.
3. Clarify, discuss, and generate possible solutions.  Solutions should promote collaboration and teamwork.
4. Determine if resolution has been reached internally using the Decision-Making Process. If resolution is not reached, the Executive Directors will meet to discuss sources of disagreement and create a proposal for a course of action. If no joint understanding can be reached, our Vera technical assistance providers will be contacted to mediate.
5. If no agreement is made after the Vera mediation is concluded, the Vera associate will decide if another Vera staff is needed, or if OVW should be contacted.

As we move through the process of our work, we may face conflict outside of the SAMI Project collaboration members, especially during implementation. We, as a collaboration, will work with staff and clients to help them understand the necessity of systems change and the values of our work.

# **Communications Plan**

A vital component of successful collaboration is a strong commitment to intentional and open communication.  In order to ensure that communication is centered within the collaborative, the following communications plan is intended to guide internal and external communication and mitigate potential conflicts.

## **Internal Collaborative Communication**

The SAMI collaborative is committed to active collaboration in an open and ongoing manner, and as such, commits to the following communication plan for internal collaborative communication:

* Weekly in-person meetings will be scheduled for the duration of the collaboration’s work.  These weekly meetings will be a combination of the core collaboration group (approximately three times per month) and the Co-Project Directors (approximately one time per month).
* The Executive Directors will meet with the Core Team on a quarterly basis to receive progress updates and participate in policy or procedural changes necessary to the project.
* The Core Team will establish clear due dates for reviewing materials.
* Collaborative members will clearly document expectations in writing.
* When information is time sensitive, communication will occur between scheduled meetings.  When necessary, this may include phone calls, emails, and in-person meetings as soon as possible.
* All communications with Vera technical assistance staff by a Project Director will include the other Project Director in order to ensure both Directors are receiving information in a timely manner.
* All communication with OVW program manager will be via IowaCASA Project Director or other IowaCASA director as appropriate and will be shared with NAMI Iowa Project Director.
* Collaborative partners will immediately share any information or requests for media regarding the SAMI Project with each other.  All media requests regarding the SAMI Project will use the talking points as established.

## **External Collaboration Communication**

In order to share the goals and accomplishments of the SAMI Project, communication between collaborative members, their larger organizations, and the public will be necessary.  In order to ensure that communication is successful, the collaborative has agreed on the following points to use when sharing information beyond the collaborative.

* Social media communications and posts will be trauma-informed, use universal design guidelines, and promote both partners utilizing a unified message.
* Regular updates on the goals and work plan of the SAMI Project will be shared with the staff of NAMI Iowa and IowaCASA by the Core Team members.
* Learning community communication will be concise, made accessible using universal design, and approved by all Core Team members.
* When media inquiries are received, the media contact or appropriate designee of the organization receiving the inquiry will respond using the outlined media talking points in this charter.
* All press releases and proactive media outreach materials will be drafted by IowaCASA in consultation with both SAMI Project Co-Directors.

## **Media Talking Points**

**Who:**

* **The SAMI Project** (Sexual Assault Survivors with Mental Illness) is a statewide collaboration between the Iowa Coalition Against Sexual Assault (IowaCASA) and the National Alliance on Mental Illness--Iowa (NAMI Iowa).
* **IowaCASA** is a statewide organization whose mission is to end sexual

violence and improve support available to survivors of sexual assault. We provide a bridge between advocates at sexual assault service programs, statewide policy makers, and federal responses to sexual violence and violence against women.

* **NAMI Iowa** provides education, support, and advocacy to people with mental illness and their families. As a statewide grassroots advocacy organization, we engage our members in legislative and public advocacy to affect policy change.  We also provide peer and family-based program training to NAMI Affiliates and leaders across the state of Iowa.

**What:**

* Our goal is to create a comprehensive service model that allows survivors of sexual violence living with mental illness to find help through multiple support systems.
* We want to create an environment that, wherever a survivor living with mental illness shares their experience, they will be able to find help that includes an understanding of their mental health needs and the supports necessary to aid in their healing.
* Through the efforts of this partnership between NAMI Iowa and IowaCASA, we hope to identify gaps in services while exploring solutions to assist sexual assault and mental health programs better serve those living with mental illness who have experienced sexual abuse or assault.
* We are currently working though the planning and development phase of this project, and during this time no changes will be made to current policies and procedures as a result of this project.

**How:**

* Through on-going learning exchanges between organizations across the state, we hope to foster long-term collaboration that includes:
  + institutional policy and practice evaluation;
  + supporting organizational growth and transformation;
  + and achieving a greater understanding between organizations, allowing them to work together more efficiently to better meet the needs of all survivors.

**Why:**

* People living with mental illness experience significantly higher rates of sexual victimization. *(H. Khalifeh, et al. (2014) “Domestic and Sexual Violence in Patients with Severe Mental Illness”; Cambridge University Press; doi: 10.1017/S0033291714001962)*
  + Over 60% of women and more than 20% of men who have experienced one or more psychiatric hospitalizations have had one or more experiences of sexual assault since the age of 16.
  + Over half of individuals living with mental illness described being suicidal following an incident of sexual abuse or assault, compared with 3% of survivors without a mental illness.
* We recognize that significant stigma still exists in public opinion which often defines those who commit violent acts, including sexual violence, as mentally ill. People who identify as living with mental illness often face increased stigma in media and society when someone who is perceived to have behavioral health issues engages in a violent act. However, we know this not to be the case.
  + In a study of crimes committed by people with serious mental disorders, very few (only 7.5%) were directly related to symptoms of mental illness, according to new research published by the American Psychological Association (APA). The study shows that the vast majority of people with mental illness are not violent, not criminal, and not dangerous. (“How Often and How Consistently do Symptoms Directly Precede Criminal Behavior Among Offenders With Mental Illness?”; Jillian Peterson, PhD, Normandale Community College; Patrick Kennealy, PhD, University of South Florida; Jennifer Skeem, PhD, University of California-Irvine; Beth Bray, BA, University of North Dakota; and Andrea Zvonkovic, BA, Columbia University; *Law and Human Behavior*, online April 15, 2014.)
  + We can reframe the message by pointing out that it is far more likely for someone living with a mental illness to be sexually abused or assaulted than it is for them to commit sexual abuse or assault.
* NAMI and IowaCASA are fully committed to breaking down barriers that exist for survivors living with mental illness. We believe all people, no matter their situation or lived experiences, have the right to services that are inclusive, liberating, and equitable.
  + The needs of survivors living with mental illness have been ignored for far too long. We must empower these survivors by ensuring they have the services they need, wherever they choose to find help.
  + Survivors living with mental illness should be able to talk about their experiences wherever they feel most comfortable.
  + We hope to enhance accessibility and equity in the services and support that our programs provide by improving the services available to survivors living with mental illness.
* Because IowaCASA and NAMI Iowa are seen as thought leaders on this very issue, we seek to define a unified message to support survivors of sexual violence while also combatting the stigma and discrimination against people living with mental illness.

# **Confidentiality Protocol**

## **Shared values of confidentiality**

In order to achieve the mission of the SAMI Project, we must ensure a safe, supportive and confidential environment for team members, staff members, member programs and affiliates, and the people our organizations serve. Without the trust and safety created through a shared commitment to confidentiality we cannot help to empower survivors living with mental illness to participate in and lead their own recovery journeys.

Though the confidentiality policies of IowaCASA and NAMI Iowa differ due to statute and organizational structure, they are not mutually exclusive. In fact, these policies support the shared value of creating confidential space for individuals to seek and receive services wherever they are most comfortable, a central goal of the SAMI project. They also allow organizations engaged in this collaborative work to fully participate in the learning and healing activities, planning, learning exchanges, and trainings that may result from the SAMI Project.

Therefore, through our work on the SAMI Project, we commit to the following:

**Confidentiality of Collaboration Partner and Subrecipient Information:**

We feel strongly that a sense of safety and comfort needs to be established in order to enable an effective working environment. We understand that information about individual team members, our organizations, or subrecipient organizations and their staff or volunteers may be shared as a result of our work to improve delivery and access to services among survivors living with mental illness. Such disclosures may include, but are not limited to, personal disclosures of abuse or violence, personal disclosures about mental health, job-related concerns, organization financials, service delivery protocols, and personnel capacity.  Collaboration partner and subrecipient information may only be used to guide and enhance our work and shall not be used in any punitive manner. To ensure a safe and open collaborative environment, information about individuals and organizations involved in the collaboration will be treated with respect and care and never shared outside the SAMI Project partners.

**Confidentiality of the People We Serve:**

We uphold and respect the right to confidentiality for all individuals.  Information about the individuals we serve will be regarded by team members as confidential and not shared outside the team without the express, written consent of the individual.  Information about individuals we serve will only be shared within the collaboration for the purpose of advancing our work as a collaboration in creating systems change. No personally identifying information concerning survivors, victim advocates, peers, or affiliates participating in the SAMI project and associated activities will be shared, and all discussions will comply with both organizations’ confidentiality policies and governing legal authority.

Mandatory Reporting:

IowaCASA staff, victim services staff and volunteers, NAMI Iowa and NAMI affiliate staff, trainers, program leaders, and volunteers are not designated as mandatory reporters by Iowa law. The only exceptions are those staff who are hired by programs to provide treatment or services in their capacity as a licensed mental health professional. Therefore, the SAMI Project’s collaborative mandatory reporting policy is as follows:

* According to Iowa code Section 232.69 (see appendix 1), licensed mental health professionals, health care professionals, and other professionals denoted in in the code are listed as mandatory reporters of evidence of abuse solely within the capacity of their job; they work in an agency that provides healthcare/treatment of children or dependent adults; and information or evidence of abuse obtained outside of the treatment setting is not subject to mandatory reporting under Iowa code.
* SAMI Project activities do not constitute treatment of children or dependent adults. Therefor information obtained during the course of the SAMI Project is not subject to mandatory reporting under Iowa code or the collaboration’s policies.
* This policy and the definition of permissive reporting will be explained in plain language to all participants in SAMI Project activities.

As defined by Iowa code, no person currently sitting on the SAMI Project team is a mandatory reporter.

**If there is a breach of confidentiality during any phase of the SAMI Project we will:**

* Notify the affected parties of the breach
* Utilize our conflict resolution plan to ensure that the breach is an isolated incident
* Issue a reminder of our shared confidentiality policy to all participants of the SAMI Project

# **Glossary of Terms**

**Advocate:** One who promotes or defends the rights of a person, cause, or policy, such as a victim’s rights advocate, mental health advocate, or a comprehensive sexual education advocate.

**Affiliate:** Refers to an affiliate of the National Alliance on Mental Illness (NAMI). The affiliate is the local organization of NAMI, and in Iowa may organize as an independent, incorporated nonprofit or as a program of NAMI Iowa.

**Certified victim counselor:** A staff member or volunteer under the supervision of a crime victim center that has completed a minimum of 20 hours of training as outlined in Iowa Code Section 915.20A.  A crime victim center is a program with a mission of providing services to victims of sexual violence, domestic violence, homicide, and other violent crimes as defined by Iowa Code 915.20A.1b.  This designation provides confidentiality and privilege of communication between the crime victim and victim counselor under Iowa Code.

**Certified sexual abuse advocate:** In the state of Iowa, a certified sexual abuse advocate is a certified victim counselor who has completed an additional course of training as provided by the Iowa Coalition Against Sexual Assault, is a volunteer or employee of an IowaCASA member program, and has completed the at least 40 clock hours of direct service and 6 months of supervision.  This certification is required to meet IowaCASA member program service standards.

**Co-advocacy:** a collaborative process in which organizations work together to ensure that they are providing appropriate resources and services to all individuals they serve. This process acknowledges that any single organization may not have the capacity, resources, or training to provide all the services that the individual needs or wants, and aims to create a plan to assist the individual based on their goals, strengths, and needs.

**Complex trauma**: The result of multiple experiences in a person’s life that each individually create a traumatic reaction.  Complex trauma may be composed multiple experiences of sexual violence, events that happened in any stage of life or development, and is identified by the individual victim or survivor.

**Disability:** A physical, intellectual, developmental, cognitive, or mental condition that impacts one or more activities of daily living of a person.

**Holistic:** A focus on the individual’s whole self, as opposed to their diagnosis, experience, or a specific identity. As it relates to goals, recovery, or healing with regard to all aspects of the person’s life. This may include physical, mental, and emotional well-being along with community, familial, and social well-being.

**Identity-first language:**  A form of self-identification that places the identity before the person in written text or spoken language.  This language is used by individuals in communities that believe their identity is core to their culture, such as in the Deaf community.  This language is favored by many Deaf, Autistic, and disabled people and advocates working within these communities.

**Intersecting identities**: The reality that a single person holds more than one identity, and all these identities impact a person’s lived experiences.

**Intersectionality**: Framework that considers that various forms of social stratification do not exist separately from each other but are woven together. This includes identities such as class, race, sexual orientation, age, religion, creed, disability, gender, and immigration status.  This framework was created by Kimberle Crenshaw as a feminist approach beyond sex or gender. Intersectionality is designed to explore the dynamic between co-existing identities (such as being a woman and African-American) and connected systems of oppression (such as racism and sexism).

**Member program:** Refers to a sexual violence victim services program that is a member organization of the Iowa Coalition Against Sexual Assault (IowaCASA).

**Mental health advocacy:**  Activities intended to support individuals living with mental illness, including working to safeguard individual rights, legal and service assistance, and advocating for systems or policy change.

**Mental illness:** A condition that affects a person’s thinking, feeling, or mood. Such conditions may affect someone’s ability to relate to others and function each day. Each person may have different experiences; these effects can be distressing or cause disruption to the life and personal functioning of the individual.

**Peer**: A person with personal lived experience of mental illness

**Peer support:** Peer support includes the activities and interactions between people who share lived experiences. In the realm of mental health services these shared experiences may include living with mental health conditions, substance use disorders, or both. In addition, as a professional service model, training and certifications are available in Iowa for mental health peer support specialist and recovery specialist.

**Permissive reporter:** anyone that reasonably believes that a child or dependent adult has suffered abuse but does not fall under one of the mandatory reporter categories defined by Iowa law. A permissive reporter is not legally required to report known or evidence of child or dependent adult abuse.

**Person-centered planning**: Used in mental healthcare settings to refer to treatment planning that focuses on the strengths of the individual as well as already established support networks that the individual has in place

**Person-first language:**  A form of self-identification that places the person before the condition in written text or spoken language.  For example, the SAMI collaborative uses the language of “people living with mental illness” to signify that the mental illness is an experience of the person, not the core identity.  This language is favored by many people living with mental illness and advocates working within these communities.

**Recovery**: The process in which an individual lives a meaningful life that they have chosen. They have acknowledged their mental illness and still experience symptoms but have learned to recognize and manage their symptoms with their supports such as family, friends, community and professionals.

**Recovery support:** interchangeable term with **peer support** (see definition above).

**Secondary victim:** Any person who is a supportive loved one of a victim or survivor who is impacted by the sexual violence.  This may include friends, family members, partners, children, or others as identified by the victim or survivor.

**Self-advocate**: Survivor, victim, or a person with a mental illness who is empowered to advocate for themselves.

**Self-determination**:  The belief that people are experts of their own experiences and, as the expert, determine what their own recovery looks like and control over their own narrative.

**Self-identifying**: Rather than society, providers, or other individuals placing labels on an individual, the individual determines how they identify allowing the individual to control their own narrative and to have both public and private identities.

**Sexual violence:** Forms of violence that includes all unwanted sexual acts meant to harm, humiliate, control, and intimidate the target of the violence.  Used as an inclusive term, sexual violence includes sexual assault, sexual harassment, rape, sexual abuse, child sexual exploitation, and a variety of other forms of violence that are sexual in nature.  As with all victim-centered services, sexual violence is defined by the person experiencing the violence.

**Survivor or victim**: Someone who has experienced sexual violence.  Each person identifies individually if they are a survivor or victim of sexual violence, and the identity may be fluid and changing.

**Trauma:** An event that overwhelms the coping skills of an individual.  For example, this may be sexual violence, a natural disaster, or a car accident.  Each person’s experience of the event is different, and trauma is the normal reaction to a situation beyond the person’s norm.

**Trauma-informed:** The understanding, recognition, and response to the impacts of trauma over the course of a person’s life and how it uniquely affects them.

**Vicarious or secondary trauma:** Emotional remains felt by helping professionals, such as advocates and counselors, when helping survivors heal from their pain and trauma.  It can manifest in issues such as nightmares, flashbacks, exaggerated startle reflex, a negative shift in worldview, or an overall feeling of fear or isolation, much like the trauma survivors experience.  It is separate and distinct from trauma experienced by loved ones of survivors in that the trauma is experienced through the helping role, rather than direct impact on the life of the helper.

**Victim-centered services:** An approach to services that is guided by the victim or survivor in order to minimize re-traumatization and empower them to guide their healing process.  In this approach, the victim or survivor is the expert, advocates are available to provide support and resources as requested, and the goal is healing rather than criminal justice or institutional outcomes.

## **Abbreviations**

DOJ - United States Department of Justice

OVW - Office on Violence Against Women

VAWA - Violence Against Women Act

VOCA - Victims of Crime Act

CVAD - Crime Victims Assistance Division of the Iowa Attorney General’s Office

SV - Sexual Violence

MH - Mental Health

SMI - Serious Mental Illness

SAMI Project - Sexual Assault Survivors with Mental Illness Project

NAMI - National Alliance on Mental Illness

IowaCASA - Iowa Coalition Against Sexual Assault

OCA - Office of Consumer Affairs

DHS - Department of Human Services

PSS - Peer-Support Specialist

ADA - Americans with Disabilities Act

LGBTQIA+ - Lesbian, Gay, Bisexual, Transgender Queer, Intersex, Asexual/Aromantic

HIPPA - Health Insurance Portability and Accountability Act

HCBS - Home and Community Based Services

DIA - Department of Inspections and Appeals

IME - Iowa Medicaid Enterprise

MHI - Mental Health Institute

SCL - Supported Community Living

CMHC - Community Mental Health Center

SANE - Sexual Assault Nurse Examiner

SART- Sexual Assault Response Team

236(A)- Sexual Abuse Order of Protection

CIL - Center for Independent Living

NSO - NAMI State Organization

NA - NAMI Affiliate

# **Appendix 1**

## **Iowa mandatory reporting code & Duty to Warn**

**Iowa Code 2019, Section 232.69 (19, 3)**

232.69 Mandatory and permissive reporters — training required. 1. The classes of persons enumerated in this subsection shall make a report within twenty-four hours and as provided in section 232.70, of cases of child abuse. In addition, the classes of persons enumerated in this subsection shall make a report of abuse of a child who is under twelve years of age and may make a report of abuse of a child who is twelve years of age or older, which would be defined as child abuse under section 232.68, subsection 2, paragraph “a”, subparagraph (3) or (5), except that the abuse resulted from the acts or omissions of a person other than a person responsible for the care of the child. a. Every health practitioner who in the scope of professional practice, examines, attends, or treats a child and who reasonably believes the child has been abused. Notwithstanding section 139A.30, this provision applies to a health practitioner who receives information confirming that a child is infected with a sexually transmitted disease. b. Any of the following persons who, in the scope of professional practice or in their employment responsibilities, examines, attends, counsels, or treats a child and reasonably believes a child has suffered abuse: (1) A social worker. (2) An employee or operator of a public or private health care facility as defined in section 135C.1. (3) A certified psychologist. (4) A licensed school employee, certified para-educator, holder of a coaching authorization issued under section 272.31, or an instructor employed by a community college. (5) An employee or operator of a licensed child care center, registered child development home, head start program, family development and self-sufficiency grant program under section 216A.107, or healthy opportunities for parents to experience success – healthy families Iowa program under section 135.106. (6) An employee or operator of a substance abuse program or facility licensed under chapter 125. (7) An employee of a department of human services institution listed in section 218.1. (8) An employee or operator of a juvenile detention or juvenile shelter care facility approved under section 232.142. (9) An employee or operator of a foster care facility licensed or approved under chapter 237. (10) An employee or operator of a mental health center. (11) A peace officer. (12) A counselor or mental health professional. (13) An employee or operator of a provider of services to children funded under a federally approved medical assistance home and community-based services waiver. (14) An employee, operator, owner, or other person who performs duties for a children’s residential facility certified under chapter 237C. 2. Any other person who believes that a child has been abused may make a report as provided in section 232.70. 3. a. For the purposes of this subsection, “licensing board” means a board designated in section 147.13, the board of educational examiners created in section 272.2, or a licensing board as defined in section 272C.1. b. A person required to make a report under subsection 1, other than a physician whose professional practice does not regularly involve providing primary health care to children, shall complete two hours of training relating to the identification and reporting of child abuse within six months of initial employment or self-employment involving the examination, attending, counseling, or treatment of children on a regular basis. Within one month of initial employment or self-employment, the person shall obtain a statement of the abuse reporting requirements from the person’s employer or, if self-employed, from the department. The person shall complete at least two hours of additional child abuse identification and reporting training every five years. c. If the person is an employee of a hospital or similar institution, or of a public or private institution, agency, or facility, the employer shall be responsible for providing the Sat Dec 08 18:37:30 2018 Iowa Code 2019, Section 232.69 (19, 3) §232.69, JUVENILE JUSTICE 2 child abuse identification and reporting training. If the person is self-employed, employed in a licensed or certified profession, or employed by a facility or program that is subject to licensure, regulation, or approval by a state agency, the person shall obtain the child abuse identification and reporting training as provided in paragraph “d”. d. The person may complete the initial or additional training requirements as part of any of the following that are applicable to the person: (1) A continuing education program required under chapter 272C and approved by the appropriate licensing board. (2) A training program using a curriculum approved by the director of public health pursuant to section 135.11. (3) A training program using such an approved curriculum offered by the department of human services, the department of education, an area education agency, a school district, the Iowa law enforcement academy, or a similar public agency. e. A licensing board with authority over the license of a person required to make a report under subsection 1 shall require as a condition of licensure that the person is in compliance with the requirements for abuse training under this subsection. The licensing board shall require the person upon licensure renewal to accurately document for the licensing board the person’s completion of the training requirements. However, the licensing board may adopt rules providing for waiver or suspension of the compliance requirements, if the waiver or suspension is in the public interest, applicable to a person who is engaged in active duty in the military service of this state or of the United States, to a person for whom compliance with the training requirements would impose a significant hardship, or to a person who is practicing a licensed profession outside this state or is otherwise subject to circumstances that would preclude the person from encountering child abuse in this state. f. For persons required to make a report under subsection 1 who are not engaged in a licensed profession that is subject to the authority of a licensing board but are employed by a facility or program subject to licensure, registration, or approval by a state agency, the agency shall require as a condition of renewal of the facility’s or program’s licensure, registration, or approval, that such persons employed by the facility or program are in compliance with the training requirements of this subsection. g. For peace officers, the elected or appointed official designated as the head of the agency employing the peace officer shall ensure compliance with the training requirements of this subsection. h. For persons required to make a report under subsection 1 who are employees of state departments and political subdivisions of the state, the department director or the chief administrator of the political subdivision shall ensure the persons’ compliance with the training requirements of this subsection. [C66, 71, 73, 75, 77, §235A.3; C79, 81, §232.69] 83 Acts, ch 96, §157, 159; 84 Acts, ch 1279, §4, 6; 85 Acts, ch 173, §3 – 5; 87 Acts, ch 153, §3; 88 Acts, ch 1238, §1; 89 Acts, ch 89, §17; 89 Acts, ch 230, §5; 89 Acts, ch 265, §40; 94 Acts, ch 1130, §3; 97 Acts, ch 85, §1; 99 Acts, ch 192, §27, 33; 2000 Acts, ch 1066, §42; 2001 Acts, ch 122, §2, 3; 2002 Acts, ch 1047, §2, 20; 2002 Acts, ch 1142, §1, 31; 2005 Acts, ch 121, §2; 2007 Acts, ch 10, §164, 165; 2008 Acts, ch 1072, §3; 2013 Acts, ch 129, §54; 2018 Acts, ch 1113, §1 Referred to in §135H.13, 232.68, 232.70, 232.75, 232.77, 235B.16, 237.9, 237A.5, 272.31, 907.3, 915.35 Subsection 1, paragraph b, NEW subparagraph (14)

# **Appendix 2**

## **NAMI Iowa Confidentiality and Mandatory Reporting Policies**

As a nationwide alliance of organizations that provide mutual support, education and advocacy to people with mental illness and their families, NAMI, NAMI Iowa, and all NAMI local affiliates in Iowa are required to adhere to a standardized confidentiality policy for all staff, volunteers, leaders and program participants. All NAMI programs incorporate the principles of mutual trust and respect among participants and leaders. Additionally, all staff, leaders, and volunteers agree that they may not disclose or make accessible any confidential information obtained through their affiliation with any NAMI state organization or affiliate. The only exception is for disclosure of information that is required by law.

NAMI’s national policy is that NAMI state organizations and affiliates must adhere to the mandatory reporting statutes of the state in which they operate.

Mandatory reporting in Iowa is defined by Iowa Code 232.69.1.b[1].  Under this code section, health care professionals are designated as mandatory reporters when working in the scope of their professional employment responsibilities, including a licensed or certified professional such as a social worker, therapist, teacher, other social services professionals, as well as health care professionals and support staff in health care settings which provide treatment of children or dependent adults. Anyone who is not a mandatory reporter under Iowa Code is considered a permissive reporter, including NAMI staff, volunteers, and program leaders.

Because NAMI programs are evidence-based models based on mutual support, NAMI program leaders, staff and volunteers are not considered health care staff in their capacity with NAMI. Further, NAMI program leader qualifications are based on training and eligibility criteria requiring status as a person with lived experience in recovery from mental illness, or a family member of a person with a mental illness.  When engaged in NAMI activities, work, or volunteering, program leaders, staff, or volunteers who have professional licenses or certifications do not act in the capacity of their licensure, and therefore are permissive reporters.

The only exception to this rule is when a NAMI affiliate and local mental health providers have a staff sharing agreement, and the staff person is employed by the mental health provider to conduct NAMI programs within a clinic, recovery center, or other health care entity.  For instance, a certified peer support/recovery specialist who is also a trained NAMI Connection facilitator might, in their capacity with a community mental health center, provide a NAMI Connection group to the population served by the CMHC during work hours, for which they are paid by and considered an employee of the CMHC.  In this situation, the specialist would be a mandatory reporter of child or dependent adult abuse in the capacity of their employment at a facility providing treatment, and is required by NAMI policy to inform group participants of mandatory reporting policy of their employer.

Alternately, if that certified peer support/recovery specialist volunteered or is paid and employed by the local NAMI Affiliate to provide a Connection group to the community outside of their CMHC work hours, they would be acting solely in their capacity as a volunteer or employee of the NAMI Affiliate, and would be a permissive reporter in this instance, governed by NAMI’s Confidentiality Policy [3].  Where questions and concerns arise regarding requirements to report information gained through NAMI groups and activities, NAMI leaders, staff, and volunteers are encouraged to consult with their affiliate leaders and NAMI Iowa.

[1]<https://www.legis.iowa.gov/docs/ico/section/232.69.pdf>

[2] See NAMI Mandatory Reporting Policy (page 42)

[3] See NAMI Confidentiality Policy (pages 42-43)

## **NAMI Mandated Reporting Policy**

Mandated reporting

* A mandated reporter is a person who, because of his or her profession or training is legally required to report any suspicions of potential harm or neglect of a person to the relevant authorities. The specifics of these laws vary from state to state.
* NAMI program leaders are not considered mandated reporters by virtue of their NAMI training. If a NAMI leader has additional certification or licensure (e.g., Certified Peer Specialist, mental health counselor), and/or has been trained in their respective state’s laws around mandated reporting, they are obligated to follow those laws.
* A NAMI program leader who also has the designation of being a mandated reporter in his or her state is required by NAMI to inform the participants in the class/support group of their status even if their specific mandated reporter regulations do not require this disclosure.
* Participants in NAMI programs, who are also mandated reporters, should follow the requirements of their licensure and state and may not be required to inform participants of their presence.
* A NAMI program leader, who is not a mandated reporter in his or her state but who is concerned about something reported by a participant in their class/support group, should discuss those concerns with the sponsoring NAMI state organization (NSO) or NAMI Affiliate (NA) and follow the policies and procedures of that organization, which must comply with the laws in that state.

*NAMI National Education Programs 2019 Policies and Procedures*

## **NAMI confidentiality policies**

Confidentiality

* All NAMI programs incorporate the principles of mutual trust and respect among participants and leaders.
* All NAMI program leaders are trained in the importance of creating and maintaining an atmosphere of respect in NAMI programs that is conducive to participants’ ability to gain valuable information and support around mental health conditions.
* This atmosphere of respect includes the assurance of confidentiality regarding participation in NAMI programs as well as any information shared by participants about themselves or others. If confidentiality is broken, the NSO and NA are responsible for addressing the incident and preventing future violations.
  + If a program leader violates confidentiality, they may be suspended or decertified
  + If a participant violates confidentiality, they may be asked not to return to the program
* The only reason confidentiality should be broken is for the safety of the participant or someone else.
* Audio or videotaping during any NAMI programs is not permitted.
* Observers are not permitted to attend or audit any NAMI class or support group, e.g., media, researchers, students.

*NAMI National Education Programs 2019 Policies and Procedures*

# **Appendix 3**

## **Iowa code on advocate privilege**

**Iowa Code 2019, Section 915.20A (16, 0)**

915.20A Victim counselor privilege. 1. As used in this section: a. “Confidential communication” means information shared between a crime victim and a victim counselor within the counseling relationship, and includes all information received by the counselor and any advice, report, or working paper given to or prepared by the counselor in the course of the counseling relationship with the victim. “Confidential information” is confidential information which, so far as the victim is aware, is not disclosed to a third party with the exception of a person present in the consultation for the purpose of furthering the interest of the victim, a person to whom disclosure is reasonably necessary for the transmission of the information, or a person with whom disclosure is necessary for accomplishment of the purpose for which the counselor is consulted by the victim. b. “Crime victim center” means any office, institution, agency, or crisis center offering assistance to victims of crime and their families through crisis intervention, accompaniment during medical and legal proceedings, and follow-up counseling. c. “Victim” means a person who consults a victim counselor for the purpose of securing advice, counseling, or assistance concerning a mental, physical, or emotional condition caused by a violent crime committed against the person. d. “Victim counselor” means a person who is engaged in a crime victim center, is certified as a counselor by the crime victim center, and is under the control of a direct services supervisor of a crime victim center, whose primary purpose is the rendering of advice, counseling, and assistance to the victims of crime. To qualify as a “victim counselor” under this section, the person must also have completed at least twenty hours of training provided by the center in which the person is engaged, by the Iowa organization of victim assistance, by the Iowa coalition against sexual assault, or by the Iowa coalition against domestic violence, which shall include but not be limited to, the dynamics of victimization, substantive laws relating to violent crime, sexual assault, and domestic violence, crisis intervention techniques, communication skills, working with diverse populations, an overview of the state criminal justice system, information regarding pertinent hospital procedures, and information regarding state and community resources for victims of crime. 2. A victim counselor shall not be examined or required to give evidence in any civil or criminal proceeding as to any confidential communication made by a victim to the counselor, nor shall a clerk, secretary, stenographer, or any other employee who types or otherwise prepares or manages the confidential reports or working papers of a victim counselor be required to produce evidence of any such confidential communication, unless the victim waives this privilege in writing or disclosure of the information is compelled by a court pursuant to subsection 7. Under no circumstances shall the location of a crime victim center or the identity of the victim counselor be disclosed in any civil or criminal proceeding. 3. If a victim is deceased or has been declared to be incompetent, this privilege specified in subsection 2 may be waived by the guardian of the victim or by the personal representative of the victim’s estate. 4. A minor may waive the privilege under this section unless, in the opinion of the court, the minor is incapable of knowingly and intelligently waiving the privilege, in which case the parent or guardian of the minor may waive the privilege on the minor’s behalf if the parent or guardian is not the defendant and does not have such a relationship with the defendant that the parent or guardian has an interest in the outcome of the proceeding being favorable to the defendant. 5. The privilege under this section does not apply in matters of proof concerning the chain of custody of evidence, in matters of proof concerning the physical appearance of the victim at the time of the injury or the counselor’s first contact with the victim after the injury, or where the counselor has reason to believe that the victim has given perjured testimony and the defendant or the state has made an offer of proof that perjury may have been committed. 6. The failure of a counselor to testify due to this section shall not give rise to an inference unfavorable to the cause of the state or the cause of the defendant. 7. Upon the motion of a party, accompanied by a written offer of proof, a court may compel disclosure of certain information if the court determines that all of the following conditions are met: Sun Dec 09 20:04:29 2018 Iowa Code 2019, Section 915.20A (16, 0) §915.20A, VICTIM RIGHTS 2 a. The information sought is relevant and material evidence of the facts and circumstances involved in an alleged criminal act which is the subject of a criminal proceeding. b. The probative value of the information outweighs the harmful effect, if any, of disclosure on the victim, the counseling relationship, and the treatment services. c. The information cannot be obtained by reasonable means from any other source. 8. In ruling on a motion under subsection 7, the court, or a different judge, if the motion was filed in a criminal proceeding to be tried to the court, shall adhere to the following procedure: a. The court may require the counselor from whom disclosure is sought or the victim claiming the privilege, or both, to disclose the information in chambers out of the presence and hearing of all persons except the victim and any other persons the victim is willing to have present. b. If the court determines that the information is privileged and not subject to compelled disclosure, the information shall not be disclosed by any person without the consent of the victim. c. If the court determines that certain information may be subject to disclosure, as provided in subsection 7, the court shall so inform the party seeking the information and shall order a subsequent hearing out of the presence of the jury, if any, at which the parties shall be allowed to examine the counselor regarding the information which the court has determined may be subject to disclosure. The court may accept other evidence at that time. d. At the conclusion of a hearing under paragraph “c”, the court shall determine which information, if any, shall be disclosed and may enter an order describing the evidence which may be introduced by the moving party and prescribing the line of questioning which may be permitted. The moving party may then offer evidence pursuant to the court order. However, no victim counselor is subject to exclusion under rule of evidence 5.615. 9. This section does not relate to the admission of evidence of the victim’s past sexual behavior which is strictly subject to rule of evidence 5.412. 98 Acts, ch 1090, §16, 84; 2008 Acts, ch 1032, §92 Referred to in §22.7(2), 235D.1, 709.22, 915.20, 915.40, 915.86

# **Appendix 4**

## **IowaCASA Confidentiality, Advocate Privilege, and Mandatory Reporting:**

Iowa Code 232.69.1.b[1] defines what professionals are mandatory reporters within the state of Iowa.  Under this code section, these professionals are designated mandatory reporters when working in the scope of their professional employment responsibilities, including when licensed or certified professional such as a social worker, therapist, teacher, or other social services professional.  Individual people are not mandatory reporters within the state of Iowa, which means that a person is not required to report abuse of a child, a person with a disability, or a dependent or older adult. Anyone who is not a mandatory reporter under Iowa Code is considered a permission reporter, including victim advocates.

Victim advocates have privilege through Iowa Code 915.20A[2], Victim Counselor Privilege.  When working or volunteering for an organization that is a crime victim center, individuals who have received a minimum of 20 hours of training as outlined within the code section are working under that privilege.  Through this privilege and the confidentiality rules as outlined by the Violence Against Women Act[3], advocates are permissive reporters in the state of Iowa for abuse of children, people with disabilities, and dependent or older adults.

The only exception to this rule is for staff members of programs that have been trained and certified as advocates and are working in a capacity that requires training or certification in a professional role that is designated by 232.69.1b as a mandatory reporter.  For example, if a sexual assault advocacy program employs a licensed mental health counselor to provide therapeutic services, then that individual employee of the organization is deemed a mandatory reporter under Iowa Code. However, if a program chooses to hire this person in a role as an outreach advocate and the job duties do not include the provision of therapeutic services, that that person is bound by victim counselor privilege and is working as a permissive reporter.  If a person is working in a position that requires them to be a mandatory reporter, IowaCASA expects that the program and individual staff person will make all survivors seeking services with through that staff person aware of their status as a mandatory reporter in writing and verbally at the beginning of services.

As permissive reporters in the state of Iowa, advocates can report abuse of a child, person with a disability, or a dependent or older adult under certain circumstances.  VAWA allows for an exception to be made to confidentiality for rules or laws set forward by a state statute or court order. These cases and circumstances are when a person’s life and immediate safety is at risk, such as severe physical or sexual abuse and active suicidality or homicidality that includes an immediate plan and the means to complete the action.  IowaCASA expects that any advocate acting as a permissive reporter will first consult with the individual survivor that is the subject of the report to make them aware and give them the option to self-report. Additionally, it is expected that the advocate will also consult with their supervisor or director prior to making the report. IowaCASA does not condone an advocate breaking confidentiality without taking good faith steps to notify, consult, and give options in these serious situations.

All IowaCASA staff are to abide by these rules and statutes when working with individual survivors, advocates, community allies, and member programs.  Only employees working under a professional licensure or certification, such as staff attorneys, are considered mandatory reporters by IowaCASA. All other staff are to act as permissive reporters, honor advocate confidentiality, and work to ensure survivor autonomy every step of the way.

[1]<https://www.legis.iowa.gov/docs/ico/section/232.69.pdf>

[2]<https://www.legis.iowa.gov/docs/code/915.20A.pdf>

[3]<https://www.justice.gov/ovw/page/file/1006896/download>