



Sexual Assault Medical Forensic Exams and VAWA 2005

Payment Practices, Successes, and Directions for the Future

Janine M. Zweig
Urban Institute

Lisa Newmark
George Mason University

Darakshan Raja
Urban Institute

Megan Denver
University at Albany



URBAN INSTITUTE

Justice Policy Center

2100 M STREET, NW

WASHINGTON, DC 20037

www.urban.org

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ABSTRACT

The Violence Against Women Act (VAWA) required that as a condition of federal STOP (Services*Training*Officers*Prosecutors) grant program eligibility—a major federal avenue for funding violence against women programs, services, and criminal justice strategies—the state or another entity must bear the full out-of-pocket costs for sexual assault medical forensic exams. This was amended in VAWA 2005 to provide that the state has to ensure the exam is paid for regardless of whether the victim reports to law enforcement or participates with the criminal justice system. States were given until January 5, 2009, to meet this new federal requirement. In 2010 the National Institute of Justice (NIJ) funded the Urban Institute, George Mason University, and the National Sexual Violence Resource Center to study sexual assault medical forensic exams (MFEs). In particular, this study aimed to fill gaps in information regarding: (1) which entities pay for MFEs in state and local jurisdictions throughout the United States, and the policies and practices determining payment; (2) which services are provided in the exam process, and how exams are linked to counseling, advocacy, and other services; (3) whether exams are provided to victims regardless of their reporting or intention to report the assault to the criminal justice system; (4) how MFE kits are being stored for victims who choose not to participate in the criminal justice system process; and (5) whether the VAWA 2005 requirement is generally being met throughout the country.

The study included national surveys of state victim compensation fund administrators, state STOP administrators, state-level sexual assault coalitions, and local sexual assault service providers. We also conducted case studies in six selected states to examine how MFE processes were implemented locally.

We present several themes based on the study's findings and articulate a series of implications. The first theme identifies that victim compensation funds are by far the largest designated source of funds to pay for MFEs across the United States. Second, in the case-study jurisdictions examined here, most victims are able to receive exams without having to report to law enforcement and receive exams free of charge, with very few exceptions. Survey respondents reported the same holds true in much of the country, though not everywhere. Third, despite the first and second conclusions, *barriers to even accessing the exam are real* and prevent some victims from seeking help; this is especially true for individuals identifying as non-English speakers, immigrants, or American Indians. Fourth, most victims who get MFEs report the assaults to the police at the time of the exam. Among the victims who get MFEs but do not report at the time of the exam, few convert their kits to reported cases at a later date. Fifth, sufficient funds to pay for MFEs are a major concern.

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GLOSSARY OF ACRONYMS

AVA	Association of Violence Against Women Act Administrators
CCR	Coordinated community response
CODIS	Combined DNA Index System
EVAWI	End Violence Against Women International
FBI	Federal Bureau of Investigation
FNE	Forensic nurse examiner
IRB	Institutional Review Board for the Protection of Human Subjects
MCASA	Maryland Coalition Against Sexual Assault
MFE	Sexual assault medical forensic exam
NACVCB	National Association of Crime Victim Compensation Boards
NSVRC	National Sexual Violence Resource Center
NIJ	National Institute of Justice
OVW	Office on Violence Against Women
SAFE	Sexual assault forensic exam
SANE	Sexual assault nurse examiner
SART	Sexual assault response team
SSA	State STOP administrator
STI	Sexually transmitted infection
STOP	Services*Training*Officers*Prosecutors (A federal formula grant program that provides funding for violence against women programs, services, and criminal justice strategies)
VAWA	Violence Against Women Act

REPORT HIGHLIGHTS

WHAT WAS THE PURPOSE OF THIS STUDY?

The Violence Against Women Act (VAWA) required that as a condition of federal STOP (Services*Training*Officers*Prosecutors) grant program eligibility—a major federal avenue for funding violence against women programs, services, and criminal justice strategies—the state or another entity must bear the full out-of-pocket costs for sexual assault medical forensic exams. This was amended in VAWA 2005 to provide that the state has to ensure the exam is paid for regardless of whether the victim reports to law enforcement or participates with the criminal justice system. States were given until January 5, 2009, to meet this new federal requirement. In 2010 the National Institute of Justice (NIJ) funded the Urban Institute, George Mason University, and the National Sexual Violence Resource Center to study sexual assault medical forensic exams (MFEs). In particular, this study aimed to fill gaps in information regarding: (1) which entities pay for MFEs in state and local jurisdictions throughout the United States, and the policies and practices around determining payment; (2) which services are provided in the exam process and how exams are linked to counseling, advocacy, and other services; (3) whether exams are provided to victims regardless of their reporting or intention to report the assault to the criminal justice system; (4) how MFE kits are being stored for victims who choose not to participate in the criminal justice system process; and (5) whether the VAWA 2005 requirement is generally being met throughout the country.

WHO PARTICIPATED IN THE STUDY, AND HOW WERE THE DATA COLLECTED?

This study included:

- ***A national survey of crime victim compensation fund administrators*** to obtain administrator perspectives on current compensation practices, the extent to which victims are compensated for MFEs and associated medical costs, and whether legislative stipulations regarding MFEs in VAWA 2005 are being communicated to victims and followed. We analyzed survey data to determine how compensation policies related to MFE payments across the country.
- ***A national survey of STOP administrators*** to gain state perspectives on what actions STOP administrators are taking to promote the VAWA 2005 MFE requirement, whether administrators believe local stakeholders are implementing it, and what is working to improve practices to serve the needs of victims. We analyzed STOP administrators' responses to examine how it is followed across the country.
- ***A national survey of sexual assault state coalitions and a survey of local community-based victim service providers across the country*** to determine how the MFE payment requirement is being implemented locally.

The information gathered via the surveys guided our second major data collection effort: ***case studies in six selected states***. We conducted interviews at the state level, and with local stakeholders, and victims in at least three localities per state (in all but one state) to gain a more nuanced understanding of local, on-the-ground implementation practices of the MFE

requirement. During site visits to each jurisdiction, project team members engaged in observational data collection methods (e.g., tours of hospitals and clinics where MFEs are conducted); face-to-face interviews with local stakeholders, including health care–based exam providers, advocates, law enforcement, and prosecution; and focus groups and interviews with victims who have had varying experiences with the MFE process.

WHAT DID WE LEARN ABOUT MEDICAL FORENSIC EXAMS?

Focusing on VAWA 2005 and the issues surrounding its implementation, we draw five main conclusions from this study.

- **First**, victim compensation funds are by far the largest designated source of funds to pay for MFEs across the United States, and compensation fund administrators are most likely to be the designated paying agency (whether using compensation funds or a special funding source). With two-thirds of states using compensation funds to pay for at least some MFEs and more than one-third using *only* such funds to pay for MFEs, there is no other source of funding that is tapped so heavily for this purpose.
- **Second**, in the case-study jurisdictions examined here, with very few exceptions, most victims are able to receive exams free of charge and without having to report to law enforcement. Survey respondents reported that the same is true in much of the country, though not everywhere.
- **Third**, despite the first and second conclusions, *barriers to even accessing the exam are real* and prevent some victims from seeking help. Specifically, individuals identifying as non-English speakers, immigrants, or American Indians face barriers to getting the exams due to lack of cultural competency among first responders, availability of trained Sexual Assault Nurse Examiners (SANEs), language barriers, and other reasons. When victims are unable to get the exams, or do not get the exams in a culturally competent and appropriate manner, everyone loses: victims are not helped, perpetrators' crimes remain unaddressed, and public safety is not improved.
- **Fourth**, most victims who get MFEs report the assaults to the police at the time of the exam. Among the victims who get MFEs but do not report at the time of the exam, few convert their kits to reported cases at a later date. It is more likely that victims who do not report their assaults to the police have not gotten exams. This means that victims who do not report to police miss out on receiving other necessary medical, advocacy, and counseling services.
- **Fifth**, sufficient funds to pay for MFEs are a major concern. Although many areas reported seamless payment systems at the time we collected data, worries over money remained. The level of continued funding for designated payers to cover the costs of exams each year and caps imposed on payments to providers might jeopardize these seemingly successful systems.

IMPLICATIONS FOR POLICY AND PRACTICE

Though presented in summary form above, the full findings from this report point to several implications for policy and practice:

- *Ensure funding levels are adequate for designated payers:*
 - *Funds dedicated to payment of MFEs should be provided whenever possible.* In states that use compensation funds to pay for all or some portion of MFEs, it is important to ensure that this obligation does not compete with funding for other services to victims.
 - *Consider exploring ways to use law enforcement and prosecution funds to pay for MFEs for victims while preserving the smooth operations that statewide payment procedures for providers seem to afford.* Our data show that very few states use law enforcement or prosecution funds to cover the costs of MFEs. Given that these agencies benefit from the evidence collection to build a criminal case, it may make sense to explore ways to use such funds for MFEs. For example, statewide agencies that have experience in providing payments such as these (such as compensation administrators) could be provided funding by criminal justice agencies to pay for MFEs, without having to use designated crime victim compensation funds.
- *Routinely examine if payment levels or caps imposed on payments to providers are adequate.* The cost of an MFE can vary for a variety of reasons throughout a state. In states that impose a cap on the amount paid for an MFE, hospitals in certain geographic areas may often provide these services at a loss. Routinely conducting reviews (through surveys, audits, etc.) across the state to ensure that payment levels are adequate is important.
- *Train medical providers and hospital personnel on the VAWA 2005 requirement and the states' or localities' process for paying for MFEs.* When we heard about challenges related to victims being billed, it was typically due to misunderstandings on the part of hospital and administrators about who should be billed. Training this group on MFE policies and practices might prevent future problems.
- *Consider broadening definitions of what should be paid for as part of the MFE process.* Wide variation in what services are covered as part of an MFE exists state to state and, in some cases, jurisdiction to jurisdiction. States and localities that employ narrow definitions of what should be paid for through designated payers might consider expanding their covered services, perhaps including treatments for pregnancy (e.g., emergency contraception), sexually transmitted infections (STIs) and HIV (e.g., screening, testing, prophylaxis, and counseling), and injuries.
- *Continue efforts to make trained examiners available throughout states.* Availability of more trained exam providers (e.g., SANEs) and suitable facilities with specialized or appropriate equipment (especially for American Indian victims and for rural areas) is critical to the MFE process. Continued funding, technical assistance, and training efforts at the federal and state level are essential to continue progress in this area.
- *Train first responders, such as nurses, advocates, and law enforcement, to appropriately respond to individuals in historically marginalized groups.* Efforts to improve cultural competency of first responders are important to curtail barriers to exam access for several groups, including individuals identifying as American Indians, non-English speakers, and immigrants.
- *Continue to provide training and technical assistance around storage practices for nonreported kits, particularly opportunities for anonymous reporting by victims, which includes their consent.* Assistance in negotiating and implementing systems whereby

victims can participate in anonymous reporting, if they so choose, may be particularly useful. Additionally, rigorous evaluation of various storage practices and how they relate to victim satisfaction, case outcomes, and public safety is necessary.

- *Consider public awareness campaigns on MFE access.* While progress has been made in setting up systems to provide exams free of charge and without having to report to law enforcement, the general public might not be aware of this option. Public outreach to inform people of such options seems critical.
- *Link advocates to victims during the exam process.* Though many places we visited reported that advocates were often present at exams, it might be important to assist with funding and resources to ensure advocates are a part of all exams (with the victim's consent), to further efforts to improve victim well-being and offender accountability. If an advocate is present at the exam, they provide an important link to legal advocacy, counseling, and other services.
- *If victims so choose, consider allowing them the chance to talk with law enforcement "off the record" as part of their decision-making process about whether to make an official report.* Victim contact with police officers before they decide to make an official report might give victims the chance to ask important questions and realistically assess their options so that they can make more informed choices about reporting; however, such a practice must not be considered lightly and would need to be implemented with the utmost care and compassion. Training the officers who provide this service would be essential: If victims encounter resistance or a lack of compassion during this informational interview process, then it may have the opposite effect of *discouraging* victim reporting. In addition, rigorous evaluation of the success of this approach is warranted.
- *Train law enforcement and prosecution:*
 - *About the utility of the MFE.* Investigators and prosecutors must understand the value of the kit, regardless of the findings, and learn ways to build strong cases for a variety of outcomes. For example, if analysis of the kit does not provide probative evidence, as happens about half the time, then it can be helpful to have SANEs testify as to why a lack of evidence for an assault is not the same as positive evidence disconfirming an assault (Greeson, Campbell, and Kobes 2008).
 - *On appropriate treatment of victims.* Though clear progress has been made in this area, more work can be done. Such training might include successful approaches for law enforcement and prosecutors staying in contact with victims, creating more trauma-informed approaches that support victims during the often long criminal justice process, providing an opportunity for victims to speak about what is important to them, and, if a case is not going to proceed, having a detective and/or prosecutor meet with a victim to explain why.
- *Increase victim confidence in the criminal justice system response.* This can be done by improving arrest, charging, and conviction rates. If victims believe that something will happen after they go through the invasive process of getting an exam and reporting to law enforcement, then perhaps they would be more likely to get exams and report assaults.
- *Review state legislation for ambiguity of language.* Thoughtful, clear legislation about who should pay for MFEs, which services should be covered through MFEs, and how kits for nonreporting victims should be handled can be a good initial step to ensuring that

victims are receiving exams free of charge and without having to report to law enforcement.

CHAPTER 1. INTRODUCTION

PURPOSE OF THE STUDY

Although the provision of free sexual assault medical forensic exams (MFEs) was part of the original Violence Against Women Act (VAWA) legislation in 1994, the law permitted states to condition free exams based on victim cooperation with law enforcement. Within a few years after VAWA passed, it became clear that not all victims across the country were being provided exams free of charge and that, in many places, victims were indeed required to report assaults to police before gaining access to exams. While reporting requirements were not contrary to federal law, they were not considered best practices. This issue was addressed in VAWA 2005 to provide that the state has to ensure the exam is paid for regardless of whether the victim reports to law enforcement or participates with the criminal justice system. States were given until January 5, 2009, to meet this new federal requirement.

In 2010 the National Institute of Justice (NIJ) funded the Urban Institute, George Mason University, and the National Sexual Violence Resource Center to study sexual assault MFEs. In particular, this descriptive study aimed to fill gaps in information regarding: (1) which entities pay for MFEs in state and local jurisdictions throughout the United States, and the policies and practices determining payment; (2) which services are provided in the exam process and how exams are linked to counseling, advocacy, and other services; (3) whether exams are provided to victims regardless of their reporting or intent to report the assaults to the criminal justice system; (4) how MFE kits are being stored for victims who choose not to participate in the criminal justice system process; and (5) whether the VAWA 2005 requirement are generally being met throughout the country.¹

Toward that end, we conducted two primary activities. First, we conducted a series of online surveys with a variety of stakeholders in the field for a national perspective on the issues of interest. Stakeholders included representatives from state-level sexual assault coalitions, state STOP administrators, state victim compensation fund administrators, and local sexual assault service providers. Second, we conducted case studies in 19 jurisdictions across six states, during which we spoke with state-level stakeholders, local law enforcement, prosecutors, MFE providers (e.g., Sexual Assault Nurse Examiners [SANEs]), victim service providers, and sexual assault victims. The purpose of the case studies was to delve deeply into how the VAWA 2005 requirement works on the ground.

This report documents the study findings. The remainder of this chapter provides some background about sexual assault, MFEs, the need for the VAWA 2005 requirement, and models for storing kits for those victims who choose not to report the assault to law enforcement. It also outlines the research questions that guided the study. Chapter two describes the study's methodology, including the survey and case-study designs, measures, and participants. Chapters three through six present the findings of the study, including MFE payment policies and

¹ This project was not intended to provide a report card of individual states and their ability to meet the VAWA 2005 requirement. Thus, we examine meeting requirements in general terms and maintain state confidentiality throughout the report.

practices; exam components and barriers to access; kit storage and victim participation in the criminal justice system; and meeting the VAWA 2005 policy requirement. Finally, chapter seven provides overall conclusions and implications of the study's findings on policy and practice.

BACKGROUND OF THE ISSUES

Sexual Assault, MFEs, and the Reporting Quandary

Sexual assault, including forcible rape and other various types of unwanted sexual contact and levels of sexual coercion, is a pervasive form of victimization. The National Crime Victimization Survey estimates that approximately 270,000 sexual assaults are committed against women ages 12 and older each year (Planty et al. 2013). Although males are also victims of sexual assault, more than 90 percent of victims are female (Planty et al. 2013). Put another way, almost 1 in 5 women (18 percent) and 1 in 71 men (1 percent) in the United States have been raped at some time in their lives (Black et al. 2011).² Sexual assault victimization is harmful not only physically—more than half of female victims sustain physical injuries during the assault (Planty et al. 2013)—but also psychologically. Sexual assault survivors constitute the largest share of those who suffer from post-traumatic stress disorder (Campbell and Wasco 2005).

Assistance is available to help victims heal from the impacts of sexual assault. Victims can receive medical care from hospitals, clinics, or community-based health care facilities. Counseling, advocacy, and other forms of support are available from national and statewide hotlines and coalitions, and from locally based rape crisis centers and dual domestic violence/sexual assault programs. However, only 35 percent of victims who are injured during sexual assaults report receiving medical care, and only 23 percent of all victims report receiving assistance from a victim service agency (Planty et al. 2013).

Victims can also seek justice, safety, and, in some cases, empowerment by reporting the crime to the police and participating in the justice system's efforts to hold the offenders accountable. Reporting a sexual assault to the police not only initiates a justice system response to protect the public and hold the offender accountable, it may also benefit the victim directly. Reporting is associated with a greater likelihood of receiving medical care (Rennison 2002) and victim assistance services (Langton 2011).

Medical forensic exams, or MFEs (also called Sexual Assault Forensic Exams [SAFEs]), are a critical early gateway to services for victims. As defined in the federal Violence Against Women Act of 2005 (VAWA 2005, 42 U.S.C. 3796gg-4[d]), an MFE should at a minimum include: (1) examining physical trauma; (2) determining penetration or force; (3) interviewing the patient; and (4) collecting and evaluating evidence. The US Department of Justice has recently released an updated SAFE Protocol, a voluntary best-practices guide that includes recommendations to standardize high-quality victim-centered care (US Department of Justice 2013).

² Although VAWA funds support services for both women and men, because women are more likely to be victims, we often use the noun "women" throughout this report to refer to victims of sexual assault.

The MFE has two major components: medical services and forensic evidence collection services. The medical services are intended to treat minor injuries and concerns around possible pregnancy or sexually transmitted infections (STIs). More serious injuries are referred for additional services, if not treated before the exam. The forensic evidence collection services are intended to build the criminal case through documentation of injuries and other indicators of force or coercion, such as drugging, and to establish sexual contact and the identity of the offender through biological evidence.

The exam can also serve as a valuable link to additional medical services that may be needed and to counseling and advocacy services. Having an exam can help victims to regain a sense of control and begin the healing process (DuMont, White, and McGregor 2008).

MFEs may be performed by SANEs or forensic nurse examiners (FNEs), who have received specialized training and have met clinical requirements for forensic evidence collection. The provision of exams by SANEs using specialized equipment and standardized procedures and materials, often called a rape kit, is considered a best-practices model. Research has shown that SANEs benefit the criminal case. They provide better evidence more quickly; their cases have higher arrest, prosecution, and conviction rates; and patients are more comfortable participating with law enforcement after the exam (Bulman 2009; Campbell 2004). SANE programs have also been shown to positively affect victims' emotional healing from the assault (Crandall and Helitzer 2003). However, sometimes MFEs may be performed by emergency department physicians or nurses, who may not have specialized training or equipment, and may not use a standardized rape kit.

Because one of the purposes of an MFE is to collect forensic evidence for use in a criminal case, there has been a strong link between the forensic exam and law enforcement. In many communities, law enforcement has served as the gatekeeper to forensic exams: authorizing them; transporting, processing, and storing the evidence; and paying for exams or authorizing payment by other entities such as prosecutors' offices or state agencies. However, law enforcement cannot authorize exams for victims who do not report the assault to them, and nearly two-thirds of sexual assault victims *do not* report the crime to the police (Planty et al. 2013).

There are many reasons a victim may choose not to report an assault, including an ongoing relationship between themselves and their assailants that can make the decision to involve the justice system difficult (Tjaden and Thoennes 2006); fear of further violence from the perpetrator in retaliation for reporting the assault; shame from the assault and a desire to keep it private; distrust in or apprehension of the justice system; and fear that participating in illegal activities (such as drug use, underage drinking, prostitution) or immigration status may have negative repercussions for themselves if the police become involved (Rennison 2002).

Reporting a sexual assault to the police initiates a process that may have various impacts on a victim's life and should be considered very carefully. Many victims need time to think through the implications of reporting in order to make informed decisions. This may be especially true in the immediate aftermath of the crime, when emotions are strong and the ability to think through complex issues clearly and objectively may be compromised.

However, exams should be performed as soon as possible after the assault to be most useful for evidence collection (before evidence erodes) and for timely services to promote the victims' physical and psychological healing. This is the quandary that victims who are undecided about police reporting are faced with when seeking an MFE: *When a report to law enforcement is required before an exam will be performed, and the exam needs to be performed as quickly as possible, victims are placed in the very difficult position of having to make an important and far-reaching decision in a short timeframe and during a time of acute crisis. This may be why some victims never reach out for medical care.*

Provisions of VAWA 2005 and 2013 Reauthorizations

VAWA 2005 contains two particularly important provisions for states to maintain their federal STOP grant program eligibility: (1) victims must not be charged for MFEs; and (2) victims must not be required to file law enforcement reports in order to receive free MFEs. The purpose of the first provision is to ensure that all victims have access to exams regardless of their ability to pay, and the second provision is designed to encourage women to have timely exams without having to make immediate decisions about reporting to the police, while retaining the option of filing a report later. VAWA 2013, which takes effect in March 2015, refines the first provision by requiring that victims cannot be required to pay upfront costs for exams with subsequent reimbursement; rather, victims must bear no costs for the exams at any point in time.³

Free Medical Exams. VAWA 2005 specifies that states, Indian tribal governments, and local governments must provide victims with no-cost exams by paying the exam costs upfront or by reimbursing victims for the full costs, including deductibles and co-pays. When a reimbursement system is used, victims must be informed of how to obtain reimbursement at the time of the exam, they must be allowed one year to apply for reimbursement, and they must be reimbursed within 90 days of their application. This is important because exams can be quite costly, and many victims would be unable to receive exams if they had to bear those costs themselves. Recognizing that bearing upfront costs for even a 90-day period can be burdensome on victims, VAWA 2013 forbids reimbursement practices.

VAWA 2005 does not specify the use of any particular funding source so that states and localities are free to fund the exams from various possible sources. Practices differ both across and within states, but a common source is state crime victim compensation programs. Notably, such programs have standard eligibility criteria that apply to all crimes—including law enforcement reporting requirements, payer of last resort requirements (meaning insurance billing), and contributory misconduct requirements (which may bar victims who were engaged in illegal behavior at the time of the crime from receiving compensation). It is important that these requirements do not conflict with the VAWA requirement when using compensation funds for MFEs.

States may also use STOP funding to pay for exams. When these funds are used, VAWA 2005 prohibits requirements for victims to submit exam bills to their private insurance companies (due to privacy concerns) and requires that the exams must be performed by SANEs or other specially trained examiners (which, in practice, has not always been the case).

³ See <http://www.ovw.usdoj.gov/docs/consolidated-stop-faqs-bla.pdf>.

Exams might also be paid through other state funds, local law enforcement funds, or prosecution funds; however, VAWA 2005 does not require that states or local governments pay for medical services to treat injuries, allowing victims or their insurance companies to be billed for some exam fees when medical services are also provided. VAWA 2005 also does not address caps on charges or payments, and states may bill victims or their insurance companies for fees in excess of payment amounts. Fees for medical services and caps on charges and payments are important points to address when examining how states and localities comply with VAWA prohibitions against charges to victims.

Prohibition of Law Enforcement Reporting Requirements. VAWA 2005 specified a new mandate, taking effect on January 5, 2009, forbidding states or localities to require victims to report to law enforcement in order to receive free exams, whereas prior to the reauthorization states were allowed to condition exams based on cooperation with law enforcement. This is a very important provision, designed to allow victims access to timely exams without feeling pressured into making police reports right away; rather, they reserve the right to make a report at a later time, if they so choose. Previous research has found that 70 percent of states imposed law enforcement requirements (Burt et al. 1998), which indicates that many jurisdictions may have needed to change this requirement to be in compliance with new VAWA provisions.

Technical Assistance to Enhance Compliance with VAWA 2005

Recognizing that new mandates may present challenges for many jurisdictions, the Office on Violence Against Women (OVW) has funded several technical assistance projects to help states and localities maintain compliance. The Maryland Coalition Against Sexual Assault (MCASA) operated the VAWA Forensic Compliance Project, which produced a Toolkit for States and Territories in December 2008. The Forensic Compliance Project also formed a National Working Group of 15 nationally recognized experts to guide project activities and respond to requests for technical assistance.⁴

In May 2009, End Violence Against Women International (EVAWI) was awarded the OVW technical assistance project, which builds on MCASA's progress and has included intensive work with communities to develop tools and resources that other jurisdictions can adapt for local use. EVAWI currently provides a number of resources, including a community self-assessment tool for multidisciplinary evaluation of current practices; training materials on VAWA provisions and medical reporting mandates; sample protocols, documents, and forms; data collection tools; a compendium of state laws on MFEs; and public service announcements for public education.⁵

Basic Principles of Model Kit Storage Approaches for Non-Reporting Victims

A major focus of concern about VAWA 2005 compliance centered around the issue of kit storage. As more victims become eligible for free exams—because nonreporting as well as reporting victims must have access under federal law—the number of exams being conducted

⁴ See www.mcasa.org/index.php?page=vawa-forensic-compliance-project for further details.

⁵ See <https://www.evawintl.org/> for further details.

could increase. Because one of the purposes of providing forensic evidence collection services to nonreporting victims is to have that evidence available should the victim later choose to report, the kits from exams on nonreporting victims must be retained and must meet the same standards for chain of custody and evidence storage as the kits of reporting victims. With more kits to track and store within finite evidence-storage facilities, communities needed to plan how to meet this challenge. Several approaches have been developed.

Law enforcement storage only: Medical facilities perform the exam and transfer the evidence to a local, county, or state law enforcement agency. In this scenario, kits are stored by law enforcement—with or without identifying information—but cases are not opened for investigation unless the victim files a report.

No law enforcement involvement: Medical facilities perform the exam and securely store the evidence either at the medical facility or at an alternative location, such as a victim service provider. If the victim later chooses to report, the kit is provided to the law enforcement agency with jurisdiction over the case.

Anonymous reporting: Nonidentifying information about the victim and the perpetrator is provided to law enforcement along with the kit. Law enforcement stores the kit and may choose to open an investigation and send the kit to the crime lab for analysis even without a victim report but on an anonymous basis.

STUDY RESEARCH QUESTIONS

Given the large-scale change in MFE payment processes and implementation since VAWA 2005 passed, many unanswered questions remained about how states and localities addressed such changes and what current practices across the nation were.⁶ Thus, this study was guided by the following research questions:

Payment Policies and Practices

1. **Who pays?** What agencies are responsible for paying for MFEs, and what funding sources are being used? What is the variation of agency responsibility within and across states?
2. **What are the practices regarding payments?** Are there restrictions on which services can be paid and payment amounts? Do payment practices vary by the type of payer agency?
3. **To what extent are victims of sexual assault being charged, either directly or indirectly, for the cost of the MFEs they receive?** Is the victim's insurance charged to cover the cost of the exams? If the forensic evidence collection is paid for by someone other than the victim, are victims still charged for the medical component of the exams? Do victims make insurance claims to cover payment, and do victims absorb deductible and co-pay charges? Do victims pay upfront costs and receive subsequent reimbursements?

⁶ This study's design and research questions pertain to VAWA 2005 regulations only and predate legislative changes in VAWA 2013.

Exam Procedures

1. Is medical care part of the exam process?
2. Are counseling and advocacy referrals part of the exam process?
3. Do non-English speakers encounter greater obstacles to receiving MFEs than do English speakers?
4. What other barriers do victims face in terms of receiving MFEs?

MFE Kit Storage and Victim Participation in the Criminal Justice System

1. **Does the extent to which victims participate with law enforcement affect:** Whether or not they receive an MFE? Whether they are charged for the exam, either directly or indirectly? How the kits are stored, and the length of time the kits are stored and maintained? How their rape kits are processed? How the information gathered during the exam is used for law enforcement investigation and prosecution?
2. **For victims not participating:** What kit storage models are used to assist nonreporting victims in getting MFEs? Do these kit storage models encourage victims to get MFEs regardless of their interests in participating with the criminal justice system?

Meeting the Policy Requirement

1. What are stakeholders' perspectives on the extent to which the VAWA 2005 requirement has been met in their states and localities?
2. What is working when it comes to meeting the VAWA 2005 requirement?
3. What challenges exist when it comes to meeting the VAWA 2005 requirement?
4. What are stakeholder perspectives on payment policies?

CHAPTER 2. STUDY METHODS

To address the study's research questions, the design includes multiple methods and data sources. In this chapter, we describe the study design, the state- and local-level surveys, and the case-study process. We also describe the final sample of case-study states.

DESIGN

The design of this descriptive study includes both quantitative and qualitative data collection methodologies. We used a two-pronged approach to collecting data regarding sexual assault medical forensic exams (MFEs): (1) a series of surveys of relevant state and local stakeholders; and (2) case studies including a specific set of states and local jurisdictions. First, we conducted national surveys to obtain state-level information from state STOP administrators (SSAs), victim compensation fund administrators, and state-level sexual assault coalitions. Second, surveys were conducted with nonprofit, nongovernmental, local sexual assault service providers.⁷ Surveys were distributed to potential respondents in all 50 states, the District of Columbia, and US territories that held these state-level positions. These surveys were intended to offer a snapshot of state and local policies and practices around MFEs and to provide us with a foundational understanding of variations and similarities in such practices across the country.

Respondents were chosen for their expertise in the field. Each group *should be* respondents informed about payment practice and policies around MFEs. SSAs are required to certify to the federal Office on Violence Against Women (OVW) their states' compliance with the VAWA 2005 regulations. Documentation of victim compensation funds shows that these funds can cover MFEs in many states⁸—thus, administrators of these funds also are likely to be aware of payment policies and practices in their states. In states where victim compensation funds are not used to pay for MFEs, administrators may be less informed on these issues. State coalitions may have played a role in negotiating the payment practices in their states and what is covered by the payee agencies; these coalitions may also provide technical assistance around their states on these issues. Finally, local sexual assault service providers are the on-the-ground practitioners that help ensure victims receive free exams. Clearly, they have information and expertise that can shed light on the issues of interest in this study.

The information was supplemented with state-by-state cost and compensation practice profile data from the Office for Victims of Crime (OVC) and the National Association of Crime Victim Compensation Boards (NACVCB). In the few cases of conflicting responses or incompatible information, we called state-level survey respondents to verify practices. In addition, we distributed local-level surveys through an extensive listserv maintained by the National Sexual Violence Resource Center (NSVRC) that contained contact information for local community-based sexual assault victim service providers across the country.

Survey data collection included the following goals:

⁷ In most cases, the local service providers targeted for this study were not based in governmental agencies and were the membership agencies of state coalitions.

⁸ <http://www.ovc.gov/pubs/crimevictimsfundfs/intro.html#VictimComp>

- ***A national survey of crime victim compensation fund administrators*** to obtain administrator perspectives on current compensation practices, the extent to which victims are compensated for MFEs and associated medical costs, and whether legislative stipulations regarding MFEs in the Violence Against Women Act (VAWA) 2005 are being communicated to victims and followed. We analyzed survey data to determine how compensation policies related to MFEs payments across the country.⁹
- ***A national survey of STOP administrators*** to gain state perspectives on what actions STOP administrators are taking to promote the VAWA 2005 MFE requirement, whether administrators believe local stakeholders are implementing the requirement, and what is working to improve practices to serve the needs of victims. We analyzed responses from STOP administrators to examine how the requirement is followed across the country.
- ***A national survey of sexual assault state coalitions and a survey of local community-based victim service providers across the country*** to determine how MFE payment is being implemented locally.

The information gathered during the survey efforts guided the second major data collection effort—***case studies in six selected states***. We conducted interviews at the state level, with local stakeholders, and with victims in at least three localities per state (in all but one state, due to various constraints) to gain a more nuanced understanding of local, on-the-ground implementation practices of the MFE requirement. During site visits to each jurisdiction, project team members engaged in observational data collection methods (e.g., tours of hospitals and clinics where MFEs are conducted); face-to-face interviews with local stakeholders, including health care-based exam providers, advocates, law enforcement, and prosecution; and focus groups and interviews with victims who had varying experiences with the MFE process. Although we aimed to complete each item listed in each jurisdiction—and that was the case in most jurisdictions—we were unable to do all forms of data collection in some jurisdictions due to site-specific issues, such as inability to recruit victims for focus groups or interviews, or unwillingness of a particular stakeholder to conduct an interview with us.

SURVEYS

Survey Development

The research team drafted the survey instruments, including items specific to the respondents of each survey that would allow us to answer the study's research questions and inform the site selection process. Items covered such topics as

- Survey respondent's position;
- State statutes and policies regarding MFE payment processes and implementation;

⁹ The 1984 Victims of Crime Act created the Crime Victims Fund, which allows victims to seek reimbursement for expenses incurred as a result of their victimization experiences; for example, medical and mental health treatment costs, funeral and burial expenses, lost wages or support, crime scene cleanup, dental or eye care, etc. (see US Department of Justice, Office for Victims of Crime, <http://ovc.ncjrs.gov/topic.aspx?topicid=58>). Funds come from penalties and fines paid by federal and state offenders, and not from tax dollars. Although there are federal guidelines for how the funds can be used, each state also has legislative guidance for the use of these funds.

- MFE payment sources and payment processes;
- Amount of funding used for MFE payment (if applicable), funding caps, and policies around timing for MFE payment;
- Kit storage for victims who report the crime to law enforcement and those who do not;
- Which portions of the MFE are covered;
- Jurisdictional issues related to MFE payment;
- Use of victim insurance for MFE or related medical care;
- Reflections on the state's or jurisdiction's adherence to the VAWA 2005 requirement;
- Challenges to meeting the VAWA 2005 requirement; and
- What is working well when meeting the VAWA 2005 requirement.

We drafted specific surveys for each type of respondent: state-level sexual assault coalitions, state STOP administrators, state victim compensation fund administrators, and local sexual assault victim service providers. Survey content and length were geared toward each respondent type. Surveys were lengthier for state-level sexual assault coalitions than for others, given that we anticipated they would have broad-based insights and information about issues surrounding MFE payment processes and operations. Surveys for state STOP administrators also were lengthier than those for others because we anticipated that they too would have insight and information, given they are the entities required by the OVW to certify their state's compliance with the VAWA 2005 requirement. On the other hand, given that victim compensation fund administrators had just recently completed surveys on this topic conducted by the state of Indiana,¹⁰ and, we assumed, that administrators who do not pay for MFEs would have no reason to have insights and information on these issues, surveys for this group were relatively shorter. Therefore, two separate surveys were drafted for victim compensation fund administrators: one version for states that used compensation funds to cover the costs of MFEs, and another, shorter version for states that do not use compensation funds for this purpose. Thus, while some questions appear on all surveys, others do not. Throughout later chapters that report survey findings we indicate the specific respondents for each set of findings.

Once drafted, the surveys were sent to the NSVRC staff for review and comment, and they were revised based on feedback on the content of the questions, clarifications, and suggestions for specific audiences. In addition, two members of the Association of Violence Against Women Act Administrators (AVA—the association for SSAs) and the executive director of the NACVCB reviewed the surveys specific to their members and approved them as surveys they would encourage members to take.

We programmed the surveys into CheckBox, a secure online survey software program, which allowed for individual usernames and passwords (thus, respondents could open and reopen a single survey if they were unable to complete it during one session, and we could track responses to send reminders to noncompleters), sample validation checks, and elaborate skip patterns (to ease a user's navigation through the survey by skipping questions automatically based on responses to other questions).¹¹ Next, both research team members and NSVRC staff members

¹⁰ The Indiana Victim Compensation Fund Survey. Data unpublished.

¹¹ To learn more about Checkbox, see <http://www.checkbox.com/>

pilot-tested the online versions of the surveys. Final edits and adjustments were made to surveys based on pilot-test feedback. Appendix A displays the final survey instruments.

Survey responses are based on respondents' impressions in the field. In some cases, respondents may have consulted empirical data about their states or jurisdictions, but others may not have done so. We did not ask if their impressions were based on such data; thus, the data reported herein are based on the impressions of the respondents. However, these impressions are informed based on respondents' expertise and time spent in the field.

State-Level Survey Data Collection Process

Contact information was publicly available for SSAs, as was information for victim compensation fund administrators, though NACVCB provided updated information as needed.¹² NSVRC provided contact information for state coalitions.

In February 2011, a member of the project team attended the annual AVA meeting to conduct a presentation on the study, and in June 2011, we conducted a webinar with state-level coalition leaders through the NSVRC. Both presentations were prior to our first contact with potential survey respondents, and the goal was to inform SSAs and coalitions about the study, describe the nature of the data collection efforts, and encourage their support for the study. In early July 2011, both the AVA and NSVRC sent e-mail notifications to their respective members to introduce us as legitimate researchers and to encourage voluntary participation by their constituents. During the same week, we sent one-page letters to all potential state-level survey respondents that included information about the study's purpose and goals, information about participants' rights (e.g., the ability to skip any question if respondents are uncomfortable), as well as unique usernames and passwords with the survey web address so users could log into CheckBox and complete the survey. Although a few respondents logged in after receiving the initial letter, after approximately two weeks (late July 2011), we began mailing reminder letters and sending e-mail reminders through the CheckBox system over the next two months. In mid-September, we attended the NSVRC's National Sexual Assault Conference and distributed information and surveys to coalitions and local sexual assault service providers to increase participation. In addition to having paper copies available and postage-paid mailing envelopes for respondents to take with them, we also set up four laptops so that participants could take the survey on site. Three coalition representatives did, and a few updated their contact information.

In September 2011, we transitioned to making calls to nonresponding SSAs, compensation fund administrators, and state-level sexual assault coalitions to request their participation. In addition, the AVA and the NSVRC periodically sent reminder e-mails to their constituent groups. In cases where the best method of survey completion was over the phone, we logged into CheckBox and walked the respondent through the online survey. In most cases, though, the reason for nonresponsiveness was due to outdated contact information; after recording updated information, the appropriate respondent was e-mailed the survey link, username, and password. As a final

¹² NACVCB also provided valuable information on whether each state used victim compensation funds for MFEs at the time of the study in order for us to determine which version of the survey particular states should receive.

effort, we mailed paper surveys with postage-paid envelopes and website log-in information to any remaining state-level personnel.¹³

Table 1 shows final response rates. The variations in potential respondents are based on which US territories have these state-level agencies—thus, there are a total of 56 state STOP administrators and 53 victim compensation fund administrators. In addition, some states had more than one state-level coalition, with one state having three. Survey completion response rates ranged from 81 percent to 93 percent. Within victim compensation fund administrators, there was some variation in response rate, with 95 percent of administrators from states that do not use their compensation funds to pay for MFEs completing the survey and 76 percent of those that do use such funds for MFEs responding. This is likely due to the length of the survey, as it was much shorter for those states not using compensation funds for MFEs. Overall, the response rates were high, with 36 states and territories having all three respondent groups completing surveys.

Table 1. Final Response Rates for State-Level Surveys

	State STOP administrators (SSAs)	State Crime Victim Compensation Fund administrators	State Sexual Assault Coalitions
Respondents/total potential respondents	52/56	44/53	47/58
Response rate	93%	83%	81%

Local Community-Based Victim Service Provider Survey Data Collection Process

The NSVRC provided contact information for local sexual assault service providers from a national database that it maintains. From an original list of 1,674 providers, the sample was reduced to 1,641 due to duplicate agencies. After initial mailings were sent out, the sample decreased again due to agencies closing, incorrect/outdated mailing information, satellite offices (we requested that only the primary office complete the survey), agencies outside of the project scope (such as centers providing domestic violence services only), or agencies where VAWA would not be applicable (such as military-based agencies). The final number of potential respondents was 1,107.

In our first contact with potential respondents, we mailed a letter introducing the study in early July 2011. Approximately one month later, we sent an electronic invitation through the Checkbox system. However, this method was discontinued because only a small sample of the potential respondents (n=650) had e-mail addresses listed, and out of this group, close to one-third of the e-mails bounced back. Another batch of mailed letters was sent the first week of August. At the National Sexual Assault Conference in September, 14 local community-based victim service providers took the survey on site. In addition, we learned of two dozen new agencies, were able to spread the word and generate interest in the project, and updated contact

¹³ There was only one state-level respondent who preferred a language other than English, and a bilingual researcher conducted all follow-up e-mails and phone calls.

information for merging or changing organizations. Finally, we mailed postcards to service providers (briefly summarizing the project and log-in information) multiple times as an alternative method of contact. Given the size of the sample, we were not able to conduct follow-up phone call reminders to local providers.

In total, 442 local community-based victim service providers completed surveys. The final response rate for this survey was 40 percent.

Local Site Selection Criteria

- Diverse geography
 - One SART
 - A mixture of challenges and successes
 - One tribal population (if applicable)
-

CASE STUDIES

Based on survey results, we constructed detailed state profiles for all 50 states, the District of Columbia, and the US territories. We were interested in selecting locations for case studies to maximize the diversity of practices included in the study. First, we chose states based on designated funding sources for MFEs and on who administers those payments to ensure we included sites that varied on this primary criterion. Next, we varied states on several other criteria, including: geography, whether

victim's insurance is used, the model for storing kits for victims who did not report the assault to the police,¹⁴ the percent of jurisdictions with sexual assault response teams (SARTs), who provides most MFEs (trained or untrained medical personnel), tribal populations, challenges and successes, and jurisdictional issues. State profiles on these criteria were reviewed during the site selection meeting, which included the Urban Institute/George Mason University project team, our partners at NSVRC, and our NIJ grant monitor. Six states were selected, along with four back-up states.¹⁵ Those final six states represented one each of the following regions: New England, the Midwest, the Southwest, the Northeast, the South, and the Mid-Atlantic.

After the six states were selected, we began outreach to state coalitions to discuss the project and explain the case-study process. We requested that the state coalitions provide recommendations on localities to visit based on four main criteria: a mixture of urban,

State Site Selection Criteria

- Geography
 - Designated funding source and who makes payments
 - Whether victim's insurance is used
 - The storage model for non-reported kits
 - Percent of jurisdictions with SARTs
 - Trained or untrained medical personnel conduct most of the MFEs
 - Tribal populations
 - Challenges and successes
 - Jurisdictional issues
-

¹⁴ We categorized a question on storage models into three survey response options: no law enforcement storage (medical facilities perform the exam and store the kits), law enforcement storage (medical facilities perform the exam and transfer kits to law enforcement), and anonymous reporting (the kit is stored by law enforcement, and a report is made, but there is no identifying information about the victim as part of the report).

¹⁵ One primary state was replaced with a back-up due to multiple scheduling conflicts and refusals to participate by various stakeholders.

rural, and suburban geography; one local jurisdiction with a SART; variety in areas doing well and those facing challenges; and one location with a tribal population or jurisdiction, if applicable. If coalitions ranked two locations as equally advantageous to visit, then we prioritized localities geographically close to one another for travel purposes. While most of our locations were cities, we also had several sites at the county level. In total, 19 local jurisdictions served as case studies. Table 2 describes some characteristics of these 19 jurisdictions. The characteristics are reported by category to protect the confidentiality of the jurisdictions.

We designed the case-study process in each state to consist of one day interviewing state-level personnel, followed by one day at each of the three selected local jurisdictions. Interviewees included:

- The victim compensation fund administrator, state STOP administrator, state coalition director (or an appointed staff member), and sometimes crime lab or other state justice agency personnel, at the state level; and
- Law enforcement, prosecution, victim advocacy staff from community-based sexual assault service providers,¹⁶ and health care–based exam providers at the local level.

Finally, we concluded each local jurisdiction visit with a focus group¹⁷ with victims of sexual assault. We were interested in speaking with victims who had a variety of experiences, such as reporting to law enforcement (or choosing not to) and receiving an MFE (or choosing not to). The only requirement for participation was that the person be 18 years of age or older. With the participants' approval, we tape recorded each session in addition to making handwritten notes.¹⁸

We asked local community-based victim service providers to arrange the focus group sessions for several reasons.¹⁹ First, although we were not asking specific questions about the crime, offender, or other related details, due to the highly sensitive nature of this type of focus group session, we did not want to have any contact information for any of the participants. By having advocates arrange the sessions, we never needed to know the victims' names, phone numbers, or other identifying information. Thus, their participation could truly be anonymous.

¹⁶ In most cases, advocates were from community-based nonprofit service providers or, in three cases, based at service providers on a university campus. Only one victim service agency included among the advocate pool or respondents was a government-based agency, though a member agency in their state coalition.

¹⁷ In a few jurisdictions, only one individual attended the focus group session, and we transitioned to a one-on-one interview instead. We were unable to hold focus groups in several jurisdictions due to a lack of participants.

¹⁸ The audio tapes were transcribed by a contracted organization, which signed confidentiality pledges.

¹⁹ Although they arranged the sessions, none of the advocates were present during any of the focus group sessions. Instead, we asked that an advocate be available in case a participant required assistance or wanted to speak to someone during or after the focus group meeting.

Table 2. Case-Study Jurisdiction Characteristics

Jurisdiction	Population density: ^a Persons per square mile ^a	Percent non- white ^b	Percent population living below the poverty level ^c	Violent crime rate per 100,000 population ^d	Forcible rape rate per 100,000 population ^e
National Average	87.4	31–40	11–15	100–199	21–30
1	1,000–1,499	<=10	>30	<100	<=10
2	500–999	<=10	16–20	100–199	11–20
3	3,000–3,999	11–20	16–20	300–399	51–60
4	7,000–7,999	51–60	21–25	>1,000	>90
5	1,000–1,499	<=10	16–20	na ^f	na
6	1,500–1,999	21–30	6–10	Na	na
7	0–499	<=10	5 or less	Na	na
8	1,000–1,499	41–50	16–20	>1,000	>90
9	1,000–1,499	51–60	>30	800–899	51–60
10	Na	>90	16–20	400–499	<=10
11	2,500–2,999	51–60	16–20	700–799	61–70
12	4,000–4,999	21–30	21–25	900–999	41–50
13	Na	>90	11–15	300–399	>90
14	6,000–6,999	51–60	21–25	>1,000	71–80
15 ^g	2,500–2,999	41–50	5 or less	<100	11–20
	1,000–1,499	51–60	5 or less	100–199	11–20
16	1,000–1,499	41–50	6–10	100–199	<=10
17	4,000–4,999	31–40	26–29	400–499	61–70
18	1,000–1,499	51–60	21–25	300–399	41–50
19	Over 9,000	61–70	16–20	>1,000	31–40

Sources: US Census Bureau, <http://quickfacts.census.gov>; FBI Uniform Crime Reports, <http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2010/crime-in-the-u.s.-2010/tables>.

^a These numbers have been placed into categories to support the confidentiality of the site: 0–499, 500–999, 1,000–1,499, 1,500–1,999, 2,000–2,499, 2,500–2,999, 3,000–3,999, 4,000–4,999, 5,000–5,999, 6,000–6,999, 7,000–7,999, 8,000–8,999, greater than 9,000.

^b This represents data from 2006–2010. Categories: <= 10, 11–20, 21–30, 31–40, 41–50, 51–60, 61–70, 71–80, 81–90, >90.

^c Categories: 5 or less, 6–10, 11–15, 16–20, 21–25, 26–29, >30.

^d Categories: <100, 100–199, 200–299, 300–399, 400–499, 500–599, 600–699, 700–799, 800–899, 900–999, >1,000.

^e Categories: <= 10, 11–20, 21–30, 31–40, 41–50, 51–60, 61–70, 71–80, 81–90, >90.

^f na=Data not available.

^g This jurisdiction spanned two counties.

In addition to this layer of victim protection, we also expected potential participants to be more responsive to the session with the support of the local service providers. The disadvantage in this recruitment strategy was that some agencies were nonresponsive (often because they had trouble contacting clients or clients were not interested in participating) or reluctant to recruit participants (likely due to time constraints). However, many agencies were very cooperative and invaluable in arranging these sessions. To thank focus-group participants for their time, we provided \$40 to each of them.²⁰

All interviews and focus-group procedures and protocols were approved by the Urban Institute (UI) Institutional Review Board for the Protection of Human Subjects (IRB). Consistent with the requirements set forth in Title 45, Part 46 of the Code of Federal Regulations, UI has established an IRB to ensure its research practices and procedures effectively protect the rights and welfare of human subjects. Given the sensitive nature of this study and the direct contact research and other project staff had, we went through an IRB review to ensure that procedures were in place regarding: gaining consent from participating victims as appropriate; fully briefing respondents of their rights as study participants (that the information they provided was anonymous, their participation was voluntary, they were not required to answer every interview question, and individual people would not be identified in data summaries); developing distressed respondent protocols; and ensuring that data were collected and stored securely and seen only by project staff who signed confidentiality pledges.

The stakeholder interview protocols for the site visits were developed based on specific areas of experience with the MFE, reporting to law enforcement, the criminal justice system process, and so on (see appendix B for stakeholder interview protocols and the focus group protocol). After multiple revisions, we shared the protocols with NSVRC staff members and revised them based on their feedback. All interviews and focus groups were designed to be semi-structured. Thus, the questions solicited very specific information from respondents, with the opportunity for elaboration.

Responses during case-study interviews are based on respondents' impressions in the field. In some cases, respondents may have consulted empirical data about their states or jurisdictions. We did not ask if their impressions were based on such data or not. Thus, the data reported herein are based on the respondents' impressions. However, these impressions are informed based on their expertise and time spent in the field.

Table 3 shows the number of local-level stakeholders who participated in interviews and the number of victims who participated in either interviews or focus groups in the six case-study states we visited. In all but one state, where we were unable to garner support from law enforcement or prosecution, we were able to meet with at least one or more stakeholders in each of the categories. Across the states, we met with 30 law enforcement officers/investigators, 16 prosecutors, 32 victim advocates, and 21 SANEs or nurses trained to conduct MFEs, SANE program directors, and hospital personnel who bill for MFEs.

²⁰ We also asked participants to use pseudonyms during the sessions and to sign receipts with a number, pseudonym, or mark acknowledging they received \$40 as a thank-you for their time.

Table 3. Number of Local-Level Interviewees by State and Jurisdiction, by Stakeholder Group

	Law enforcement	Prosecution	Victim advocacy	Nurses / program representatives / hospital personnel	Victims
State 1	5	2	3	2	7
Juris. 1	2 ^a	--	5	--	2
Juris. 2	2	2	3	1	4
Juris. 3	1	--	1	1	1
State 2	7	3	6	6	20
Juris. 4	1	--	3	1	5
Juris. 5	1	1	1	2	10
Juris. 6	3	1	1	3	5
Juris. 7	2	1	1	--	--
State 3	5	3	9	3	14
Juris. 8	1	1	2	1	3
Juris. 9 & 10	3	1	2	1	--
Juris. 11	1	1	5	1	11
State 4	5	3	5	4	6
Juris. 12	1	1	1	1	6
Juris. 13	3	1	2	2	--
Juris. 14	1	1	2	1	--
State 5	8	5	8	5	8
Juris. 15	6	2	3	1	8
Juris. 16	--	1	3	1	--
Juris. 17	1	1	1	1	--
Juris. 18	1	1	1	2	--
State 6	--	--	1	1	7
Juris. 19					
Totals:	30	16	32	21	62

^aThis site included one law enforcement officer and one student conduct officer.

Although we were not able to speak with victims in every jurisdiction visited, we were able to meet with victims in each state (total n=62). Participating agencies recruited only women for these focus groups. Of the women who participated in focus groups or one-on-one interviews, 53 percent were White/Caucasian, 18 percent were Native American, 8 percent were Black/African American, 5 percent were Hispanic/Latina, 2 percent were Asian, 2 percent were Middle Eastern, and 13 percent reported being of mixed races by checking more than one category. In terms of age, 27 percent were between the ages of 18 and 21, 15 percent were between the ages of 22 and 25, 26 percent were between the ages of 26 and 35, 21 percent were between the ages of 36 and 45, and 11 percent were older than 45 years of age.

Table 4 shows some key characteristics of the case-study states. Three of the states designated victim compensation funds to pay for MFEs, one used other state funds, one used STOP funds, and one had a county-determined system whereby each individual county chose the source of MFE funding. Four out of the six states had statutes specifying when providers could bill the victim's insurance: Two indicated that a victim's insurance could be billed as long as s/he consented; the two other states indicated that some portion of the exam had to be covered and victim's insurance could be used for services outside of the forensic evidence collection or outside of services considered to be a full MFE. In terms of storage methods for kits of nonreporting victims, three states used mixed models for storage throughout the state, and three others had anonymous storage by law enforcement of kits for victims who did not report, though this did not mean they had anonymous reporting. The case-study state sample showed variation in the extent to which the states had jurisdictions with SARTs. Two states reported nearly all the jurisdictions in their states had some sort of SART or multidisciplinary team to address sexual assault. Only one state said that between 0 percent and 25 percent of their jurisdictions had SARTs. Finally, five of the six states indicated that *most or all* of the MFEs conducted in their state were conducted by specially trained medical personnel. Only one state reported that most of the MFEs were conducted by untrained personnel.

Reporting of Results from Case Studies

Case-study results are documented in the remainder of this report's chapters. Results were generated through a consensus-driven process in two ways. First, each site's findings were documented in a site report (based on a series of specific questions). Both researchers attending the site visit discussed the responses to these questions to consensus. Second, the entire research team (four researchers) identified a set of themes in response to the study's research questions, based on their experiences on site and the site reports. Individual researchers drafted responses to research questions based on these themes. The full team read and approved each section of the report.

Table 4. Characteristics of Case-Study States

State	Designated funding source	Use of victim's insurance by statute	Model for storing nonreported cases	Percent of jurisdictions with SARTs (percent)	Who provides most of the MFEs
1	Victim Compensation	Only for services outside of MFE	Anonymous storage by law enforcement (not anonymous reporting)	76–100	Untrained personnel
2	County determined (law enforcement, prosecution, human services)	Forensic is covered; other aspects of MFE billed with victim's consent	Mixed storage model for nonreporting	26–50	Specially trained examiners
3	Other state funds	Not specified	Mixed storage model for nonreporting	51–75	Specially trained examiners
4	Victim Compensation	Bills insurance with victim's consent	Mixed storage model for nonreporting	26–50	Specially trained examiners
5	Victim Compensation	Bills insurance with victim's consent	Anonymous storage by law enforcement (not anonymous reporting)	0–25	Specially trained examiners
6	STOP	Not specified	Anonymous storage by law enforcement (not anonymous reporting)	76–100	Only specially trained examiners

CHAPTER 3. MEDICAL FORENSIC EXAM PAYMENT POLICIES AND PRACTICES

The passage of the new requirement around sexual assault medical forensic exams (MFEs) in the reauthorization of the Violence Against Women Act (VAWA) in 2005 laid the foundation for changes in policies and practices throughout the states to ensure that victims are provided exams free of charge and without having to report to law enforcement. This chapter examines payment policies and practices in terms of who pays for MFEs, what the practices are around such payments, and the extent to which victims of sexual assault are charged, either directly or indirectly, for the cost of the MFE.

PAYING FOR SEXUAL ASSAULT MEDICAL FORENSIC EXAMS ACROSS THE COUNTRY

As we collected the data for this study, it became clear that when we asked about MFE payment, some respondents answered in terms of who (or which agency) actually paid the bills, while others answered in terms of which funding sources were used. As a result, we take special care to describe both designated funding *sources* and designated *payers* in this section of the report. Table 5 shows designated funding sources along with which agencies administer those funds for the 50 states and the District of Columbia.²¹ Because some states use a combination of funding sources—or blended models of payment—there are more than 51 entries in the table. However, the bolded numbers in the following narrative add up to 51, representing a mutually exclusive count of funding-source designees.

Victim compensation funds are the most commonly designated source of funds to pay for MFEs. Also, victim compensation fund administrators are by far the most common agencies to administer funds to pay for MFEs, including both compensation funds and other funding sources such as special funds designated for MFEs. The least likely designated source of funding to cover MFEs is STOP (Services*Training*Officers*Prosecutors) funds, and STOP administrative offices are the least likely to pay MFE bills. This is ironic, given that what is at stake when the VAWA 2005 requirement is not met is the state's STOP program eligibility, risking a primary source of funding for services and criminal justice approaches to address violence against women.

More specifically, 34 states use victim compensation funds distributed by the compensation fund administrator to pay for MFEs or parts of MFEs, but only **19** of those *only* use victim compensation funds. Other compensation fund administrators are distributing both compensation funds and other sources of funds to cover MFEs. For example, **10** combine both compensation funds and special funds (e.g., a state budget line item specific to MFE payment) to cover MFEs. Sometimes these funds are kept distinct and tracked separately; in other cases, there is no distinction, and the two sources are simply combined and used to cover the costs of MFEs as needed.

²¹ Data for this table were compiled via state-level survey responses and, in some cases, follow-up phone calls to states where responses were unclear. Additional sources of information include the Indiana Victim Compensation survey of state fund administrators and AEquitas' 2013 report, *Rape and Sexual Assault Analyses and Laws*.

Table 5. Designated Sources of Funding for MFEs and the Agencies That Administer the Funds

Designated fund sources for MFEs:	Public agency that administers payment:				
	Crime victim compensation program	State Depts. of Health, Mental Health, Human Services	Victim service office or state-level coalition	Law enforcement and/or prosecution	County-level designee (varies by county)
Crime victim compensation funds	34				
State health, mental health, or human services funds		1	1		
Law enforcement and/or prosecution funds				11	
STOP funds			2		
Special dedicated medical forensic exam funds	10	1	1	3	
County funds (varies by county)					3

Note: N=51, States include the District of Columbia. Six states use blended-funding models based on whether a victim participates in the criminal justice system and 10 states that have compensation fund administrators administer the program use both compensation and special funds; thus, these designees are shown twice in the table.

Six states use blended models to pay for MFEs, five of which involve victim compensation administrators and/or funds. For example, some may use law enforcement or prosecution funds for victims who report their assaults, but use compensation or special funds for nonreporting victims. Another example of such a blended model is states that use one source of funding (e.g., law enforcement) for the forensic portion of the exam and another source of funding (e.g., victim compensation funds) for the medical portion of the exam.

Eleven states use law enforcement or prosecution funds administered by those agencies. However, only **seven** of those states *only* use law enforcement or prosecution funding; the other four use such funding in blended models discussed above, so that these sources are not paying for medical portions of the exam (in some cases) or for MFEs for nonreporting victims (in other cases). **Three** states use a county-by-county model whereby individual localities designate funding sources and payment agencies. Thus, in some counties in these states, law enforcement and/or prosecution funds may be designated for MFEs, as well as county departments of health or social services. Regardless of the funding source designated, county payers may vary based on specific local arrangements made for how these exams get paid. For example, a county's prosecution agency may contract with the local sexual assault nurse examiner (SANE) program to provide payments to providers for MFEs, as is the case for a county within one of our case-study states. In this case, the *source* of MFE funding is prosecution and the independent SANE program is the *payer* that responds to bills submitted by hospitals and pays its own staff as appropriate.

Finally, in the remaining states, **three** designate special funds only to cover the costs of MFEs (administered by various agencies), and **two** designate monies from state departments of human services, health, and/or mental health. Two states designate STOP funds to cover MFEs, but just **one** uses *only* STOP funds to cover the costs. The other state using STOP funds does so in a blended-funding model format.

Paying for Sexual Assault MFEs in the Case-Study States

The six case-study states represent various models of funding sources and payers.

- Five used statewide mechanisms of payment for MFEs:
 - Three case-study states designated victim compensation funds to cover the cost of MFEs administered by the fund administrator;
 - One designated STOP funds administered by a grants administration agency; and
 - One designated other state-level funding administered by the statewide victim service agency.
- The sixth state used a county-determined model for which the majority of counties, although not all, designated either law enforcement or prosecution funds to pay for MFEs administered by various agencies. While the majority of counties designated law enforcement or prosecution funds to pay for MFEs, some large-population counties designated other funding streams, such as special line items in county budgets or the department of human services. In addition, one large county designated prosecution funds as the funding source, but the office contracted with the local independent SANE

program to do the administrative work to implement the MFE funding program. Therefore, some site respondents in this state estimated that though more than half of *counties* in the state designated prosecution or law enforcement funds to pay for MFEs, the vast majority of *exams* were paid by non-criminal-justice agency staff. This was because the most populous counties were those that paid for exams through agencies other than criminal justice ones.

Anonymous Payment?

As MFE policies and practices have evolved, a great deal of focus has been put on whether law enforcement agencies store kits for nonreporting victims and, if they do, whether they do so without knowing the identity of the victim. One case-study state has taken this idea even further and has created a system by which the designated MFE exam payer does not know the identity of the victims. The payment system is a statewide payer through the victim compensation fund. The state provides standardized, numbered kits for use by health care providers. Health care providers bill the compensation fund directly to cover the costs for particular kit numbers, regardless of whether the victim reported to the police. Victims who report to the police may pursue compensation funds to cover costs related to the sexual assault that are not routinely covered as part of the exam, and at that point the fund would learn the identity of the victim. But, beyond this scenario, the victim compensation fund never knows the identity of the victims for whom they pay for exams.

What Services Are Covered by Designated Payers?

Not only do designated funding sources and paying agencies vary across the country, but so does what is considered part of the MFE process and what is paid for by such designated sources. As required by VAWA 2005, all six case-study states cover forensic evidence collection procedures, which often includes facilities' fees, emergency room triage, emergency room doctor fees, SANEs' fees, colposcopy and endoscopy, and other photographic imaging. In addition, all six states cover testing for pregnancy and sexually transmitted infections (STIs), and five cover treatment and prophylaxis for pregnancy and STIs. Two states cover prophylaxis for HIV: One covers the first three days of the treatment, and the other covers the treatment only under certain circumstances. States cover ambulance fees and alcohol and drug testing under certain circumstances. In one state, testing for drug-facilitated rape requires approval from a prosecutor in order to be covered by the designated payer.

Beyond the services stated above, states cover other services in varied ways or not at all. Only one case-study state routinely covers testing or treatment for injuries (e.g., X-rays, computed tomography scans [CT or CAT scans], treatment for broken bones) that occurred during the assault, but only up to \$150. Another state covers treatment of injuries only under certain circumstances. There are several ways the remaining costs for these services are paid in this state and others. If available, the victim's insurance might be billed for those additional treatments, or victims can access compensation funds to cover other medical interventions if they have reported the assault to the police (though the victim's insurance still might be billed because victim compensation is the payer of last resort). In some states, the act of having had an MFE, regardless of whether the assault is reported to the police, satisfies the condition to qualify for

compensation. Similarly, as is the situation in one case-study state, health care providers who perform MFEs are considered adjunct criminal justice agencies, therefore having an exam meets the condition of cooperation with the criminal justice system to qualify for compensation. In addition, many respondents across case-study states indicated that some hospitals typically absorb any remaining cost of the MFEs and medical treatments as part of their community service efforts. In one state, respondents said this could be between \$700 and \$2,500 for every MFE.

Notably, four case-study states had specified maximum amounts (payment caps) the designated payer would provide for allowable MFE services. These caps were either overall total amounts for all allowable services (e.g., a maximum payment of \$750 or \$1,200) or specific caps for specific services (e.g., \$150 for medical services). According to site-level respondents, MFEs often cost more than the payment caps. With prohibitions in some states against billing the victim's insurance (either at all or for the balance of the bill), the exam provider is faced with the choice of covering the remaining costs or billing victims for services specified in state legislation as part of an MFE. Based on feedback from respondents in the case-study states, victims are typically not being billed for the uncovered costs of the services specified as part of the MFEs or covered by the public payer under state statutes. However, they might be billed for other services that are not covered by the public payer as specified in state statutes. This distinction may be lost for victims—a bill is a bill.

In addition, in the case-study state employing a county-administered payment program, individual counties negotiated designated funding sources and payers, as well as the particular services that are covered for an MFE payment. The counties must cover *at least* what is required by state statute (doctor/SANE fees, facilities' fees, emergency room doctor triage, colposcopy, endoscopy, pregnancy testing, and STI testing); some counties have negotiated additional services to be included in standard MFE payments (see sidebar). Thus, victims in some portions of the state have many more services paid for via designated MFE payers than do victims in other portions of the state.

In sum, in case-study states, the forensic evidence collection portion of MFEs is covered regardless of the designated funding source or payer. States vary as to what other services are covered during exams, but it seems that in each of these states, *at least* testing for STIs and pregnancies are also routinely paid for as part of the MFE. Payment for treatments for STIs, pregnancies, and injuries varies from state to state.

Negotiating MFE Payment

One county in the county-administered case-study state appears to have an approach to MFE payment that focuses primarily on the victims' needs. The designated payer (a government-based victim agency) negotiated a payment process with the local hospital that conducts all of the MFEs in that region through a hospital-based SANE program. The contract between the county and the hospital is that the county will pay for all reasonable services conducted during an MFE, some of which are not legally required to be paid, and the hospital will give the county a 50 percent discount on all such services. Thus, the county pays for 50 percent of the initial exam, testing, and services provided during the first visit to the program. In addition, the agreement includes payment for one follow-up visit, up to \$500. The hospital representatives reported they write off about \$500 to \$700 per exam as a result of this agreement; however, there are limitations to this agreement. The county will not pay for victim injuries and the cost of a hospital stay. When this occurs, either the victim's insurance is billed or the hospital writes off the additional treatment costs.

THE VICTIMS' ROLE IN PAYMENT FOR MEDICAL FORENSIC EXAMS

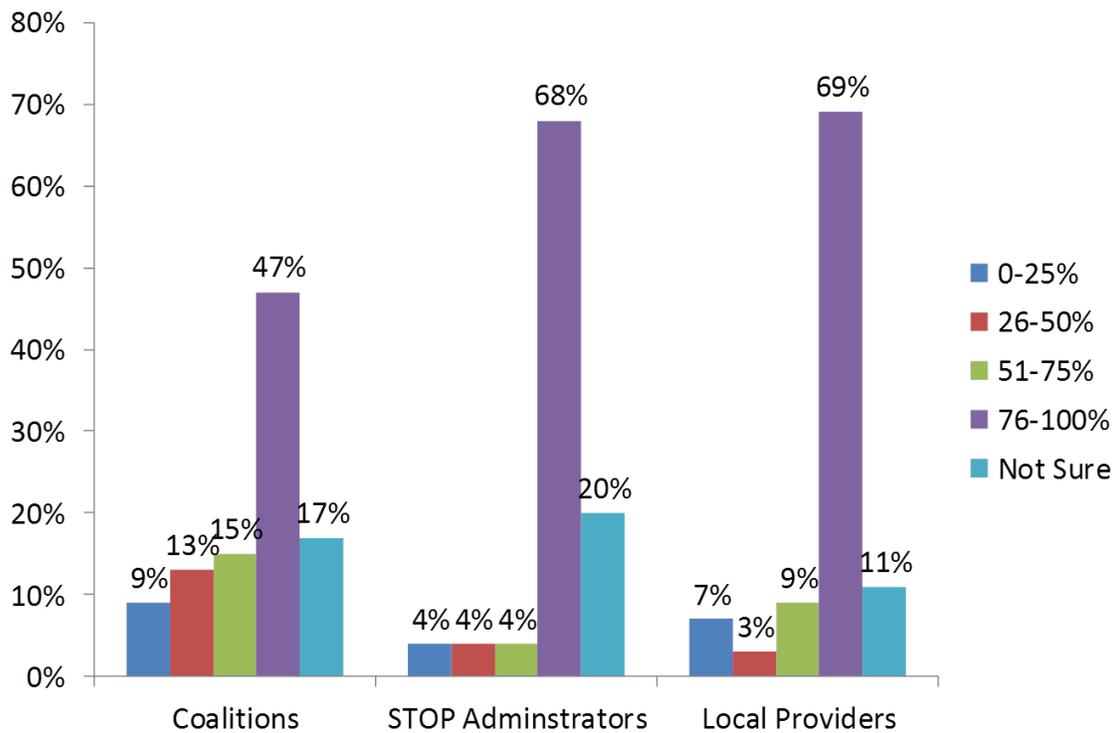
Victims may access free exams in one of two ways: without ever paying any exam fees, or by paying upfront charges and getting reimbursed. Our surveys of state STOP administrators (SSAs), state-level sexual assault coalitions, and local victim service providers asked for their perspectives on how victims access free exams. The majority of SSAs, coalitions, and providers indicated that most victims receive free exams with no upfront charges. Only a small number of survey respondents felt that many victims receive free exams through reimbursement of out-of-pocket expenses.

Survey Findings about Free Exams²²

Figure 1 documents the perceptions of SSAs, coalitions, and local providers on the proportion of victims who receive exams free of charge without paying any out-of-pocket expenses. The respondents' perceptions were fairly similar, indicating that the most common scenario is for most victims in their states to receive free exams with no upfront charges. Between 47 percent and 69 percent of these respondents reported that at least 76 percent and up to 100 percent of victims receive free exams without incurring out-of-pocket expenses. Between 62 percent and 78 percent indicated that more than half of all victims receive free exams with no upfront charges, with only 8 percent to 22 percent reporting that fewer than half of all victims receive free exams without ever paying. Not everyone reported their judgment; between 11 percent and 20 percent of the respondents were not able to provide estimates.

²² State-level sexual assault coalitions, SSAs, and local providers were asked questions regarding free exams.

Figure 1. Perceptions of the Percent of Victims Who Receive Medical Forensic Exams Free of Charge without Paying Anything Out of Pocket²³



N=47 valid responses from state-level sexual assault coalitions

N=50 valid responses from state STOP administrators

N=407 valid responses from local providers

Voices of Victims: Exam Costs Paid Upfront without Billing Victims

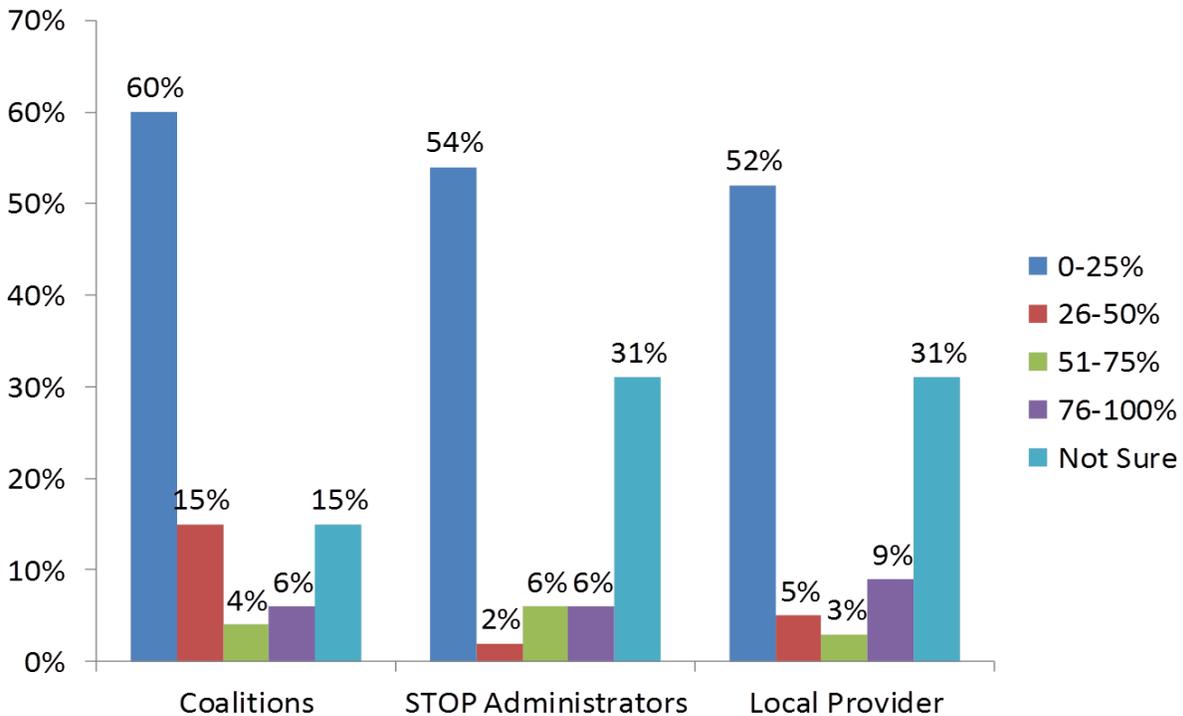
“Where I went, they had a contract with the state where I never paid for the exam . . . They mentioned that there was no cost, like I don’t have to pay for it.”

“I was prepared to pay for whatever it cost. But they didn’t bill me.”

Figure 2, below, shows that SSAs, coalitions, and providers were again remarkably consistent in reports, indicating that it is relatively uncommon for many victims to receive free exams through reimbursement procedures. More than half to 60 percent of these survey respondents reported that from 0 percent to 25 percent of victims received free exams through reimbursement. Only 10 percent to 12 percent reported that more than half received free exams through reimbursement. However, 15 percent to 31 percent of respondents did not offer estimates.

²³ Due to rounding, the numbers in figures and tables throughout the report may not add up to exactly 100 percent.

Figure 2. Perceptions of the Percent of Victims Who Receive Medical Forensic Exams Free of Charge through Reimbursement of Out-of-Pocket Expenses



N=47 valid responses from state-level sexual assault coalitions

N=48 valid responses from state STOP administrators

N=399 valid responses from local providers

Voices of Victims: Victims Billed but Reimbursed

“They kept on mailing me a bill, but I just ignored it. I’m trying to get [advocacy program] to help me with it, but it showed up on my credit report.”

Case-Study Findings on Exam Payment

To explore the victim’s role in exam payment in more depth through our case-study interviews and focus groups, we asked the professionals and the victims we met about victim billing, the use of the victim’s insurance, and the use of compensation for any exam services not covered by the designated exam payer for the state.

Victim Billing

Medical care and forensic evidence collection are much more accessible to victims if they do not have to bear the financial burden of those services. Our case-study findings indicate that, consistent with the survey results, the large majority of victims do receive free exams, and they receive them without having to pay any upfront expenses for which they are later reimbursed. We heard from SSAs, coalitions, state compensation fund administrators, local victim service providers, and exam providers that the standard practice was for victims to receive free exams without ever being billed. Few of the victims in our focus groups reported being billed for exams, and several expressed their appreciation for no-cost services.

Voices of Victims: Importance of Free Exams

“I was told that it would be paid for by the state, that it wasn’t going to be no cost at all to me, and that was such a big relief. That was such a big burden.”

“I love that they did everything free, and that they vaccinated me for STDs and HIV and AIDS and whatnot, and checked for all that, and I think that was great.”

Some of the staff we interviewed reported that a victim would very occasionally be billed by mistake, but this seemed to be an infrequent occurrence. One situation in which victims might be billed by mistake occurs when the victim has injuries that require services in the hospital’s emergency department, and the exam is also provided. In those cases, the hospital’s billing department may not flag the exam as a service that should be charged to the state’s designated payer agency. Rather, the exam fees may get rolled into the bill for the emergency department services and included in bills to the victim or her insurance. In cases with billing mistakes, an advocate can assist the victim in getting the bill redirected to the public exam payer or in getting reimbursement for charges the victim has already paid. Victims reported that when they were billed, they were able to work with an advocate or the hospital billing department to have the bill redirected to the appropriate payment source.

Voices of Victims: Billing Mistakes

“Mine was billed to insurance, too. I got a \$1,000 bill in the mail—I’m not even sure how they got my information. I talked to a woman on the phone—someone in the billing department—and she took care of it. I didn’t have to pay.”

Use of the Victim’s Insurance

VAWA 2005 specifies that the victim’s insurance cannot be billed *if* STOP funds are used to pay for the exams. Because only two states use STOP funds for exams, this leaves most states free to determine their own policies on use of victim’s insurance. Some states have laws or policies that

specifically address the use of insurance, but others do not. Practices may vary widely in states that do not have laws or policies on use of insurance.

According to a recent legislative review and analysis by AEquitas (2012), only 15 states have laws addressing use of insurance, and these laws vary considerably. Four states require exam providers to bill the victim's insurance before seeking payment from the state. This policy is designed to conserve state funds and allow the state to pay for more uninsured victims' exams by using insurance funds, when available. Use of insurance may also help to cover more of the providers' costs, given that government agencies' payment caps often fall short of actual expenses. However, this policy may also compromise victims' confidentiality, as when victims' parents or other family members may receive explanation of benefits statements from the insurance companies that detail sexual assault exam charges. To protect confidentiality, three states' laws take the opposite approach of forbidding exam providers from billing the victim's insurance (although one state makes an exception if the state payer's funds are exhausted). The other states take a more middle-of-the-road approach: six states allow insurance billing with the victim's consent, and two other states allow insurance billing only for services outside the scope of the MFE.

Our case studies indicated that exam providers' understanding of state laws and policies—and the providers' actual practices around insurance billing—may vary widely. For example, in one state some providers routinely bill the designated paying agency without first billing insurance, while others bill insurance, based on different understandings of state laws. In another state, some providers seek victims consent to bill their insurance, others bill insurance without getting consent, and still others routinely bill the designated payer without pursuing insurance billing at all.

Insurance billing practices may also vary by the type of service provided. The designated payer often does not cover all services that a victim may need. For example, basic medical services may be covered, but more extensive treatment of injuries or prophylaxis for pregnancy or STIs may not be covered. This may vary state by state, as determined by each state's laws and policies. Some providers may bill the victim's insurance for uncovered services; other providers may write them off and absorb those expenses themselves. Crime victim compensation funds may also be used for expenses not covered by the designated exam payer.

Voices of Victims: Use of Insurance and Confidentiality Concerns

“I was just worried about it going on my parents' insurance and them seeing it if I never told them.”

(Were you concerned about being billed?) “More than anything. I'm on my mom's insurance. So, if it would get billed, I didn't want it to be on her insurance.”

(From a victim who chose not to get the exam) “I would have been very concerned about paying for it, especially since I'm sure they would have billed my insurance, and my insurance at the time was with my dad, and I'm also a child sexual assault survivor, and my dad is the offender, so I wouldn't have wanted that bill to go through his insurance because I knew that he monitored that insurance.”

Use of Victim Compensation for Uncovered Expenses

As noted previously, in many states, the victim compensation program is the designated payer agency for exams. Standard compensation program regulations require victims to report crimes to law enforcement and cooperate with reasonable requests, both to verify the crime and to encourage participation in the justice system. Since VAWA 2005 specifically forbids reporting requirements as a condition for free exams, compensation programs that pay for exam expenses waive this requirement for exam claims. Some have established special exam payment programs within the compensation system, with their own sets of regulations and procedures that do not require victims to participate in the justice system.

Whether or not the victim compensation program is the designated payer for exams, it can be a source of payment for additional expenses not covered by the exam payer. This might include medical treatment beyond the basic services covered in the MFE or additional needs, such as mental health counseling or lost wages. In most case-study states we visited, victims must comply with the standard compensation requirements, including police reporting, to access compensation benefits to cover these expenses. In several states we studied, compensation regulations specify that having the exam satisfies the reporting requirement for “regular” compensation, so that victims who get exams can access compensation for additional expenses whether or not they report to the police.

Voices of Victims: Paying for Uncovered Expenses

“The pharmacy is charging me now, but I have applications in for different health care programs to see if they can go back and cover it. It was like \$2,000 just for the meds (*HIV prophylaxis*).”

“I never received a bill for the exam, except for some of the medications associated with the exam.”

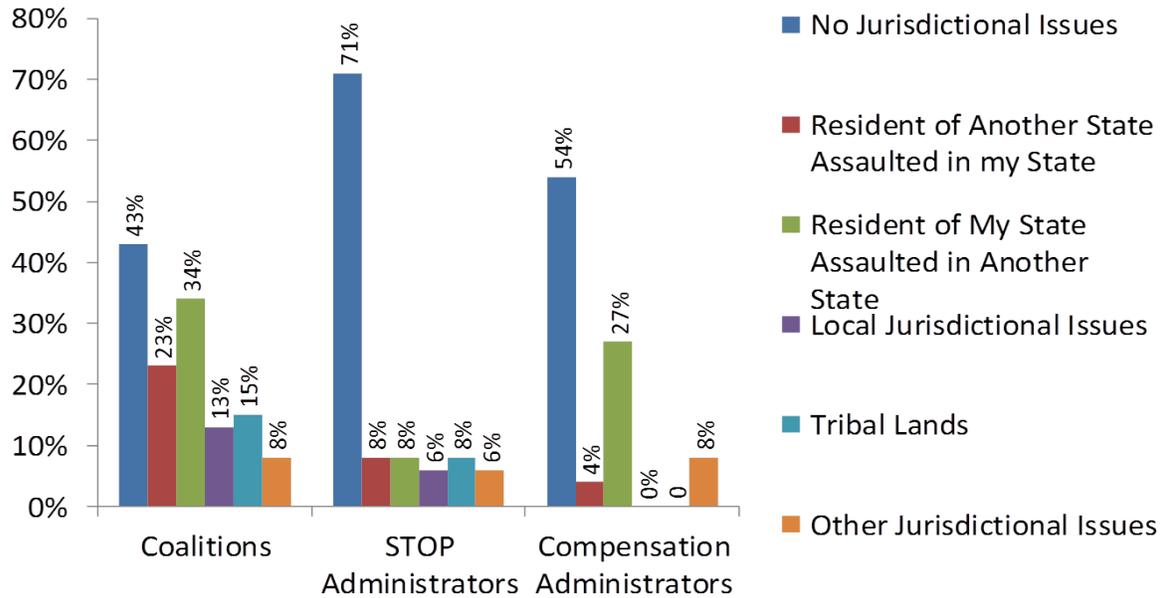
“With the medical bills, they sent me a form to apply . . . I guess an organization can help you pay for the ER visit . . . They have a different, I guess, program that can help with that and they sent me the paperwork so I could petition for them to pay for my medical bills.”

JURISDICTIONAL ISSUES RELATED TO EXAM PAYMENT

One possible concern linked to MFE payment policies and practices is related to jurisdictional tensions—who should be the identified payer in particular circumstances that cross jurisdictional lines. For example, when a resident of one state is assaulted in another state, or when a victim gets the exam in a different jurisdiction than the one in which she was assaulted. Figure 3 documents the reports from surveys with state coalitions (N=47), state STOP administrators (N=52), and state compensation fund administrators (N=26; from states where compensation funds are used to pay for exams) on the types of jurisdictional issues that exist within their respective states regarding exam payment. Respondents were allowed to answer with more than one response to characterize the myriad issues victims in their state may be facing.

More than half of state STOP and compensation fund administrators reported no jurisdictional issues with exam payment, while only 43 percent of state coalitions reported victims within their state faced no exam payment issues due to jurisdiction. Although some states reported no jurisdictional issues, some still went on to indicate specific issues that we laid out.

Figure 3. Percent of Respondents Reporting Jurisdictional Issues Related to Exam Payment²⁴



N=47 valid responses from state-level sexual assault coalitions

N=52 valid responses from state STOP administrators

N=26 valid responses from state compensation fund administrations (that pay for MFEs)

The most commonly reported jurisdictional problem with payment was when residents of their states were assaulted in another state; this was reported by 34 percent of state coalitions and 27 percent of victim compensation fund administrators. Only 8 percent of STOP administrators reported this concern. Twenty-three percent of state coalitions reported that there were also jurisdictional payment issues when victims from another state were assaulted in their states. However, only 4 percent of compensation fund administrators and 8 percent of STOP administrators reported this problem. Local-level jurisdictional issues related to MFE payment were identified by 13 percent of state coalitions and 6 percent of STOP administrators, yet no compensation administrators reported local-level jurisdictional issues. This may be because states that use compensation funds to pay for MFEs typically have a statewide mechanism for payment through the compensation program. Finally, jurisdictional payment issues related to tribal lands appear to occur in some states. Fifteen percent of coalitions and 8 percent of STOP administrators reported such problems when it comes to paying for MFEs on or near tribal lands.

²⁴ Local providers were not asked questions regarding jurisdictional issues related to payment.

In sum, although most STOP and victim compensation fund administrators reported through surveys no payment issues based on jurisdiction in their states, more than half of state coalitions reported the opposite. The most commonly reported payment issues around jurisdiction occurred when victims from the respondents' states were assaulted in other states.

Findings from Case Studies on Jurisdictional Issues Related to Exam Payment

State-level and local respondents from case-study sites reported jurisdictional issues with exam payment similar to those the survey respondents reported. However, what became clear during our case-study interviews was not whether there were issues because a resident from one state was assaulted in another state (as we asked during the survey and reported above). Rather, the jurisdictional issues revolved around where the *assault* took place or where the *exam* took place. Thus, the major jurisdictional issues related to exam payment arise when an exam is conducted in another state for an assault that occurred in the respondent's state (or vice versa), local jurisdictional issues with exam payment when a state did not have a statewide mechanism for payment, and payment for exams conducted for cases from tribal jurisdictions.

State-to-State MFE Payment Issues

We identified some issues with MFE payment at the state level during our case studies. One representative from one state-level sexual assault coalition noted that they may not be aware of all jurisdictional issues with exam payment in his or her state because victims would typically come forward to a local victim services provider to make a complaint before they would report the issue to the state coalition. That said, the primary state-to-state MFE payment challenge we identified regarded paying for exams conducted in one state for assaults that took place in another. Three of the six state sexual assault coalitions provided examples of cases where there were issues with exam payment when it was conducted in another state for an assault that occurred in their states. A compensation fund administrator reported that a possible reason for the confusion may be due to the variation in state practices surrounding exam payment and internal state policies that allow only for payment of exams conducted within that state. However, though identified as a problem, respondents generally reported that these issues could get resolved. In one such state where this problem was identified, the victim compensation fund administrator said they assisted victims in identifying the payers in the states in which the exams took place and in ensuring the exams were paid for by those states' designated payers. In addition, two coalitions reported that these jurisdictional issues were resolved for victims assaulted in their states after they worked with compensation fund administrators from the other state to cover the exam.

We heard the opposite about paying for exams conducted in respondents' states for assaults that occurred in other states. In two states using a statewide mechanism of exam payment through the victim compensation fund, fund administrators reported that their payment relationship was directly with health care providers. Thus, in both cases, the provider would bill the victim compensation fund directly. Therefore, as long as the provider was in the state, the exam would be covered regardless of where the assault happened.

One area we visited presented a complex example of exam payment issues based on jurisdiction and, in fact, we received conflicting reports as to whether the payment issues were valid. The sexual assault coalition reported that, because there was a confluence of states in this particular geographic region, they face many jurisdictional issues regarding exam payment as well as chain-of-custody of the kit and kit storage. Due to these jurisdictional concerns, there have been instances where victims seeking an exam have been asked to get the exam in the jurisdiction where the assault took place, which, the coalition reported, was not feasible for some victims. In contrast, the director of the SANE program and the state STOP administrator reported that exams in that jurisdiction were paid for even when the assault had occurred in another state. Hence, it appears stakeholders had conflicting reports regarding payment practices in cases where the exam was conducted in one jurisdiction for an assault taking place in another.

County-to-County MFE Payment Issues

In the case-study state in which MFE payment practices are decided at the county level, two issues regarding MFE payment came to light. First, both state- and local-level respondents reported some confusion throughout the state regarding who the designated payers are within each county. In this case, people just did not know who should be paying for MFEs within their counties or state. To alleviate this, a state agency has provided a list identifying county-level paying agencies with contact information; however, the confusion still exists.

Second, the statute regarding MFE payment articulates that the county in which the assault occurred is the county responsible for paying for the exam. So, unlike in the states with statewide mechanisms of payment, discussed above, where the important distinction is where the exam is conducted, in this state what matters is where the assault occurred. Victims may or may not choose to go to the hospital in the county where the assault occurred. For example, the closest hospital might not be in the same county as where the assault happened, victims may choose to travel to a larger hospital than those available to them in the county where the rape occurred, or victims may not want to go to a local hospital if they know the staff. In cases where this happens, it may take some time for hospitals to work out what agency to bill; however, reports from hospital administrators, SANE nurses, and other representatives indicated that victims were typically not billed for the exam due to this confusion. Rather, it might take the hospital longer to get paid as they sort out which agency to bill, and they may mistakenly first bill the wrong designated payer.

In one large county, the designated paying agency for MFEs reported that they pay for about 30 exams per year for assaults that do not happen there. To date, they have not concerned themselves about billing the other counties for the 30 exams done for assaults in other counties. But the respondent expressed some worries about this continued practice, and said they should consider billing the other counties where the assaults occur. Other counties bill them when victims go to those counties for exams for assaults that happen in their county—per year they pay for about 100 to 150 exams conducted in other counties for assaults that occur in their own.

Tribal Jurisdictions

Payment of exams conducted for assaults that occurred on tribal reservations can become challenging in the case-study state we visited that designated payers at the county level. Within this state, some of the tribal jurisdictions are under Public Law 280²⁵ (state and local jurisdiction over crime), and some are not under Public Law 280 (federal jurisdiction). Further, in some of these areas, multiple law enforcement agencies have concurrent jurisdiction. Determining who should be responsible for exam payment on the reservation can get confusing. One particular case was caught up in this issue. A victim was billed, a dispute ensued between the Federal Bureau of Investigation (FBI) and local law enforcement about who should pay, and advocates went to the hospital and the tribal chief to help resolve this issue. The resolution: The FBI has determined that they will not pay for exams unless the victim reports it to them specifically; thus, they will only pay for exams for victims who report the assaults. As a result, the county sheriff near the reservation has agreed to pay for exams occurring for victims who choose not to report to the FBI. While, in this particular geographic area, payment for both reporting and nonreporting victims has been sorted out, it is not clear that this has occurred for other reservations throughout the state.

The other two case-study states we visited with a particular focus on tribal reservations had statewide mechanisms for payment to which exam providers bill that fund directly. Thus, in these two states, paying for exams for assaults occurring on reservations was not raised as an issue. Importantly, for American Indian victims, access to the exam may be a bigger concern than payment for it. This issue is discussed further in chapter four.

REFLECTIONS ON MFE PAYMENT POLICIES AND PRACTICES

Several broad issues around payment policies and practices emerged during our case studies. These matters center around the use of statewide versus local payment mechanisms, the sufficiency of payment funds and caps, and the use of crime victim compensation funds to pay for MFEs. These issues have broad implications for the success and sustainability of exam payment systems, and we learned about perspectives and experiences that may be beneficial to states and localities considering these issues.

Statewide vs. Local Payment Mechanisms

Most states use the same payment mechanism for the whole state, whereas a small number leave the payment process to local authorities, such as county-level agencies in the justice system or other systems. The extent to which the payment function is centralized or decentralized affects payment policies and processes, and both centralized and decentralized models have advantages and drawbacks.

Statewide payment systems have the advantage of providing consistency across the state. Policies for which expenses are covered and payment amounts, as well as billing and payment procedures, are uniform. This promotes a sense of fairness and parity. It also eliminates

²⁵ Public Law 280 outlines which tribal nations are under federal law enforcement authority and which are not.

jurisdictional issues within the state, so that it does not matter if the victim was assaulted in one locality but received the exam in another locality; a statewide agency pays for all exams across the state.

However, the consistency provided by a statewide payment system can also be its chief drawback. Several of the people we interviewed noted that cost of living can vary widely from one area of a state to another, so that pay scales and other operating expenses for exam providers can be very different. Having set payment amounts for all providers does not acknowledge cost-of-living differentials, which means that providers in some parts of the state get more of their expenses covered than those in others. A similar issue results from paying the same amounts for exams provided by trained and certified SANEs with specialized equipment, as for exams provided by personnel without specialized training or equipment. One disadvantage is that exams provided by the more qualified and better-equipped staff cost more because their qualifications warrant higher pay scales, and the equipment is expensive. Since those exams are paid at the same rate, less of the actual cost is covered. A related disadvantage is that there is no financial incentive for facilities to promote training and buy the equipment since they would still receive the same reimbursement from the state and, thus, would lose more money by spending more money to get the same amount back. One possible way to alleviate these drawbacks is to establish exam payment systems that take cost-of-living issues and provider qualification issues into account.

A few states use decentralized payment systems in which payment policies and processes are in the hands of local authorities, such as law enforcement, prosecution, or other county or city government agencies. This approach has the advantage of allowing local agencies to work out policies and procedures that take local conditions into consideration. Some localities have negotiated systems that operate smoothly and make efficient use of funds available to cover costs, and are pleased with local control. Other localities, however, have not been able to negotiate favorable arrangements and may prefer a statewide system that would establish different policies and procedures.

For instance, the case-study community discussed previously, in which the payer agency in one locality negotiated a contract with the local exam provider (with the payer covering legally required services and other reasonable services as determined by the patient's needs, but at a 50 percent discount from the provider's usual fees), is an example of a locality that is making this system work. Both the payer agency and the exam provider find this to be an advantageous arrangement and are satisfied with the terms negotiated under local control.

However, several other communities in that case-study state are not as satisfied with their arrangements. Some find the payment process itself to be tedious "clerical" work and would prefer to have a statewide system that centralizes claim processing responsibilities in a statewide agency. Another complaint is that these payers were not able to negotiate discounted rates with their local exam providers and so can only pay for the legally required services. People in these communities were much more interested in exploring a statewide payment mechanism than those in the community where everyone was satisfied with their arrangements—the latter group worried that a uniform statewide system might lead to less favorable arrangement than their current ones.

Sufficiency of Funding Levels and Payment Rates

A very common theme that we heard in our case studies was that funds available for exams are frequently insufficient. Whether federal, state, local, or a combination of these funds are used, funds allocated for exam payment may be exhausted so that funds must be obtained from other sources to cover obligations. For example, there was a recent year in which one state's allocation for exam payment covered only 75 percent of the funds needed, so additional funds had to be reallocated.

In order to spread thin funds as far as possible, states have set caps on payments to providers. The caps may take the form of a flat fee per exam, regardless of services provided, or they may be on a fee-for-service basis so that bills need to itemize specific services, which are paid at a set rate. Whichever cap system was used, we frequently heard that these caps often fall far short of covering providers' actual expenses. Exam providers cited shortfalls from several hundred to several thousand dollars per exam, depending on the services provided and the area of the state (providers in rural areas with lower pay scales and other operating expenses may have more of their expenses covered, even within payment caps). Some providers bill the victim's insurance (when they have insurance) to make up the shortfalls, but many simply write off these costs and absorb the losses. While this has the short-term effect of spreading state or local funds to provide at least partial coverage for a larger number of exams than could be paid at full coverage levels, the potential long-term consequences may be dire. It is difficult for a health care agency, even a nonprofit, to continue to provide services on which they take a loss, and it does not encourage other providers to offer this service when each time they provide it, they stand to lose money.

Crime Victim Compensation as a Payment Mechanism

State victim compensation programs are the most common designated agency to pay for MFEs, with about two-thirds of all states centralizing payment responsibilities in the compensation program (see table 5). In most of the states, compensation pays for all exams, but in a few states they only pay for certain exams (such as exams for victims who do not report the crime to law enforcement). Some of these states provide special funds dedicated to exam payment, but most require the compensation program to use their "regular" funds that cover all types of eligible expenses for all types of eligible victims (not just sexual assault victims). We discussed a number of issues around the use of compensation to pay for exams in our case-study interviews.

We found that there are distinct advantages to having victim compensation programs pay for MFEs. For one, compensation programs are in the business of evaluating and paying claims for victims' crime-related expenses, including medical expenses, and are well positioned to expand this responsibility to exam expenses. They have the staff, systems, and procedures in place. As the compensation administrator in one state put it, "the fix was in" and the choice of compensation was inevitable because of the efficiency of using a system already in place rather than building a new one from scratch.

Another advantage is that use of compensation is a very effective way to leverage state funds to attract federal funds. The Office for Victims of Crime in the US Department of Justice distributes

federal Crime Victim Funds allocations to state victim compensation programs on a matching basis. The formula is a 60 percent match, so that every dollar of state funds spent on compensation is matched in a future year with 60 cents of federal funds. Thus, 38 percent of all funds spent by states on compensation are federal funds, and the more of its own funds a state spends, the more federal money it brings in. Increasing total compensation spending by paying for MFEs increases federal allocations to match state dollars spent. States that use compensation funds for MFEs expand, on average, about 15 percent of their total compensation payments on MFEs.²⁶

However, adding exam payments to compensation programs' responsibilities does not necessarily increase state spending on compensation. If compensation programs are expected to pay for exams in addition to all their other obligations, using current funding levels rather than receiving an additional allotment of state funds to cover exam costs (which is more often the case), then compensation dollars are stretched even thinner. In fact, personnel in several states reported that their compensation funds are very tight, and it can be difficult to pay for exams in addition to meeting other obligations. This produces a situation in which funds spent on exams cannot be spent on other services to victims, effectively pitting obligations against each other in competition for scarce resources.

This brings up a philosophical objection that has been raised to the use of victim compensation funds for MFEs. Victim compensation is intended to pay for services that directly benefit victims. These victims are most often victims of violent crimes, including sexual assault, as well as physical assault, domestic violence and stalking, homicide, child physical and sexual abuse, drunk driving, and robbery. The most common types of expenses compensated are medical and dental services, mental health counseling, lost wages, and funeral/burial expenses. It is clear that the medical services provided in an MFE directly benefit victims and are in keeping with the mission of compensation. Further, the exam can serve as an important link to additional medical services as well as referrals to counseling, advocacy, and other services to directly benefit victims.

However, some have questioned—through this study and otherwise—whether funds intended to benefit victims should be used to pay for forensic evidence collection intended to build a criminal case. Is forensic evidence collection a benefit to victims, or is it a benefit to the justice system? Victims who have had negative experiences with the justice system might say that it is no benefit to victims at all. No other evidence collection activities (such as autopsies, crime scene processing, ballistics analysis, and so on) are paid for with funds meant for services to victims. When compensation funds are tight and every dollar spent on forensic evidence collection cannot be spent on services that directly benefit victims, the issue moves beyond the philosophical to one of very practical importance.

SUMMARY

VAWA has long required that victims of sexual assault should not have to pay for MFEs. This means that public funds must be used to pay for exams, whether for victims who do not have

²⁶ <http://www.ojp.usdoj.gov/ovc/>

health insurance coverage, for co-pays and deductibles for insured victims, or for all victims if the state so chooses. Our analysis found that the general rule seems to be that victims do receive free exams—and with no upfront charges. A variety of public funds and administrators are used to pay for exams, but by far the most common is state victim compensation programs. Other state funding sources administered by state agencies may also be involved. Only in a minority of the states is exam funding and payment administration decentralized to county or city authorities.

Several complications may arise around payment policies and practices. One important issue is that the amounts covered by public payment sources often fall short of the actual costs of providing the exam. It can be difficult for hospitals or other organizations to provide adequate levels of service—including specially trained staff using specialized equipment—when they lose money on every exam they provide. Another limitation is that while forensic evidence collection services are typically covered, only very basic medical services are paid for (although this varies across and even within states), which may leave victims with bills for additional services needed. Finally, jurisdictional issues may sometimes complicate payment procedures—most often when a victim is assaulted in one jurisdiction and receives the exam in another.

CHAPTER 4. EXAM PROCESSES AND BARRIERS TO ACCESS

As part of examining how states pay for sexual assault medical forensic exams (MFEs), we also thought it was important to understand the full exam process for victims. We explored the services that encompass the exam, how exams relate to other services, and how exams are accessed by victims. During this investigation, we uncovered several barriers some victims might face when trying to reach out for help.

EXAM PROCESSES

Exam Providers, Kits, and Facilities

Coalitions were asked during surveys if trained medical personnel provided exams in their states, if untrained medical personnel provided exams in their states (that is, medical personnel who do not have certifications specific to providing MFEs), or both. Based on survey responses from 47 state coalitions, 94 percent reported that trained medical personnel provided exams in their states, and 77 percent reported untrained medical personnel provided exams. Based on this, most states have a combination of trained and untrained medical personnel providing exams. When asked who in the state provided *most* of the MFEs, about half of state coalitions said most were conducted by trained personnel, and about one-fifth reported most were provided by untrained personnel.

We found in many of our case-study communities that sexual assault nurse examiners (SANEs) are often the primary providers of exams but usually not the sole providers. In other communities, such as rural areas and tribal lands, often SANEs are not available, and so either exams are done by untrained personnel or victims may be transported to other communities for exams, when possible.

In many communities, one or a few hospitals or other facilities are established as the preferred provider of exams, and these facilities employ SANEs to provide the exams or have independent SANE programs come into the hospital to provide services. Agreements are in place with law enforcement and other medical facilities to transport victims who report to other facilities to the preferred facility for the exam, whenever possible. In some cases, SANEs can go to another hospital to provide an exam there when victims cannot or will not be transported to the preferred hospital. However, it is quite possible that some victims “slip through the cracks” and receive exams at other hospitals from medical personnel who are not specially trained and may not have access to specialized equipment, even under this model.

Maintaining an adequate staff of trained and certified SANEs to provide 24/7 coverage is a challenge in many case-study communities. Nurses must be willing to undertake the SANE training program, and their employers must be willing and able to meet the costs of the training. In addition, much of this work is done on an on-call basis, and it can be very difficult to retain staff willing to work on call. SANE program directors in several communities we studied are

trying to build MFE expertise among all nurses in the hospital, so that whoever is on duty can provide a good exam without having to use an on-call system.²⁷

SANEs in rural areas find it very difficult to maintain certification and competency, as very few exams are performed because of the sparse population and victims' difficulty accessing transportation. One state with very large rural areas developed a model that uses satellite clinics where SANEs take portable examining equipment to bring exams closer to the victims.

A standardized set of procedures and materials for use by the SANEs (or other health care providers) in collecting forensic evidence is used in five of our six case-study states. This may be called a "rape kit," a "sexual assault evidence kit," or a similar name. The kits are often developed by multidisciplinary teams of exam providers, crime lab personnel, law enforcement, and advocacy, and they are distributed broadly throughout the state (to all facilities, not just those with SANE programs). However, the kit may vary from state to state because there is no nationally adopted standard in use. There was no standard kit in one state, and exam procedures and materials used were likely to vary from one locality to another.

We found an interesting array of exam facilities in case-study jurisdictions. Many communities provide exams in hospitals, with some based in the emergency department or another unit, and others in a dedicated sexual assault examining unit within the hospital. Some communities use a stand-alone clinic-type facility; in one locality, the examining facility is co-located in the same building as the victim advocacy program, across the street from the hospital. This has the advantage of facilitating on-scene advocacy response to victims during the exam process and is very convenient for victims who self-report to the hospital or who need more extensive medical services than can be provided during the exam. In another community, exams are performed at the family justice center, where a range of advocacy, justice system, and social services agencies are all co-located. This model also facilitates on-scene advocacy response, but some victims (such as undocumented immigrants and victims with legal problems of their own) are reluctant to go to a site where justice agencies are housed.²⁸

Forensic and Medical Services Provided During the Exam

An exam begins with the nurse interviewing the victim to hear her or his account of the assault. Though best practice dictates that nurses do a full exam and collect as much evidence as possible (Office on Violence Against Women 2013), some nurses use this history to guide the exam procedures so that only areas of the body involved in the assault are examined. This spares the victim unnecessary procedures and an overly lengthy exam process. By nature, these exams are very intrusive and can be physically and emotionally difficult to undergo in a time of trauma. The exam itself can take several hours and may begin after the victim has waited an hour or more for an on-call nurse to arrive at the facility. On the other hand, some nurses, mindful that this is their one and only chance to collect any evidence that may be available and that some victims may not have an accurate recall of the assault, encourage victims to do a full exam regardless of the victims' history and documentation of the events surrounding the assault.

²⁷ One caution with this approach is that not all nurses are emotionally equipped to conduct such sensitive exams.

²⁸ This may also include those that simply fear being forced into reporting, though not specifically discussed during these research interviews.

The procedures that are performed and those that are paid by the designated MFE payer vary from state to state, and can vary within a state, but, in general, the following procedures are commonly performed.

Medical services include

- identifying and treating of minor injuries,
- identifying and referring patients for more serious injuries,
- testing for pregnancy and prophylaxis, and
- testing for sexually transmitted infection (STI) and/or prophylaxis.

Forensic services include

- identifying and documenting (e.g., photographing) injuries that suggest the use of force,
- collecting the victim's blood or urine for toxicology testing to detect for the use of drugs as means of coercion, and
- collecting biological samples (e.g., semen or saliva) to establish sexual contact and for DNA analysis to identify the assailant.

From the victims' perspective, as important as the services provided is the provider's demeanor. Interactions with providers could have a profound impact on victims' experiences. The victims in our focus groups and interviews appreciated SANEs who gave emotional support through the ordeal of having an exam and who provided information on each step in the exam, as well as what to expect after it was completed.

Voices of Victims: Emotional Support from SANEs

“Her (*nurse examiner*) demeanor, the way that she spoke to me. She didn't speak to me like being a victim. She actually talked to me like I was a human being. She talked first to me before we actually did the exam, and what was going to come afterwards, so it was more like we kind of established rapport with each other to kind of make it a little bit easier during the exam. . . . Everything that she did, like every step, she was saying, ‘We're going to do this next, and I'm doing this now.’ And that if I wanted to stop just to let her know. So, she really kept like checking in on me as she was doing the exam. . . . She was very professional, she was very caring, very friendly, and I remember what her tone sounds like. I remember, you know, just how very warm. . . . She was very professional. She did an excellent job.”

“The nurse was really empathetic in answering my questions, I remember. . . . They did a really good job of assuring me that this wasn't my fault and that I'm out of the situation, that I didn't ask for it. . . I felt comfortable even though it was a bad situation. I didn't feel pressured in any way.”

“They didn't make me feel embarrassed or anything. And every time—I was trying to be strong, but the tears rolled—they were like there, they paused, you know. They let me come back to grips and things like that. They were really nice. I really do appreciate everything that happened. I really needed those clothes, too. . . . They just medicated me. They said they weren't gonna

wait for any of the results. . . . They treated me (*for injuries*) and I ended up staying in the hospital for four or five days.”

Voices of Victims: Information from SANEs

“(The nurse) explained everything. ‘I’m going to touch you here, and I’m going to insert this, and I’m going to do this, I’m going to use this comb,’ and she said every little detail. ‘Here’s clothing. You can use the shower, if you want to take a shower. If you need this, this, or this.’”

“The people from the hospital pretty much explained how everything was gonna work, and they explained it in very good detail. They told me if at any point I wanted them to stop that I could just let them know, and they’ll stop and get out of the room so I can have time.”

“They told me what will happen next in my case, that all the information that they had gotten was going to be forwarded to the police department that had the case. . . . And they were gonna use the pictures for the charges and stuff. And they also said that my stuff will be on file. . . . And that anytime I wanted it, I can have it.”

Unfortunately, some victims did not have positive experiences with the SANEs who provided their exams, and this has important implications for their experiences in terms of seeking other services and help. These victims complained of treatment that was impersonal, insensitive to their needs, or even revictimizing. One victim refused to complete the exam because of the way the nurse treated her.

Voices of Victims: Impersonal Treatment by SANEs

“The nurse didn’t personalize anything. The situation felt like it was happening all over again, like the assault. It just felt like they were workers, and it made me feel worse about the assault.”

“I think my experience here (*with the exam*) was probably the worst I’ve ever had—ever. . . . I was more devastated by having to come here and the lack of compassion, I guess, that my nurse and my advocate showed. It was everything I could do not to just leave. . . . They said, ‘Oh, be there at 6:00.’ So, we got here at 6:00, and they said, ‘Oh, it’s going to be another two hours.’ And the exam was just very unfriendly. It was very sterile, let’s say.”

Voices of Victims: Insensitivity to Victims’ Perspectives

“I had a guy photographer and that was, like, not the perfect time for that. It was horrible. I kept telling them, ‘Why does he have to do it?’ They’re like, ‘We need the evidence. You don’t have to do the pictures, but he has to do it.’ . . . They couldn’t have found a female? It had to be a male?”

“I actually insisted on having a female photographer. That’s why it took so long for me. There

was no way a guy was gonna be taking pictures of me down there. Absolutely no way, especially after all that. . . . I was in the ER for probably about 11 hours.”

Voices of Victims: Poor Treatment by SANE Can Undermine the Exam

“I started the exam and stopped it—it was an absolute nightmare. . . . My nurse was pissed that she was called in, and she let everyone know it. She was on call that day. . . . She made it known she was at a picnic. . . . She said to me, ‘And you didn’t fight back? Why?’ . . . I shut the whole thing down . . . I didn’t let her do the internal exam—I didn’t want her to touch me. . . . I thought, ‘I can’t imagine what the world is going to think of me if this is what a professional thinks.’ . . . It comes down to that nurse. She changed the whole course. The advocate was appalled and let her know. . . . Police, me, and the advocate—we all made a report against her. I let them (*police and advocate*) know how I was treated—it was almost like a camaraderie. . . . Who is this crazy lady (*nurse*) terrorizing us? They let me know they were making a complaint.”

Counseling and Advocacy Services

Another important function of the exam can be to link victims to counseling and community-based advocacy services to assist in their recovery and healing from the assault. Calling in victim advocates for an on-scene response at the time of the exam is the earliest point at which exam providers can facilitate this link. Advocates can provide emotional support, information, and referrals to many services, including counseling, practical assistance (such as toiletries to use after the exam); serve as a liaison with family members; and in some cases make follow-up contact several days later. Our case studies found that some communities are more likely than others to provide on-scene response to victims at the time of the exam, depending on the strength of the link between the SANE program/medical provider and advocacy groups, and the availability of sufficient advocacy resources. In some places, systems were in place to ensure an advocate could be responsive to a victim during an exam 24/7; in other areas, agencies simply did not have the staff or cadre of volunteers to provide this service 24/7.

Some case-study communities we visited have very strong links between exam providers and victim services, and sufficient levels of victim services, so that an on-scene advocacy response is a part of standard policy and procedure. Nurses routinely call advocates for all victims, and advocates routinely respond to the scene. Advocacy services in several communities facilitate this link through a dedicated hotline for nurses to call. In one city and its surrounding suburban counties, a regional network of three victim service agencies and six hospitals has been established to make best use of available advocacy resources to ensure that advocates can respond to every call.

In other localities, the on-scene advocacy response may be less uniform. When calling an advocate is not an institutionalized practice but is left to the discretion of the nurse providing the exam; some nurses may be more likely to call than others. This can depend on their views of the victim response and on whether they feel that it is a violation of the victim’s privacy to call an advocate automatically without first getting patient consent. We learned that when asked first, victims will sometimes not authorize a call to advocates because they do not want to “bother” the

advocate, but few victims will turn away an advocate's services when the advocate is there and offering to help them.

The consistency of the advocacy response can also be affected by the level of resources the victim service programs have available to provide on-scene response. Advocacy services in some communities may be able to respond to some calls, but not all, and no on-scene response may be possible in other communities. In some communities, the advocacy programs may not have culturally appropriate services for some victims, or the culturally appropriate victim service provider may not have the link with the exam provider to be called for on-scene response.

Voices of Victims: Emotional Support from Advocates

“They (*advocates*) both sat and held my hand and kinda pulled me through it (*the exam*).”

“There's just no way I would be where I'm at right now without her (*advocate's*) help. I can't thank her enough, to be honest. . . . She just supports me. . . . She is just there. She is just so wonderful.”

Voices of Victims: Information and Follow-Up from Advocates

“There was an advocate that stayed there the whole time for the exam in the emergency room. And then they came the next day to check on me, to see how I was doing. And she brought me a folder and gave me all kinds of information. . . . She's called a couple of times too.”

“My biggest concern when I found out my daughter was being abused is what was the best interest for her. So, I actually had to call (*advocacy program*) and talked to them, and discussed the merits and demerits . . . of contacting the police or going to the emergency room, or the different ways we could play the scenario of trying to figure what's really the best for her.”

Voices of Victims: Practical Assistance from Advocates

“They go out of their way to make you feel comfortable. . . . Support—‘we'll call whoever you need.’ They went out of their way. They drove me to go pick up my son . . . and then to go take me somewhere else. Wow, you guys are awesome.”

“(*Advocate*) was great. She helped me with getting hooked into therapy here, and then . . . just checking in, willing to do whatever I needed to help me. She's helped me with my transition here and willing to help with my connection with law enforcement back in (*state where assault occurred*) and all that. So, it's been good.”

Voices of Victims: Advocates Liaison with Victim's Family

“He (*victim's husband*) was pretty angry when he came in, so (*advocate*) took him aside and said, ‘She is not gonna have you in there if you're gonna be saying you're gonna kick somebody's butt or whatever. You can't come in if you're gonna have that attitude.’ And he snapped out of it pretty quick, so she was very helpful that way and in a lot of ways. But that

specifically helped me out a lot. Because he can get very defensive about me when it comes to that situation.”

Voices of Victims: Importance of the Link to Counseling

“I find it (*counseling*) extremely helpful. To this day I blame myself. . . . I met him online. I put myself in that situation.”

“It (*counseling*) actually does help. I wouldn’t go, but the nightmares just kept coming back and coming back. They weren’t gonna go away. . . . So I went, and it’s helped with the nightmares. It’s helped a lot with everything, actually.”

“I thought it was my fault. It was my ex-boyfriend, and I let him in my house. I thought he was a good person. I can talk about it now (*after counseling*) without being fearful.”

“It (*counseling*) saved me. I’d be a different person if I didn’t go. I wouldn’t be as mentally stable without it. It was imperative.”

ACCESSING THE EXAM

Victims in our focus groups and interviews reported a variety of ways that they learned about or got to the exam. Victims can present at a hospital themselves to get an exam, be brought by an advocate, be brought by the police, or be referred by a variety of others, such as families or friends. Victims also reflected on the voluntary nature of getting the exam and on their reasons for seeking the exam. Victims have many different reasons, some related to their health, others to the criminal investigation, and others to social pressures.

Voices of Victims: Getting to the Exam

“I gave my statement and they (*police*) brought me here. I just went with the flow.”

“She (*police officer*) just informed me about it, that it would be something good to have on record in case they can’t find him or don’t have any proof of him actually doing it. . . . I actually never knew about the exam, that I could go straight to the hospital to get it done.”

“I called the police like 36 hours after it happened, and then after speaking with the police, they asked if I wanted to go. And so I was brought by the police.”

“I had heard about the exam, but during the time when I was talking with the police that was the last thing I was thinking of. So, the police said, ‘Okay, now we’re going to escort you to the hospital for the exam.’ . . . I especially wanted my blood to be drawn, because I really did feel that I was drugged. And so, in that respect, I wish that they would have done the exam a whole lot earlier because it may have been like three or four hours had passed.”

“I didn’t know about it (*the exam*). I just made an anonymous call to (*advocacy program*). I was coming because I get very paranoid about STDs or something and I wanted to get myself checked.”

“I didn’t know it (*the exam*) existed at all. My friends looked it up online while I was flying home. . . . My friends were the reason why I came. I just wanted to go home and sleep. I didn’t even care.”

Voices of Victims: Voluntary Decision to Get the Exam

“Yeah, it was my choice whether or not to actually have the exam.”

“He (*police officer*) wanted me to (*get exam*). . . . And I was like, ‘I don’t need one, I’m fine. I’m fine.’ You know, he was like, ‘Oh, we can’t make you do it, but I’m gonna give you this card,’ and he gave me a card with the case number. . . . He said even though I had been drinking, he thinks it’s a good idea that I be checked because something might be actually wrong with me.”

Voices of Victims: Reasons to Get the Exam

“I didn’t want to see anything happen to anyone else. And I had to make sure my health was okay.”

“I also wanted to do it (*the exam*) myself to provide more proof on his DNA to find him.”

“I didn’t want to get HIV, so in order to get the PEP meds and the shots for everything, we had to do the forensic examination. . . . So it wasn’t necessarily my choice to get the rape kit done. Well, it was, but it wasn’t like my first thought. It was more in the background. I just wanted to make sure I was healthy.”

“I knew that I wanted to prosecute and that that was the only way to potentially get evidence for it.”

“I mean it just was really important to me. I have three daughters, and it was really important to me that I do this right and that I set an example . . . at the time, all I was thinking about was how I was gonna explain this one day, and I made sure that I did this, you know, the ‘right way.’”

“I got picked up by one of my friends, and his mom made me go, because I didn’t want to go and let anybody know. I didn’t even want my parents to know.”

Barriers to Accessing the Exam

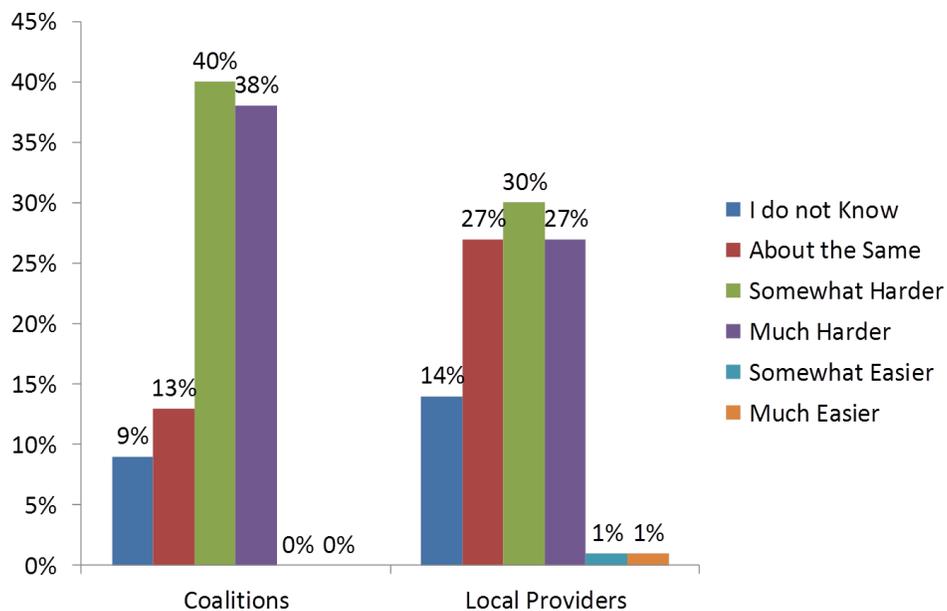
Much of this report focuses on what happens during an MFE, who pays for it and how the payment mechanisms work, how exams are stored, and how the exams are used during investigation and prosecution. But also critically important to discuss is the ability of victims to *access* an MFE. We found in many areas that some victims face barriers to even receiving the exam, never mind understanding how it is paid for and how it is used during investigation. The following describes the themes that emerged from the surveys and case studies regarding barriers to accessing the exam. The surveys focused on questions about barriers for non-English-speaking

victims, specifically. The case studies created an opportunity to talk about other types of barriers to the exam as well.

According to state-level sexual assault coalition and local service provider survey respondents, victims who do not speak English have a more difficult time accessing the exam, compared to English-speaking victims. Figure 4 shows that 78 percent of coalitions and 57 percent of local providers reported that non-English-speaking victims had a somewhat or much harder time obtaining MFEs than did English-speaking victims. Thirteen percent of coalitions and slightly more than one-quarter of providers reported the ability to access exams for English-speaking and non-English-speaking victims at about the same rate. Nine percent of coalitions and 14 percent of providers reported they did not know whether accessing the exam was harder for non-English-speaking victims. Ten respondents (2 percent) indicated it was *easier* for non-English speakers to obtain exams than for English-speaking victims.

We also asked coalition and provider survey respondents in what ways it is harder for non-English-speaking victims to obtain exams. Across both respondent groups, these barriers included both language barriers and cultural barriers. During case studies, these themes were reiterated in several interviews. Further information about these themes—and some additional themes discussed during case studies, such as geographic issues and issues for American Indian women and tribal jurisdictions—is presented below.

Figure 4. Percent of Respondents Reporting Non-English Speaking Victims Have Difficulty Obtaining an Exam Compared to English Speaking Victims²⁹



N=47 valid responses from state-level sexual assault coalitions
 N=409 valid responses from local providers

²⁹ Only state-level sexual assault coalitions and local victim service providers were asked about issues for non-English speaking victims accessing the exam.

Language Barriers

State and local survey and case-study respondents reported that non-English-speaking victims—specifically because they do not speak English—face many challenges to accessing the exam, understanding the exam process, and/or understanding the criminal justice process and their rights as victims. Several respondents from case studies discussed the problem of not having interpretation services in their areas (either at all or for specific language groups); of not having bilingual SANEs, medical personnel, or social workers; and of not having written materials in languages other than English or Spanish when many other languages might be spoken in that region. Without interpreters, victims have a difficult time communicating their questions and concerns to first responders and health care providers; while at the same time, it is difficult for SANEs to understand the chronology of events that happened to the victims and to make decisions on what types of evidence to collect. In some cases, such individuals may use family members or members of law enforcement to communicate for them, yet when law enforcement is used, it further complicates the victims’ rights related to reporting the sexual assaults. In other cases, victims simply go without the ability to clearly communicate with first responders and medical personnel.

In some areas, interpreters are available, and some areas use the Language Line (a service that can be delivered over the phone, via webcam, or in person).³⁰ While these are helpful, some issues that might occur were identified. First, having to wait for an interpreter to arrive at a hospital might result in longer wait times to receive the MFE. Second, it can be difficult to find competent interpreters who can translate material properly for victims, including concepts of justice and victim rights. One local provider reported that even when interpreters are trained, these concepts can be challenging to competently translate. Third, there were different perspectives on the use of the Language Line. Some interviewees reported that using the Language Line provides privacy and anonymity. But others reported it felt awkward, does not produce the best translation services because the person is not actually present, and delays the overall process.

Cultural Barriers

Non-English speakers and immigrant populations face many cultural barriers to accessing MFEs and other services. Primary among these barriers is a lack of sensitivity and cultural competency on the part of local service providers. Some state coalition representatives and local providers during case-study interviews reported that some immigrant sexual assault victims are not taken seriously when they make a report or come forward, and some agencies do not have an understanding of these victims’ cultures. They also reported a lack of patience with non-English speakers, especially within states where there might be a culture of discrimination and hostility toward immigrants and non-English speakers.

Also, immigrant and/or non-English-speaking victims might have a lack of awareness of the availability of the MFEs, types of reporting options, and other services. Coalitions reported minimal outreach to such communities to educate them on how to contact local sexual assault

³⁰ <https://www.language.com/>

service providers. They also added that within certain immigrant communities, there is misinformation about accessing services and the type of sexual assault responses the local jurisdiction can offer victims.

Both through survey responses and during case-study interviews, we heard that immigrant/non-English-speaking populations were fearful of the criminal justice system and were reluctant to seek help from the professional medical community and advocates. This fear serves as a major barrier to such victims accessing MFEs. This fear might be based on fear of deportation or mistrust of government systems more generally. For example, one local provider reported that due to the anti-immigration policies and laws within their state, undocumented victims are afraid to seek services.

This fear played out in one local jurisdiction we visited during our case studies. In this locality, an innovative approach to accessing exams and services was designed by co-locating the exam services in the same facility that housed law enforcement, prosecution, and the victim service agencies. Initially, a local victim service provider focused on the undocumented and immigrant community was also housed in the facility. But, they soon found that undocumented victims stopped coming forward for services. The SANE indicated that these undocumented victims did not want to risk deportation or arrest by coming in for services. As a result, the agency focused on this group of victims moved out of the co-location facility so that their clients would feel comfortable coming forward again.

In addition to lack of adequate services, lack of knowledge of services, and fear of law enforcement and service providers, some respondents reported that cultural norms add another challenge to reaching immigrants or non-English-speaking victims. Some cultural norms might play a role in preventing victims from coming forward to seek help. Local providers reported that within some communities, shame, stigma, and the lack of acknowledgement of rape and sexual assault are enormous factors that prevent victims from coming forward. One prosecutor noted that while all victims of sexual assault may experience shame, within certain communities, shame is a far more powerful factor and plays a significant role in the reluctance of victims to report their assaults. The consequences attached to the stigma and shame that victims face can in some cases lead to victims being shunned or ostracized from their communities. Some providers speculated that the lack of cooperation from some victims is a result of the lack of support they receive from their families and communities, and that some victims even face unsafe environments as a result.

Geographic Barriers

Geographic barriers to accessing an MFE may also present obstacles. Large sections of rural areas may be many miles from a hospital or other facility with a SANE program. In some cases, victims do not receive exams conducted by someone specially trained to conduct them because there is no such provider within a reasonable travel distance. In other cases, victims may travel long distances to get examined by a trained provider. One state with large rural areas is developing a satellite system of mobile SANE units that are based in hospitals but can respond to clinics in more rural settings in order to reduce victims' travel burden.

Intimate Partner and Acquaintance Rape

Sometimes the nature of the relationship between the victim and perpetrator prevents victims from being able to define what happened to them as rape or to seek help. Although we never specifically asked professional stakeholders about whether victims did not access exams because of the relationship they had with their perpetrators, this theme came up in several victim focus groups and interviews. Some victims reported that they did not access the exams because they did not understand that what happened to them could be classified as rape (perhaps because of a previous or current relationship with the perpetrator, a friendship with the perpetrator, or because it was someone that they had been attracted to before it happened). Others blamed themselves for what happened.

Voices of Victims: Not Knowing What Happened to Them Was Rape

“It was with an acquaintance that was my boyfriend at the time. So, that was hard for me to understand that that was rape for a long time. . . I was in such a state of shock and denial that it wasn’t something I could wrap my head around. . . .”

“I had gone over to his house with the intent to have sex with him, and during the lead-up to that I changed my mind and he did not honor that. . . . I told him to stop, but I was already kind of there, and I don’t think I was really aware at that time that there was a SANE exam. . . . So, I was just like, ‘Well, we’re just going to pretend like none of this ever happened. . . .’”

“The incident was with a guy I was already having consensual sex with. . . . I went to a party with him and the last that I remember was that he got my drink, and I don’t remember anything else except I know that I woke up the next day in an insane amount of pain. . . . Maybe I just got really drunk and forgot, but there was a huge part of me that wanted to go because I wanted to see if I was drugged. I really, really, really thought I was drugged, but I was also like, ‘Nothing is going to come of it because we were already having consensual sex. What is it, what is this going to do, what does it matter?’ . . . I didn’t remember anything that had happened, and I didn’t really know what I would say. . . . I think if I had been very aware of what had happened it would have been different, but I didn’t really know what to say.”

“I thought about it (*the exam*), but at that time, I was still like kind of confused on what actually happened, so I didn’t go until a while later. . . . I didn’t feel comfortable because at that point, I was still a freshman in college, and I didn’t really want people to know. You know, I didn’t want my information to be out there, so I was nervous. I didn’t go for like another four or five months. . . . This person was actually an athlete on campus, so I was more concerned about retaliation as well, like I would get probably hazed from the teammates or like, ‘Oh, she lied,’ and I didn’t want to deal with that. . . . I decided not to say anything. . . . I don’t want to be known as ‘that girl.’ I don’t want to be a victim my whole life.”

“I was like nervous to come forward. And like, I didn’t really know of a good way to go about doing it. I didn’t even tell people for a couple of weeks after, and so I wish I would’ve done that. . . . I was petrified of retaliation. . . . It’s hard to kind of get the confidentiality. . . . I felt like for some reason, I didn’t want to get in trouble. I didn’t want justice . . . because he was my friend so it was like you have to rethink yourself and check yourself a thousand times.”

American Indian Victims and Tribal Jurisdictions

In three case-study states we were able to learn about American Indian victims' experience with services after sexual assaults. We met with stakeholders—including victim service, SANEs, law enforcement, and prosecution—on two different tribal reservations, a state-level American Indian coalition, and three local jurisdictions that served American Indian women within both urban and tribal localities. Several of these respondents indicated that rates of sexual assault victimization among the American Indian population are higher than among other groups of women.³¹ Respondents speculated that from one- to two-thirds of American Indian women have been sexually assaulted and that these women often experience multiple victimizations throughout their lifetimes. Further, various respondents reported that in some cases sexual assaults and hate crimes are committed together.

Although large numbers of American Indian women have experienced sexual assaults, it seems that few get the help and response they might need to restore their well-being and hold their perpetrators accountable. Across all respondents focused on the American Indian population, we heard that these women face many challenges to accessing and receiving the MFE and other services, and to receiving a criminal justice response. The following describes the major themes reported as challenges to these women: access to services, cultural competency, and cultural barriers.

Access to Services

Across the three states with sizable Native American populations, American Indian victims on tribal reservations face significant challenges to accessing MFEs and other services. In one state with multiple reservations, we learned that only one reservation had SANE services. In other areas, victims had to travel off the reservation to receive the exam and treatment. One state-level respondent reported that her perception is that few Native women get exams. This has to do with both access and, perhaps more disturbingly, the criminal justice response Native women receive. This participant noted that when one expects something to happen in response to a report, and nothing does, one is less likely to refer women for an exam.

In the two other states where we visited tribal reservations, we learned more about the significant issues faced when accessing MFEs. In one of these states, sexual assault cases are forwarded to Indian Health Services facilities, but these facilities do not have trained SANEs. Obstacles to going off the reservation were related to familiarity and trust in the local non-Native community, transportation over sometimes significant distances, and a lack of knowledge about services off the reservation (e.g., that the services are free). In general, victims may not get exams because they do not know that they are free or because they assume the exams require police reporting, and they may not want to involve law enforcement.

³¹ These local assessments mirror reports for the nation. BJS's national study found that American Indian/Alaska Native women are victimized at higher rates than White, Black, Hispanic/Latina, and Asian/Pacific-Islander women (Planty et al. 2013).

In another state, issues around accessing the MFE were even more complex. Like the first reservation, their local health service did not have the ability to provide SANE services because they would be required to have 24-hour emergency services, which this clinic did not offer. However, three American Indian nurses from this reservation were trained SANEs, although they did not have the opportunity to practice on the reservation because the clinic was not considered a provider of emergency services (which was a requirement). These SANEs pursued gaining access to two area hospitals off the reservation and met several challenges. Both hospitals expressed reluctance to letting these nurses in to use their facilities to perform exams for the Native population. In one case, the request was met with outright hostility. It was unclear to the nurses if the response was due to the hospitals being territorial about doing the exams themselves or if it was due to racism. The contact person has since reconnected with the nurses to attempt a relationship, but has required what the nurses perceive to be an enormous amount of paperwork. Thus, these trained nurses are left feeling powerless and thwarted in their efforts to help fellow women. At the time of our visit, next steps were still being considered.

Beyond the MFEs, other services might be difficult to access because of either the lack of a provider on the reservation or limited advocacy resources in the local off-reservation community. As one director noted, providing victim services is a huge task placed on the shoulders of only a few advocates.

Native victims also face challenges to accessing the exam free of charge without having to report to law enforcement. In a state with multiple reservations—some of which are Public Law 280 jurisdictions, and some are not—access to the exam free of charge without reporting to law enforcement depended on the agency that had criminal jurisdiction over the case. In the case of state jurisdiction, local law enforcement appeared to be paying for exams regardless of reporting. In the case of federal law enforcement jurisdiction (the FBI), the perception was that MFEs were not paid for unless victims reported the crime. Because VAWA applies to states and local jurisdictions specifically, federal agencies do not have to comply with the requirement for free exams regardless of reporting.

Cultural Competency

Across several stakeholders during case studies, we learned there was a lack of cultural competency in working with American Indian women, which made it more difficult for these women to go through the MFE process. Service providers and medical personnel were not trained to understand how to interact with Native women, which sometimes led to misunderstandings. Women might be interpreted as reluctant to cooperate or passive about their experience; yet, this might not be the case. As one advocate noted, she had witnessed SANEs becoming impatient with women's pace of participating in the process, lack of crying, and quietness, misunderstanding the value of silence in the Native communities. The exam process can be another assault on the senses for those not comfortable with the intrusive nature of the questioning and procedures.

Beyond cultural competency, various stakeholders posited racism as a primary theme they encountered when working with American Indian victims, living both on the reservation and within the urban community as they come forward to seek help. Experiences with racism related

directly to women’s reluctance to pursue an exam, other services, or assistance from the criminal justice system. We heard about a 9-1-1 call that went unanswered by local counties with jurisdiction over the tribe; a SANE who asked inappropriate questions of the victim, including whether she had dropped out of school and used drugs; a nurse who told a woman who came in for an exam that the hospital was not a “pill shop”; and several examples of how law enforcement treated Native victims differently from women from other groups. What was striking about these reports of perceived racism was that these themes came up during interviews with each and every agency that works with American Indian women, including victim service providers, law enforcement, nurses, and prosecutors. These respondents reported seeing these types of experiences happening with other providers with less experience and/or interest in working with this group.

Cultural Barriers

Finally, several stakeholders during case studies connected aspects of American Indian culture to barriers preventing access and use of the justice system. The perception of sexual assault victims within American Indian communities and the shame, stigma, and fear of retaliation contributed to women’s reluctance to seek help. When both victims and perpetrators are Native, the issue is further complicated. Some respondents indicated lack of support for the victims and their families in these cases, and greater support for the perpetrators. A non-Native respondent who works with Native women reported there appeared to be some tribal protection of the perpetrators in these cases.

In addition, several respondents cited American Indian communities’ distrust of systems—such as law enforcement agencies, child protective services, hospitals, and other government agencies—as another barrier to victims’ seeking help. This mistrust was based on historical trauma and mistreatment of tribal communities by such systems. Advocates noted mistreatment from the past (e.g., nonconsensual sterilization of Native women) and from the present (e.g., not being taken seriously or being treated like they had mental illnesses by first responders) that contribute to this sense of mistrust.

SUMMARY

SANEs provide many MFEs to some victims of sexual assault, but not all. SANE programs are often based in hospitals but may also be found in other facilities, such as clinics, family justice centers, or other independent agencies. Some communities, especially in rural or tribal areas, may not have SANEs; therefore, victims must either travel to other communities or receive exams from providers without specialized training in exam procedures.

Some states use standardized sets of procedures and materials for the MFE, and they distribute them across the state to facilities with SANE programs as well as those without. This helps to promote standardization of the forensic evidence collection and basic medical services provided by both trained and untrained providers.

The exams can be valuable opportunities to receive caring and compassion from the exam providers, which is important in victims healing from the assault. The exam can also serve as a

link to counseling and advocacy services, when these services are available, and there's a strong link between health care and advocacy so that the referrals are made.

Victims may access the exams by self-reporting to a health care facility or through previous contacts with advocates or law enforcement. Some victims are faced with barriers when they try to access exams, including geographic, linguistic, and cultural barriers. Cultural barriers may include lack of cultural competence in service providers and aspects of the victim's culture, such as victim blaming and shaming, that discourage reaching out for help.

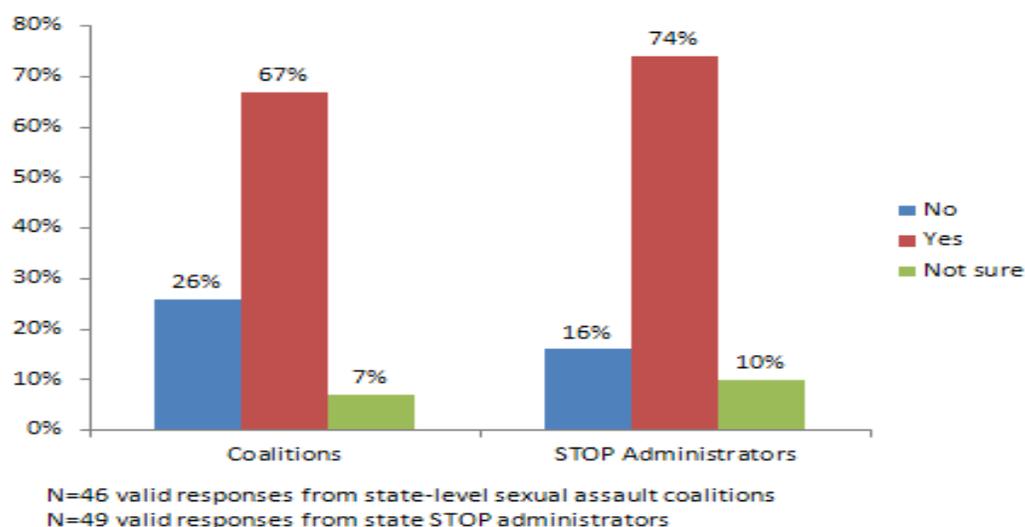
CHAPTER 5. AFTER THE EXAM: KIT STORAGE AND VICTIM PARTICIPATION IN THE CRIMINAL JUSTICE SYSTEM

The passage of the new requirement around sexual assault medical forensic exams (MFEs) in the 2005 reauthorization of the Violence Against Women Act (VAWA) was premised on the anticipation that such changes would encourage victim participation in the criminal justice system, through the ability to delay reports to law enforcement after time for consideration. To allow for such a change, states needed to take stock of how MFE kits for victims who had not reported the crime to law enforcement were stored, pending a possible conversion to a reporting status. States needed to consider the length of time that such kits should be retained and what agency should take responsibility for them. An important practical consideration was what facilities were available to house them. Below, we first examine state MFE kit storage practices and then discuss victim participation in the criminal justice system.

MFE KIT STORAGE³²

We asked survey respondents whether their states actually had a requirement for storing exams, the length of time kits were stored for victims who reported to law enforcement, and the length of time kits were stored for victims who had not made a report to law enforcement by the time of the exam (see figure 5). Overall, kit storage is a requirement in most states. According to state coalitions (N=46) and state STOP administrators (SSAs; N=49), 67 percent and 74 percent, respectively, reported their states required kits to be stored. Seven percent of state coalitions and 10 percent of SSAs were not sure if their states required kits to be stored.

Figure 5. Percent of States That Require Medical Forensic Exam Kits to Be Stored



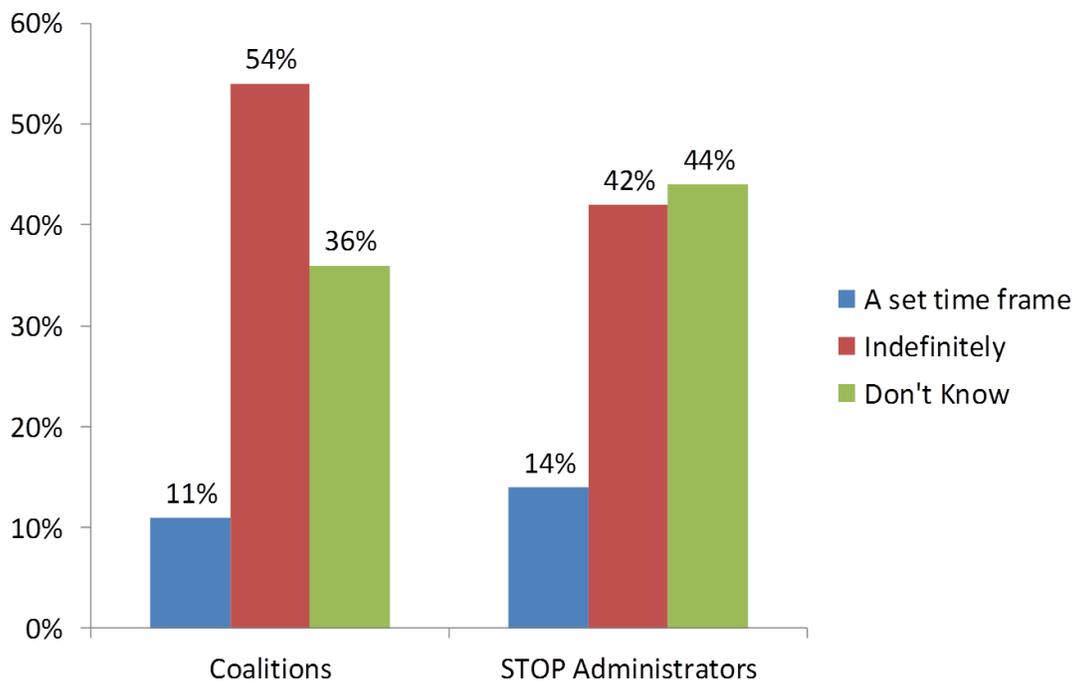
³² State-level sexual assault coalitions and state STOP administrators were asked about kit storage requirements.

We examined not only whether there were regulations about MFE kit storage in states but also how long kits are *supposed* to be stored. We asked state coalitions (n=31) and SSAs (n=36) that reported having storage regulations around the length of time kits should be stored for assaults that were reported to law enforcement and assaults that were not.

Figure 6 depicts survey respondents' answers regarding storage length for kits when assaults were reported to law enforcement. Similar proportions of state coalitions and SSAs reported that MFE kits were stored for either a set time frame or indefinitely. Based upon their best estimation, 11 percent of state coalitions and 14 percent of STOP administrators reported that kits were stored in their states for a set time frame, while 54 percent of state coalitions and 42 percent of SSAs reported kits were stored indefinitely. Notably, this question was one for which large proportions of reporters said they did not know the answer, with slightly more than one-third of coalitions and nearly half of SSAs saying as much.

While similar proportions of state coalitions and SSAs reported that kits were stored for a set period of time, there was little agreement about how long kits should be stored. State coalition respondents said the length of time kits in cases reported to the police should be stored ranged from 2 to 50 years, with an average length of 21 years. SSAs reported the storage time ranged from a month to 30 years, with an average storage time of 6 years.

Figure 6. Percent of Respondents Reporting Lengths of Time for Storing Kits for Cases Reported to Law Enforcement

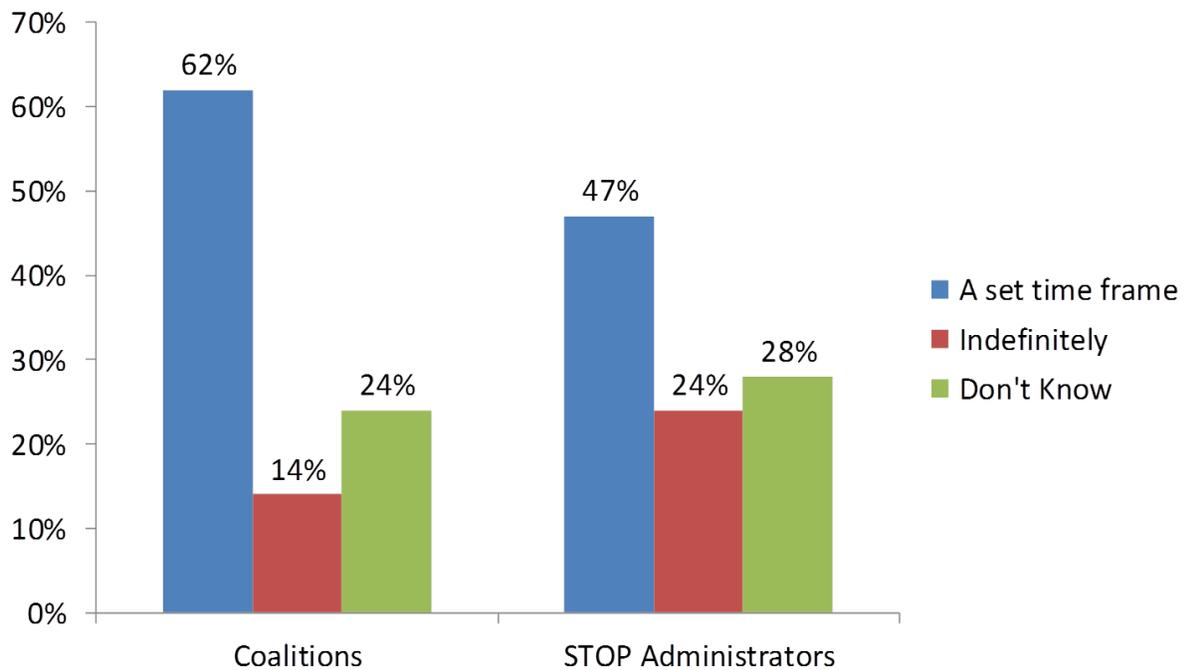


N=28 valid responses from state-level sexual assault coalitions
N=36 valid responses from state STOP administrators

MFE kits for assaults that *are* reported to the police are typically stored by the police with jurisdiction over the case, according to case-study data. These kits may or may not be processed for evidence testing. State statute typically dictates the length that kits for these cases, which may be open or closed, are stored.

Figure 7 depicts survey respondents’ answers regarding storage length for kits when assaults were *not* reported to law enforcement for 29 state coalitions and 34 SSAs who reported that storage regulations existed in their states. It shows similar patterns of reports between the two groups, though at different rates. Sixty-two percent of state coalitions reported a set time frame for storage of kits not reported to the police that ranged from one month to 10 years, with an average time of 19 months. Forty-seven percent of SSAs reported kits should be stored for a set period of time that ranged from one month to 30 years, with an average storage time of 32 months. Fourteen percent of coalitions and 24 percent of STOP administrators said that kits should be stored indefinitely. About one-quarter of both groups said they did not know if kits for victims who did not report the assault should be stored for a set time or indefinitely.

Figure 7. Percent of Respondents Reporting Lengths of Time for Storing Kits for Cases Not Reported to Law Enforcement



N=29 valid responses from state-level sexual assault coalitions

N=34 valid responses from state STOP administrators

Our case-study stakeholders reported varying lengths for kit storage in nonreported cases. Some states had requirements for the length kits should be stored; in other areas, storage length was determined by individual jurisdictions or localities. For example, one state had a rule to hold kits for nonreported assaults for 30 days. One jurisdiction in this state followed the policy. Another

said that they kept kits indefinitely and had basically kept all kits for nonreported assaults to date.

In general, representatives in many case-study places reported that they kept kits far longer than they were required to. Some would do so until the statute of limitations for the crime had expired; others until they ran out of space, and would destroy kits in order of age as space became an issue. In some places where reporters indicated they would hold kits until space became an issue, hospitals or victim service agencies would call the nonreporting victims before destroying the kit to ensure it was appropriate to do so and that they had no intention of converting the kit to a reported assault.

Among many people we spoke to during case studies, the concern was to hold the kits as long as possible in case victims changed their minds about reporting. One particular police officer respondent indicated that she was uncomfortable destroying a kit because she does not know why women did not report the crime: What if she was in residential treatment or in a domestic violence relationship that prevented her reporting? Thus, this officer preferred to keep kits through the statute of limitation for the assaults, so that victims could always convert the assaults to reported cases if they wanted to.

*Models for Storing MFE Kits for Victims Not Reporting Assaults to Law Enforcement*³³

In order to gain a better understanding of practices surrounding MFE kit storage models used for victims who do not report to law enforcement, we asked state-level sexual assault coalitions during the survey about their best estimation of the storage models being used across their states. We asked about three storage models: (1) law enforcement storage only; (2) no law enforcement involvement in storage; and (3) anonymous reporting.

1. *Law enforcement storage only:* Twenty-nine coalitions said that some portion of the jurisdictions in their states used an MFE kit storage model where medical facilities perform the exam and transfer the evidence to a local, county, or state law enforcement agency. In this scenario, kits on nonreported assaults are stored by law enforcement—with or without identifying information—but cases are not opened for investigation.
2. *No law enforcement storage:* Twenty coalitions reported that some portion of their jurisdictions used a storage model where law enforcement has no involvement in storage, so that medical facilities perform the exam and securely store the evidence.
3. *Anonymous reporting:*³⁴ Seventeen coalitions reported that at least some jurisdictions in their state used an anonymous reporting model. In this model, nonidentifying information about the victim and the perpetrator is provided to law enforcement along with the kit, law enforcement stores any evidence that is provided by the victim, and investigations of cases may be opened and kits may be processed.

³³ Only state-level sexual assault coalitions were asked for kit storage models for nonreporting victims.

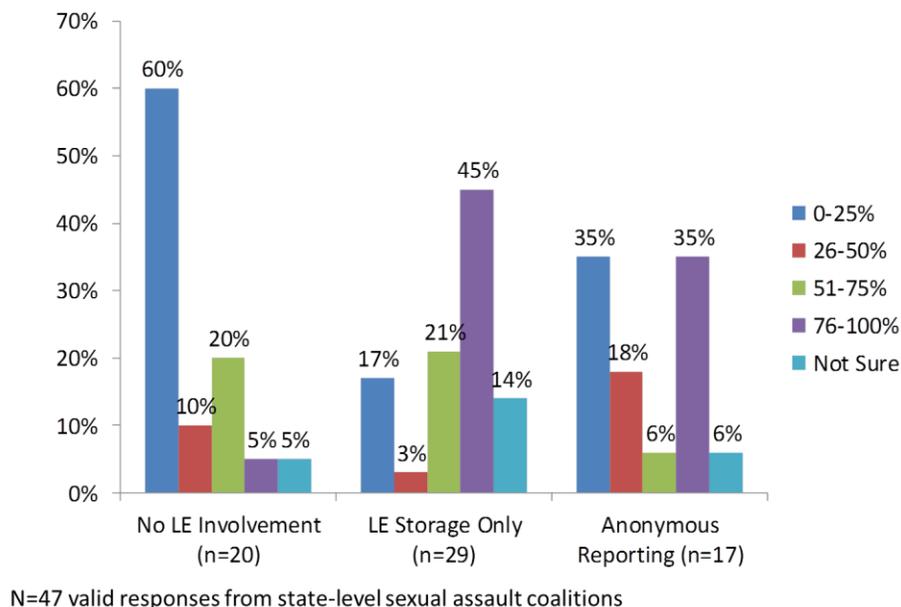
³⁴ This definition of anonymous reporting is a working definition for the purposes of this study, and the term may be used differently by different organizations. Notably, to be clear throughout this study, this definition was provided to coalition respondents as part of the survey question.

Figure 8 presents survey findings about MFE kit storage practice models. Law enforcement storing MFE kits without any further action seems to be the most common storage practice. From state coalitions that reported their states use a law enforcement storage only model (n=29), most respondents (66 percent) reported 51 percent or more of jurisdictions within their states used this model, 45 percent of whom said nearly all or all the jurisdictions in their states use this model (76 percent to 100 percent of jurisdictions). Twenty percent of coalitions reporting this model said that 50 percent or less of the jurisdictions in their states use a law enforcement storage only model. Fourteen percent of respondents did not know the extent of jurisdictions in their states that used this model.

In regard to our case-study states, in five of the case-study states we visited, law enforcement storage for nonreported assaults was at least a possibility. In two of the cases, this was true in every jurisdiction, and kits were stored anonymously via identification number only, rather than with identifying information about the victim. In the other three states, kit storage was decided by individual jurisdiction or county, which involved law enforcement in some situations but not in others. It also may or may not mean kits are stored anonymously without identifying information about the victim.

Storage practices that had no law enforcement involvement are uncommon (see figure 8). Sixty percent of state coalitions who said they had such storage practices in their states during the survey (n=20) reported a small percentage (0–25 percent) of local jurisdictions using a storage model that did not involve law enforcement, and another 10 percent reported that 26 percent to 50 percent of jurisdictions used this model. Only 25 percent of coalitions reported this storage model was happening in 51 percent or more of their jurisdictions. Another 5 percent of state coalitions reported they were not sure the extent to which a storage model with no law enforcement involvement was used in their states.

Figure 8. Percent of Respondents Reporting Types of MFE Kit Storage Models Used for Nonreporting Victims



In three of the case-study sites, hospitals or health care providers that perform the exam could be the location where kits for nonreported assaults are stored. In one state, in all but one county, kits for nonreported assaults were held by health care providers. Kits were stored with identifying information about the victim, so they were not stored anonymously. In the state where MFE policies and practices were decided by each local county, three of the counties we visited chose the hospital in which the exam was performed to store the kits for victims who did not report the assault. The length of time they kept the kits varied by county.

Anonymous Law Enforcement MFE Kit Storage

In one state, all kits from nonreported assaults were held in the local police department with jurisdiction where the assault occurred. Kits in this state are tracked by number. Victims are given their kit number and can trace their kit via that number for reporting the assault to law enforcement if they choose to convert their case.

In another state, if law enforcement was identified as the place to store kits for nonreported cases, the kits were stored by identification number but sealed inside the kit was an envelope with the victim's name on it, should they choose to report.

Non-Anonymous Law Enforcement MFE Kit Storage

In one location, kits from nonreported assaults were held in the local police department. In this city, once a week, an employee of the police department picks up from the area hospitals kits from both reported and nonreported cases. All kits have the victims' names on them, so even though a kit may be for a nonreported assault, the police have the kit and know the victim's name. A member of the local victim service agency pointed out that this essentially turns the kit into a reported case as a result of the identifying information on it. This process is apparently not transparent to the victims, and in some cases the police department will *actually submit* the kit for testing to add to their suspect profile database. Again, this testing of the kit is *without* the victim's knowledge or permission.

Even fewer state coalition representatives (n=17) reported during the survey that anonymous reporting models were used in their state than reported either law enforcement storage only or storage practices that do not involve law enforcement (see figure 8). Of the coalitions that reported this model, 41 percent of respondents reported that more than half of all jurisdictions within the state use such a model. However, 53 percent of respondents reported that half or less of the jurisdictions in their states are using an anonymous reporting model. Another 6 percent of respondents were not sure how many jurisdictions within their states used such a model.

In our case-study states and jurisdictions, only one locality was offering the option of anonymous reporting. While several places stored anonymously labeled kits in law enforcement agencies, in most cases these agencies merely stored the kit; they did not consider the receipt of an

anonymous kit as a report of the assault. Rather, they were merely storing the kit for a nonreported assault, as described above. However, in one location, anonymous kits *were* processed with the permission of the victim. See the sidebar for a fuller description of their process.

Though not raised as a concern during the interviews regarding this model, this practice may have an unintended consequence. If no physical evidence is found through the kit, learning about the lack of evidence may have a detrimental effect on the victim’s healing process. Thus, it might be helpful to discuss this possibility with a victim during the informed consent procedures before the exam and, if this is the case for an individual, it would be important for advocates to address this when they contact a victim with the results of the analysis of her/his kit.

Anonymous Reporting Procedures

One county we visited offers an anonymous reporting option to victims. Nurses performing the MFEs give victims three options related to reporting: (1) have a kit done and report to police; (2) have a kit done with your name on it and submit it to the victim service agency to hold until you are ready to report; or (3) have a kit done anonymously and submit it to the police for testing. Originally, they gave only the first two options to victims, but since the third anonymous reporting option became available, the second option is not chosen as much, and victims are more likely to choose the third option. Victims who choose option 3 sign a document giving permission to take their kit (without identifying information on it) to the police and for police to submit that to the relevant crime lab for testing and analysis.

The sheriff’s department in the county submits kits to the crime lab for all anonymously reported assaults throughout the entire county. The local victim service agency keeps the victims’ identifying and contact information to connect with her/him after the results of the analysis come back. If there’s a Combined DNA Index System (CODIS) hit or other kit findings and the victim wants to go forward with the case after learning the results of the analysis, the sheriff and prosecutor contact the town or city law enforcement agency with jurisdiction over the assault to do the rest of the investigation. Prior to this contact, the law enforcement agency with jurisdiction would have had no knowledge of the assault. Thus, in this county, anonymous reporting to law enforcement is really happening, and all local law enforcement agencies agreed to this model.

Finally, we asked state coalitions during surveys if there were any other storage practices beyond the three we specifically asked about happening in their state. Examples of other kinds of storage practices include medical facilities performing the exam and then a courier transporting the exam to the department of health for secure storage, or medical facilities performing the exam and then submitting it to the state lab for storage for up to 120 days or until a report is made to law enforcement.

VICTIM PARTICIPATION IN THE CRIMINAL JUSTICE SYSTEM

From the justice system’s perspective, it is important for victims to report crimes to law enforcement and participate in the investigation and prosecution so that the system can hold offenders accountable and protect public safety. Participating in the quest for justice can also be very empowering and healing for some victims; however, not all victims are eager to participate

with the justice system, for a variety of reasons. VAWA 2005 takes a new approach to encouraging victims to participate with the system by allowing them to get access to the services they need without pushing them to report to law enforcement in order to receive them.

Exams without Victim Participation in the Criminal Justice System

In addition to requiring that victims have access to free exams, VAWA 2005 also requires that free access is provided regardless of whether the victim participates in the justice system—that is, free exams cannot be conditioned on filing a crime report with law enforcement, and law enforcement and prosecution do not have the authority to prevent victims from getting free exams. This requirement is premised on the idea that victims who are unsure about working with the justice system should be allowed time to make that decision while still being encouraged to receive medical care and provide forensic evidence in a timely manner, while it is still available. The hope is that victims will decide to participate with the justice system and file a police report to initiate a criminal investigation at some point after the exam. In this case, the evidence from the exam will already be available, although the opportunity to collect other evidence (from interviewing witnesses, processing the crime scene, and so on) may be lost.

Voices of Victims: Importance of Exams Even without Justice System Involvement

“My biggest point I would like to make to people is: Don’t go home, don’t go shower, go straight to the police, or go to a center to get yourself help, or go to the ER. Just go to the ER. They can do it all confidential. You can get a card, doesn’t even have your name on it. It has your case number. Once you have your case number, you can open that back up anytime you want. So, just to go and get that information collected, just to have it is going to be huge. It’s going to be in your favor, and you can take your time from then. It doesn’t have to be all thrown into a day.”

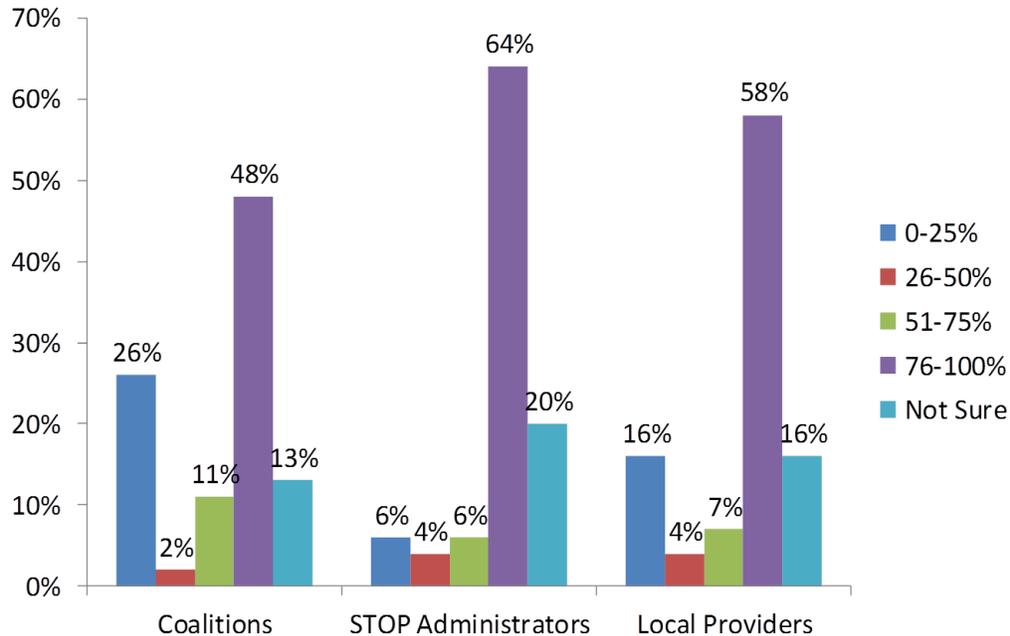
“They’re really good at the (*victim service program*) about not pressuring you on this. They say it’s your choice whether you decide to press charges or not, and you have a time frame. . . . They emphasize in case you change your mind in a day or two or in a month or so within the time frame. It’s something you can do now to go through with the exam just in case. Even if you don’t press charges, but if you change your mind, it’s there.”

Survey Findings on Victims’ Access to Free Exams without Requiring Justice System Participation

Our surveys of state-level sexual assault coalitions, SSAs, and local victim service providers asked for their perspectives on what proportion of victims in their states or communities can receive free exams without having to report to law enforcement. Figure 9 shows that from 48 percent to 64 percent of respondents reported a large majority—between 76 and 100 percent—of their victims could receive free exams without having to report to law enforcement. From 59 to 70 percent of respondents said that half or more of the victims in their states or localities could receive free exams regardless of participation in the justice system, and 10 to 28 percent reported that fewer than half of the victims had this access. There is a moderate difference among respondents, with more coalitions and service providers, compared with SSAs, reporting that

only 25 percent or fewer of their victims could get free exams without reporting to law enforcement. From 13 to 20 percent of respondents did not provide estimates.

Figure 9. Perceptions of the Percent of Victims Who Have Access to Free Exams without Having to Report to Law Enforcement³⁵



N=46 valid responses from state-level sexual assault coalitions
 N=50 valid responses from state STOP administrators
 N=406 valid responses from local providers

Case-Study Findings on Free Exams Regardless of Justice System Participation

We took a closer look at this question in our case studies by examining whether victims have access to free exams regardless of police reporting, how many victims actually *do* receive exams without having reported to law enforcement, how many of these victims convert to a reporting status after the exam, and why victims may be reluctant to participate in the justice system.

Can Victims Receive Free Exams without Justice System Participation?

In all the states and communities we visited, the general rule seems to be that the large majority of victims can receive free exams whether or not they report to law enforcement. We found remarkable consensus, both within personnel at sites and across the sites, that policy and practice forbid requiring law enforcement reporting or authorization of exams by law enforcement or prosecution. In many communities, sexual assault nurse examiners (SANEs) and victim advocates discuss with victims who have not already contacted the police the advantages and disadvantages of reporting and not reporting, so that the victims can freely make informed

³⁵ Victim compensation fund administrators were not asked their perceptions about access to free exams without having to report to law enforcement.

choices. Thus, many victims receive the exams regardless of whether they choose to report. Most of the victims in our focus groups and interviews understood that involving law enforcement was their choice.

Voices of Victims: Voluntary Reporting to Law Enforcement

“It was straightforward—there was a choice (*on reporting to the police*).”

A number of sites, however, noted that there are occasional exceptions to this rule. Several sites noted that some medical staff, particularly at hospitals that do not have SANE programs, may still be automatically calling law enforcement when a victim presents for an exam, without asking the victim if she wants the police involved. At least one victim, however, stated that the hospital required police involvement. This may be a training issue; medical staff may not be aware of the change in federal and state laws and policies. It may also be a matter of confusion about the application of mandatory reporting laws (typically, only for child victims or vulnerable adults, such as the elderly or disabled), so that medical staff may believe that all sexual assaults must be reported to law enforcement. One health care provider discussed an incident in which the victim had previously talked to the police, then gone to the hospital for an exam. The police contacted the hospital and told the staff not to provide the exam because they felt the allegation was unfounded, so the nurse refused to perform the exam. This is not in the spirit of providing exams on demand regardless of justice system participation. While these examples are troubling, from all reports they seem to occur fairly infrequently.

Voices of Victims: Law Enforcement Involvement Required

“The hospital gave them all my information. I had to sign a law enforcement statement.”

Importantly, whether reporting is required and whether first responders understand that can sometimes be a moot point: Victims may feel pressured to report to police, regardless of whether it is required. The pressure may come from several avenues—first responders, friends, family, and so on. Some victims in focus groups and interviews felt pressured into reporting to the police, resulting in varying outcomes. The *Voices of Victims* box below illuminates thoughts from one victim who did report under pressure, while another was pressured, but did not report.

Voices of Victims: Pressure to Report

“It just seemed like they (*nurse*) were taking photographs and stuff, and they were like, ‘Have you talked to the cops yet? Did you call the cops?’ I kept telling them, ‘No, we didn’t.’ And then all the people that were close to me, my parents, they were talking to them about how I should because I was underage. And so they made me go do it, because I wasn’t going to.”

“It just seemed like it was the only option, you know, like, ‘Why won’t you?’ . . . It was asked so many different times by so many different people that I just kind of felt like, ‘Well, should I just give in and do it?’ . . . But I just felt like I needed to at least stand up for myself on that part, you

know. . . . They said that they would keep it (*the exam evidence*) for six months, the evidence itself, and there would be a report made and the report on the evidence would be kept on file for a year. So, I have up to a year to report it.”

Do Victims Receive Free Exams without Justice System Participation?

Sexual assault is one of the most underreported crimes, with many victims choosing not to participate in the justice system; police reporting rates have been estimated from 12 percent to 50 percent (Kilpatrick et al. 2007; Planty et al. 2013; Truman 2011). This means that there are at least as many unreported assaults as there are reported assaults. Now that victims who have not reported to the police can also receive free exams, are they, in fact, accessing them?

There was considerable consensus in our case-study sites that few nonreporting victims receive MFEs or even medical exams. When the personnel we interviewed were able to provide estimates on the percentage of all exams that are provided to victims who had not reported to the police, their estimates typically ranged from 5 percent to 10 percent (with one state estimating 2 percent to 4 percent). A few localities estimated higher percentages of exams provided to nonreporting victims: 13 or 14 percent in two cities, 25 percent in two cities, and 50 percent in one city, but this was very unusual. Still, some of the victims in our study did have exams without having reported to law enforcement.

Voices of Victims: Exam without Police Reporting

“I got options on what I can do. And six months to come back. It (*exam evidence*) was in a sealed envelope with no identification on it.”

“The hospital said they’d hold it (*exam evidence*) for six months.”

Why don’t more victims who haven’t decided to participate in the justice system get exams? One common hypothesis our respondents had was that the public is simply not aware that getting an exam does not require police reporting. Notably, four victims from one particular state indicated that they did not get the MFE because they thought they would have to report the assault to law enforcement to do so. Those who have not decided to involve the police may stay away from medical services as well. This means that many victims may be foregoing necessary medical services—and a link to advocacy services and counseling—from a misunderstanding about the link between medical services and the justice system. So, while it appears that most places we visited had effective systems in place to ensure victims could access the exam without a police report, the general public may not be fully aware of this. While conducting public education around this information might be challenging, given that few people may think about MFEs unless they are in a situation where they need one, some type of outreach might be helpful to ensure victims come forward for help regardless of their interest in reporting the assault to the criminal justice system.

Do Nonreporting Victims Who Receive Exams Later Convert to a Reporting Status?

The rationale behind VAWA 2005's requirement that victims have access to free exams, including forensic evidence collection, regardless of police reporting, is the hope that with time, victims will decide to file police reports. We asked personnel in our case-study sites how often victims who had the exam without having reported later converted to a reporting status. Some did not have access to statistics, so they reported that "few or none," "few," or "a small handful" of nonreporting victims with exams later reported. Others estimated conversion rates from 3 percent to 5 percent, with one respondent estimating a 15-percent conversion rate.

Why are conversion rates so low? Some interviewees speculated that victims tend to know right away whether they want to involve the justice system. Several people said that the few conversions that do occur tend to occur quickly, within days or weeks of the exam, although one person said that the first anniversary of the assault may be a trigger that leads to conversion in some cases.

Several personnel we interviewed said that victims need more than just time to make the decision; they need to believe that involving the justice system will be beneficial to them. They need to believe that the system will treat them well and will achieve the outcomes they desire—punishing the offender and preventing additional assaults. A few of the victims we spoke with had received an exam without having reported to the police and were still considering filing an official report to initiate a criminal case. One of the victims had converted to a reporting status over time, working with an advocacy agency.

Voices of Victims: Conversion from Nonreporting to Reporting

"They (*advocates*) told me I could come and not have to contact the police, but if I wanted they would release the records. And actually later, they did end up releasing that. They kept the file, and I would call them every month and tell them to keep the file because I didn't know what I was going to do. And so then it was eventually released to the police . . . with my consent. Yeah, I called them, but there was never any pressure."

When victims receive follow-up support and information, they may be more willing to convert to a reporting status. They may feel stronger and more empowered to become involved in the justice system. They may also have better access to the mechanisms necessary to initiate a criminal case. For example, staff in one site said that nonreporting victims must sign a consent form to release their exam evidence to law enforcement, and this is much more feasible when staff take the form to them rather than require the victims to come to the office. Although it is difficult for some communities to provide an on-scene advocacy response to victims even at the time of the exam, it might increase conversion rates if advocacy resources were available for post-exam follow-ups (though this is not necessarily a goal of community-based advocacy). This follow-up might provide emotional support to victims, information not otherwise available about the justice system and what initiating a criminal case would entail, information on the storage timeline for the exam evidence and when the date for destruction of their nonreported kit is

approaching, and easy access to the steps needed to convert to a reporting status, if a victim so chooses.

What Are Victims' Concerns about Participating in the Justice System?

Many victims are reluctant to involve the justice system for a variety of reasons. Some are well aware of societal attitudes of victim-blaming that often occur in sexual assault cases, and they may even blame themselves. Some are concerned about their privacy, especially in rural or tribal communities where everyone knows everyone else, and they fear public humiliation. Some fear retaliation from the offender or his social group. Some are focused on their own healing and simply are not interested in a justice system response.

Voices of Victims: Nonreporting Due to Shame

“On the reservation no one speaks about sexual assault, and I was ashamed.”

Voices of Victims: Nonreporting Due to Self-Blame

“I didn't understand then that what had happened to me was rape.”

Voices of Victims: Nonreporting Due to Fear of Retaliation

“It was a group of guys, and I was intimidated to report them.”

“I got the exam but I didn't report it (*to the police*) because there were threats to my family made.”

Voices of Victims: Nonreporting Due to Privacy Concerns and Fear of Humiliation

“I had considered it (*reporting to the police*), but I decided against it for the same reason that I did not seek medical attention. I just didn't want anyone to find out. I didn't want to be judged for it. I didn't want my parents to, you know, do anything about it.”

Voices of Victims: Nonreporting Due to Lack of Interest in Justice System

“I just wanted to forget about the whole thing, really. . . . It's his word against mine, and I just didn't want to put myself through all that.”

“I have low self-esteem. . . . Having to go through that in court. . . I couldn't talk about it for a long time.”

Some victims do not want to involve the justice system because of negative personal experiences or cultural attitudes toward the police (such as perceived racism among law enforcement toward minority communities). Some fear law enforcement will not treat them well, will not believe them, or will blame them for the assault. Some may have been involved in illegal or questionable

activities at the time of the assault (such as drug use or underage drinking) or may have legal difficulties, such as undocumented immigrant status, and may fear getting into legal trouble if they report. Some may worry about the burdens of being involved in a criminal case or simply fear the unknown if they are not familiar with how the system works. Some may believe that the justice system will not achieve the outcomes they desire. According to advocates in one locality, the police may discourage victims from reporting unless it is a “slam dunk” case, from concern for political sensitivities around crime statistics, and the desire to avoid low closure rates by not taking on cases that would be very difficult to clear.

Voices of Victims: Nonreporting Due to Victims’ Expectations of Police Response

“I think that’s part of the reason why I didn’t want to report it, because I don’t feel they (*the police*) take you seriously. I feel like a lot of the cops in this town actually put the blame toward the victim. ‘What did you do to get yourself in this situation?’”

“I’ve actually known a lot of people who have tried (*reporting to the police*). They’ve told the cops or whatever, and it’s just been hell. And so for me . . . I’m not going to put myself through that when I don’t think there’s going to be any sort of charges that are going to come out of it. . . . I’m not going to call the cops because it’s not going to go anywhere and why should I put myself through that hell. I’ve watched too many people do that.”

Voices of Victims: Nonreporting Due to Victims’ Expectations of Justice System Response

“When I was younger, I was sexually assaulted by my stepdad. And we went through the whole process of getting a lawyer and a court date, being interviewed and all that, and it just went nowhere. And I just didn’t want to put myself through all that and, you know, be let down in the end. So, I just didn’t want to go through that whole thing.”

Other victims do choose to involve the system to assist in their own healing, to prevent additional victimizations, and to bring the offender to justice. Victims from focus groups and interviews spoke about this as well.

Voices of Victims: Reporting to the Police for Recovery and to Serve Justice

“I talked to the police and reported because I wanted closure on the incident.”

“(Victim initiated criminal case) for their (*other victims*)’ sake and to be able to say, ‘This is what you did to me. You deserve everything you’re gonna get.’ And, you know, I just think that would be really powerful, and I know it’s gonna help me to say to him, ‘Well, you put me through hell and dragged me down, but look at me now. I’m off my meds again. I’m strong and I didn’t let you take me down.’”

“I was kind of iffy on whether I wanted to press charges but I knew I needed the exam. The nurse who gave me the exam . . . talked with me and the case worker talked with me. And I felt

more and more certain that the right thing to do was to press charges.”

Law enforcement can address victims’ concerns about the justice system while still leaving the option of filing an official report open to the victim. Officers can offer victims informational interviews in which they establish rapport with the victims, inform them about how the system works and what being involved in a criminal case would require of them, and answer their questions and concerns. This contact should be either off the record or written up in an anonymous report, if documentation is required (Lonsway and Archambault 2010). We found in our case-study sites that some agencies/officers will provide this service, while most have a policy that any contact with a victim constitutes an official report that initiates a criminal investigation. Some advocates in communities where the police offer this service felt that it can be very helpful to victims as they make the reporting decision. A police officer also observed that even if it does not lead to a criminal case, this procedure at least gives law enforcement a fuller picture of crimes occurring in the community.

Speaking to law enforcement in order to help make a decision about reporting may help victims make decisions they will not regret later. We heard from a few victims who chose not to report to the police that these decisions have stayed with them, and they have regretted not initiating a criminal case that might have stopped the perpetrator from committing another rape.

Voices of Victims: Reflections on the Choice Not to Report the Assault

“I’m sure he’s done it before and will again, and I feel guilty for that. But there was no evidence, and because it was a ‘he said, she said’ case. . . .”

“On bad days it (*not having reported to police*) does come up, and I do regret not going to the police, mostly because I feel like this guy could be doing the same thing to other women. And I wish that I would have been the one to be able to prevent that. But I didn’t, and we’re moving past it.”

“I think to this day, I could’ve gotten the police involved because who knows if he’s done that again. And that’s still something that’s on my mind . . . but I think I did the best that I could at that time.”

Law Enforcement Investigation

The purpose of the forensic portion of the MFE is to collect evidence for law enforcement to use in the investigation, to make an arrest, and to build a case for prosecution. The exam can benefit the investigation by providing evidence of nonconsensual sexual contact that may identify who perpetrated the assault on the victim.

The exam can provide evidence of sexual contact by collecting biological specimens left on the victim, such as semen, saliva, hair, and so on. DNA analysis conducted in the crime lab can

identify who these specimens came from. The results of the analysis may confirm or exclude a known suspect or produce a “hit” that identifies a suspect when the DNA profile from the victim is uploaded to the Combined DNA Index System (CODIS) database and a match is found. However, DNA identification is successful in between one-third to one-half of all kits submitted to crime labs (Gingras et al. 2009; Grossin et al. 2003; Jänisch et al. 2010), although that fraction is increasing as lab processes become more sensitive (Roman et al., forthcoming).

Evidence of the use of force, such as identification and documentation of injuries, can establish that the sexual contact was nonconsensual. However, it is not foolproof since consensual sex can also produce injuries and nonconsensual sex does not always cause injuries. But if there is evidence of injuries, it can back up the victim’s statement that the sexual contact was nonconsensual. Nonconsensual sexual contact can also occur if the victim was drugged, and toxicology analysis of blood and urine samples obtained in the exam can test for the use of drugs. The exam must be done very soon after the assault for these tests to be valid, and it can be difficult for some communities to provide refrigerated storage space needed for liquid samples. In addition, sophisticated toxicological testing is not always considered a standard part of the exam and is quite expensive. In one case-study state, prosecutors needed to approve this type of testing and pay for it, which was outside the scope of other exam procedures and payment mechanisms.

Our interviews with law enforcement and other personnel in our case-study sites found a wide range of perspectives on the usefulness of MFEs in law enforcement investigations. Some felt that exams are always useful, even if they don’t provide evidence, because the very fact that a victim was willing to undergo the exam supports that she or he was a victim of sexual assault. Defense counsel cannot say, “If you were assaulted, then why weren’t you willing to have an exam?” As one detective phrased it, the exam “always gives me something.” While helpful to the case, the exam puts an immense burden on victims of sexual assault that does not exist for victims of other types of crime.

Other personnel felt that the exams were only useful under certain conditions. Many pointed out that exam evidence is not necessary to establish sexual contact and identify the suspect when a known suspect admits sexual contact but claims it was consensual. In that case, only evidence from the exam of use of force or coercion to establish lack of consent would be helpful to the investigation.

However, if a known suspect denies sexual contact, DNA identification of a sample from the victim that matches a sample from the suspect conclusively proves that there was sexual contact, and that the suspect lied about it. If the suspect’s identity is unknown, but he has an identified sample in CODIS, DNA identification of a sample from the victim that is uploaded into CODIS and is matched to the suspect sample in CODIS identifies the suspect.

If a sample from a victim is matched to a sample from another victim in CODIS but not to a sample from an identified suspect, then the analysis has at least established a link between the two cases. Any other identifying information from one case (such as a physical description of the suspect) can also be used to investigate the other case (Lonsway and Archambault 2010).

Some respondents felt that inconclusive exam results could actually harm the case. Because of the “*CSI* effect” and “*Law & Order SVU* effect” (when members of the public expect to see scientific evidence in every case, from watching television shows like *CSI*), some felt that inconclusive results may be interpreted by the jury as disproving that an assault happened. In that case, they would rather the exam had not been performed.

Law enforcement and prosecution agencies have different policies for sending exam evidence to the crime lab for analysis. One major consideration is whether the victim has filed a report with the police. Without a complaining witness, the police do not have a case to investigate, so the kit is typically stored pending a victim report to initiate a criminal case. While this policy respects the victim’s wishes and preserves crime lab resources for active investigations, it also foregoes the opportunity to find evidence in CODIS to identify a serial rapist who presents a serious threat to public safety. The exception to this is jurisdictions that choose to offer anonymous reporting options to victims (see previous sidebar).

Many of the personnel we interviewed said that while the MFE can be very useful to the investigation, it is not always a critical component. There was some agreement that a strong statement from a credible witness (often the victim) is the most important piece of evidence. Other corroborating evidence from the scene is also considered critical evidentiary material.

Law Enforcement Treatment of Victims

Building rapport between law enforcement officers and victims is very important for situations where the victim has decided to report as well as for those where the victim is still considering the reporting decision. For ethical reasons, victims should not be revictimized by insensitive officers; also, victims who are treated well will be more interested in participating with the justice system and providing evidence.

Many of the stakeholders we met with during our case studies, including nurses and advocates, felt that most officers, and especially most detectives or investigators as compared to patrol officers, generally interact well with victims. Some of the victims we spoke with reported very positive interactions with the police. Positive interactions means officers who believe the victims, provide emotional support, stay in touch and provide information, and pursue an investigation to identify and apprehend the suspects.

Voices of Victims: Believing the Victim

“When my friend took me to the police department and right then and there they were, like, on it, you know. . . . And the detective on the case, he suggested that I come over here (*exam provider*) and get things done. . . . He believed me.”

Voices of Victims: Emotional Support from the Police

“So, I went in there (*police agency*), and I had the most amazing man, the most compassionate person that happened to talk to me. . . . That man is just so wonderful. I can’t but thank God for him because he said, ‘Of course we can do something about it.’ And he connected me with

(advocacy program). He brought me right over himself.”

“I had a wonderful experience with the detective. She was nice and wonderful. The officer that came as well and took my statements, she was very empathetic. And she said, ‘Here’s my badge number if you want to get in touch with me,’ because I knew my assailant, who was the creepozoid that I dated on match.com. . . . It’s taking forever to hear back on how that’s progressing, but at least when I call I don’t get stuff, she listens and is patient. Unfortunately, it’s a long process.”

Voices of Victims: Staying in Contact and Providing Information

“I’ve talked to a detective a couple of times. . . . She’s called to check on me and let me know what’s going on. She let me know he was being released. Let me know when he was being transferred. . . . She’s been in contact with me.”

Voices of Victims: Investigating the Case

“They (*city police*) were fabulous. They supported me the whole way. We identified him through a photo lineup in October. They explained everything to me, including going in front of the grand jury. And finding him and getting him—they did a good job.”

However, not all victims have such positive experiences with law enforcement. Some professional stakeholders from case-study sites felt that some officers may push victims to file the report (or push advocates or nurses to push the victims to report), whereas others felt that some officers discourage victims from reporting unless it is an “easy” case to investigate and close (strong evidence and a “good” victim who would be seen as credible in court). Victims we spoke with reported several concerns about law enforcement interactions, including being disbelieved, blamed, dismissed, or stonewalled; being treated insensitively or facing racism; and facing law enforcement incompetence. Victims in some minority communities, especially American Indian communities, have reported significant levels of racism, mistreatment, and cultural misunderstandings on the part of non-Native law enforcement officers.

Voices of Victims: Police Disbelieving the Victim

“That was a bad experience with the police . . . I was hesitant (*to press charges*) because the police were so rude . . . they treated me like it was my fault. One night after I was attacked and I was unconscious and they did CPR on me, and then they found DNA and whatnot, the police officers said to me—and I had two black eyes—they said, ‘Maybe a bird flew into you and hit you.’”

“They (*the police*) wouldn’t always go to see if he—he would always leave the scene or whatever. They wouldn’t always follow up. . . . The police were just so slow about it and then they would tell me, ‘Oh, it was consensual, he says it’s consensual.’ . . . So, my experience wasn’t great with law enforcement.”

“They should not default to, ‘I don’t believe you.’ They should just default to, ‘Tell me as much as you know.’ . . . ‘I’m just going to take an objective statement from what you can tell me about whatever happened.’ Don’t default to, ‘I don’t believe you.’ That’s absolutely unacceptable.”

Voices of Victims: Victim-Blaming by the Police

“I didn’t like his (*police officer’s*) attitude. . . . He was more or less blaming me for everything that was going on. He’s just like, ‘Well, you probably had too many drinks. And you’re probably a little obnoxious and you guys just got out of hand.’ . . . I was just like, ‘Oh, whatever.’ And I don’t even want him around me anymore. . . . So, that’s why I was like, ‘No, I’m not going anywhere.’ . . . I think that’s why I didn’t go (*to the hospital*) the night of.”

“She (*detective*) just put stuff in my head like, ‘Wow. Why did you say that? Why did you do that? Are you sure it really happened?’ And I shouldn’t have done that, and I shouldn’t have said this. And it’s like, ‘Oh my god.’”

“They (*law enforcement*) are supposed to serve and protect, right? Not humiliate (*the victim*) and defend the perpetrator.”

“One of the first questions the (*city*) police ask you is, ‘Have you been drinking?’ Drinking is legal, and it shouldn’t matter. Just because there is alcohol, it shouldn’t make it alright to be raped.”

Voices of Victims: Dismissiveness by the Police

“I go to see the detective . . . and he decided that I was a drug addict whore and that was the end of the case. . . . I told him how hard it was and how scared I was. I was crying. I’m showing him text messages from this guy like threats and sexual things and threats and sexual things nonstop. And he just said, ‘Well, I don’t know what you expect me to do.’ It was a throwaway phone, so you can’t trace those or anything. ‘What do you want me to do? Nothing I can do about that.’ I was so upset. I was just like, ‘Yup, thanks for your time. Goodbye.’”

“I just don’t feel like I was taken seriously or it really isn’t important to them as it is to me. I understand, I probably shouldn’t have been drinking and walking home, wasn’t the smartest choice, but. . . .”

“I just had issues with the police. When my assault happened, we’d been drinking, and I’m pretty sure that I was drugged, and I told them that. And when he asked me what my symptoms were, he pretty much just blew it off and said, ‘Well, isn’t that what happens when you have a hangover?’ And I was like, ‘Are you freaking serious?’ . . . I know what a hangover is, and the fact that I couldn’t even hold on to two ounces of Sprite in a 24-hour period, that’s not a hangover. That’s something more.”

Voices of Victims: Insensitivity by the Police

“They (*the police*) escorted me out . . . and I was just like, ‘Why can’t one of my friends come with me?’ (*to the hospital for the exam*). My friends were really adamant about wanting to at least go with me, but they (*the police*) wouldn’t even give them information so they could follow us to the hospital. Then I was kind of like, okay, I’m being put back into the same situation, not being able to leave. And I kept asking them, ‘Why do I have to sit in the back (*of the police car*)? I’m not a suspect.’ But they put me in the back and once we get to the hospital, then they segregate me and they put me into this tiny little room, and then both of the male detectives are talking to me, then they leave and they lock the door, so it’s kind of like I was by myself, couldn’t talk to no one or anything like that. . . . No one would let me talk to anyone pretty much, and I was kind of just left by myself for like a couple of hours or so.”

Voices of Victims: Stonewalling by the Police

“It was their demeanor and their tone. They were just saying, ‘Well, if you want to press charges, this is what is going to happen, but it doesn’t look like you have any physical harm done, so most likely we’re not going to prosecute.’ Yeah. And then afterwards they said, ‘Well, do you want to press charges?’ And I said yes, and then maybe like a couple of weeks later they said, ‘Oh, we didn’t really follow up. We weren’t really exactly sure that you wanted to press charges.’ And I told them, like, ‘Yes, I do,’ and it became a conflict. . . . They knew the guy’s address, and they had his phone number, and they had a copy of his driver’s license. . . . They knew where he was staying at and they refused to go interview him. . . . They had us on hotel surveillance, and so they didn’t interview him until maybe like two to three months later. And they said that’s because our local prosecutor is most likely not going to prosecute. And so it was just going to be a case of “he said, she said,” so it doesn’t really matter whether or not we interview him.”

Voices of Victims: Incompetence in the Police Response

“I knew the guy. I went to the police, got the exam, and they arrested him. The police said they lost my rape kit, and then let him go. He is out in the community.”

Voices of Victims: Racism in the Police Response

“It’s definitely harder to go to the police if you’re a woman of color. The stereotype is that we are alcoholic, drunk, and that we cause the incident. That’s the stereotype they have of a Native person. If something happened to a white woman, they would have blasted it all over the news, but it happens to us all the time.”

“Almost all of the officers are white, very rarely are they Native. They are not sensitive to us and our community.”

Officers and advocates at several of the communities we visited have been working together to develop training and guidelines for officers on how to interview victims, as well as how to investigate cases and gather evidence. In two of the six states we visited the state sexual assault

coalitions estimated that up to 80 percent of cases were not forwarded from law enforcement agencies to prosecution, because of insufficient evidence. Law enforcement officers who are more sensitive to victims' concerns may be more effective at building cases that lead to offender accountability.

Prosecution

Increasing the ability to hold sexual assault perpetrators accountable has been one goal of VAWA since its inception in 1994, with an emphasis on prosecution as a central theme. During our case studies, we saw wide variation in prosecution efforts, with a few sites reporting innovative efforts to enhance prosecution, while others reported lackluster efforts or even a virtual lack of prosecution.

The types of sexual assault cases forwarded from law enforcement for prosecution include marital, acquaintance, and date rape cases; child sexual abuse and incest cases; and stranger rape cases. Across jurisdictions, however, prosecutors reported that most of their caseloads include nonstranger rapes, and, in a few local jurisdictions, prosecutors reported they had not seen a stranger rape case for years. While these types of cases make up the majority of their sexual assault caseload, several prosecutors across all states, along with other system responders, reported that acquaintance rape cases are difficult to prosecute. We commonly heard these cases being referred to as “he said, she said” cases, for which the victim’s and perpetrator’s accounts of what happened are at odds and the victimization is difficult to prove. What is at issue is not whether or not the sexual encounter occurred but, rather, whether it was consensual.

Based on qualitative reports from respondents across stakeholder groups—prosecutors, law enforcement, advocates, and SANEs—rates of prosecutorial declination for sexual assault cases appeared to be high across the six states. Although prosecutors did not provide actual numbers, perceptions of many of their local counterparts were that many sexual assault cases were not addressed or not addressed adequately, and that prosecutors pick particular cases to pursue and not others. The most extreme example occurred in one state, where respondents indicated that prosecution of sexual assault cases was rarely taking place. As one victim advocate put it, “It is open season here,” to describe the lack of prosecutorial response to sexual assault cases. In this state, the advocates referred to law enforcement as their “grassroots partners” in addressing sexual assault, with prosecution being the link in the chain where these cases failed.

On the other hand, when cases were chosen to move forward, they were likely to be successful. The pressure for prosecutors to win cases appeared to be quite real. Prosecutors in case-study sites reported the types of cases they charge are cases they can prove to a jury beyond a reasonable doubt. A few prosecutors reported there is a distinction between whether they *believe* a victim had been sexually assaulted and whether they could *prove* a victim was sexually assaulted. Despite this nuanced understanding, the overall perception of other stakeholders in several jurisdictions is prosecutors are taking “slam dunk” cases, where there is clear evidence, physical resistance, and force. These cases also rarely involve the issue of consent, such that defendants might argue the encounter was consensual.

However, we also visited a few jurisdictions where prosecution was praised for their approach to sexual assault cases. For example, in one such jurisdiction, the district attorney pushed prosecutors to take unconventional sexual assault cases, try them, and use them as an opportunity to educate juries. The prosecutor's office also had pushed law enforcement to take more cases. Another prosecutor from a different jurisdiction reported there is always corroborating evidence within every case, and there is no such thing as a "he said, she said" case. According to her, it is the job of the prosecutor to find and gather the corroborating evidence and present it to a jury.

Cases that are forwarded for prosecution are often resolved through plea bargains, where most offenders will take a guilty plea to a lesser charge. In the few cases that do move forward to trial, some prosecutors in case-study sites stated that one challenge they face is the unwillingness of juries to convict in sexual assault cases. Juries are tough on victims, and sometimes even when prosecutors bring forward a strong case, some juries will not convict. Some prosecutors mentioned the "CSI effect" and the "Law & Order SVU effect," as mentioned previously, as raising the expectations of juries regarding the types and levels of evidence they will hear about in such cases. One prosecutor we met with who seemed to have victims' concerns at heart would ask them to have a realistic expectation of the criminal justice system. She would tell victims that if they could handle seeing juries acquit their perpetrators in front of their eyes, then they should go forward with their case. Otherwise, as another victim advocate stated after years of working with victims and dealing with law enforcement, prosecution, and juries, if they want justice, "the last place to look is the criminal justice system."

Voices of Victims: A Victim Comment on Plea Bargaining

"Mine only took like six months and it was done. . . . They took a plea agreement, and my attorney advised me not to go to trial because they could have gotten away with it otherwise, is what he said. But I was not happy with that. I wanted to go to trial, because they got, like, three years at max."

According to various system responders in case-study sites, having a prosecution validates a victim's experience. Some prosecutors reported the experience can be empowering for victims, and it can give victims a sense of safety and closure; however, victim advocates report the process is difficult and scary for victims.

Voices of Victims: Action by the Prosecutor

"When it went to the DA's, that was fairly quick. And then within two weeks, he was arrested. I couldn't even believe it, they had so many warrants out for him. And the advocate at the DA's called me . . . 'I just wanted to let you know that we picked (*suspect*) up three minutes ago. . . . That shows they care, like, three minutes . . . that meant so much to me.'"

But getting to a successful prosecution can be challenging and might take a long time. Some victims spoke about how disconcerting the court process was to participate in—that it could be terrifying, retraumatizing, invasive, and embarrassing. In addition, from both prosecutors and

victims we heard about how long the process can take to move a case through investigation and prosecution, particularly trials. Some prosecutors indicated it was a matter of the priority to prosecute sexual assaults; others spoke about court resources being inadequate, with not enough bench time available to cover all the cases they need to take to trial.

Voices of Victims: Victim's Reflections on Court Experience

"The grand jury was terrifying. . . . You feel judged."

"When I had to have my evidentiary hearing, there were pictures of my vagina up on the screen for the whole court to see. . . . His lawyer demanded that it be shown, and the judge let it be shown. Yeah, the process is actually probably more violating than the actual assaults."

"I'm just now realizing how invasive this legal process is, because they're going back to, they're asking me for stuff from high school. They are going back to high school, all of my medical records, anything. . . . I sincerely regret having told anyone that there was a condom inside of my vagina and that I needed to go to the hospital, because had I known that my life would have fallen apart the way it has, there's no chance in hell that I would have said the thing, there's no way. Because I can't get out of it now. I mean there's nothing that I can do."

Voices of Victims: The Slow Process of Justice

"I've been really shocked and disappointed in our justice system and how long it takes, and the fact that my trial has been delayed twice. It'll be two years in June that I was raped, and my court date is now set for September."

"I do believe that people need to be held accountable for the things that they do. And when it's dragged out for two years, there is no accountability, and something has to happen. . . . I mean, it's victimization all over again. It really is when it takes that long."

"I know that the healing process takes time, but I really believe that in order to start the healing process, there has to be closure on this aspect of it (*the criminal case*). . . . After they extended his court date, I just totally started regretting even calling the cops. My life is all focused on this now."

MFEs and Prosecution

As with arrest and investigation, the MFE can be central to prosecutorial efforts. Across many prosecution respondents, the MFE was identified as a key piece to moving forward with charging sexual assault cases and ensuring convictions, and some reported the importance of a victim getting the entire MFE done, as prosecutors never know which piece of the exam will be helpful to their case. For those prosecutors who find the MFE useful, many reported its utility both when evidence is found during the exam process and even when it is not.

In the case where MFEs identify evidence, the utility is unquestionable to many prosecutors. As one prosecutor reported: if they have the evidence from the MFE, that case is not going to trial because it will plead out. Another noted that when there is MFE evidence, you cannot argue with it. This is especially true when a defendant says they did not know the person or that they did not have sex with the person. Further, a relatively innovative prosecutor discussed that even when a defendant is not disputing the sexual contact, but rather the consensual nature of it, the MFE serves as a way to “fill in the holes” the defense tries to create in these cases.

A few prosecutors in case-study states indicated that if no evidence is found in an MFE, it may undermine the credibility of a case because all that is left is the victim’s testimony. Victim credibility was raised as an important factor that law enforcement, prosecutors, and juries consider in a sexual assault case. Respondents indicated that victim credibility is impacted in cases that involve alcohol and drug use, inconsistent statements from victims, and victims withholding information about their own behaviors prior to the assault or their relationship with the defendant. To counter what defense attorneys might do to attack inconsistencies in victims’ stories, one savvy investigator reported that they no longer tape victim interviews. Because of the nature of trauma and how it unfolds for victims, he reported that victims’ stories are likely to change some over time as they remember more facts and as they become better able to talk about the experience.

Despite those prosecutors who found no utility in the MFE if no evidence was found during the process, still others stated the *act* of obtaining MFEs is useful to their cases and the fact that victims underwent the process of getting MFEs *adds* credibility to their stories, regardless of whether any evidence was found. Even without evidence from the MFE, prosecutors can describe to juries how difficult the exam process is and can call on SANEs as expert witnesses. One prosecutor stated she tells juries the difficulty of taking the HIV prophylaxis for victims—in that it can make one ill—and that someone would not just take such medications for the “heck” of it.

Alternatively, in areas where we heard limited prosecution was taking place, prosecutors reported that the MFE loses its utility in acquaintance rape cases and/or cases where what was at issue was consent. These prosecutors thought the evidence from this kit no longer mattered if defendants admitted to sexual contact. In fact, in the aforementioned state where we heard little prosecution took place, the state coalition representatives also reported the utility of the kit was limited because of this prosecution practice. One noted that the general utility of the exam is “not what it used to be. Any defense attorney with any skill doesn’t deny the sexual activity—so let’s start from there.”

According to the victims we spoke to during focus groups and interviews, most (but not all) felt that the exam was an important component of the criminal case. They noted that the exam facilitated the investigation and prosecution of the case. Some also noted the role of the exam in their psychological healing, in terms of confirming what had happened to them and allowing them an opportunity to take back control, and in their physical recovery.

Voices of Victims: Importance of Exam Evidence for Criminal Case

“It’s (*the exam*) a crucial element if you’re going to press charges that you have every little bit of evidence there can possibly be, no matter how humiliating the whole exam is. It’s just if you’re even considering pressing charges, without that, you’ve got nothing to stand on anyhow.”

“(Did having the exam make a difference in the case?) Yeah, I think it did. . . . Because it doesn’t really give him that leverage to say that we don’t really have evidence that it happened.”

“Mine (*the exam*) was worthwhile because six to nine months ago the detectives knocked on my door . . . letting me know they had been working on it (*the criminal case*).”

“I don’t regret it (*having the exam*). I mean, it was not fun, but without it, I wouldn’t have been able to make the—my case wouldn’t have been prosecuted.”

“I was kind of iffy on whether I wanted to press charges, but I knew I needed the exam. The nurse who gave me the exam . . . talked with me and the case worker talked with me. And I felt more and more certain that the right thing to do was to press charges. . . . She kind of assured me that regardless if I felt fear of retaliation that if I reported it, the police would be aware of that. She would make sure I was safe, you know, so I kind of felt more at ease after. . . . It was a little bit disturbing to hear that if it went to the DA’s, it might take up to two years to prosecute him. That was very disturbing to hear, and that kind of held me a little bit, but once I started realizing if I don’t get the process started now, then things could be lost, you know, information can be lost, testimony can be lost, memory can be lost. And I knew after hearing all those facts that I had to get things started.”

Voices of Victims: Exams Don’t Always Provide Evidence

“They didn’t get much evidence from it (*the exam*), so it didn’t really make a difference, I guess.”

Voices of Victims: Role of Exam in Psychological and Physical Recovery

“I didn’t know what had happened. . . . I woke up on the floor. . . . So, I was glad to get it (*the exam*) as proof to myself that something did happen and that I wasn’t nuts. . . . It was reassuring to myself and then also so that they (*the police*) can pursue some type of investigation now.”

“The way I thought about it is that the assault I couldn’t control. This is totally not my thing and it was scary, but when it came to my health, if I did not take the HIV meds and those were available, then I’m the idiot and it’s bad on me. So, when it came to the examination, this is something that I can take control over, even though it is something that is extremely invasive and it just makes you feel so small. But when it comes to my health and there are things that are out there that will help me be healthy, then I’m going to do it, and so I’m glad I did the examination. . . . I will heal, my body will physically heal, and that’s how I feel that the examination is kind of a starting point through your physical body healing.”

Prosecution Treatment of Victims

In cases where prosecution declines to move forward, victims may feel retraumatized by the criminal justice system. For example, a victim advocate stated that victims walk away feeling powerless because the decision not to move forward with their cases is made for them, not by them. In a few jurisdictions, we heard that prosecutors would meet with victims to explain their decisions for declining cases, which can provide some sense of closure for victims. However, in other jurisdictions, victim services providers and/or local law enforcement agencies are left to notify victims that their cases were declined by prosecution.

In the state discussed above that, by all accounts, had very minimal focus on prosecution, law enforcement expressed as much frustration with holding offenders accountable as the advocates did. Advocates and law enforcement worked hand in hand to build strong cases, but both reported that these cases were not moved forward due to prosecutorial decisions, rather than failures on the part of law enforcement to build a case. Some law enforcement officers in this state expressed regret—in having to meet with victims to let them know the prosecutor was not going to move forward with their cases—and frustration—that they were the ones to provide this information rather than the prosecutor meeting with the victims directly. They reported that victims often would blame them, rather than the prosecution, for the case being dropped, but they understood and shared the victims' frustration.

Prosecution for Cases Involving American Indian Victims and Tribal Jurisdictions

In the places we visited for case studies, prosecution rates for tribal victims of sexual assault are minimal, and the overall perception is that little is done in cases when American Indian victims come forward. Victim advocates across tribal jurisdictions and agencies that specifically focused on working with American Indian victims reported these victims are just not believed when they report to the criminal justice system. The director of an agency that represents American Indian women used the word “pathetic” to describe this country's criminal justice responses to these victims, and a law enforcement officer stated that, “We have created a class of people with no rights.” Advocates from more than one agency reported struggling with asking victims to come forward to get MFEs when the overall perception is that nothing will happen after the exams. As one advocate reported, she has seen cases that one would think would be easily prosecuted slip through the cracks.

Issues surrounding jurisdiction were named as tantamount to the lack of prosecution. Nuances related to where an assault took place (on or off a reservation) and by whom (a Native or non-Native person) made it hard to know which investigating and prosecuting agencies had authority, in some areas, or the will to move forward, in other areas. In one area we visited, a tribal judge suggested that the referral of cases to the federal justice system was the “black hole” where cases were not being addressed. In an interview with an FBI officer, we learned that they were only investigating sexual assault cases for victims aged 12 and younger due to the high volume of cases they received. He stated they were taking “the worst of the worst cases.”

Further complicating jurisdictional issues, some victim advocates and law enforcement officers reported that there are significant barriers and challenges in investigating and prosecuting cases

from the tribal jurisdictions when the perpetrator is an American Indian. These respondents indicated a lack of community support for the victim and, in some cases, overt support for the perpetrator. One respondent gave an example of a case from a tribal jurisdiction where an uncle took his niece off the reservation and sexually assaulted her in the town. The prosecutor reported that when the police arrested the uncle and the case was being processed, up to 80 members of the tribe appeared and protested in support of the uncle.

Finally, from an investigation and prosecution perspective, American Indian victims' access to MFEs (as described previously in chapter four) is a challenge. The lack of trained SANEs available to those living on reservations, as well as the reluctance to come forward for those who do have SANEs nearby, makes it challenging to build cases. One federal-level law enforcement agency noted that even when victims do come forward for MFEs, the lack of trained nurses on the tribal reservation make it difficult to move forward with cases because the evidence was collected by someone who has not been trained.

Overall, prosecutions of cases involving American Indian victims rarely take place. This pattern seemed consistent in the three states where we specifically met with and interviewed individuals (both advocates and law enforcement) working in and with American Indian communities.

COLLABORATION AMONG AGENCIES

Coordinated community response (CCR) systems have long been recognized as a best-practices response model to sexual assault (Burt et al. 2000; Burt et al. 2001; Campbell 1998; Campbell and Ahrens 1998; Campbell and Bybee 1997; Zweig and Burt 2004, 2006). Coordinated response systems, when lines of communication across agencies are open and their policies are aligned, can provide seamless services to victims and prevent gaps, duplications, or inconsistencies. This approach is expected to improve victim and system outcomes as well as to maximize agencies' operational efficiency. In the case of sexual assault response, it also often starts at the MFE—in many areas, advocates are present with nurses at the time of the MFE, and if the victim makes a report to the police, then police might be present as well.

However, coordination across agencies is not always easy. The success of the effort depends in part on the individuals involved. Personnel with credibility and authority both within and outside their own agency, and who have a personal commitment to collaboration, may be most effective. The mix of personalities involved in coordinating bodies can be important, as can any political context or other history between the agencies and individuals involved. Further, these efforts often involve the initiative of one individual who takes the lead to start the collaborative process and/or keep it alive.

On a more systemic level, agencies differ in their missions and in how they view their clientele. Health care providers' primary mission is to provide medical care based on the patient's needs. While SANEs also provide forensic evidence collection services for a possible criminal case, health care is paramount from their perspective. Advocates' primary concern is with the empowerment and healing of the individual, which may or may not mean participating in the criminal justice system. Law enforcement and prosecutors have victim-witnesses, and their primary concern is to protect the current victim and the public at large by holding the offender

accountable through criminal investigation, arrest, and prosecution. Depending on the circumstances of the case, these different missions may not always lead down the same path.

One particular area of tension between community-based advocates (those working in nonprofit victim service agencies outside the justice system) and criminal justice personnel (law enforcement and prosecutors) is around the role of the advocate in the criminal case. Victims do not always choose to participate in the case, and private-sector advocates place primary emphasis on empowering the victim's choices. Some law enforcement officers and prosecutors in several communities we visited do not allow these advocates to attend their meetings with victims because they are concerned that the advocates may not encourage victims to participate in the case and provide key evidence needed for its success. Others allow advocates to be present, but only if they remain silent during the interview. Despite whether advocates were welcomed by criminal justice agencies, many victims in focus groups and interviews expressed their appreciation for an advocate's presence during the process.

Voices of Victims: Legal Advocacy

“She (*advocate*) was explaining to the officer, ‘Just be gentle,’ because some of the officers can be pretty tough and pretty ignorant and pretty insensitive.”

“They (*advocates*) would explain to me why the cop was doing what the cop was doing, because of the process or whatever.”

“The (*advocacy program*) can be there for those things, the police report. Not fill it out, but be there with you in a supporting presence. And that is really helpful for people who are able to take advantage of that. There's people in group that decided to file police reports on their experience, and there were people from the (*advocacy program*) that physically went with them and were there to support them. Not just a text before they go, like ‘Good luck’; they were there. And I feel like if something like that had been offered to me when I was younger, I probably would have been more inclined to go (*report to the police*).”

Community-based advocates may also have different perspectives on confidentiality of client communications, and their communications are much less likely to be subject to subpoena or the discovery process than are communications between victims and justice agency personnel, including system-based victim service providers. We met with some law enforcement officers who expressed frustration with private-sector advocates' emphasis on confidentiality. One expressed the wish that the advocacy agencies in his community would at least provide nonidentifying information on assaults reported to them, but not to the police, so that the police could have a better idea of the crimes occurring in the community.

Another possible disadvantage of CCRs, raised by advocates in several states, is that one key role of the community-based advocates is to identify problems in systems' responses and advocate for change. It can be difficult for advocates to serve as agents of change for a system in which they are an integral component. As one advocate put it, being “co-opted” by the system may make advocates less effective at changing the system.

Importantly, victims notice when agencies seem to be working together and when they are not. When victims from our focus groups and interviews spoke about collaboration, they did so based on their experiences of receiving the MFEs.

Voices of Victims: Community Coordination

“In the hospital, when they were all together, I felt like they were all working together. . . . They were taking turns, asking each other questions and asking me questions, being considerate of each other’s thoughts and mine. . . . They were all staying together and nothing there I would call a detour from what the main goal was, and that was my safety and him getting his punishment.”

“I believe that if one needed, like, if the officer needed more information, that he would probably end up calling (*victim service provider*) or the (*hospital*) medical examiners. . . . They’re all on the same page.”

“They do seem to be working together. (*Is that helpful?*) Very. It’s not as fast as it could be, but yeah.”

Voices of Victims: Lack of Coordination

“I got contradictory information from my nurse examiner and then my follow-up nurse. My nurse examiner was, like, . . . ‘You have 30 days to report to the police if you decide to do that.’ And then my follow-up nurses . . . said, ‘You have six months.’”

“I don’t believe that the police were on the same page. They obviously were not. And at the hospital, the doctor had to go out there and talk to them and make them do their job. So no, I don’t feel like they were on the same page at all.”

Voices of Victims: Multiple Activities at One Time—A Victim’s Perspective

“One thing I didn’t like about it was that the investigator came and talked to me. It was, like, after I go through all this crap and now I have to . . . and he wanted all the details, and he’s like, ‘Can you remember more than that?’ . . . And I’m just like, I really don’t want to talk to the investigator right now when I’m having my exam. . . . It was while they were doing some tests for me or whatever. . . . He kept begging me to tell him more details, but I can’t even think right now.”

Approaches to Coordinated Community Response Systems

Some states have policies or even laws that require coordinated community responses to victims of sexual assault. Many, but not all, of the communities in our case studies reported having some sort of CCR system, but different models are used to coordinate policies and services to victims.

One dominant model that has been developed for coordinated response to sexual assault is the sexual assault response team (SART) approach (Ledray 1999). This approach emphasizes a

coordinated on-site first response to victims involving nurses, advocates, and, at the victim's request, law enforcement. One way of facilitating coordinated on-scene response is to establish communication links among the providers so that whichever agency the victim contacts first, the others are called in at the victim's request. One community we visited has established a regional hotline program to link several victim service agencies with a number of hospital-based SANE programs across the region.

Regional Coordination between SANEs and Advocates

SANEs and advocates in one small city and several surrounding counties have established a regional approach to coordination. Three advocacy programs in the region have volunteers who are specially trained in an on-call hospital accompaniment program. One of these agencies operates a centralized hotline number that SANEs in the six hospitals across the region can call to request an on-scene response to victims. On receiving a request from a SANE, the hotline operator dispatches an advocate from one of the three programs to the hospital to meet with the victim.

In some case-study communities, health care, advocacy, and justice agencies are physically co-located in the same facility, which has several advantages. Working together in the same space facilitates informal links between staff at different agencies, so they can get to know each other as individuals and engage in informal cross-training on the work of each agency. It also eases victims' access to a wider variety of services when they do not have to go to different locations to meet with different providers. We visited several localities in which the SANE program and examining room are in the same office suite with the advocacy program, enhancing the link between these services. One community had a very wide range of health care, advocacy, justice, and social services agencies all co-located in the same office suite.

Co-Location of SANE and Advocacy Services

In one small town we visited, the victim advocacy and the SANE program share the same office space, which greatly facilitates coordination across the agencies and a coordinated on-scene response to victims. This office is conveniently located within an easy walk of the hospital, so that victims who self-report to the emergency department but do not need emergency medical services can be escorted to the exam facility without having to wait in a busy emergency department.

However, there are potential disadvantages to co-location of different agencies. Victims who have immigration issues or criminal matters against them may be very reluctant to enter facilities where justice system agencies are housed, even to access victim service providers. An agency that works with immigrant populations at one of our selected communities experienced a steep decline in clients when they co-located with police and prosecution offices. Another disadvantage is that ties between agencies can suffer when the agencies are competing for the same limited set of resources, such as office space, equipment, or supplies. One co-located system needed to establish dispute resolution procedures to ease relations among agencies.

Another type of approach to coordination is less likely to provide a coordinated on-scene response to victims, and less likely to offer co-located services, but it can still be useful for improving communications, aligning policies, and troubleshooting areas of conflict across agencies. These coordination bodies function at the policy level, often through quarterly or other regular meetings of policymakers from advocacy, health care, law enforcement, prosecution, social services, and other relevant agencies. In some communities, it is formalized with memoranda of understanding between agencies, while others function more informally. One example is a community in which law enforcement officers and advocates are working together to develop guidelines for officers to use when interviewing victims in order to avoid revictimization and to improve collection of evidence. While coordination that includes co-location or on-scene coordinated response also works at this policy level, the distinction here is that other communities *only* work at the policy level.

SUMMARY

When victims have an exam without having reported to law enforcement, questions can arise around how long to keep the exam kit, in hopes the victim will later decide to file a report, and who should store the kit. Most states require that kits on nonreported exams be stored, with the storage periods varying from a month to many years, or indefinitely. In practice, these kits are stored beyond the required storage period in many communities as long as they have the space for them. Kits are most commonly stored by law enforcement agencies, either anonymously or with the victim's identifying information, and the most common practice is for the police to store the kits without taking further action on the case if it has not been reported to them by the victim.

The rationale behind providing free exams even to victims who have not reported to law enforcement is that more victims will get exams and later convert to a reporting status, and the evidence will be available to the criminal case. Our work found that in most localities we visited, the general rule was that free exams are available to all victims, including those who have not reported the assault. However, few victims seem to avail themselves of this opportunity. Personnel in the communities we visited estimated that only about 5 percent to 10 percent of victims who get exams have not reported to law enforcement. The public may not be aware that exams no longer require a police report, so those who have not decided to report may bypass urgently needed medical services. For the few cases in which nonreporting victims have exams, only a small handful of those (estimated around 5 percent) actually convert to a reporting status at some point after the exam. These victims may need follow-up contacts and support to encourage them to report the assault so that the justice system can respond. Unfortunately, there are many reasons that victims may be reluctant to involve the justice system, including shame, self-blame, fear, privacy concerns, and negative attitudes toward and experiences with law enforcement and prosecution.

CHAPTER 6. MEETING THE POLICY REQUIREMENT

The passage of the new requirement around sexual assault medical forensic exams (MFEs) in the reauthorization of the Violence Against Women Act (VAWA) 2005 resulted in state and local stakeholders taking stock of how their jurisdictions paid for exams and whether reporting was required to access free exams. Some states found that they were meeting the policy requirement prior to the passage of VAWA 2005 because they had already addressed payment and reporting issues. Other states required great change in order to meet the new policy requirement. We asked stakeholders about what challenges arose, about what seems to be working to meet the requirement, and about their perceptions of the impacts of the VAWA 2005 policy requirement in their jurisdictions.

WHAT CHALLENGES EXIST TO MEETING THE REQUIREMENT?

We asked state-level sexual assault coalition, SSA (state STOP [Services*Training*Officers*Prosecutors] administrator), and local provider survey respondents to shed light on the challenges their states and localities face in implementing the VAWA 2005 requirement around MFEs. We presented a series of challenges that may arise and also allowed respondents to add their own unique contributions. Table 6 reports those findings. In order to focus on the main challenges faced, we examine the top five most commonly reported challenges by each respondent group. We identify these in the table with italics.

In general, the survey respondent groups report a fair amount of agreement about the challenges that states and jurisdictions face, which fall into three main categories: (1) training, (2) funding and payment levels, and (3) law enforcement issues. First, the observation that state agencies have difficulties providing training to localities about how to improve local practices was within the top five most commonly reported challenges by all three respondent groups. On the other side of this, local providers reported among their top five challenges that local community stakeholders are not willing to participate in training to improve local practices. Though few case-study stakeholders pointed to training as an important factor in increasing their ability to meet the VAWA requirement, it was the estimation of the study team that training might be useful in reference to many of the challenges discussed (more on this and other implications for practice can be found in the final chapter of this report). Thus, training—both the ability to provide it and the willingness to participate in it—appears to be a barrier to implementing VAWA 2005 adequately.

Second, funding and payment levels were also reported by state-level stakeholders as issues being faced when implementing the requirement. Among the top five most commonly reported challenges for both state-level coalitions and SSAs were: (a) payer agencies lack the funds to provide free exams to all victims who choose to have them, including both reporting and nonreporting victims; and (b) payment levels are too low for the services provided, causing difficulties for medical service providers. These survey findings mirror many qualitative reports heard across the case-study sites from both state-level and local stakeholders. Concerns about whether there is adequate funding for the designated payer agency to cover the costs for all MFEs were commonly mentioned, as were concerns about payment levels for individuals⁷

MFEs, which were often lower than the actual costs to the medical providers. As mentioned previously, this leaves hospitals with the choice of covering the remaining costs of the exams, which cannot be billed to victims as per VAWA, or not offering to provide MFEs.

Third, each of the respondent groups reported issues related to law enforcement as part of the top five most commonly reported challenges to meeting the VAWA 2005 requirement. State-level coalitions and local providers reported that law enforcement agencies in their states (or localities) resisted changes in processes for providing MFEs, such as not requiring law enforcement or prosecution authorization for free exams. SSAs and local providers reported that law enforcement agencies in their states (or localities) generally did not work well with sexual assault victims, and SSAs reported the same for law enforcement's work with sexual assault service agencies. While state-level coalitions reported that prosecution also resisted change in practices for providing MFEs as among their top five challenges, they were the only respondent group to identify issues with prosecution as a main challenge.

Survey respondents who wrote in challenges other than those listed in the survey reported a variety of issues. While only reported by one or a few, these challenges are still interesting to consider. For example, a few respondents noted either statutory ambiguity or general confusion about what should be covered by the payment mechanism in terms of services (e.g., what is considered forensic evidence and what is medical treatment), or that the current system does not cover the medical portion of the exam. An additional few respondents reported that hospitals misunderstand who should be billed, and sometimes victims or their private insurance are billed. Two respondents each reported that there were insufficiently trained MFE providers (sexual assault nurse examiners, or SANEs), concerns over funding SANE programs, and kit storage issues when the victim chooses not to report to law enforcement. Two respondents noted that local or county-based systems mean there is no uniformity across the state in terms of what is covered during the exam and who pays for it. Finally, one person noted that because his or her state does not use STOP funds to pay for MFEs, the VAWA 2005 requirement has less impact there.

Table 6. Percent of Respondents Reporting Challenges States Face in Implementing the VAWA 2005

	State-level coalitions (n=47)	State STOP administrators (n=52)	Local providers (n=442)
My state has laws that conflict with one another.	4	8	4
My state's laws are not clear about which agencies should pay for exams.	15	6	8
My state lacks a statewide payment mechanism for forensic medical exams.	19	10	9
Paying agencies lack the funds to provide free exams to all victims who choose to have them, including both reporting and nonreporting victims.	23	14	9
Payment levels are too low for the services provided, causing difficulties for medical service providers.	30	17	10
Law enforcement agencies in my state (or locality) resist changes in processes for providing forensic medical exams, such as not requiring law enforcement or prosecution authorization for free exams.	38	10	14
Prosecution agencies in my state (or locality) resist changes in processes for providing forensic medical exams, such as not requiring law enforcement or prosecution authorization for free exams.	23	6	5
Law enforcement agencies in my state (or locality) generally do not work well with sexual assault victims.	17	12	15
Law enforcement agencies in my state (or locality) generally do not work well with sexual assault service agencies.	13	12	10
Prosecution agencies in my state (or locality) generally do not work well with sexual assault victims.	17	8	11
Prosecution agencies in my state (or locality) generally do not work well with sexual assault service agencies.	4	4	8
Medical personnel in my state (or locality) who provide sexual assault forensic exams generally do not work well with sexual assault victims.	4	0	6
Medical personnel in my state (or locality) who provide sexual assault forensic exams generally do not work well with sexual assault service agencies.	4	2	6
State agencies have difficulties providing training to localities about how to improve local practices.	23	17	17
Local community stakeholders are not willing to participate in training to improve local practices.	21	8	17
I'm not sure.	2	12	26

Note: The top five most commonly reported challenges by each respondent group are identified in italics

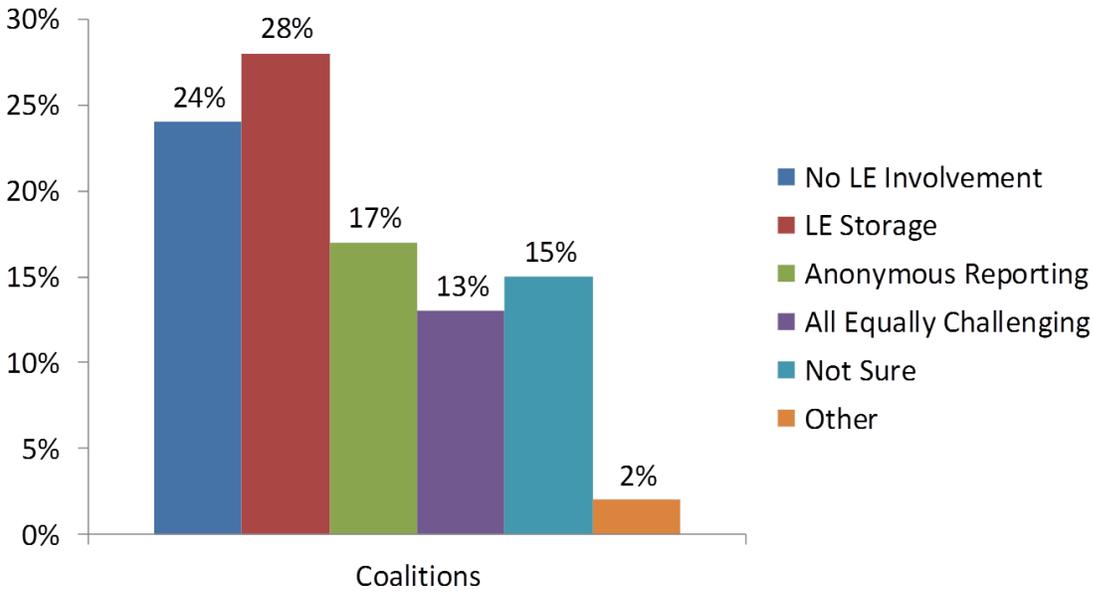
State Coalition Opinions about Challenges Related to Models of Storage Practices

Knowing that kit storage for nonreporting victims has been a primary focus of technical assistance to states since VAWA 2005 was passed, we asked state-level sexual assault coalitions during surveys about their perceptions of which kit storage models present the biggest challenge for meeting the requirement. Figure 10 documents responses related to models that present the biggest challenge for providing exams without having to report to law enforcement. As one might expect, the kit storage model that the most coalitions noted as the most challenging to this effort is the model where law enforcement stores the kits for victims who do not report their assaults (28 percent). However, nearly as many reported that models that had no law enforcement involvement were the most challenging (24 percent). These challenges may arise for different reasons; law enforcement storage of kits on nonreported assaults may bring into question whether the assault was truly nonreported, whereas storage by agencies other than law enforcement may challenge their limited storage capacities because they do not necessarily have evidence collection facilities.

Figure 11 documents responses related to models that present the biggest challenge for providing exams free of charge, and nearly identical proportions of coalitions reported that models with no law enforcement involvement and models with law enforcement storage are the greatest challenges (28 percent and 26 percent, respectively).

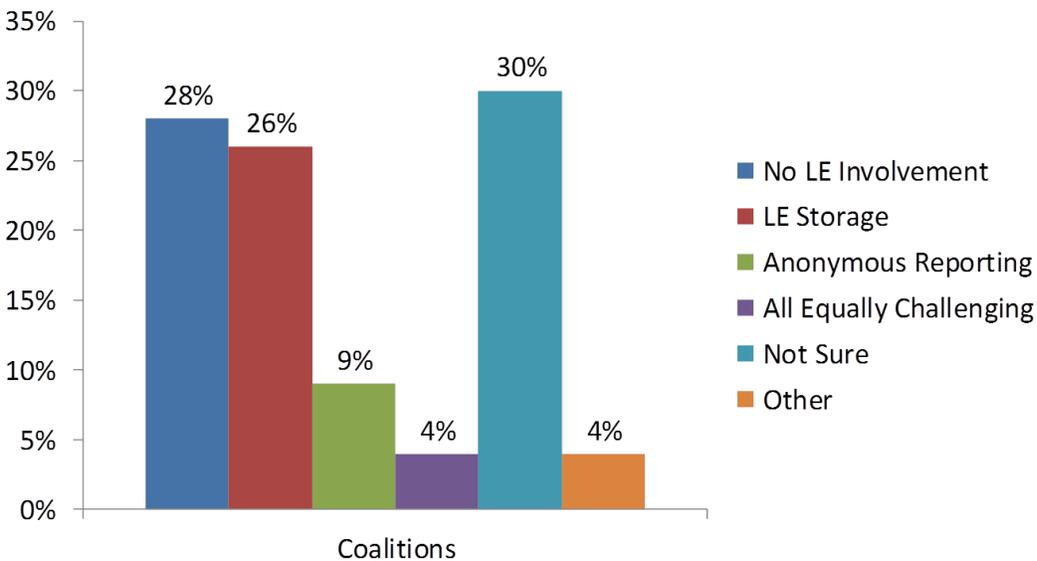
Comparing figures 10 and 11, 17 percent of coalitions found anonymous reporting models the most challenging for providing exams without law enforcement reports, but only 9 percent found this model the most challenging when providing exams free of charge. Similarly, three times the number of coalitions (13 percent) found all models equally challenging when it came to storing kits for nonreporting victims, compared with those that reported all models were equally challenging when it came to providing exams free of charge (4 percent). Finally, twice the number of coalitions (30 percent) were not sure which kit storage for nonreporting victims model was the biggest challenge for providing exams free of charge as for providing exams without having to report to law enforcement (15 percent).

Figure 10. Percent of Coalitions That Report Storage Models Presenting the Biggest Challenge for Providing Exams without Having to Report to Law Enforcement



N=46 valid responses from state-level sexual assault coalitions

Figure 11. Percent of Coalitions That Report Storage Models Presenting the Biggest Challenge for Providing Exams Free of Charge



N=47 valid responses from state-level sexual assault coalitions

WHAT WORKS WHEN MEETING THE REQUIREMENT?

We asked state-level sexual assault coalition, SSA, and local provider survey respondents to shed light on what they think works well in their states and localities in implementing the VAWA 2005 requirement around MFEs. These reports are based on respondents' informed impressions about what works well in their areas. We presented a series of possibilities and also allowed respondents to add their own unique contributions. Table 7 reports those findings. In order to focus on the main ideas about what worked, we examine the top five most commonly reported strategies by each respondent group. We identify these in the table with italics. Notably, larger proportions of each respondent group reported strategies that work well than the proportions that reported challenges in table 6.

As with challenges, in general, the respondent groups report a fair amount of agreement about what seems to work, which fall into three main categories: (1) the effectiveness of exam providers, (2) statewide mechanisms for payment, and (3) laws. All three respondent groups reported in their top five most commonly cited strategies for what seems to work that medical personnel in their states (or localities) who provide sexual assault forensic exams generally worked well with sexual assault victims (between 45 and 58 percent) and sexual assault service agencies (between 47 and 54 percent). In our view, this speaks volumes about the critical role that MFE exam providers (SANEs and others) play in ensuring that victims receive exams free of charge and without having to report the assault to law enforcement.

Nearly two-thirds of both state-level coalitions and SSA survey respondents reported that having a statewide payment mechanism for MFEs seemed to work well to meet the VAWA 2005 requirement. As noted previously, our qualitative findings indicated both pros and cons with such statewide programs. However, in those sites we visited that relied on statewide payment strategies, we found seamless payment practices, with either no glitches or very rare reports of victims being billed for exams, or being compelled to report to the police before getting a free exam.

Finally, 45 percent of coalitions and 62 percent of SSAs reported that state laws help them implement policies that truly help sexual assault victims, and 47 percent of coalitions and 58 percent of SSAs reported that state laws were clear about which agencies should pay for exams. This indicates that thoughtful, unambiguous legislation can be a good initial step to ensuring that victims are receiving exams free of charge and without having to report to law enforcement.

Table 7. Percent of Respondents Reporting What Seems to Work Well in Implementing VAWA 2005

	State-level coalitions (n=47)	State STOP administrators (n=52)	Local providers (n=442)
My state has laws that help us implement policies that truly help sexual assault victims.	45	62	35
My state's laws are clear about which agencies should pay for exams.	47	58	30
My state has a statewide payment mechanism for forensic medical exams.	64	65	39
Paying agencies have the funds to provide free exams to all victims who choose to have them, including both reporting and nonreporting victims.	28	35	27
Payment levels are adequate for the services provided.	28	29	15
Law enforcement agencies in my state (or locality) generally work well with sexual assault victims.	13	31	40
Law enforcement agencies in my state (or locality) generally work well with sexual assault service agencies.	36	40	46
Prosecution agencies in my state (or locality) generally work well with sexual assault victims.	19	31	38
Prosecution agencies in my state (or locality) generally work well with sexual assault service agencies.	30	42	43
Medical personnel in my state (or locality) who provide sexual assault forensic exams generally work well with sexual assault victims.	45	58	52
Medical personnel in my state (or locality) who provide sexual assault forensic exams generally work well with sexual assault service agencies.	47	54	51
State agencies are able to provide training to localities about how to improve local practices.	32	39	19
Local community stakeholders are willing to participate in training to improve local practices.	36	35	22
I'm not sure.	9	6	16

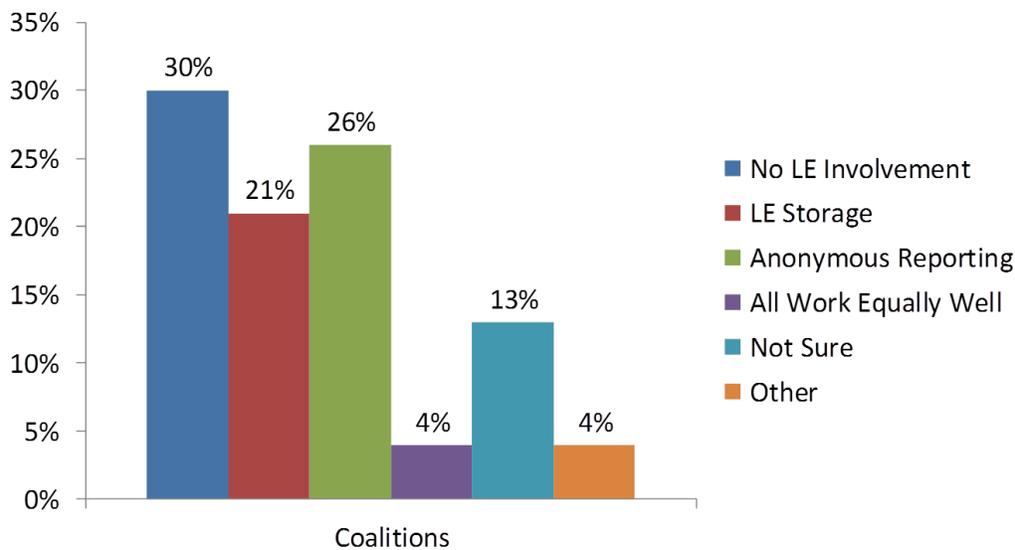
Note: The top five most commonly reported strategies by each respondent group are identified in italics

State Coalition Opinions about What Works Related to Models of Storage Practices

Again, knowing that kit storage for nonreporting victims has been a primary focus of technical assistance to states since VAWA 2005 passed, we asked state-level sexual assault coalitions during surveys about their perceptions of which kit storage models worked best for meeting the requirement. Figure 12 documents responses relating these impressions about models that work best for providing exams without having to report to law enforcement, and figure 13 documents responses relating these impressions to models that work best for providing exams free of charge. Patterns of responses for what works best were less clear than patterns reported previously regarding models that presented the biggest challenges.

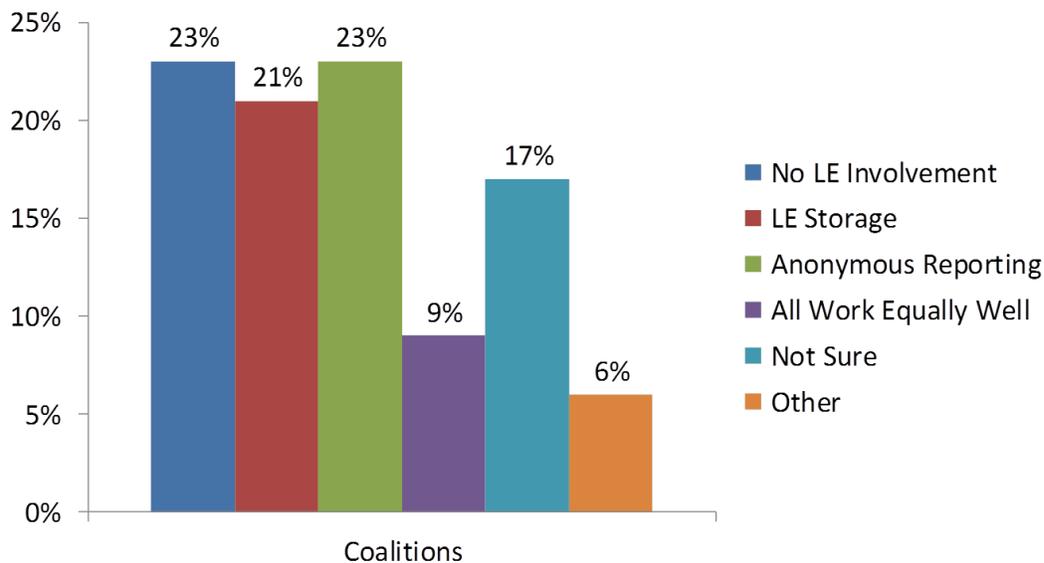
That said, 30 percent of coalitions reported their impressions that no law enforcement involvement seemed to work best for storing kits without having to report to law enforcement, followed by anonymous reporting (26 percent). Equal proportions of coalitions reported the same when it came to providing exams free of charge (23 percent each for both no law enforcement involvement and anonymous reporting). Twenty-one percent of coalitions thought that law enforcement storage seemed to be the best model for both kits of nonreporting victims and for providing exams free of charge. Twenty-one percent of coalitions thought that law enforcement storage seemed to be the best model for both kits of nonreporting victims and for providing exams free of charge.

Figure 12. Percent of Coalitions Reporting Storage Models That Work Best for Providing Exams without Having to Report to Law Enforcement



N=46 valid Responses from state-level sexual assault coalitions

Figure 13. Percent of Coalitions Reporting Storage Models That Work Best for Providing Exams Free of Charge



N=47 valid responses from state-level sexual assault coalitions

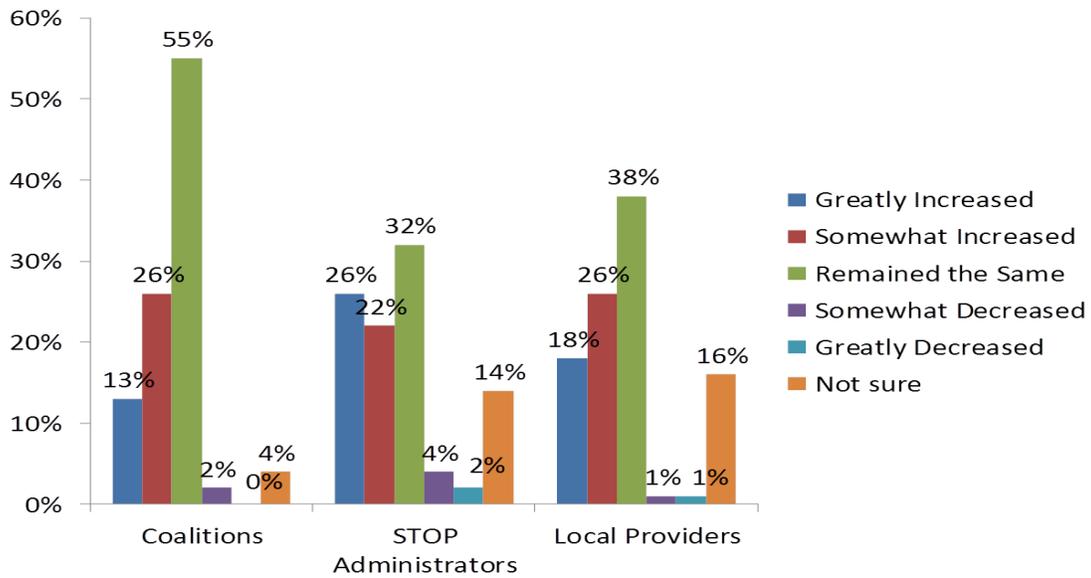
REFLECTION ON CHANGES IN STATES' ABILITY TO PROVIDE EXAMS FREE OF CHARGE SINCE 2009³⁶

In surveys for state-level sexual assault coalitions, SSAs, and local victim service providers, we asked respondents, “Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that for victims who receive forensic medical exams, the ability of your state (or locality) to provide these exams free of charge has increased, decreased, or remained the same?” Figure 14 documents responses to this question.

Very few survey respondents reported that their state’s or locality’s ability to provide exams free of charge had diminished since the VAWA 2005 requirement was implemented. Fifty-five percent of coalitions, 32 percent of SSAs, and 38 percent of local providers reported that the ability to provide exams free of charge had remained the same since January 2009. However, another 39 percent of coalitions, 46 percent of SSAs, and 44 percent of local providers reported that this ability had increased since that time. When asked about whether the change was due to VAWA 2005 or something else (see figure 15), among those that reported change, most reported it was due to VAWA 2005 (67 percent of coalitions, 78 percent of SSAs, and 78 percent of local providers). Thus, most reported that there was no change or that the ability to provide exams free of charge had increased.

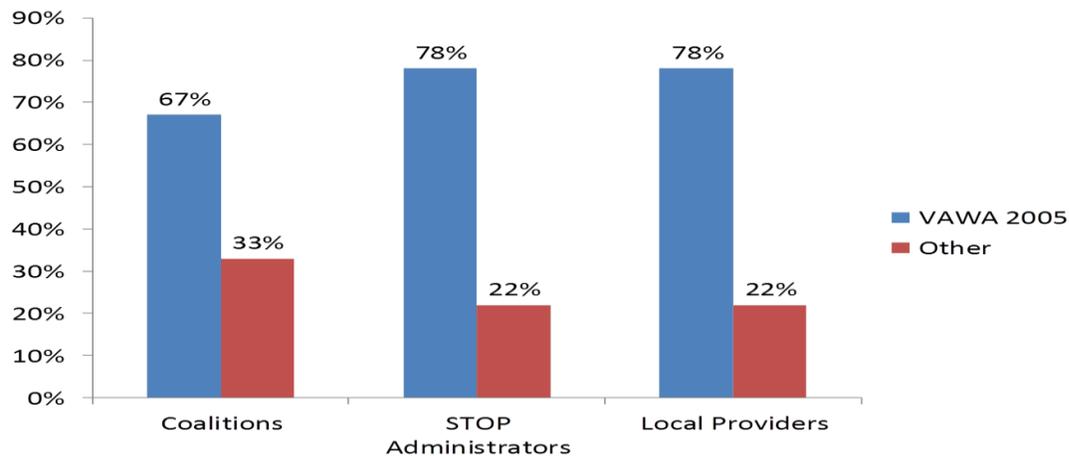
³⁶ Victim compensation fund administrators were not asked questions about their perspectives on change since January 2009.

Figure 14. Percent of Respondents Reporting Perspectives on Change in States' Ability to Provide Exams Free of Charge since January 2009



N=47 valid responses from state-level sexual assault coalitions
 N=50 valid responses from state STOP administrators
 N=407 valid responses from local providers

Figure 15. Percent of Respondents Reporting Perspectives on Why There Was a Change in States' Ability to Provide Exams Free of Charge since January 2009



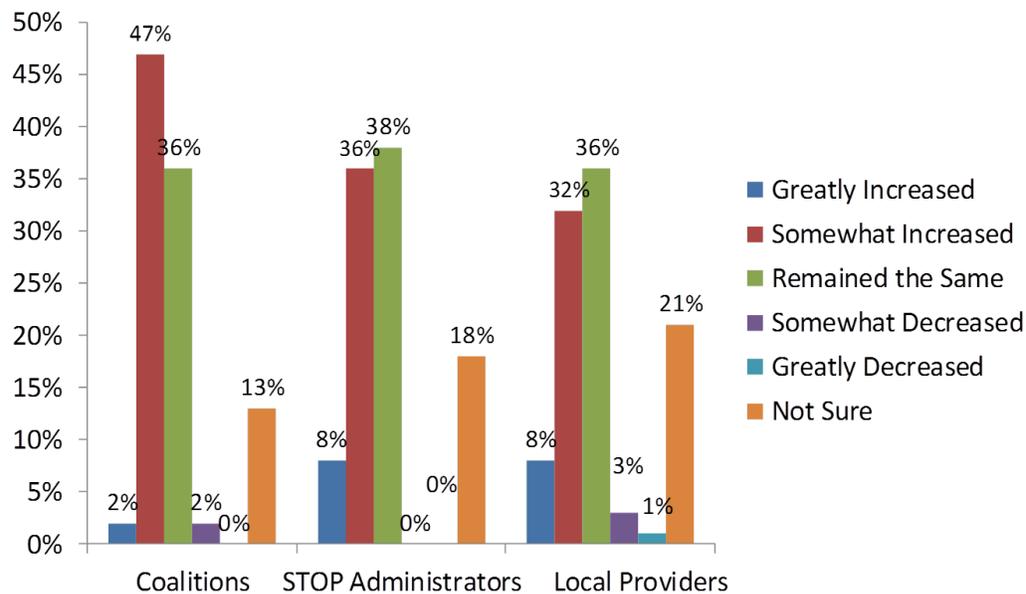
N=15 valid response from state-level sexual assault coalitions
 N=24 valid responses from state STOP administrators
 N=168 valid responses from local providers

REFLECTIONS ON WHETHER MORE VICTIMS ARE GETTING THE EXAM SINCE JANUARY 2009

In surveys for state-level sexual assault coalitions, SSAs, and local victim service providers, we asked respondents, “Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that the percentage of victims of sexual assault who receive forensic medical exams in your state (locality) has increased, decreased, or remained the same?” Figure 16 documents responses to this question.

Very survey few respondents reported that fewer victims were getting MFEs since the VAWA 2005 requirement was implemented. Thirty-six percent of coalitions, 38 percent of SSAs, and 36 percent of local providers reported that the number of victims getting the exams had remained the same since January 2009. Notably, 49 percent of coalitions, 44 percent of SSAs, and 40 percent of local providers reported that more victims were getting the exams since that time. Additionally, a sizable portion of respondents were not sure how to answer this question, with 13 percent of coalitions, 18 percent of SSAs, and 21 percent not providing a response. When asked about whether the change was due to VAWA 2005 or something else (see figure 17), among those who reported change, most reported it was due to VAWA 2005 (61 percent of coalitions, 70 percent of SSAs, and 66 percent of local providers). When it comes to the number of victims getting exams since January 2009, the largest proportion of all three types of respondents reported increases.

Figure 16. Percent of Respondents Reporting Perspectives on Changes in Percentage of Victims Getting Exams since January 2009

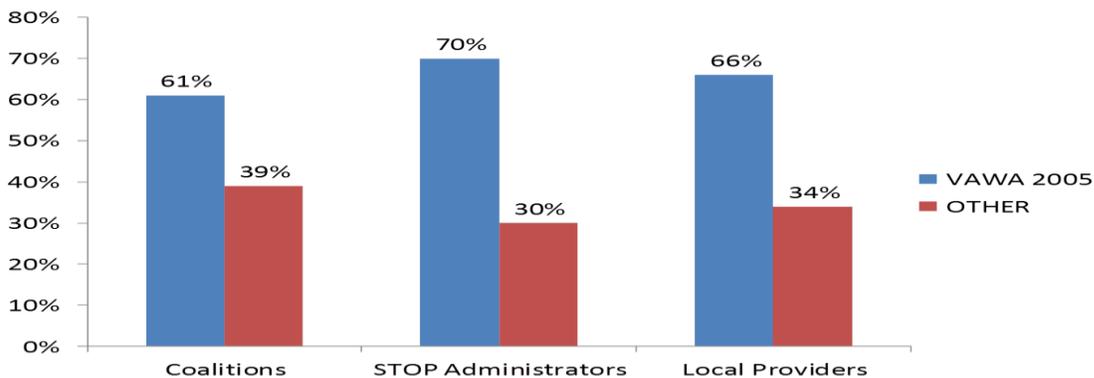


N=47 valid responses from state-level sexual assault coalitions

N=50 valid responses from state STOP administrators

N=408 valid responses from local providers

Figure 17. Percent of Respondents Reporting Perspectives on Why There Was a Change in Percentage of Victims Getting Exams since January 2009



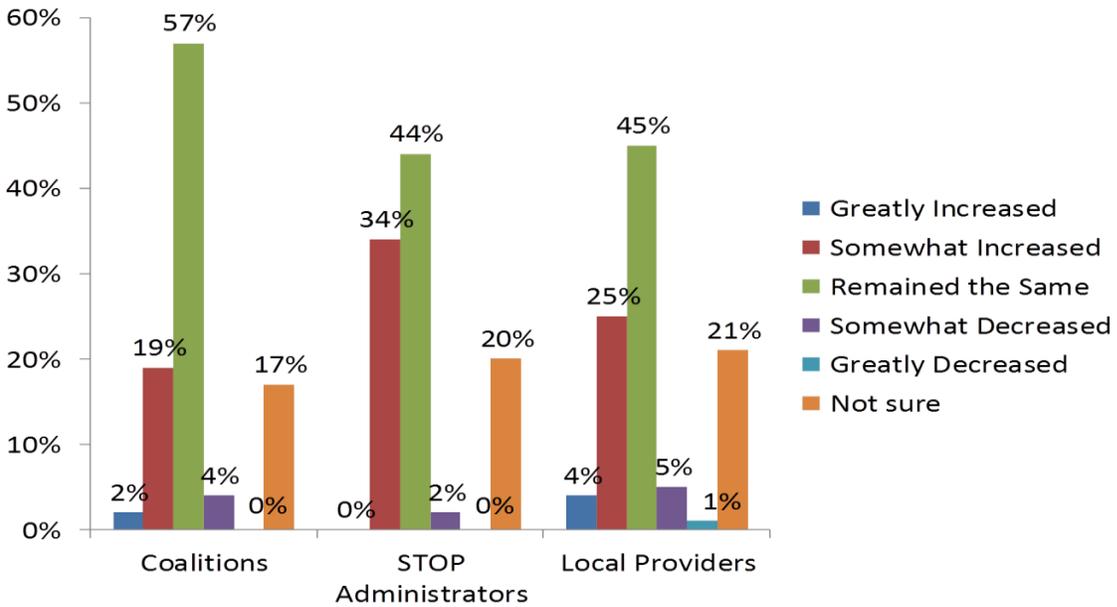
N=23 valid responses from state-level sexual assault coalitions
 N=20 valid responses from state STOP administrators
 N=165 valid responses from local providers

REFLECTIONS ON WHETHER MORE VICTIMS ARE REPORTING ASSAULTS TO THE CRIMINAL JUSTICE SYSTEMS SINCE JANUARY 2009

In surveys for state-level sexual assault coalitions, SSAs, and local victim service providers, we asked respondents, “Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that the percentage of victims of sexual assault who report their assaults to law enforcement in your state (locality) has increased, decreased, or remained the same?” Figure 18 documents responses to this question.

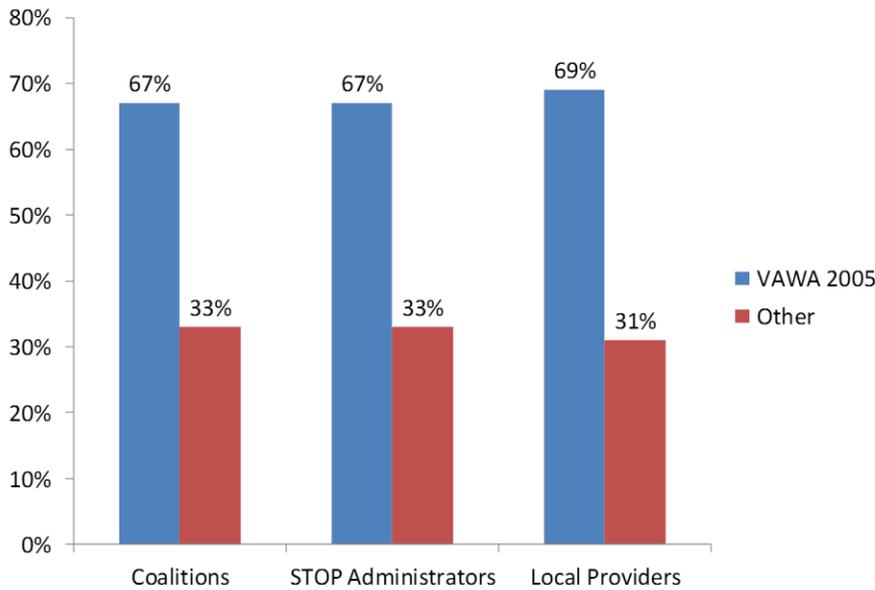
As with other measures of change, very few survey respondents reported that fewer victims report their assaults to law enforcement since the VAWA 2005 requirement was implemented. Fifty-seven percent of coalitions, 44 percent of SSAs, and 45 percent of local providers reported that the number of victims reporting sexual assaults to law enforcement remained the same since January 2009. Fewer reported increases in this area. Only 21 percent of coalitions, 34 percent of SSAs, and 29 percent of local providers reported that more victims were reporting to law enforcement since that time. Additionally, a sizable portion of respondents were not sure how to answer this question, at 17 percent of coalitions, 20 percent of SSAs, and 21 percent of local providers. When asked about whether the change was due to VAWA 2005 or something else (see figure 19), among those who reported change, most reported it was due to VAWA 2005 (67 percent of coalitions, 67 percent of SSAs, and 69 percent of local providers). Thus, though sizable proportions of all three respondents reported some increase in reporting to law enforcement, more said the number remained the same.

Figure 18. Percent of Respondents Reporting Perspectives on Changes in Percentage of Victims Reporting to the Criminal Justice System since January 2009



N=46 valid responses from state-level sexual assault coalitions
 N=50 valid responses from state STOP administrators
 N=408 valid responses from local providers

Figure 19. Percent of Respondents Reporting Perspectives on Why There Was a Change in Percentage of Victims Reporting to the Criminal Justice System since January 2009



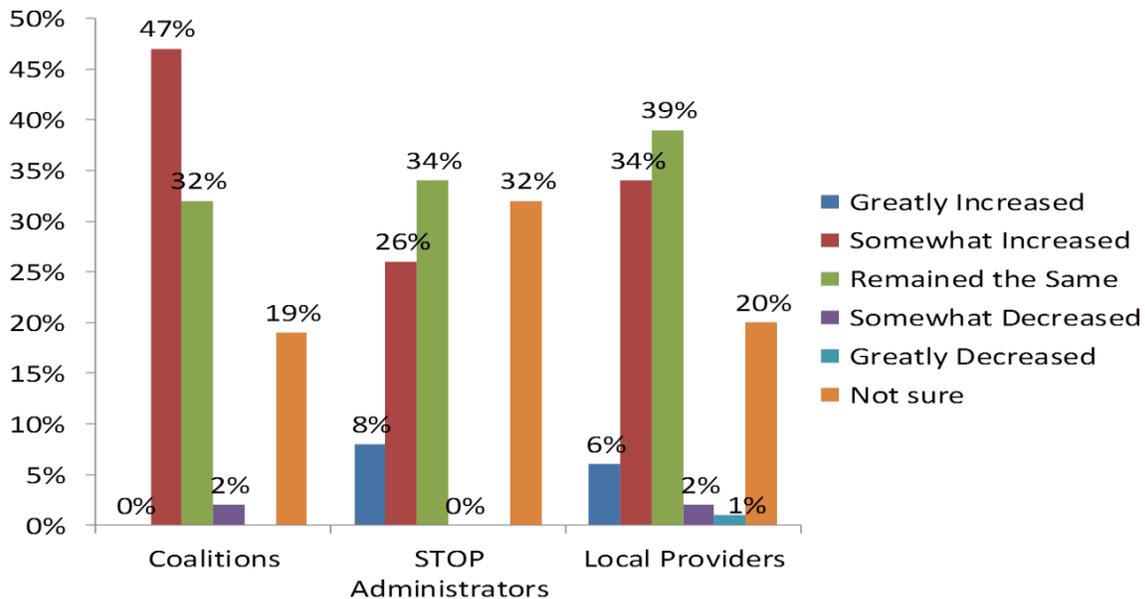
N=9 valid responses from state-level sexual assault coalitions
 N=15 valid responses from state STOP administrators
 N=124 valid responses from local providers

REFLECTIONS ON WHETHER MORE VICTIMS ARE GETTING MEDICAL CARE SINCE 2009

In surveys for state-level sexual assault coalitions, SSAs, and local victim service providers, we asked respondents, “Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that the percentage of victims of sexual assault who receive medical care after their assaults in your state (or locality) has increased, decreased, or remained the same?” Figure 20 documents responses to this question.

As with the other measures of change, very few survey respondents reported that the number of victims receiving medical care diminished since the VAWA 2005 requirement was implemented. Forty-seven percent of coalitions, 34 percent of SSAs, and 40 percent of local providers reported the number of victims receiving medical care increased since January 2009. However, another 32 percent of coalitions, 34 percent of SSAs, and 39 percent of local providers reported that the number remained the same since that time. Additionally, a sizable portion of respondents were not sure how to answer this question, with 19 percent of coalitions, 32 percent of SSAs, and 20 percent of local providers providing no estimate. When asked about whether the change was due to VAWA 2005 or something else (see figure 21), among those who reported change, most reported it was due to VAWA 2005 (72 percent of coalitions, 69 percent of SSAs, and 72 percent of local providers). Thus, most reported that there was no change in the number of victims getting medical care since January 2009 or that the number had increased.

Figure 20. Percent of Respondents Reporting Perspectives on Changes in Percentage of Victims Getting Medical Care since January 2009

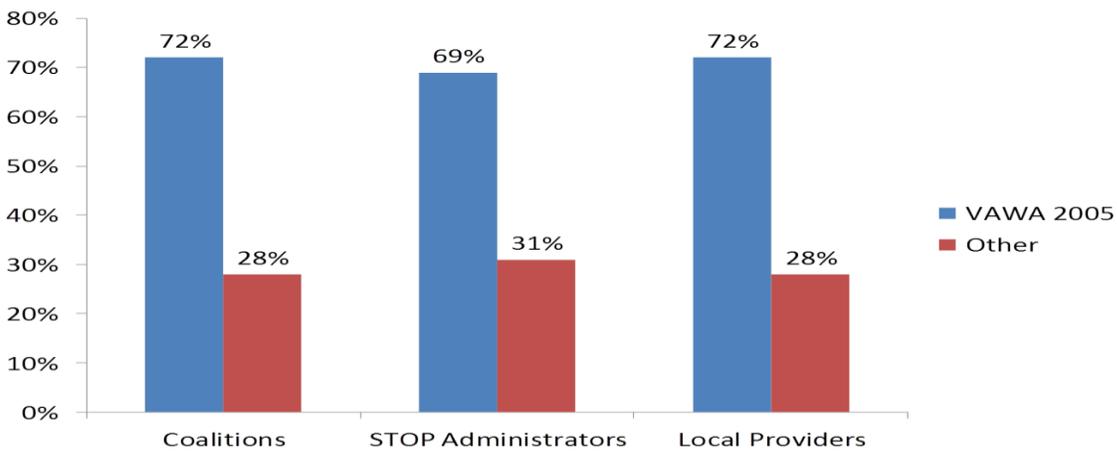


N=47 valid responses from state-level sexual assault coalitions

N=50 valid responses from state STOP administrators

N=405 valid responses from local providers

Figure 21. Percent of Respondents Reporting Perspectives on *Why* There Was a Change in Percentage of Victims Getting Medical Care since January 2009



N=18 valid responses from state-level sexual assault coalitions
 N=16 valid responses from state STOP administrators
 N=158 valid responses from local providers

CASE-STUDY REFLECTIONS ON MEETING THE VAWA 2005 REQUIREMENT

In all but one state we visited, legislative and policy changes that meet the VAWA 2005 requirement predated the federal legislation. In two states, providing exams free of charge without having to report to law enforcement predated 2000. In fact, when asked about meeting the VAWA 2005 requirement, one state-level sexual assault coalition director quipped, “That was so last century.” As noted throughout other sections of this report, legislation and policy do not necessarily translate into practice. However, for the states and jurisdictions we visited, it appears that most victims (with few exceptions) are able to access MFEs for free and do so without having to report the assaults to the criminal justice system.

For one case-study state, VAWA 2005 changes jump-started their process to address these issues, leading to new laws and policies in order to meet the requirement. Prior to VAWA 2005, the process for obtaining an exam in this state involved nurses getting law enforcement authorization before they could conduct the exam. Then the bill was forwarded to prosecutors for payment. Initially, there was a great deal of concern that, with access to free exams regardless of police reporting, the number of exams would skyrocket and overwhelm police storage facilities, as well as health care providers’ capacity to conduct the exams. However, the number of exams has not increased appreciably since these changes.

SUMMARY

The federal VAWA 2005 required compliance by January 2009. While some states were already in compliance, others had to undertake significant policy and practice changes to come into compliance. In general, consensus on the challenges to meeting the requirement centers around training issues, adequacy of funding amounts and payment levels, and resistance from law

enforcement. Storage of kits on unreported assaults has been a particular area of concern, and different models have been developed for kit storage. While there is no clear consensus, it may be that having law enforcement store unreported kits is most likely to present challenges to meeting the goal of offering exams without requiring police reporting.

There was also a fair amount of agreement on what seems to work well toward meeting the federal requirement. Survey respondents generally agreed in their impressions that the exam providers are very effective in their work, statewide mechanisms for exam payment seem to work well, and clear laws specifying payment procedures are helpful.

We also asked survey respondents what changes they had seen since January 2009 and whether they attributed any changes to the effects of VAWA 2005. We asked about changes in the state's ability to provide free exams, whether more victims are getting exams, whether more victims are reporting assaults to law enforcement, and whether more victims are getting medical care. The common threads across these questions and the different types of respondents was that between approximately one-third and somewhat more than half of the respondents reported that conditions had remained the same. This is not too surprising, considering that some states were already in compliance with federal standards before they took effect. Of those who reported change since January 2009, most reported that conditions had improved at least somewhat, with very few reporting that these conditions had gotten worse (although some were not able to provide an answer).

For those who reported changes since VAWA's effective date, between 60 percent and 75 percent of the respondents attributed this change to VAWA, rather than to other factors. Overall, it appears that respondents perceive VAWA to have produced some positive changes in some states, although other states were meeting federal standards even before they were required to do so.

CHAPTER 7. CONCLUSIONS AND IMPLICATIONS

This descriptive study aimed to fill gaps in information regarding: (1) which entities pay for sexual assault medical forensic exams (MFEs) in state and local jurisdictions throughout the United States, and the policies and practices regarding payment; (2) which services are provided in the exam process, and how the exam relates to other services; (3) whether free exams are provided to victims regardless of their intention to report the assault to the criminal justice system; (4) how MFE kits are being stored for victims who choose not to participate in the criminal justice system process; and (5) whether the Violence Against Women Act (VAWA) 2005 requirement for free exams regardless of police reporting are generally being met throughout the country.

In this concluding chapter, we revisit the goals of the project and what we had hoped to learn. Below, we briefly summarize findings, addressing each goal, and offer implications for policy and practice based on what we learned through the quantitative and qualitative data collected for this study. After, we identify limitations to our study design and offer suggestions for future research. Lastly, we offer our final thoughts on the most significant conclusions to draw from this study.

WHAT DID WE LEARN ABOUT MEDICAL FORENSIC EXAM PAYMENT POLICIES AND PRACTICES?

Our review of MFE payment policies and practices revealed many findings. First and foremost, victim compensation funds are the most widely used source of funds to cover MFEs in the United States. The contribution from any other source of funds pales in comparison. With 34 states designating compensation funds to cover MFEs, 19 of which *only* use compensation funds, it is by far the most common way in which exams are paid. Given this, practical and philosophical debates about the appropriateness of using compensation funds to cover MFEs have ensued and merit further inquiry. As we discussed in chapter three, when compensation funds are tight and every dollar spent on forensic evidence collection cannot be spent on services to directly benefit victims, the issue of whether MFE payment is a suitable use of compensation funds moves beyond the philosophical to the very practical.

In contrast, only two states designate STOP (Services*Training*Officers*Prosecutors) funds to cover MFEs, one of which uses *only* STOP funds. The irony of this reality is that STOP program eligibility is contingent on adherence with the VAWA 2005 requirement. State STOP administrators (SSAs) are required to certify their states are in compliance with the requirement and, if they are unable to do so, risk losing portions of their STOP funding—a primary source of funding for their states' response to sexual assault, domestic violence, and stalking. Given that so few states actually use STOP funds to cover MFE costs, it would seem that SSAs might have little leverage to demand adherence to the regulations.

Yet, by all accounts through our surveys and case studies, it appears that most victims do receive free exams across the United States, regardless of their participation in the criminal justice system. Both state-level and local respondents reported remarkable agreement in that few victims

faced being billed for exams—or at least the portions of the exams required to be covered by state statutes. In cases where victims do get billed for services that should be covered by designated payers, it appears these bills can be resolved through the help of advocates or others interested in ensuring the exams are free.

Related to this, states' statutes vary widely regarding what is required to be covered during an MFE by state-designated paying sources. Some states cover only the services to collect forensic evidence, as they are required to, while others pay for sexually transmitted infection (STI) and pregnancy testing, and still others pay for treatment of STIs, pregnancy, and, in rarer cases, HIV and injury. In some states, little distinction is made between evidence collection and medical services, so the variety of services covered is wide; for others, it is very narrow. Because states interpret these distinctions differently, they vary in their definitions of what constitutes a standard MFE, with some providing victims with a variety of types of help (as described above), while others do not. In states that offer statewide mechanisms for payment, services that are covered are universal. In states that have locally controlled payment policies and practices, services eligible for coverage vary across counties/jurisdictions.

Finally, the sufficiency of payment caps implemented by many states is a challenge for health care providers. Our qualitative findings indicate that payment caps often fall far short of covering providers' actual expenses, with shortfalls from several hundred to several thousand dollars per exam, depending on the services provided and the area of the state. Some providers bill the victim's insurance (when victims have insurance) to make up for these shortfalls, but many simply write off these costs and absorb the losses. Perhaps one unintended consequence of the VAWA 2005 requirement is that hospitals and medical providers are being pushed to share the costs of MFEs, whether or not it is their intention to do so. Some hospitals absorb the cost as part of their contribution back to the community, but how long can we realistically expect providers to do this? It may be the case that hospitals will face the choice of continuing to cost-share MFE procedures or not providing this service at all.

Implications for Policy and Practice

There are several ways the above findings lend themselves to implications for policy and practice, including the following:

- *Ensure funding levels are adequate for designated payers:*
 - *Funds dedicated to payment of MFEs should be provided whenever possible.* In states that use compensation funds to pay for all or some portion of MFEs, it is important to ensure that this obligation does not compete with funding for other services to victims.
 - *Consider exploring ways to use law enforcement and prosecution funds to pay for MFEs for victims while preserving the smooth operations that statewide payment procedures for providers seem to afford.* Our data show that very few states use law enforcement or prosecution funds to cover the costs of MFEs. Given that these agencies benefit from the evidence collection to build a criminal case, it may make sense to explore ways to use such funds for MFEs. For example, statewide agencies that have experience in providing payments such as these

(such as compensation administrators) could be provided funding by criminal justice agencies to pay for MFEs, without having to use designated crime victim compensation funds.

- *Routinely examine if payment levels or caps imposed on payments to providers are adequate.* The cost of an MFE can vary throughout a state for a variety of reasons. In states that impose a cap on the amount paid for an MFE, hospitals in certain geographic areas may often provide these services at a loss. Routinely conducting reviews (through surveys, audits, etc.) across the state to ensure that payment levels are adequate is important.
- *Train medical providers and hospital personnel on the VAWA 2005 requirement and the states' or localities' process for paying for MFES.* When we heard about challenges related to victims being billed, it was typically due to misunderstandings on the part of hospital and administrators about who should be billed. Training this group on MFE policies and practices might prevent future problems.
- *Consider broadening definitions of what should be paid for as part of the MFE process.* Wide variation in what services are covered as part of an MFE exists state to state, and in some cases jurisdiction to jurisdiction. States and localities that employ narrow definitions of what should be paid for through designated payers might consider expanding their covered services, perhaps including treatments for pregnancy (e.g., emergency contraception), STIs and HIV (e.g., screening, testing, prophylaxis, and counseling), and injuries.

WHAT DID WE LEARN ABOUT EXAM PROCESSES AND BARRIERS TO ACCESS?

Forensic evidence collection and medical services provided during MFEs were quite uniform across the case-study localities we visited, despite whether designated MFE payers covered the costs of these activities. Most MFEs involve identification and documentation of injuries; collection of blood and urine for toxicology testing; collection of biological samples to establish sexual contact; treatment of minor injuries; pregnancy testing and prophylaxis; and STI testing and prophylaxis. With few exceptions, agency stakeholders and victims reported that the SANE conducting the MFE was critical to the process of building a case and prosecuting it, and also in supporting the victim with compassionate care and concern.

These services are critically important, both as first steps in addressing victim injuries and restoring physical and mental health, as well as in building criminal justice cases if the victims choose to report. Moreover, the MFE also provides a primary avenue by which victims can access advocacy services and counseling. In many areas we visited, it was standard practice to contact an advocate when someone presented at a hospital for an MFE. Often, advocates are the individuals who bring the victims to the hospital for the exams. In another familiar scenario in which law enforcement brings victims to the hospital for the exams, the officers may already have called the advocates for assistance before they arrive. Agency stakeholders across the system and victims alike reported how important it was for victims to have advocates present during the MFE, with rare exceptions.

Thus, when victims face barriers to even *accessing* exams, they lose much more than the evidence that might build a criminal case against their perpetrator and an immediate medical

response—both of which are obviously important. They also lose opportunities to engage in critically important services in both the short- and long-term periods following the assault. Both survey and case-study respondents identified a number of barriers victims might face in accessing the exams, regardless of concerns about who might pay for it or whether they want to report to the police.

Specifically, barriers were identified for people who identify as non-English speakers, immigrants, or American Indians (living on and off reservations), and people in rural and geographically remote areas. People who identify as non-English speakers or immigrants face language barriers, cultural issues, and a lack of culturally competent responses from first responders, as identified in chapter four. American Indian women face similar challenges. Victims living in rural towns or geographically remote areas might face long distances to travel to trained providers. In many cases, these challenges actually *prevent* women from getting the MFEs and all the benefits and services that might come from the process. When victims are not able to get the exams, or get exams in a culturally competent and appropriate manner, everyone loses. Victims are not helped, perpetrators' crimes remain unaddressed, and public safety is not improved.

Implications for Policy and Practice

There are several ways the above findings lend themselves to implications for policy and practice, including the following:

- *Continue efforts to make trained examiners available throughout states.* Availability of more trained exam providers (e.g., SANEs) and suitable facilities with specialized or appropriate equipment (especially for American Indian victims and rural areas) is critical to the MFE process. Continued funding, technical assistance, and training efforts at the federal and state level would be essential to continue progress in this area.
- *Train first responders—such as nurses, advocates, and law enforcement—to appropriately respond to individuals in historically marginalized groups.* Efforts to improve cultural competency of first responders are important to curtail barriers to exam access for several groups, including individuals identifying as American Indians, non-English-speakers, and immigrants.

WHAT DID WE LEARN ABOUT KIT STORAGE?

Critical to adherence to VAWA 2005 are methods to store kits for nonreporting victims so that the decision not to report to the police is acknowledged and respected. It has been a central focus of technical assistance and policy and practice revision around states and localities throughout the United States since the requirement passed.

Both survey and case-study findings show that the most common strategy is for the law enforcement agency with jurisdiction where the assaults took place to store the kits of nonreporting victims. In some cases, kits are stored by number or some other identifier so victims' names are anonymous to law enforcement, and in other cases, kits have victim identifying information on them. The next most common strategy is for other agencies to store

the kits, so that no law enforcement involvement is necessary. In these situations, kits are stored in the medical facilities in which they were conducted, in other types of facilities (such as state health agencies), or less commonly, in victim service provider facilities. Key to this is that law enforcement is not even made aware of such kits unless victims choose to convert their cases to reported status.

A minority of locations implement an anonymous reporting process for nonreporting victims. Here, the kit for a victim who does not want to report is sent to law enforcement without any identifying information on it, and, with the victim's permission, an investigation is opened and the kit is processed. If progress is made in the case, the victim would be contacted (by a SANE or victim service provider) to ask if they would like to convert the case to a reported one. Only one of our case-study jurisdictions embraced this type of model. Respondents from this site indicated that once this option became available, most victims who did not want to report their assault opted to consent to their kit being processed anonymously, rather than have a non-law enforcement agency store the kit without any processing.

Though this process has not been evaluated through rigorous methodology—and should be—it holds out promise as a way to balance victims' needs and criminal justice system goals. We speculate that the anonymous reporting option might allow victims one possible helpful scenario in the face of such a traumatizing event. It ensures the necessary forensic evidence is collected in a timely manner, and it may provide victims the opportunity to know how their cases might proceed through the criminal justice process, based on what is found when the kits are processed. Yet, it also affords the victim the space to not have to report to the police during the immediate crisis.

In addition, anonymous reporting by victims may promote a possible positive scenario to promote public safety. In a context that includes the victim's consent, law enforcement is afforded an opportunity to understand the scope of the sexual assault problem in their jurisdiction, examine biological evidence, and enter suspect evidence into Combined DNA Index System (CODIS) in order to identify serial rapists and other threats to the community. In models with no law enforcement involvement, the system is at a loss to really understand the extent of sexual assaults in their area if they are not even made aware of kits that are collected. When law enforcement collects kits for victims but cannot investigate the cases, it provides them with a sense of the extent of sexual assault occurring but leaves them unable to address the problems.

Implications for Policy and Practice

There are several ways the above findings lend themselves to implications for policy and practice, including the following:

- *Continue to provide training and technical assistance around storage practices for nonreported kits, particularly opportunities for anonymous reporting by victims, which includes their consent.* Assistance in negotiating and implementing systems whereby victims can participate in anonymous reporting, if they so choose, may be particularly useful. Additionally, rigorous evaluation of various storage practices and how they relate to victim satisfaction, case outcomes, and public safety is necessary.

WHAT DID WE LEARN ABOUT VICTIM PARTICIPATION IN THE CRIMINAL JUSTICE SYSTEM?

Most case-study respondents across stakeholder groups indicated the majority of victims who have MFEs report the assaults to law enforcement (estimates of 75 percent or more, with one exception). As some speculated, some victims may know right away whether they want to involve the justice system. Few victims convert their kits to reported cases (a very small minority, by all accounts), and if they do, it is typically within days or weeks of the exam. While this information indicates that the majority of victims who get the exams also report the assaults, it does not mean the majority of individuals who are assaulted report. Last year, the Bureau of Justice Statistics found that only one in three victims of rape and sexual assault in 2010 reported it to law enforcement (Planty et al. 2013).

One reason that victims might be reticent to report their assaults to law enforcement is concerns about how law enforcement will treat them. While many mentioned advancements in law enforcement's treatment of victims, some stakeholders from across the system and victims themselves reported victim mistreatment by criminal justice officials. Whether discouraging them to report, doubting their stories, or indicating there was not much they could do based on the situations in which the assaults took place, some law enforcement clearly communicated to victims that their cases were unlikely to proceed. Alternatively, when we spoke to victims who found the police to be supportive and encouraging, and diligent in the investigation, cases were more likely to be successful and victims were more likely to be glad they had reported.

Another reason victims might be reticent to report is lack of confidence that their cases will move forward and result in prosecution. Across many jurisdictions we visited, stakeholders and victims reported that the minority of sexual assault cases resulted in convictions. In some areas, some prosecutors discussed their unwillingness—or lack of know-how—to address complicated sexual assault cases that involved acquaintances or intimate partners, which are the most common cases reported. There was wide variation in perceptions of the utility of the kit outside of stranger rape cases, with seemingly savvy and successful investigators and prosecutors never losing sight of its utility and their ability to use kit evidence (or the act of getting an exam) to add strength to their case.

Importantly, in large part, victims who receive MFEs report their assaults to law enforcement. But, once the exam occurs, there is still much work to be done. And given that only about one in three victims report their assaults to law enforcement (Planty et al. 2013), it is clear there is still much left to be done in terms holding perpetrators accountable.

Implications for Policy and Practice

There are several ways the above findings lend themselves to implications for policy and practice, including the following:

- *Consider public awareness campaigns regarding MFE access.* While progress has been made in setting up systems to provide exams free of charge and without having to report

to law enforcement, the general public might not be aware of this option. Public outreach to inform people of such options seems critical.

- *Link advocates to victims during the exam process.* Though many places we visited reported that advocates were often present at exams, it might be important to assist with funding and resources to ensure advocates are a part of all exams (with the victim's consent) to further efforts to improve victim well-being and offender accountability. If an advocate is present at the exam, it provides an important link to legal advocacy, counseling, and other services.
- *If victims so choose, consider allowing them the chance to talk with law enforcement "off the record" as part of their decision-making process about whether to make an official report.* Victim contact with police officers before they decide to make an official report might provide victims a chance to ask important questions and consider realistic assessments of their options, so that they can make more informed choices about whether to report. However, such a practice must not be considered lightly and would need to be implemented with the utmost of care and compassion. Training of officers who provide this service would be essential. If victims encounter resistance or a lack of compassion during this informational interview process, then it could have the opposite effect of *discouraging* victim reporting. In addition, rigorous evaluation of the success of this approach is warranted.
- *Train law enforcement and prosecution:*
 - *About the utility of the MFE.* Investigators and prosecutors must understand the value of the kit, regardless of the findings, and learn ways to build strong cases for a variety of outcomes. For example, if analysis of the kit does not provide probative evidence, as happens about half the time, it can be helpful to have SANEs testify as to why a lack of evidence for an assault is not the same as positive evidence disconfirming an assault (see Greeson, Campbell, and Kobes 2008).
 - *On appropriate treatment of victims.* Though clear progress has been made in this area, more work can be done. Such training might include successful approaches for law enforcement and prosecutors staying in contact with victims, creating more trauma-informed approaches that support victims during the often long criminal justice process, providing an opportunity for victims to speak about what is important to them, and, if a case is not going to proceed, having a detective and/or prosecutor meet with a victim to explain why.
- *Increase victim confidence in the criminal justice system response.* This can be done by improving arrest, charging, and conviction rates. If victims believe that something will happen after they go through the invasive process of getting an exam and reporting to law enforcement, then perhaps they would be more likely to get exams and report assaults.

WHAT DID WE LEARN ABOUT CHALLENGES TO MEETING VAWA 2005 POLICY AND WHAT SEEMS TO WORK?

In general, survey respondents agreed about the main challenges faced in implementing VAWA 2005. First, training—both the ability to provide it and the willingness to participate in it—appears to be a barrier to implementing VAWA 2005 adequately. This could be across several types of issues—including which agency and funds are designated payers, how to bill this

system, and not compelling victims to report to police before accessing exams—and across various stakeholder groups including hospital administrators and billing departments, SANEs, law enforcement, and prosecution.

Second, funding for the designated paying source and payment levels for individual exams were cited both during surveys and case studies as real concerns by community stakeholders. There are concerns about whether there is adequate funding for the designated paying agency to cover the costs for all MFEs conducted. In an era of scarce resources, ensuring that funds exist to meet the new policy requirement is critical—although admittedly quite challenging—to the successful implementation of them. Whether payment mechanisms are statewide or administered at local levels, jurisdictions are feeling the squeeze in budgets, and concerns over continued adequate funding levels are real.

In addition, payment levels for individual MFEs, which were often lower than the actual costs to the medical providers, were also concerning. We learned across many jurisdictions that hospitals routinely were unable to recoup the costs of MFE services from the designated payer due to funding caps. This leaves hospitals with the choice of covering the remaining costs of the exam, which cannot be billed to victims as per VAWA, or no longer offering to provide MFEs.

Third, law enforcement's resistance to VAWA 2005 changes, or interactions with victims or sexual assault agencies, were reported to be challenges that communities face in implementing the new requirement. As noted above, law enforcement can be the linchpin in how the VAWA 2005 requirement moves forward. When law enforcement is engaged in making sure these changes happen successfully, we found success. When there was less engagement, moving forward with compliance was harder.

Survey respondents also reported a fair amount of agreement in their impressions about what seems to work well when implementing VAWA 2005. Primary among these reports was the effectiveness of exam providers and the role they play in ensuring that victims receive exams free of charge and without having to report the assaults to law enforcement. SANEs are critical first responders. They often are the ones to explain to victims that the exams will be free and which services will and will not be covered by the designated payer. In addition, if the victim has not already reported the assault to the police, SANEs often present victims with their reporting options and may discuss the pros and cons of these options.

Many state-level reporters indicated that having a statewide payment mechanism for MFEs seemed to work well in order to meet VAWA 2005. Most states use the same payment mechanism for the whole state, while a small number leave the payment process to local authorities, such as county-level agencies in the justice system or other systems. Both systems have advantages and disadvantages, but sizable portions of coalitions and SSAs indicate that this feature of their response to VAWA 2005 is what makes their process work well.

Statewide payment systems have the advantage of providing consistency. Policies for which expenses are covered and payment amounts, as well as billing and payment procedures, are uniform. This promotes a sense of fairness and parity. It also eliminates jurisdictional issues within the state, so that it does not matter if the victim was assaulted in one locality but received

the exam in another locality; a statewide agency pays for all exams across the state. However, several of the people we interviewed noted that cost of living can vary widely from one area of a state to another, so that pay scales and other operating expenses for exam providers can be very different. Having set payment amounts for all providers does not acknowledge cost-of-living differentials, which means that providers in some parts of the state get more of their expenses covered than those in others.

Finally, laws that truly help sexual assault victims and that are clear about which agencies should pay for exams were helpful to implementing VAWA 2005. Statutory ambiguity creates confusion and may lead to mistakes by state- and local-level designated payers and local stakeholders trying to implement unclear regulations.

Implications for Policy and Practice

There are several ways the above findings lend themselves to implications for policy and practice, the first three of which echo implications iterated above. They include the following:

- *Ensure funding levels are adequate for designated payers and routinely examine if payment levels or caps imposed on payments to providers are adequate.*
- *Provide adequate training for all first responders—nurses, advocates, and law enforcement, as well as hospital billing personnel and administrators—on payment and reporting requirement policies and practices.*
- *Continue efforts to make trained examiners available throughout states.*
- *Review state legislation for ambiguity of language.* Thoughtful, clear legislation about who should pay for MFEs, which services should be covered through MFEs, and how kits for nonreporting victims should be handled can be a good initial step to ensuring that victims are receiving exams free of charge and without having to report to law enforcement.

WHAT DID WE LEARN ABOUT MEETING VAWA 2005 POLICY?

One important issue we wanted to explore during this study was the extent to which states seemed to be in line with the VAWA 2005 requirement, despite the fact that identifying individual state compliance was not a specified goal of our research. As discussed in previous chapters, each state has designated paying funds and agencies for MFEs, and we found that the case-study states and jurisdictions were largely meeting the VAWA 2005 requirement in providing exams free of charge and not requiring victims to report to law enforcement to access a free exam. We also found that sizable proportions of survey respondents reported increases in states' ability to provide the exam free of charge. While some states still may not be adhering to the VAWA 2005 requirement, it appears that many are.

Notable, however, is whether we found that the *goal* of the VAWA 2005 requirement was being met. That is, providing exams free of charge and without having to report to law enforcement is a requirement that intends to increase the numbers of victims getting the exams and the numbers willing to report to law enforcement, if they are afforded the time to think about such reporting without pressure to do so. Toward this end, our findings are mixed.

Survey findings show that between 40 percent and 49 percent of respondents (depending on stakeholder type) reported that more victims are getting the exam since January 2009, when the VAWA 2005 regulation was required to be implemented. Far fewer report greater numbers of victims reporting to law enforcement since that time—between 21 percent and 34 percent of respondents (depending on the type of respondent) reported increases in victims reporting the assault to the police. Qualitative findings from case-study sites show that in many places, law enforcement—particularly investigators—are trying to be responsive to victims and adequately investigate sexual assault reports, though not everywhere. We also learned that if a victim pursued an MFE, then she most likely reported the assault to the police. Stakeholders in most areas estimated that the minority of victims opted to get an exam and not report; few victims who did not report converted their kits to reported cases at a later date.

Despite these promising findings, why are we not seeing more progress? We can speculate as to why. Our qualitative findings indicate that both victims and other system stakeholders lack confidence in the criminal justice process and the ability to hold offenders accountable through prosecution. Across jurisdictions, many stakeholders reported that numerous sexual assaults were not pursued for prosecution for a variety of reasons, in line with existing quantitative work (see, for example, Spohn and Tellis 2012). Only a portion of reported sexual assaults lead to an arrest, and far fewer result in prosecutorial charges and convictions. In one case-study site, respondents explicitly commented that the spirit of VAWA 2005 was not supported in their area because, although they have a seamless payment system to provide exams free of charge and victims are not required to report to police, victims are still being discouraged to access the exams and report their assaults. Similar statements might be made regarding other groups who face significant barriers to accessing the exams, such as American Indian women. And, when victims do come forward, some victims in focus groups and interviews reported feeling mistreated by law enforcement and prosecutors, and in rare cases, by medical personnel conducting exams.

Thus, while clear progress can be cited in the area of MFE payment policies and practices, and local community interaction to ensure victims are supported in their decisions whether or not to report their assaults, more work needs to be done. Serious barriers still exist related to accessing the exams and victim willingness to participate in a criminal justice system they do not feel confident will make progress with holding their perpetrators accountable.

Implications for Policy and Practice

There are several ways the above findings lend themselves to implications for policy and practice, all of which echo implications iterated above:

- *Consider public awareness campaigns regarding MFE access.*
- *Link advocates to victims during the exam process (with the victim's consent).*
- *If they so choose, allow victims to talk with law enforcement "off the record" as part of their decision making process about whether or not to make an official report.*
- *Continue to train law enforcement and prosecution on the utility of the MFE, on trying more types of sexual assault cases, and on appropriate treatment of victims.*
- *Increase victim confidence in the criminal justice system response.*

- *Continue to provide training and technical assistance around storage practices for nonreported kits, particularly opportunities for anonymous reporting.*

LIMITATIONS OF THE STUDY AND FUTURE DIRECTIONS

Like all research, this study is subject to some methodological limitations. First, the survey of victim compensation fund providers that pay for MFEs should have contained the same questions we asked SSAs and state-level coalitions on meeting the VAWA 2005 policy requirement, including what works to meet the requirement, the challenges faced, and whether there has been change since the requirement has been implemented. We implemented a shorter survey with this respondent group due to concerns over respondent burden, given that administrators had at that time recently responded to a similar survey on MFEs.³⁷ However, given that we had other respondent groups in our study (SSAs and coalitions), our information is lacking because we are not able to make comparisons to compensation fund administrators. Because they are the biggest funder of MFEs across the nation, the data collected here would have benefited from their input. Such information would have painted a fuller picture of the impact of VAWA 2005 since its implementation across the United States.

Second, while the response rates for the state-level surveys are all acceptably high, the response rate for the survey of local providers is relatively low—40 percent. Despite numerous efforts to reach out to local providers, as enumerated in chapter two, we were not able to achieve a higher response rate. Making phone contact with local providers to encourage participation might have increased this rate some, though that was beyond the scope of this study's resources. Thus, findings reported by local providers must be interpreted with this response rate in mind.

Third, while we were able to speak with a full set of multidisciplinary stakeholders in several jurisdictions, this was not the case in all of them. We also were not able to speak with victims in every jurisdiction. Though it is not unusual in case-study designs such as this one to find a reluctant stakeholder group (or two) in a community, the study would have benefited from the full participation of these groups in each site in order to cross-check information among stakeholders and to fully understand a community's response to sexual assault.

Fourth, given the number of local jurisdictions included in the case studies, findings from this portion of the study have limited generalizability. These findings represent the communities we visited, and we cannot assume that the practices described are similar in other communities. Instead, findings from case studies are illustrative in nature.

Fifth, it is important to understand that, as with any study that collects data through surveys, interviews, or focus groups, the data are based on perceptions and their validity rests on the participants' ability and willingness to provide objective, well-informed input. In some cases, respondents may have consulted empirical data about their state, but others may not have done so. We did not ask if their impressions were based on such data. Thus, the data reported herein are based on the impressions of the respondents. However, these impressions are informed based on their expertise and time spent in the field. Notably, data collection methods such as case-file

³⁷ The Indiana Victim Compensation Fund Survey, data unpublished.

reviews may provide more “hard” data on policies and practices but were beyond the scope of this study.

Future Directions for Research

Despite these limitations, the current study makes several contributions to the knowledge base on MFEs, and the findings lend themselves to implications for future research in this area. Several aspects of the findings merit further investigation.

First, while we explored it qualitatively here, it would be interesting to explore quantitative differences between statewide mechanisms for payment compared to local methods for payment. Areas of interest might include efficiencies in these two practices (e.g., payment mechanisms, erroneous billing of victims, length of time to pay providers), differences in what is and is not covered via the systems in terms of medical services, and operational costs to implement.

Second, a quasi-experimental study of models for storing kits for victims who do not report their assault to police would be useful to the field. We asked coalitions about their *perceptions* of what models seemed to work best when it came to providing exams free of charge and without having to report. However, it is important to move beyond providers’ perceptions of how models work to actually examining these questions with data from victims on appropriate billing and if victims feel pressured to report or are required to report. This design would also allow researchers to explore more deeply such questions as whether these different models relate to varying levels of case conversion (decisions of victims to convert their cases to reported cases), arrests, and prosecutions.

Third, while explored in brief here with the three case-study states that used victim compensation funds to pay for MFEs, it would be compelling to learn more about the philosophical tensions and practical pros and cons to using these funds to pay for MFEs. A qualitative, semi-structured interview approach to exploring these questions with the universe of victim compensation fund administrators that use their funds to pay for MFEs in their state—either all MFEs or some portion of them—would provide rich information that would be useful for future policymaking and practical implementation.

Fourth, it could be very informative to use more quantitative, case-based approaches to explore cases with exams of nonreporting victims who later convert to a reporting status, compared with cases with exams of nonreporting victims who do not convert, to determine why some victims convert and others do not. Similarly, it could also be useful to study how exams that do not provide probative evidence factor into criminal cases, since some practitioners feel they are still valuable, while others feel they can be harmful to the criminal case.

Fifth, given our findings on barriers to access to the exam, medical care, and cultural competency for individuals who identify as non-English speakers, immigrants, American Indians, or other minority groups, it is critical to understand more about such issues. The findings speak to the need to prioritize research that examines how greater access can be achieved through cultural competency of providers and other means.

CONCLUSION

This project set out to learn about who pays for MFEs in state and local jurisdictions throughout the United States, and the policies and practices around payment; what services are provided in the exam process; whether free exams are provided to victims regardless of their intention to report the assault to the criminal justice system; how MFE kits are being stored for victims who choose not to participate in the criminal justice system process; and whether the VAWA 2005 requirement is generally being met throughout the country. Focusing on VAWA 2005 and the issues surrounding its implementation, we draw five main conclusions from this study.

- **First**, victim compensation funds are by far the largest designated source of funds to pay for MFEs across the United States, and compensation fund administrators are most likely to be the designated paying agency (whether using compensation funds or a special funding source). With two-thirds of states using compensation funds to pay for at least some MFEs and more than one-third using *only* such funds to pay for MFEs, there is no other source of funding that is tapped so heavily for this purpose.
- **Second**, in the case-study jurisdictions examined here, with very few exceptions, most victims are able to receive exams without having to report to law enforcement and receive exams free of charge. Survey respondents reported that the same is true in much of the country, though not everywhere.
- **Third**, despite the first and second conclusions, *barriers to even accessing the exam are real* and prevent some victims from seeking help. Specifically, individuals identifying as non-English speakers, immigrants, or American Indians face barriers to getting the exams due to lack of cultural competency among first responders, availability of trained SANEs, language barriers, and other reasons. When victims are unable to get the exams, or do not get the exams in a culturally competent and appropriate manner, everyone loses: victims are not helped, perpetrators' crimes remain unaddressed, and public safety is not improved.
- **Fourth**, most victims who get MFEs report the assaults to the police at the time of the exam. Among the victims who get MFEs but do not report at the time of the exam, few convert their kits to reported cases at a later date. This means that victims who do not report to police miss out on receiving other necessary medical, advocacy, and counseling services.
- **Fifth**, sufficient funds to pay for MFEs are a major concern. Although many areas reported seamless payment systems at the time we collected data, worries over money remained. The level of continued funding for designated payers to cover the costs of exams each year and caps imposed on payments to providers might jeopardize these seemingly successful systems.

While this report is a first step in understanding how the VAWA 2005 requirement related to MFEs is being met, it does not provide the whole picture about how this process will evolve over time in terms of continued resources to the meet requirement; changes in payment policies; shifts in community approaches to kit storage, investigation, and prosecution; and changes based on the implementation of new VAWA 2013 requirements. And while barriers still exist to accessing the exam, while some victims still do not feel comfortable reporting their assaults to the criminal

justice system, and while communities still struggle to provide trained providers to conduct MFEs, there is still much work to be done.

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APPENDIX A: SURVEY INSTRUMENTS

Sexual Assault Forensic Exam Payment Practices Study Survey of State STOP Violence Against Women Act Administrators

About this survey:

The Urban Institute, in collaboration with George Mason University and the Pennsylvania Coalition Against Rape/National Sexual Violence Resource Center, is conducting a study funded by the **National Institute of Justice**, the research, development, and evaluation agency of the U.S. Department of Justice.

The purpose of this study is to:

- Understand how sexual assault forensic exams are paid for throughout the country;
- Identify best practices to ensure that victims are never required to pay for the forensic exam or to report the sexual assault to the police before receiving a free forensic exam;
- Examine obstacles related to providing free forensic exams for all sexual assault victims, and identify ways to overcome them; and
- Provide information and analysis to states and localities across the nation to help develop policies and practices that best serve victims.

This study is **not** a compliance audit, and will **not** produce a “report card” rating of states or other jurisdictions. Responses to this survey will be combined with those from all other state STOP Violence Against Women Formula Grant Program administrators around the country (referred to as STOP for the remainder of the survey) and presented as aggregate findings. We are also surveying state victim compensation administrators, state sexual assault coalitions, and local sexual assault service agencies to capture a national picture of sexual assault forensic exam payment practices. Please note:

Survey responses will never be identified by individual, agency, or state outside the research team. No one else will be able to connect what you tell us to you, your agency, or your state.

We sincerely appreciate your time and help with this survey – your responses will not only greatly inform this project, but will provide valuable information for the future development of policies and programs. We understand that you may have provided similar information to other agencies in the past. This research project is not related to any of those earlier efforts and the information we collect will be used in reports to assist you and others who are attempting to provide the best services possible to victims of sexual assault. We appreciate your contributions!

The survey should take you about 20-30 minutes to complete. You can complete the survey in more than one session if you cannot complete the whole survey at one time. Your answers will be saved. Filling out this survey is voluntary. You can choose to skip any questions that you are not comfortable answering.

Please complete the survey by **Friday, July 22nd**.

Thank you very much for your participation in this survey. If you have questions or would like to discuss the survey further, please contact Megan Denver at the Urban Institute by phone (202-261-5552) or by email at mdenver@urban.org.

Remember: Your responses to questions will never be identified by state name, by agency name, or by your name.

1. How long have you been the STOP administrator in your state/territory:

Year(s)___ Month(s) ___

2. What percent of your time/position is spent on STOP administration? _____%

2a. What percent of your time/position is spent on coordinating VAWA regulations around sexual assault payment? _____%

3. What were the total STOP funds provided to your state in:

Fiscal year 2008: _____

Fiscal year 2009: _____

Fiscal year 2010: _____

4. What are the **laws** in your state pertaining to access to sexual assault forensic exams and payment practices (this question is referring to **legislation** and not **administrative policies**)? Please check all the laws that your state has:

- My state has a law requiring that victims of sexual assault be provided forensic exams free-of-charge.
- My state has a law that requires forensic exams be provided to victims of sexual assault whether or not the victim makes a report to law enforcement.
- My state has a law that requires victims of sexual assault to report the crime to law enforcement before they are provided a forensic exam.
- My state has a law that requires victims of sexual assault to report the crime to law enforcement before they are provided a forensic exam **free-of-charge**.
- My state has a law that requires law enforcement to **authorize** forensic medical exams before they are provided.
- My state has a law that mandates medical providers to make reports of sexual assaults to law enforcement.
- My state has a law allowing victims to use a pseudonym in medical and legal documents related to a sexual assault incident (Jane Doe Reports).

- My state has a law allowing victims to report sexual assaults to law enforcement anonymously – that is, never identifying themselves or their assailants (anonymous or blind reporting).
 - My state has a law allowing victims to request their names and identifying information be kept out of public documents related to a sexual assault.
 - My state has a law that requires hospitals and other medical facilities to store sexual assault evidence and follow Chain of Custody procedures.
 - My state does not have a law regulating sexual assault forensic exam practices or procedures.
 - I do not know what my state law requires.
 - I do not know if my state has a law on sexual assault forensic exam policies or practices.
 - Other? Please specify: _____
-

5. Regardless of whether your state has laws relating to particular sexual assault forensic exam issues, we are interested in whether your state has forensic exam-related policies in place. Therefore, what are the state’s **policies** pertaining to access to sexual assault forensic exams and payment practices? Please check all the policies that your state has:

- My state has a policy requiring that victims of sexual assault be provided forensic exams free-of-charge.
 - My state has a policy that requires forensic exams be provided to victims of sexual assault whether or not the victim makes a report to law enforcement.
 - My state has a policy that requires victims of sexual assault to report the crime to law enforcement before they are provided a forensic exam.
 - My state has a policy that requires victims of sexual assault to report the crime to law enforcement before they are provided a forensic exam **free-of-charge**.
 - My state has a policy that requires law enforcement to **authorize** forensic medical exams before they are provided.
 - My state has a policy allowing victims to use a pseudonym in medical and legal documents related to a sexual assault incident (Jane Doe Reports).
 - My state has a policy allowing victims to report sexual assaults to law enforcement anonymously – that is, never identifying themselves or their assailants (anonymous or blind reporting).
 - My state has a policy allowing victims to request their names and identifying information be kept out of public documents related to a sexual assault.
 - My state has a policy that requires hospitals and other medical facilities to store sexual assault evidence and follow Chain of Custody procedures.
 - My state does not have a policy regulating sexual assault forensic exam practices or procedures.
 - I do not know what my state policy requires.
 - I do not know if my state has a policy on sexual assault forensic exam practices.
 - Other? Please specify: _____
-

6. Does your state require forensic exam kits to be stored?

- Yes (GO TO #6a)
- No (GO TO 8)
- I'm not sure (GO TO 8)

6.a. If yes, how long must it be stored if the case has been reported to law enforcement?

_____ years _____ months Indefinite time period I don't know

6.b. If yes, how long must it be stored if the case has not been reported to law enforcement?

_____ years _____ months Indefinite time period I don't know

7a. Where are the forensic exam kits stored in your state? Check all the places kits are stored in your state:

- Law enforcement agency's evidence storage facilities
- District Attorney's evidence collection rooms
- State-run laboratories where kits are tested
- Private laboratories where kits are tested
- Medical facilities where the kits are collected
- Other: Please specify: _____

7b. In your state, is there variation in where forensic exam kits are stored?

- I do not know
- No, it does not vary
- Yes, but I am not sure why there is variation in my state
- Yes – it varies depending on whether or not the sexual assault was reported to the police
- Yes – it varies in another way (Please specify: _____)

8. Do jurisdictional issues ever present a problem with payment of forensic exams in your state? Please check all that apply:

- Jurisdictional issues are not a factor in payment of forensic exams in my state.
OR
- There can be problems with payment when a resident of another state is assaulted in my state.

- There can be problems with payment when a resident of my state is assaulted in another state.
- There can be problems with payment when a resident of one local jurisdiction within my state is assaulted in another local jurisdiction within my state.
- There can be problems with payment when the assault occurs on tribal lands.
- There can be problems with payment due to other types of jurisdictional issues.
Please specify: _____

9. Does your state use STOP funds to pay for sexual assault forensic exams?

- Yes
- No

10. For this question, we are interested in which funding sources pay for sexual assault forensic exams. We are also interested in learning how much they pay compared to other sources. In your state, please select “yes” if the listed source pays for forensic exams. Then please rank the funding sources for which you marked “yes,” so that the source that pays the most is labeled “1” and the source that pays the second most is labeled “2,” and so on.

	Does this source pay? <i>(If no or you're not sure, please skip)</i>	Please rank below if you said “yes”
Victim compensation funds	<input type="checkbox"/> Yes	
STOP funds	<input type="checkbox"/> Yes	
State department of health/mental health	<input type="checkbox"/> Yes	
State law enforcement funds	<input type="checkbox"/> Yes	
State prosecution funds	<input type="checkbox"/> Yes	
Other state funds	<input type="checkbox"/> Yes	
Local law enforcement funds	<input type="checkbox"/> Yes	
Local prosecution funds	<input type="checkbox"/> Yes	
Other local funds	<input type="checkbox"/> Yes	
Victim’s insurance or public benefits	<input type="checkbox"/> Yes	
Other funds (please describe below and provide rank):		
_____	<input type="checkbox"/> Yes	

This section is for States that use STOP funds (answered “Yes” to question 9) for sexual assault forensic exams:

11. For this question, we're interested in the amount of STOP funding used to pay for exams and how many exams this funding covered in 2008, 2009, and 2010.

	2008	2009	2010
Amount of funding paid for forensic exams			
Number of exams this funding amount covered			

12. What was the first year your state starting using STOP funds to pay for forensic exams?

13. Are there caps on fees that can be paid for forensic medical exams?

- Yes (GO TO 13.a.)
- No (GO TO 14)

13.a. If yes, what is that cap? \$_____

14. Are there caps on what providing agencies can charge for forensic medical exams?

- Yes (GO TO 14.a.)
- No (GO TO 15)

14.a. If yes, what is that cap? \$_____

15. If providing agencies charge more than STOP will pay, what happens to the excess amount charged? Check all the ways the excess amount is handled.

- Providing agencies write it off
- Victim's insurance pays the difference
- Victims pay the difference out-of-pocket
- Other funding sources pay the difference (GO TO 15a)
- Other options? (*please explain*): _____

15a. What are these other funding sources?

16. Agencies that provide exams: (*please check only one response*)

- Submit bills to the STOP administrative agency (or to other agencies that receive and distribute STOP funds for forensic exams) for exams they already provided
- Receive an up-front allocation of funds to cover future exam fees

- Both
- Other: _____

17. When using STOP funds, is the payment for forensic medical exams done with a:

- Flat fee
- Fee schedule

18. When using STOP funds, is the victim's insurance billed first and then must the victim file a claim form for reimbursement?

- Yes (GO TO 18.a.)
- No (GO TO 19)
- Sometimes (GO TO 18.a.)

18.a. If yes or sometimes, is there a state time limit on when victims can file a claim for reimbursement?

- Yes (GO TO 18.a.1.)
- No (GO TO 18.b.)

18.a.1. If yes, how long is the time limit? _____ months

18.b. How long, on average, does it take for the victim to be reimbursed from the date the claim is filed until the date of reimbursement? Please fill in only one unit of time below - whichever is the most convenient for you.

_____ months
 _____ weeks
 _____ days

18c. In what percentage of these claims does payment to victims occur more than 90 days after claim receipt? _____ % (If zero, skip question 18d)

18d. Why do certain claims take longer than 90 days? _____

19. When using STOP funds, is there a time limit for collection of evidence after the crime?

- Yes (GO TO 19.a.)
- No (GO TO 20)

19.a. If yes, what is the time limit? _____ hours

20. When using STOP funds, does the payment process for forensic exams vary based on whether the victim falls into one of these classes?

- Minor victims: Yes _____ No _____ (If "yes," go to 20.a.)
- Victims in later life: Yes _____ No _____ (If "yes," go to 20.a.)
- Victims with disabilities: Yes _____ No _____ (If "yes," go to 20.a.)

20.a. Please specify how the payment process varies for the classes you indicated in #20:

21. Do forensic exam payment procedures or policies vary depending on the provider's status (for example, if the provider has received specialized training in sexual assault forensic exams or not)?

- Yes
- No

22. When using STOP funds, who provides forensic exams in your state? Please check all that apply.

- Specially trained forensic examiners, such as Sexual Assault Nurse Examiners (SANEs), Forensic Nurse Examiners (FNEs), Forensic Medical Examiners (FMEs), or other healthcare personnel trained in sexual assault forensic exams
- Healthcare personnel who have not received special training in sexual assault forensic exams
- Other (Please Describe): _____

23. What parts of exams do STOP funds cover? Please check all parts of the exam that are covered:

- Sexual assault examiner fees for the exam
- Facilities fee
- Emergency room doctor triage
- Ambulance fee
- Colposcopy
- Anoscopy
- Pregnancy test
- Tests for sexually transmitted disease
- Hepatitis testing
- HIV testing
- Pregnancy prophylaxis
- Hepatitis prophylaxis
- HIV prophylaxis
- Alcohol testing
- Drug testing
- Repair of minor wounds associated with the sexual assault
- Follow-up treatment
- Counseling services
- Cost of the forensic examination kit

- Other: _____

END OF SECTION

This section is for everyone to complete:

Questions 24 to 26 apply to victims who come forward for help. Please do not include victims who choose not to disclose to helping agencies.

24. Based on your best estimation, what percentage of victims in your state get forensic medical exams free-of-charge without having to pay anything out-of-pocket at any point in the process?

- 0 to 25 percent
- 26 to 50 percent
- 51 to 75 percent
- 76 to 100 percent
- I'm not sure

25. Based on your best estimation, what percentage of victims in your state get forensic medical exams free-of-charge through reimbursement for out-of-pocket expenses the victims paid?

- 0 to 25 percent
- 26 to 50 percent
- 51 to 75 percent
- 76 to 100 percent
- I'm not sure

26. Based on your best estimation, what percentage of victims in your state get free forensic medical exams (either the victim never pays or gets reimbursed) without requiring them to report to law enforcement or participate in the criminal justice process?

- 0 to 25 percent
- 26 to 50 percent
- 51 to 75 percent
- 76 to 100 percent
- I'm not sure

27. Does your agency provide training to local communities to meet VAWA 2005 regulations?

Click here for a description of VAWA 2005 regulation:

According to the Office on Violence Against Women, VAWA 2005 regulations are “The Violence Against Women and Department of Justice Reauthorization Act of 2005 (“VAWA 2005”), 42 U.S.C. § 3796gg-4(d), provides that states may not “require a victim of sexual assault to participate in the criminal justice system or cooperate with law enforcement in order to be provided with a forensic medical exam, reimbursed for charges incurred on account of such an exam, or both[.]” (the “VAWA 2005 forensic examination requirement”). Under this provision a state must ensure that victims have access to an exam free of charge or with full reimbursement, even if the victim chooses not to report the crime to the police or otherwise cooperate with the criminal justice system or law enforcement authorities. Prior to VAWA 2005, states were required to ensure access to such exams free of charge or with full reimbursement but could condition the exams on cooperation with law enforcement.”

<http://www.ovw.usdoj.gov/ovw-fs.htm#q12>

- Yes
- No
- I don’t know

28. What challenges does your state face in implementing the VAWA 2005 regulations?

Please check all that apply.

- My state has laws that conflict with one another.
- My state’s laws are not clear about which agencies should pay for exams.
- My state lacks a statewide payment mechanism for forensic medical exams.
- Paying agencies lack the funds to provide free exams to all victims who choose to have them, including both reporting and non-reporting victims.
- Payment levels are too low for the services provided, causing difficulties for medical service providers.
- Law enforcement agencies in my state resist changes in processes for providing forensic medical exams, such as not requiring law enforcement or prosecution authorization for free exams.
- Prosecution agencies in my state resist changes in processes for providing forensic medical exams, such as not requiring law enforcement or prosecution authorization for free exams.
- Law enforcement agencies in my state generally do not work well with sexual assault victims.
- Law enforcement agencies in my state generally do not work well with sexual assault service agencies.
- Prosecution agencies in my state generally do not work well with sexual assault victims.

- Prosecution agencies in my state generally do not work well with sexual assault service agencies.
- Medical personnel in my state who provide sexual assault forensic exams generally do not work well with sexual assault victims.
- Medical personnel in my state who provide sexual assault forensic exams generally do not work well with sexual assault service agencies.
- State agencies have difficulties providing training to localities about how to improve local practices.
- Local community stakeholders are not willing to participate in training to improve local practices.
- I'm not sure.
- Some other challenge. (Please specify):

29. What works particularly well in your state in terms of implementing the VAWA 2005 regulations?

Please check all that apply.

- My state has laws that help us implement policies that truly help sexual assault victims.
- My state's laws are clear about which agencies should pay for exams.
- My state has a statewide payment mechanism for forensic medical exams.
- Paying agencies have the funds to provide free exams to all victims who choose to have them, including both reporting and non-reporting victims.
- Payment levels are adequate for the services provided.
- Law enforcement agencies in my state generally work well with sexual assault victims.
- Law enforcement agencies in my state generally work well with sexual assault service agencies.
- Prosecution agencies in my state generally work well with sexual assault victims.
- Prosecution agencies in my state generally work well with sexual assault service agencies.
- Medical personnel in my state who provide sexual assault forensic exams generally work well with sexual assault victims.
- Medical personnel in my state who provide sexual assault forensic exams generally work well with sexual assault service agencies.
- State agencies are able to provide training to localities about how to improve local practices.
- Local community stakeholders are willing to participate in training to improve local practices.
- I'm not sure.
- Some other way this is working well. Please specify:

30. Does your state have specific directives for local communities to adapt their circumstances to meet VAWA 2005 regulations?

- Yes
- No
- I'm not sure

31. What percent of your state's local jurisdictions have Sexual Assault Response Teams (SARTs) or a coordinated community response to sexual assault in place?

- 0 to 25 percent
- 26 to 50 percent
- 51 to 75 percent
- 76 to 100 percent
- I'm not sure

32. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that the percentage of victims of sexual assault who receive forensic medical exams in your state has:

- Greatly increased
- Somewhat increased
- Remained the same (Go to #33)
- Somewhat decreased
- Greatly decreased
- I'm not sure (Go to #33)

32a. Were the changes described in Question #32 due to the new VAWA 2005 regulations or due to something else that was happening in your state around sexual assault forensic exam payment practices?

- Changes were due to new VAWA 2005 regulations
- Changes were due to something else that was happening in the state around sexual assault forensic exam payment practices. Please describe: _____

33. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that the percentage of victims of sexual assault who report their assaults to law enforcement in your state has:

- Greatly increased
- Somewhat increased
- Remained the same (Go to #34)
- Somewhat decreased
- Greatly decreased
- I'm not sure (Go to #34)

33a. Were the changes described in Question #33 due to the new VAWA 2005 regulations or due to something else that was happening in your state around sexual assault forensic exam payment practices?

- Changes were due to new VAWA 2005 regulations
- Changes were due to something else that was happening in the state around sexual assault forensic exam payment practices. Please describe: _____

34. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that the percentage of victims of sexual assault who receive medical care after their assault in your state has:

- Greatly increased
- Somewhat increased
- Remained the same (Go to #35)
- Somewhat decreased
- Greatly decreased
- I'm not sure (Go to #35)

34a. Were the changes described in Question #34 due to the new VAWA 2005 regulations or due to something else that was happening in your state around sexual assault forensic exam payment practices?

- Changes were due to new VAWA 2005 regulations
- Changes were due to something else that was happening in the state around sexual assault forensic exam payment practices. Please describe: _____

35. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that for victims who receive forensic medical exams, the ability of your state to provide these exams free-of-charge has:

- Greatly improved
- Somewhat improved
- Remained the same (Go to #36)
- Gotten somewhat worse
- Gotten much worse
- I'm not sure (Go to #36)

35a. Were the changes described in Question #35 due to the new VAWA 2005 regulations or due to something else that was happening in your state around sexual assault forensic exam payment practices?

- Changes were due to new VAWA 2005 regulations
- Changes were due to something else that was happening in the state around sexual assault forensic exam payment practices. Please describe: _____

36. Is there anything else you would like to tell us about policies and procedures around sexual assault forensic exams?

THANK YOU FOR YOUR INPUT! IT IS SO IMPORTANT TO THIS STUDY!

Sexual Assault Forensic Exam Payment Practices Study Survey of Compensation Administrators in States Where Compensation Pays for Sexual Assault Forensic Exams

About this survey:

The Urban Institute, in collaboration with George Mason University and the Pennsylvania Coalition Against Rape/National Sexual Violence Resource Center, is conducting a study funded by the **National Institute of Justice**, the research, development, and evaluation agency of the U.S. Department of Justice.

The purpose of this study is to:

- Understand how sexual assault forensic exams are paid for throughout the country;
- Identify best practices to ensure that victims are never required to pay for the forensic exam or to report the sexual assault to the police before receiving a free forensic exam;
- Examine obstacles to providing free forensic exams for all sexual assault victims, and identify ways to overcome them; and
- Provide information and analysis to states and localities across the nation to help develop policies and practices that best serve victims.

This study is **not** a compliance audit, and will **not** produce a “report card” rating of states or other jurisdictions. Responses to this survey will be grouped with those from other state compensation administrators around the country and presented as aggregate findings only. We are also surveying compensation administrators in states where compensation is not used to pay for forensic exams, as well as all state STOP Violence Against Women Formula Grant Program administrators (referred to as STOP for the remainder of this survey), state sexual assault coalitions, and local sexual assault service agencies, to capture a national picture of sexual assault forensic exam payment practices. Please note:

Survey responses will never be identified by individual, agency, or state outside the research team. No one else will be able to connect what you tell us to you, your agency, or your state.

We sincerely appreciate your time and help with this survey – your responses will not only greatly inform this project, but will provide valuable information for the future development of policies and programs. We understand that you may have provided similar information to other agencies in the past. This research project is not related to any of those earlier efforts and the information we collect will be used in reports to assist you and others who are attempting to provide the best services possible to victims of sexual assault. We appreciate your contributions!

The survey should take you about 10-15 minutes to complete. You can complete the survey in more than one session if you cannot complete the whole survey at one time. Your answers will be saved. Filling out this survey is voluntary. You can choose to skip any questions that you are not comfortable answering.

Please complete the survey by **Friday, July 22nd**.

Thank you very much for your participation in this survey. If you have questions or would like to discuss the survey further, please contact Megan Denver at the Urban Institute by phone (202-261-5552) or by email at mdenver@urban.org.

1. How long have you been the victim compensation administrator in your state/territory:

Year(s) _____ Month(s) _____

2. We obtained data from the Office for Victims of Crime's website on the amounts that state compensation programs reported spending on claims in 2010. According to this source, your program spent \$ _____ on sexual assault forensic exam claims in 2010, and \$ _____ on all claims in 2010. Just to verify that there are no mistakes, are these the correct amounts?

- a. Yes, these amounts are correct
- b. No, one or both amounts are incorrect (Please answer 2a)

2a) Please provide the correct amount(s) in the appropriate space(s):

- i. Forensic exams only: \$ _____
- ii. All claims: \$ _____

3. How many forensic exam claims were paid in 2010?

Please note that this is not the number of forensic exam claims received, as the Office for Victims of Crime's statewide report specifies, but the number of forensic exam claims paid:

4. Please indicate how much your program spent on forensic exams, and the total amount paid for all types of claims, for each of the three previous years. This would be the data you reported to OVC for 2007 through 2009.

Year	Amount paid for forensic exams	Total amount paid for all claims
2009	\$ _____	\$ _____
2008	\$ _____	\$ _____
2007	\$ _____	\$ _____

5. What was the first year that your state started using compensation funds to pay for forensic exams?

6. Does compensation pay for forensic exams through (Please check all that apply):

- _____ The regular compensation claim procedures used for all types of claims
- _____ A separate process with special procedures for forensic exam claims only

_____ Another procedure, please describe: _____

7. Do any of the following limitations apply to payment for forensic exams through compensation? (Please check all that apply)

_____ None of the limitations below apply

OR

_____ Compensation pays for forensic exams **only** for victims who do not report to law enforcement or otherwise cooperate with law enforcement or prosecution

_____ Compensation pays for forensic exams **only** for victims who do not want their insurance billed for the exam, or do not have insurance

_____ Compensation pays for forensic-related (evidence collection) services only, **not** for medical services that may be provided during a forensic exam (such as pregnancy or STD testing)

_____ Compensation pays for medical services that may be provided during a forensic exam (such as pregnancy or STD testing) only, **not** for forensic-related (evidence collection) services

_____ Other limitations apply; please describe: _____

8. Are compensation awards for forensic exam expenses paid directly to victims as reimbursement for out of pocket expenses, to service providers, or to other parties?

	Please Select "Yes" or "No" for each.	For each party that receives payment, please provide your best estimation of the percentage of all exam-related compensation funds that is paid to that party.
Payments are made directly to victims for reimbursement of exam-related out-of-pocket expenses	Yes/No	_____
Payments are made to service providers	Yes/No	_____
Payments are made to other parties	Yes/No (If yes, go to 8a. If no, skip to 9a (if there's victim reimbursement) or to 10)	_____

8a. Please tell us who these other parties are:

These questions only apply to claims in which victims are **reimbursed for out-of-pocket expenses related to the forensic exam.** Can you please tell us:

9a. How long, on average, does it take for the victim to be reimbursed from the date the claim is filed until the date of reimbursement?

(Please fill in only one unit of time below- whichever is the most convenient for you)

Months: _____

Weeks: _____

Days: _____

9b. In what percentage of these claims does payment to victims occur more than 90 days after claim receipt? _____ %

9c. Why do certain claims take longer than 90 days? (If you entered 0% for the previous question [9b], please skip).

9d. What percentage of these claims for payment directly to victims are denied or reduced? (If more than 0%, continue to 9e. If 0%, skip to #10)

0%

If more than 0%, please enter the percentage: _____

9e. What are the reasons that victim reimbursement claims may be denied or reduced? [Please check all that apply]

_____ Claim form or supporting documentation is incomplete

_____ Claim was filed after deadline

_____ Amount of compensation requested exceeds payment cap

_____ Other sources of payment are available (such as the victim's insurance)

_____ Victim non-cooperation with law enforcement or prosecution

_____ Victim falls under felony exclusion rule

_____ Victim's contributory misconduct

_____ Crime was not substantiated

10. When using compensation funds, does the payment process for forensic exams vary based on whether the victim falls into one of these classes?

Minor victims: Yes _____ No _____ (if "yes" go to 10.a.)

Victims in later life: Yes _____ No _____ (if "yes" go to 10.a.)

Victims with disabilities: Yes _____ No _____ (if "yes" go to 10.a.)

10a. Please specify how the payment process varies for the classes you indicated:

11. Do forensic exam payment procedures or policies vary depending on the provider’s status (For example, if the provider has received specialized training in sexual assault forensic exams or not)?

_____ yes _____ no

11a. If you selected “yes,” please explain.

12. Does your program have the funding, staffing, and support resources needed to meet its responsibilities for forensic exam payments along with all other types of payments for your total caseload? Or are insufficient resources available to allow your program to meet all its responsibilities without straining resources? Please check only one option:

_____ Program resources are adequate to meet all our responsibilities without too much strain

_____ Program resources are not sufficient to meet all our responsibilities without significant strain

_____ Other; please explain: _____

13. For this question, we are interested in which funding sources pay for sexual assault forensic exams. We are also interested in learning how much they pay compared to other sources. In your state, please select “yes” if the listed source pays for forensic exams. Then please rank the funding sources for which you marked “yes,” so that the source that pays the most is labeled “1” and the source that pays the second most is labeled “2,” and so on.

	Does this source pay? <i>(If no or you’re not sure, please skip)</i>	Please rank below if you said “yes”
Victim compensation funds	<input type="checkbox"/> Yes	
STOP funds	<input type="checkbox"/> Yes	
State department of health/mental health	<input type="checkbox"/> Yes	
State law enforcement funds	<input type="checkbox"/> Yes	
State prosecution funds	<input type="checkbox"/> Yes	
Other state funds	<input type="checkbox"/> Yes	
Local law enforcement funds	<input type="checkbox"/> Yes	
Local prosecution funds	<input type="checkbox"/> Yes	
Other local funds	<input type="checkbox"/> Yes	
Victim’s insurance or public benefits	<input type="checkbox"/> Yes	
Other funds (please describe below and provide rank)		

	<input type="checkbox"/> Yes	
--	------------------------------	--

14. Do jurisdictional issues ever present a problem for payment of forensic exams with compensation funds in your state? Please check all that apply:

- Jurisdictional issues are not a factor in payment of forensic exams with compensation funds.
- OR**
- There can be problems with payment when a resident of another state is assaulted in my state.
- There can be problems with payment when a resident of my state is assaulted in another state.
- There can be problems with payment when a resident of one local jurisdiction within my state is assaulted in another local jurisdiction within my state.
- There can be problems with payment when the assault occurs on tribal lands.
- There can be problems with payment due to other types of jurisdictional issues.
Please specify: _____

15. What are the challenges or barriers in using compensation funds for sexual assault forensic exams?

16. Is there anything else you would like to tell us about policies or practices around sexual assault forensic exams?

17. Do you know of anyone else in your state, other than the STOP administrator, state coalition, and local sexual assault service agencies, who we can talk to for more information about forensic exam payment policies/procedures? If so, can you share their name, agency/organization, title, and contact information with us?

THANK YOU FOR YOUR INPUT! IT IS SO IMPORTANT TO THIS STUDY!

Sexual Assault Forensic Exam Payment Practices Study Survey of Compensation Administrators in States Where Compensation Does Not Pay for Sexual Assault Forensic Exams

About this survey:

The Urban Institute, in collaboration with George Mason University and the Pennsylvania Coalition Against Rape/National Sexual Violence Resource Center, is conducting a study funded by the **National Institute of Justice**, the research, development, and evaluation agency of the U.S. Department of Justice.

The purpose of this study is to:

- Understand how sexual assault forensic exams are paid for throughout the country;
- Identify best practices to ensure that victims are never required to pay for the forensic exam or to report the sexual assault to the police before receiving a free forensic exam;
- Examine obstacles to providing free forensic exams for all sexual assault victims, and identify ways to overcome them; and
- Provide information and analysis to states and localities across the nation to help develop policies and practices that best serve victims.

This study is **not** a compliance audit, and will **not** produce a “report card” rating of states or other jurisdictions. Responses to this survey will be grouped with those from other state compensation administrators around the country and presented as aggregate findings only. We are also surveying compensation administrators in states where compensation is used to pay for forensic exams, as well as all state STOP Violence Against Women Formula Grant Program administrators (referred to as STOP for the remainder of this survey), state sexual assault coalitions, and local sexual assault service agencies, to capture a national picture of sexual assault forensic exam payment practices. Please note:

Survey responses will never be identified by individual, agency, or state outside the research team. No one else will be able to connect what you tell us to you, your agency, or your state.

We sincerely appreciate your time and help with this survey – your responses will not only greatly inform this project, but will provide valuable information for the future development of policies and programs. We understand that you may have provided similar information to other agencies in the past. This research project is not related to any of those earlier efforts and the information we collect will be used in reports to assist you and others who are attempting to provide the best services possible to victims of sexual assault. We appreciate your contributions!

The survey should take you about 10-15 minutes to complete. You can complete the survey in more than one session if you cannot complete the whole survey at one time. Your answers will be saved. Filling out this survey is voluntary. You can choose to skip any questions that you are not comfortable answering.

Please complete the survey by **Friday, July 22nd**.

Thank you very much for your participation in this survey. If you have questions or would like to discuss the survey further, please contact Megan Denver at the Urban Institute by phone (202-261-5552) or by email at mdenver@urban.org.

1. How long have you been the victim compensation administrator in your state/territory:

Year(s) _____ Month(s) _____

2. Our understanding is that in your state, agencies or entities other than the crime victim compensation program are the payment source for forensic exams, and your program is not involved in paying for these exams. We obtained data from the Office for Victims of Crime's website on the amounts that state compensation programs reported spending on sexual assault forensic exams in 2010. According to this source, your program spent \$0 on forensic exams in 2010, which confirms that your program is not involved in paying for these exams. Just to verify that there are no mistakes, is this the correct amount? *[please mark only one]*

- a. Yes, \$0 is correct -- *(please skip 2a-2g and continue to question #3)*
- b. No, \$0 is not correct –

2a) Please provide the correct amount: \$ _____

2b) If you provided an amount above, please indicate whether it is an exact amount or an estimate.

- It is the exact amount
- It is an estimate

2c) Please indicate how many exams were paid (in whole or in part) with these funds.

Can you tell us something about these expenditures, to help us understand your program's payment practices? *[Please check all that apply and add brief explanation for "yes" answers]*

2d) Were these cases with special circumstances that warranted payment?

- No
- Yes: _____

2e) Were the payments for particular types of expenses?

- No
- Yes: _____

2f) Were the payments for particular types of victims?

- No
- Yes: _____

2g) Other reasons your program paid these forensic exam-related expenses?

- No
- Yes: _____

3. What do you do when a forensic exam-related expense is included on a compensation claim?

[please mark all that apply]

- a. This never happens
- b. We pay all the forensic exam-related cost(s)
- c. We pay some or a portion of the forensic exam-related cost(s)
- d. We deny the forensic exam-related cost(s)
- e. We do something else (*Please answer 3a*)
- f. We direct that expense to another payment source -- what source(s)?

3a. Can you briefly describe what else you do:

4. Are you aware of whether there have been any discussions among policymakers in your state about having compensation pay for forensic exams?

[Please mark only one]

- There have been no such discussions to my knowledge *[please skip to question #5]*
- These discussions are ongoing *[please skip to question #5]*
- Compensation has been designated as a payment source but payment procedures are not yet fully in place, or no payments have yet been made *[please skip to question #5]*
- There have been such discussions and the decision was made not to use compensation to pay for forensic exams *[please continue to question #4a]*
- I'm not sure if there have been such discussions or not *[please skip to question #5]*

4a. Do you know why it was decided not to have compensation pay for forensic exams?

[Please mark all that apply]

- Other resources were available to pay for forensic exams
- State laws were in place designating other payment sources, and these laws were left in place
- Not feasible because of limits on compensation funds available

- Not feasible because of compensation program laws or regulations
- There were other obstacles (*please answer 4b*)
- I'm not sure
- There were objections to using funds intended for victim services for purposes of evidence collection, including: _____

4b. What were the other obstacles? _____

5. For this question, we are interested in which funding sources pay for sexual assault forensic exams. We are also interested in learning how much they pay compared to other sources. In your state, please select “yes” if the listed source pays for forensic exams. Then please rank the funding sources for which you marked “yes,” so that the source that pays the most is labeled “1” and the source that pays the second most is labeled “2,” and so on.

	Does this source pay? <i>(If no or you're not sure, please skip)</i>	Please rank below if you said “yes”
Victim compensation funds	<input type="checkbox"/> Yes	
STOP funds	<input type="checkbox"/> Yes	
State department of health/mental health	<input type="checkbox"/> Yes	
State law enforcement funds	<input type="checkbox"/> Yes	
State prosecution funds	<input type="checkbox"/> Yes	
Other state funds	<input type="checkbox"/> Yes	
Local law enforcement funds	<input type="checkbox"/> Yes	
Local prosecution funds	<input type="checkbox"/> Yes	
Other local funds	<input type="checkbox"/> Yes	
Victim’s insurance or public benefits	<input type="checkbox"/> Yes	
Other funds (please describe below and provide rank): _____	<input type="checkbox"/> Yes	

6. Does your program have the funding, staffing, and support resources needed to meet its responsibilities for paying victim compensation claims? Or are insufficient resources available to allow your program to meet all its responsibilities without straining resources? *Please check only one option:*

- Program resources are adequate to meet all our responsibilities without too much strain
- Program resources are not sufficient to meet all our responsibilities without significant strain
- Other (please explain): _____

7. Is there anything else you would like to tell us about policies or practices around sexual assault forensic exams?

8. Do you know of anyone else in your state, other than the STOP administrator, state coalition, and local sexual assault service agencies, who we can talk to for more information about forensic exam payment policies/procedures? If so, can you share their name, agency/organization, title, and contact information with us?

THANK YOU FOR YOUR INPUT! IT IS SO IMPORTANT TO THIS STUDY!

Sexual Assault Forensic Exam Payment Practices Study Survey of State Sexual Assault Coalitions

About this survey:

The Urban Institute, in collaboration with George Mason University and the Pennsylvania Coalition Against Rape/National Sexual Violence Resource Center, is conducting a study funded by the **National Institute of Justice**, the research, development, and evaluation agency of the U.S. Department of Justice.

The purpose of this study is to:

- Understand how sexual assault forensic exams are paid for throughout the country;
- Identify best practices to ensure that victims are never required to pay for the forensic exam or to report the sexual assault to the police before receiving a free forensic exam;
- Examine obstacles to providing free forensic exams for all sexual assault victims and identify ways to overcome them; and
- Provide information and analysis to states and localities across the nation to help develop policies and practices that best serve victims.

This study is **not** a compliance audit, and will **not** produce a “report card” rating of states or other jurisdictions. Responses to this survey will be grouped with those from all other state coalition leaders around the country and presented as aggregate findings only. We are also surveying state STOP Violence Against Women Formula Grant Program administrators (referred to as STOP for the remainder of the survey), state victim compensation administrators, and local sexual assault service agencies to capture a national picture of sexual assault forensic exam payment practices. Please note:

Survey responses will never be identified by individual, agency, or state outside the research team. No one else will be able to connect what you tell us to you, your agency, or your state.

We sincerely appreciate your time and help with this survey – your responses will not only greatly inform this project, but will provide valuable information for the future development of policies and programs. We understand that you may have provided similar information to other agencies in the past. This research project is not related to any of those earlier efforts and the information we collect will be used in reports to assist you and others who are attempting to provide the best services possible to victims of sexual assault. We appreciate your contributions!

The survey should take you about 20-30 minutes to complete. You can complete the survey in more than one session if you cannot complete the whole survey at one time. Your answers will be saved. Filling out this survey is voluntary. You can choose to skip any questions that you are not comfortable answering.

Please complete the survey by **Friday, July 22nd**.

Thank you very much for your participation in this survey. If you have questions or would like to discuss the survey further, please contact Megan Denver at the Urban Institute by phone (202-261-5552) or by email at mdenver@urban.org.

Remember: Your responses to questions will never be identified by state name, by agency name, or by your name.

If multiple people contribute to completing this survey, the person who did the most work on the survey should answer the first two questions below about herself/himself.

7. How long have you been working with the state coalition against sexual assault?

Years ___ Months ___

8. What is your primary position or title?

- Executive Director
- Legal/Policy Director
- Grants/Contracts Director
- Training and Technical Assistance Director
- Technical Assistance Coordinator
- Medical Advocacy Coordinator
- Outreach Coordinator
- Communications Director
- Other (please describe): _____

9. How many local sexual assault service agencies are in your state? _____

10. How many local sexual assault service agencies in your state are members of the coalition? _____

11. What are the **laws** in your state pertaining to access to sexual assault forensic exams and payment practices (this question is referring to **legislation** and not **administrative policies**)? Please check all the laws that your state has:

- My state has a law requiring that victims of sexual assault be provided forensic exams free-of-charge.
- My state has a law that requires forensic exams be provided to victims of sexual assault whether or not the victim makes a report to law enforcement.
- My state has a law that requires victims of sexual assault to report the crime to law enforcement before they are provided a forensic exam.

- My state has a law that requires victims of sexual assault to report the crime to law enforcement before they are provided a forensic exam **free-of-charge**.
 - My state has a law that requires law enforcement to **authorize** forensic medical exams before they are provided.
 - My state has a law that mandates medical providers to make reports of sexual assaults to law enforcement.
 - My state has a law allowing victims to use a pseudonym in medical and legal documents related to a sexual assault incident (Jane Doe Reports).
 - My state has a law allowing victims to report sexual assaults to law enforcement anonymously – that is, never identifying themselves or their assailants (anonymous or blind reporting).
 - My state has a law allowing victims to request their names and identifying information be kept out of public documents related to a sexual assault.
 - My state has a law that requires hospitals and other medical facilities to store sexual assault evidence and follow Chain of Custody procedures.
 - My state does not have a law regulating sexual assault forensic exam practices or procedures.
 - I do not know what my state law requires.
 - I do not know if my state has a law on sexual assault forensic exam policies or practices.
 - Other? Please specify: _____
-

12. Regardless of whether your state has laws relating to particular sexual assault forensic exam issues, we are interested in whether your state has forensic exam-related policies in place. Therefore, what are the state's **policies** pertaining to access to sexual assault forensic exams and payment practices?

Please check all the policies that your state has:

- My state has a policy requiring that victims of sexual assault be provided forensic exams free-of-charge.
- My state has a policy that requires forensic exams be provided to victims of sexual assault whether or not the victim makes a report to law enforcement.
- My state has a policy that requires victims of sexual assault to report the crime to law enforcement before they are provided a forensic exam.
- My state has a policy that requires victims of sexual assault to report the crime to law enforcement before they are provided a forensic exam **free-of-charge**.
- My state has a policy that requires law enforcement to **authorize** forensic medical exams before they are provided.
- My state has a policy allowing victims to use a pseudonym in medical and legal documents related to a sexual assault incident (Jane Doe Reports).
- My state has a policy allowing victims to report sexual assaults to law enforcement anonymously – that is, never identifying themselves or their assailants (anonymous or blind reporting).
- My state has a policy allowing victims to request their names and identifying information be kept out of public documents related to a sexual assault.

- My state has a policy that requires hospitals and other medical facilities to store sexual assault evidence and follow Chain of Custody procedures.
 - My state does not have a policy regulating sexual assault forensic exam practices or procedures.
 - I do not know what my state policy requires.
 - I do not know if my state has a policy on sexual assault forensic exam practices.
 - Other? Please specify: _____
-

13. Does your state require forensic exam kits to be stored? Please check only one answer.

- Yes (GO TO #7a)
- No (GO TO 8)
- I'm not sure (GO TO 8)

7a. If yes, how long must it be stored if the case has been reported to law enforcement?

_____ years _____ months Indefinite time period I don't know

7b. If yes, how long must it be stored if the case has not been reported to law enforcement?

_____ years _____ months Indefinite time period I don't know

7c. Where are the forensic exam kits stored in your state? Check all the places kits are stored in your state:

- Law enforcement agency's evidence storage facilities
- District Attorney's evidence collection rooms
- State-run laboratories where kits are tested
- Private laboratories where kits are tested
- Medical facilities where the kits are collected
- Other: Please specify: _____

7d. In your state, is there variation in where forensic exam kits are stored?

- I do not know
- No, it does not vary
- Yes, but I am not sure why there is variation in my state
- Yes – it varies depending on whether or not the sexual assault was reported to the police
- Yes – it varies in another way (Please specify): _____

14. Who provides forensic exams in your state? Please check all types of providers.

- Specially trained forensic examiners, such as Sexual Assault Nurse Examiners (SANEs), Forensic Nurse Examiners (FNEs), Forensic Medical Examiners (FMEs), or other healthcare personnel trained in sexual assault forensic exams
- Healthcare personnel who have not received special training in sexual assault forensic exams
- Other (Please Describe): _____

15. In your best estimation, who in your state provides the **most** forensic exams?

- Specially trained forensic examiners, such as Sexual Assault Nurse Examiners (SANEs), Forensic Nurse Examiners (FNEs), Forensic Medical Examiners (FMEs), or other healthcare personnel trained in sexual assault forensic exams
- Healthcare personnel who have not received special training in sexual assault forensic exams
- Other (Please Describe): _____

16. For this question, we are interested in which funding sources pay for sexual assault forensic exams. We are also interested in learning how much they pay compared to other sources. In your state, please select “yes” if the listed source pays for forensic exams. Then please rank the funding sources for which you marked “yes,” so that the source that pays the most is labeled “1” and the source that pays the second most is labeled “2,” and so on.

	Does this source pay? <i>(If no or you're not sure, please skip)</i>	Please rank below if you said “yes”
Victim compensation funds	<input type="checkbox"/> Yes	
STOP funds	<input type="checkbox"/> Yes	
State department of health/mental health	<input type="checkbox"/> Yes	
State law enforcement funds	<input type="checkbox"/> Yes	
State prosecution funds	<input type="checkbox"/> Yes	
Other state funds	<input type="checkbox"/> Yes	
Local law enforcement funds	<input type="checkbox"/> Yes	
Local prosecution funds	<input type="checkbox"/> Yes	
Other local funds	<input type="checkbox"/> Yes	
Victim’s insurance or public benefits	<input type="checkbox"/> Yes	
Other funds (please describe below and provide rank)	<input type="checkbox"/> Yes	

17. Is there a state time limit for collection of evidence after the crime?

- Yes (GO TO 11.a.)

- No (GO TO 12)

11.a. If yes, what is the time limit? _____ hours

18. Do jurisdictional issues ever present a problem with payment of forensic exams in your state? Please check all that apply:

- Jurisdictional issues are not a factor in payment of forensic exams in my state.

OR

- There can be problems with payment when a resident of another state is assaulted in my state.
- There can be problems with payment when a resident of my state is assaulted in another state.
- There can be problems with payment when a resident of one local jurisdiction within my state is assaulted in another local jurisdiction within my state.
- There can be problems with payment when the assault occurs on tribal lands.
- There can be a problem with payment due to other types of jurisdictional issues.

Please specify: _____

Some locations have standard practices, or a model for procedures, that they generally follow for sexual assault forensic exams, when victims initially do not want to report the assault to the police. Below we list several models of practices that exist in the field and we are interested in learning the extent to which these models are implemented in your state, if at all.

19. Which of the following sexual assault reporting models are implemented in your state for victims who initially do not want to report their sexual assault to the police? *Please check all the models being implemented in jurisdictions in your state.*

- No law enforcement involvement: medical facilities perform the exam and securely store the evidence. [If selected, please answer 13a]
- Law enforcement storage only: medical facilities perform the exam and transfer the evidence to a local, county, or state law enforcement agency. [If selected, please answer 13b]
- Anonymous/Blind reporting: information is provided to law enforcement without identifying information about the victim or perpetrator. The victim may or may not have a forensic medical exam, but law enforcement stores any evidence that is provided. [If selected, please answer 13c]
- Other (*Please Explain*): _____
[If selected, please answer 13d]

Based on your best estimation, what percentage of local jurisdictions in your state implement the following models?

13a) No law enforcement involvement: medical facilities perform the exam and securely store the evidence.

- 0 to 25 percent
- 26 to 50 percent
- 51 to 75 percent
- 76 to 100 percent
- I am not sure

13b) Law enforcement storage only: medical facilities perform the exam and transfer the evidence to a local, county, or state law enforcement agency.

- 0 to 25 percent
- 26 to 50 percent
- 51 to 75 percent
- 76 to 100 percent
- I am not sure

13c) Anonymous/Blind reporting: information is provided to law enforcement without identifying information about the victim or perpetrator. The victim may or may not have a forensic medical exam, but law enforcement stores any evidence that is provided.

- 0 to 25 percent
- 26 to 50 percent
- 51 to 75 percent
- 76 to 100 percent
- I am not sure

13d) Other (that you described previously in question 13)

- 0 to 25 percent
- 26 to 50 percent
- 51 to 75 percent
- 76 to 100 percent
- I am not sure

20. In your opinion, which of the following models works best for victims in terms of providing them with forensic medical exams without having to report to law enforcement?

- No law enforcement involvement: medical facilities perform the exam and securely store the evidence.
- Law enforcement storage only: medical facilities perform the exam and transfer the evidence to a local, county, or state law enforcement agency.
- Anonymous/Blind reporting: information provided to law enforcement without identifying information about the victim or perpetrator. The victim may or may not have a forensic medical exam, but law enforcement stores any evidence that is provided.

- All work equally well
- I'm not sure
- Other: _____

21. In your opinion, which of the following models presents the biggest challenges when it comes to providing victims forensic medical exams without having to report to law enforcement?

- No law enforcement involvement: medical facilities perform the exam and securely store the evidence.
- Law enforcement storage only: medical facilities perform the exam and transfer the evidence to a local, county, or state law enforcement agency.
- Anonymous/Blind reporting: information provided to law enforcement without identifying information about the victim or perpetrator. The victim may or may not have a forensic medical exam, but law enforcement stores any evidence that is provided.
- All provide equal challenges
- I'm not sure
- Other: _____

22. In your opinion, which of the following models works best for victims in terms of providing them with forensic medical exams free-of-charge?

- No law enforcement involvement: medical facilities perform the exam and securely store the evidence.
- Law enforcement storage only: medical facilities perform the exam and transfer the evidence to a local, county, or state law enforcement agency.
- Anonymous/Blind reporting: information provided to law enforcement without identifying information about the victim or perpetrator. The victim may or may not have a forensic medical exam, but law enforcement stores any evidence that is provided.
- All work equally well
- I'm not sure
- Other: _____

23. In your opinion, which of the following models presents the biggest challenges when it comes to providing victims forensic medical exams free-of-charge?

- No law enforcement involvement: medical facilities perform the exam and securely store the evidence.
- Law enforcement storage only: medical facilities perform the exam and transfer the evidence to a local, county, or state law enforcement agency.
- Anonymous/Blind reporting: information provided to law enforcement without identifying information about the victim or perpetrator. The victim may or may not have a forensic medical exam, but law enforcement stores any evidence that is provided.

- All provide equal challenges
- I'm not sure
- Other: _____

Questions 18 to 20 apply to victims who come forward for help. Please do not include victims who choose not to disclose to helping agencies.

24. Based on your best estimation, what percentage of victims in your state get forensic medical exams free-of-charge without having to pay anything out-of-pocket at any point in the process?

- 0 to 25 percent
- 26 to 50 percent
- 51 to 75 percent
- 76 to 100 percent
- I'm not sure

25. Based on your best estimation, what percentage of victims in your state get forensic medical exams free-of-charge through reimbursement for out-of-pocket expenses the victims paid?

- 0 to 25 percent
- 26 to 50 percent
- 51 to 75 percent
- 76 to 100 percent
- I'm not sure

26. Based on your best estimation, what percentage of victims in your state get free forensic medical exams (either the victim never pays or gets fully reimbursed) without requiring them to report to law enforcement or participate in the criminal justice process?

- 0 to 25 percent
- 26 to 50 percent
- 51 to 75 percent
- 76 to 100 percent
- I'm not sure

27. Compared to English speaking victims, how much easier or more difficult is it for non-English speaking victims to obtain sexual assault forensic exams in your state?

- Much easier
- Somewhat easier
- About the same [Go to Question 22]
- Somewhat harder
- Much harder
- I am not sure [Go to Question 22]

21a. In what ways is it easier or harder for non-English speaking victims to obtain sexual assault forensic exams in your state?

28. Does your agency provide training to local communities to meet VAWA 2005 regulations?

Click here for a description of VAWA 2005 regulations.

MAKE A LINK TO THIS ON THE SCREEN INSTEAD OF HAVING PARAGRAPH ON QUESTION PAGE: According to the Office on Violence Against Women, VAWA 2005 regulations are “The Violence Against Women and Department of Justice Reauthorization Act of 2005 ("VAWA 2005"), 42 U.S.C. § 3796gg-4(d), provides that states may not "require a victim of sexual assault to participate in the criminal justice system or cooperate with law enforcement in order to be provided with a forensic medical exam, reimbursed for charges incurred on account of such an exam, or both[]" (the "VAWA 2005 forensic examination requirement"). Under this provision a state must ensure that victims have access to an exam free of charge or with full reimbursement, even if the victim chooses not to report the crime to the police or otherwise cooperate with the criminal justice system or law enforcement authorities. Prior to VAWA 2005, states were required to ensure access to such exams free of charge or with full reimbursement but could condition the exams on cooperation with law enforcement.” (<http://www.ovw.usdoj.gov/ovw-fs.htm#q12>)

- Yes
- No
- I don't know

29. What challenges does your state face in implementing the VAWA 2005 regulations?

Please check all that apply.

- My state has laws that conflict with one another.
- My state's laws are not clear about which agencies should pay for exams.
- My state lacks a statewide payment mechanism for forensic medical exams.
- Paying agencies lack the funds to provide free exams to all victims who choose to have them, including both reporting and non-reporting victims.
- Payment levels are too low for the services provided, causing difficulties for medical service providers.

- Law enforcement agencies in my state resist changes in processes for providing forensic medical exams, such as not requiring law enforcement or prosecution authorization for free exams.
- Prosecution agencies in my state resist changes in processes for providing forensic medical exams, such as not requiring law enforcement or prosecution authorization for free exams.
- Law enforcement agencies in my state generally do not work well with sexual assault victims.
- Law enforcement agencies in my state generally do not work well with sexual assault service agencies.
- Prosecution agencies in my state generally do not work well with sexual assault victims.
- Prosecution agencies in my state generally do not work well with sexual assault service agencies.
- Medical personnel in my state who provide sexual assault forensic exams generally do not work well with sexual assault victims.
- Medical personnel in my state who provide sexual assault forensic exams generally do not work well with sexual assault service agencies.
- State agencies have difficulties providing training to localities about how to improve local practices.
- Local community stakeholders are not willing to participate in training to improve local practices.
- I'm not sure
- Some other challenge. Please specify:

30. What works particularly well in your state in terms of implementing the VAWA 2005 regulations?

Please check all that apply.

- My state has laws that help us implement policies that truly help sexual assault victims.
- My state's laws are clear about which agencies should pay for exams.
- My state has a statewide payment mechanism for forensic medical exams.
- Paying agencies have the funds to provide free exams to all victims who choose to have them, including both reporting and non-reporting victims.
- Payment levels are adequate for the services provided.
- Law enforcement agencies in my state generally work well with sexual assault victims.
- Law enforcement agencies in my state generally work well with sexual assault service agencies.
- Prosecution agencies in my state generally work well with sexual assault victims.

- Prosecution agencies in my state generally work well with sexual assault service agencies.
- Medical personnel in my state who provide sexual assault forensic exams generally work well with sexual assault victims.
- Medical personnel in my state who provide sexual assault forensic exams generally work well with sexual assault service agencies.
- State agencies are able to provide training to localities about how to improve local practices.
- Local community stakeholders are willing to participate in training to improve local practices.
- I'm not sure.
- Some other way this is working well. Please specify:

31. Does your state have specific directives for local communities to adapt their circumstances to meet VAWA 2005 regulations?

- Yes
- No
- I'm not sure

32. What percent of your state's local jurisdictions have Sexual Assault Response Teams (SARTs) or a coordinated community response to sexual assault in place?

- 0 to 25 percent
- 26 to 50 percent
- 51 to 75 percent
- 76 to 100 percent
- I'm not sure

33. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that the percentage of victims of sexual assault who receive forensic medical exams in your state has:

- Greatly increased
- Somewhat increased
- Remained the same (Go to #28)
- Somewhat decreased
- Greatly decreased
- I'm not sure (Go to #28)

27a. Were the changes described in Question #27 due to the new VAWA 2005 regulations or due to something else that was happening in your state around sexual assault forensic exam payment practices?

- Changes were due to new VAWA 2005 regulations
 - Changes were due to something else that was happening in the state around sexual assault forensic exam payment practices. Please describe:
-

34. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that the percentage of victims of sexual assault who report their assaults to law enforcement in your state has:

- Greatly increased
- Somewhat increased
- Remained the same (Go to #29)
- Somewhat decreased
- Greatly decreased
- I'm not sure (Go to #29)

28a. Were the changes described in Question #28 due to the new VAWA 2005 regulations or due to something else that was happening in your state around sexual assault forensic exam payment practices?

- Changes were due to new VAWA 2005 regulations
 - Changes were due to something else that was happening in the state around sexual assault forensic exam payment practices. Please describe:
-

35. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that the percentage of victims of sexual assault who receive medical care after their assault in your state has:

- Greatly increased
- Somewhat increased
- Remained the same (Go to #30)
- Somewhat decreased
- Greatly decreased
- I'm not sure (Go to #30)

29a. Were the changes described in Question #29 due to the new VAWA 2005 regulations or due to something else that was happening in your state around sexual assault forensic exam payment practices?

- Changes were due to new VAWA 2005 regulations
 - Changes were due to something else that was happening in the state around sexual assault forensic exam payment practices. Please describe:
-

36. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that for victims who receive forensic medical exams, the ability of your state to provide these exams free-of-charge has:

- Greatly improved
- Somewhat improved
- Remained the same (Go to #31)
- Gotten somewhat worse
- Gotten much worse
- I'm not sure (Go to #31)

30a. Were the changes described in Question #30 due to the new VAWA 2005 regulations or due to something else that was happening in your state around sexual assault forensic exam payment practices?

- Changes were due to new VAWA 2005 regulations
- Changes were due to something else that was happening in the state around sexual assault forensic exam payment practices. Please describe:

37. Is there anything else you would like to tell us about policies or procedures around sexual assault forensic exams?

THANK YOU FOR YOUR INPUT! IT IS SO IMPORTANT TO THIS STUDY!

Sexual Assault Forensic Exam Payment Practices Study Survey of Local Sexual Assault Service Agencies

About this survey:

The Urban Institute, in collaboration with George Mason University and the Pennsylvania Coalition Against Rape/National Sexual Violence Resource Center, is conducting a study funded by the **National Institute of Justice**, the research, development, and evaluation agency of the U.S. Department of Justice.

The purpose of this study is to:

- Understand how sexual assault forensic exams are paid for throughout the country;
- Identify best practices to ensure that victims are never required to pay for the forensic exam or to report the sexual assault to the police before receiving a free forensic exam;
- Examine obstacles to providing free forensic exams for all sexual assault victims, and identify ways to overcome them; and
- Provide information and analysis to states and localities across the nation to help develop policies and practices that best serve victims.

This study is **not** a compliance audit, and will **not** produce a “report card” rating of states or other jurisdictions. Responses to this survey will be grouped with those from all local service agencies around the country and presented as aggregate findings only. We are also surveying state-level sexual assault coalitions, state STOP Violence Against Women Formula Grant Program administrators (referred to as STOP for the remainder of the survey), and state victim compensation administrators to capture a national picture of sexual assault forensic exam payment practices. Please note:

Survey responses will never be identified by individual, agency, locality, or state outside the research team. No one else will be able to connect what you tell us to you, your agency, your locality, or your state.

We sincerely appreciate your time and help with this survey – your responses will not only greatly inform this project, but will provide valuable information for the future development of policies and programs. We understand that you may have provided similar information to other agencies in the past. This research project is not related to any of those earlier efforts and the information we collect will be used in reports to assist you and others who are attempting to provide the best services possible to victims of sexual assault. We appreciate your contributions!

The survey should take you about 20-30 minutes to complete. You can complete the survey in more than one session if you cannot complete the whole survey at one time. Your answers will be saved. Filling out this survey is voluntary. You can choose to skip any questions that you are not comfortable answering.

Please complete the survey by **Friday, July 22nd**.

Thank you very much for your participation in this survey. If you have questions or would like to discuss the survey further, please contact Megan Denver at the Urban Institute by phone (202-261-5552) or by email at mdenver@urban.org.

Remember: Your responses to questions will never be identified by state or locality name, by agency name, or by your name.

If multiple people contribute to completing this survey, the person who did the most work on the survey should answer the first two questions below about herself/himself.

38. How long have you been working at this sexual assault service agency?

Years____ Months ____

39. What is your primary position or title?

- Executive Director
- Direct Services Supervisor
- Counselor/Advocate
- Medical Advocate
- Legal Advocate
- Prevention Educator
- Volunteer Coordinator
- Other (please describe): _____

40. What type of agency is this: (please check only one)

- a. An independent service agency focused only on sexual assault
- b. An independent service agency focused on both sexual assault and domestic violence
- c. An independent service agency focused on sexual assault and other crimes (not domestic violence)
- d. An independent service agency focused on sexual assault, domestic violence and other crimes
- e. A service agency focused only on sexual assault which is located within a larger private non-profit (e.g., YWCA, community mental health center)
- f. A service agency focused on both sexual assault and domestic violence which is located within a larger private non-profit (e.g., YWCA, community mental health center)
- g. A service agency within a medical facility focused only on sexual assault
- h. A service agency within a medical facility focused on sexual assault, domestic violence, and other crimes
- i. Other: _____

41. What type of locality do you serve: (please check all that apply)

- a. Large city
- b. Medium or small city
- c. Suburban area outside a city
- d. Small town/combination of small towns
- e. A rural area
- f. College or university campus
- g. Tribal area
- h. Other

42. Using your best estimate, how many sexual assault clients did your agency serve in 2010?

If your agency serves several localities, please answer the remaining questions for the primary locality in which you provide services.

43. We are interested in whether your locality has forensic exam-related policies in place.

Therefore, what are the local area's **policies** pertaining to access to sexual assault forensic exams and payment practices? Please check all the policies that apply to your local area:

- My locality has a policy requiring that victims of sexual assault be provided forensic exams free-of-charge.
- My locality has a policy that requires forensic exams be provided to victims of sexual assault whether or not the victim makes a report to law enforcement.
- My locality has a policy that requires victims of sexual assault to report the crime to law enforcement before they are provided a forensic exam.
- My locality has a policy that requires victims of sexual assault to report the crime to law enforcement before they are provided a forensic exam **free-of-charge**.
- My locality has a policy that requires law enforcement to **authorize** forensic medical exams before they are provided.
- My locality has a policy allowing victims to use a pseudonym in medical and legal documents related to a sexual assault incident (Jane Doe Reports).
- My locality has a policy allowing victims to report sexual assaults to law enforcement anonymously – that is, never identifying themselves or their assailants (anonymous or blind reporting).
- My locality has a policy allowing victims to request their names and identifying information be kept out of public documents related to a sexual assault.
- My locality has a policy that requires hospitals and other medical facilities to store sexual assault evidence and follow Chain of Custody procedures.
- My locality does not have a policy regulating sexual assault forensic exam practices or procedures.
- I do not know what my local policy requires.
- I do not know if we have a local policy.
- Other? Please specify: _____

44. Does your locality require forensic exam kits to be stored?

- Yes (GO TO #7a)
- No (GO TO #8)
- I'm not sure (GO TO #8)

7.a. If yes, how long must it be stored if the case has been reported to law enforcement?

_____ years _____ months Indefinite time period I don't know

7.b. If yes, how long must it be stored if the case has not been reported to law enforcement?

_____ years _____ months Indefinite time period I don't know

7c. Where are the forensic exam kits stored in your locality? Check all the places kits are stored in your locality:

- Law enforcement agency's evidence storage facilities
- District Attorney's evidence collection rooms
- State-run laboratories where kits are tested
- Private laboratories where kits are tested
- Medical facilities where the kits are collected
- Other: Please specify: _____

7d. In your locality, is there variation in where forensic exam kits are stored?

- I do not know
- No, it does not vary
- Yes, but I am not sure why there is variation in my locality
- Yes – it varies depending on whether or not the sexual assault was reported to the police
- Yes – it varies in another way (Please specify: _____)

45. For this question, we are interested in which funding sources pay for sexual assault forensic exams. We are also interested in learning how much they pay compared to other sources. In your locality, please select "yes" if the listed source pays for forensic exams. Then please rank the funding sources for which you marked "yes," so that the source that pays the most is labeled "1" and the source that pays the second most is labeled "2," and so on.

	Does this source pay? <i>(If no or you're not sure, please skip).</i>	Please rank below if you said "yes"
Victim compensation funds	<input type="checkbox"/> Yes	
STOP funds	<input type="checkbox"/> Yes	
State department of health/mental health	<input type="checkbox"/> Yes	
State law enforcement funds	<input type="checkbox"/> Yes	
State prosecution funds	<input type="checkbox"/> Yes	
Other state funds	<input type="checkbox"/> Yes	
Local law enforcement funds	<input type="checkbox"/> Yes	
Local prosecution funds	<input type="checkbox"/> Yes	
Other local funds	<input type="checkbox"/> Yes	
Victim's insurance or public benefits	<input type="checkbox"/> Yes	
Other funds (please describe below and provide rank): _____	<input type="checkbox"/> Yes	

46. Is there a time limit for collection of evidence after the crime?

- Yes (GO TO 9.a.)
- No (GO TO 10)

9.a. If yes, what is the time limit? ____ hours

47. Does your locality:

- Provide sexual assault victims with forensic medical exams free-of-charge without requiring victims to pay anything at any point in the process.
- Provide sexual assault victims with forensic medical exams free-of-charge through reimbursement for out-of-pocket expenses the victims paid.
- Both
- Neither

48. Does your locality provide sexual assault victims with free forensic medical exams (either the victim never pays or gets fully reimbursed) without requiring them to report to law enforcement or participate in the criminal justice process?

- Yes, always
- Yes, sometimes
- No

49. Have you or others in your agency received training about VAWA 2005 regulations?

Click here for a description of VAWA 2005 regulations.

MAKE A LINK TO THIS ON THE SCREEN INSTEAD OF HAVING PARAGRAPH ON QUESTION PAGE: “The Violence Against Women and Department of Justice Reauthorization Act of 2005 ("VAWA 2005"), 42 U.S.C. § 3796gg-4(d), provides that states may not "require a victim of sexual assault to participate in the criminal justice system or cooperate with law enforcement in order to be provided with a forensic medical exam, reimbursed for charges incurred on account of such an exam, or both[]" (the "VAWA 2005 forensic examination requirement"). Under this provision a state must ensure that victims have access to an exam free of charge or with full reimbursement, even if the victim chooses not to report the crime to the police or otherwise cooperate with the criminal justice system or law enforcement authorities. Prior to VAWA 2005, states were required to ensure access to such exams free of charge or with full reimbursement but could condition the exams on cooperation with law enforcement.” (<http://www.ovw.usdoj.gov/ovw-fs.htm#q12>)

- Yes
- No

12a. If yes, who did you receive training from?

Please check all that apply.

- My state coalition
- My STOP administrator’s office
- Other (please specify): _____

50. What challenges does your locality face in implementing the VAWA 2005 regulations?
Please check all that apply.

- My state has laws that conflict with one another.
- My state’s laws are not clear about which agencies should pay for exams.
- My state lacks a statewide payment mechanism for forensic medical exams.
- Paying agencies lack the funds to provide free exams to all victims who choose to have them, including both reporting and non-reporting victims.
- Payment levels are too low for the services provided, causing difficulties for medical service providers.
- Law enforcement agencies in my locality resist changes in processes for providing forensic medical exams, such as not requiring law enforcement or prosecution authorization for free exams.
- Prosecution agencies in my locality resist changes in processes for providing forensic medical exams, such as not requiring law enforcement or prosecution authorization for free exams.
- Law enforcement agencies in my locality generally do not work well with sexual assault victims.

- Law enforcement agencies in my locality generally do not work well with sexual assault service agencies.
- Prosecution agencies in my locality generally do not work well with sexual assault victims.
- Prosecution agencies in my locality generally do not work well with sexual assault service agencies.
- Medical personnel in my locality who provide sexual assault forensic exams generally do not work well with sexual assault victims.
- Medical personnel in my locality who provide sexual assault forensic exams generally do not work well with sexual assault service agencies.
- State agencies have difficulties providing training to localities about how to improve local practices.
- Local community stakeholders are not willing to participate in training to improve local practices.
- I'm not sure
- Some other challenge. Please specify:

51. What do you think is going particularly well in your locality when it comes to implementing VAWA 2005 regulations?
Please check all that apply.

- My state has laws that help us implement policies that truly help sexual assault victims.
- My state's laws are clear about which agencies should pay for exams.
- My state has a statewide payment mechanism for forensic medical exams.
- Paying agencies have the funds to provide free exams to all victims who choose to have them, including both reporting and non-reporting victims.
- Payment levels are adequate for the services provided.
- Law enforcement agencies in my locality generally work well with sexual assault victims.
- Law enforcement agencies in my locality generally work well with sexual assault service agencies.
- Prosecution agencies in my locality generally work well with sexual assault victims.
- Prosecution agencies in my locality generally work well with sexual assault service agencies.
- Medical personnel in my locality who provide sexual assault forensic exams generally work well with sexual assault victims.
- Medical personnel in my locality who provide sexual assault forensic exams generally work well with sexual assault service agencies.
- State agencies are able to provide training to localities about how to improve local practices.

- Local community stakeholders are willing to participate in training to improve local practices.
- I'm not sure
- Some other way this is working well. Please specify:

52. Does your locality have Sexual Assault Response Teams (SARTs) or a coordinated community response to sexual assault in place?

- Yes
- No
- I'm not sure

53. Who provides forensic exams in your locality? Please check all types of providers.

- Specially trained forensic examiners, such as Sexual Assault Nurse Examiners (SANEs), Forensic Nurse Examiners (FNEs), Forensic Medical Examiners (FMEs), or other healthcare personnel trained in sexual assault forensic exams
- Healthcare personnel who have not received special training in sexual assault forensic exams
- Other (please describe): _____

54. In your best estimation, who in your locality provides the **most** forensic exams? (check only one)

- Specially trained forensic examiners, such as Sexual Assault Nurse Examiners (SANEs), Forensic Nurse Examiners (FNEs), Forensic Medical Examiners (FMEs), or other healthcare personnel trained in sexual assault forensic exams
- Healthcare personnel who have not received special training in sexual assault forensic exams
- Other (please describe): _____

Questions 18 to 20 apply to victims who come forward for help. Please do not include victims who choose not to disclose to helping agencies.

55. Based on your best estimation, what percentage of victims in your locality get forensic medical exams free-of-charge without having to pay anything out-of-pocket at any point in the process?

- 0 to 25 percent
- 26 to 50 percent
- 51 to 75 percent

- 76 to 100 percent
- I'm not sure

56. Based on your best estimation, what percentage of victims in your locality get forensic medical exams free-of-charge through reimbursement for out-of-pocket expenses the victims paid?

- 0 to 25 percent
- 26 to 50 percent
- 51 to 75 percent
- 76 to 100 percent
- I'm not sure

57. Based on your best estimation, what percentage of victims in your locality get free forensic medical exams (either the victim never pays or gets fully reimbursed) without requiring them to report to law enforcement or participate in the criminal justice process?

- 0 to 25 percent
- 26 to 50 percent
- 51 to 75 percent
- 76 to 100 percent
- I'm not sure

58. Compared to English speaking victims, how much easier or more difficult is it for non-English speaking victims to obtain sexual assault forensic exams in your locality?

- Much easier
- Somewhat easier
- About the same (Go to Question 22)
- Somewhat harder
- Much harder
- I am not sure (Go to Question 22)

21a. In what ways is it easier or harder for non-English speaking victims to obtain sexual assault forensic exams in your locality?

59. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that the percentage of victims of sexual assault who receive forensic medical exams in your locality has:

- Greatly increased
- Somewhat increased
- Remained the same (Go to #23)
- Somewhat decreased

- Greatly decreased
- I'm not sure (Go to #23)

22a. Were the changes described in Question #22 due to the new VAWA 2005 regulations or due to something else that was happening in your state around sexual assault forensic exam payment practices?

- Changes were due to new VAWA 2005 regulations
- Changes were due to something else that was happening in the state around sexual assault forensic exam payment practices. Please describe:

60. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that the percentage of victims of sexual assault who report their assaults to law enforcement agencies in your locality has:

- Greatly increased
- Somewhat increased
- Remained the same (Go to # 24)
- Somewhat decreased
- Greatly decreased
- I'm not sure (Go to #24)

23a. Were the changes described in Question #23 due to the new VAWA 2005 regulations or due to something else that was happening in your state around sexual assault forensic exam payment practices?

- Changes were due to new VAWA 2005 regulations
- Changes were due to something else that was happening in the state around sexual assault forensic exam payment practices. Please describe:

61. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that the percentage of victims of sexual assault who receive medical care after their assault in your locality has:

- Greatly increased
- Somewhat increased
- Remained the same (Go to #25)
- Somewhat decreased
- Greatly decreased
- I'm not sure (Go to #25)

24a. Were the changes described in Question #24 due to the new VAWA 2005 regulations or due to something else that was happening in your state around sexual assault forensic exam payment practices?

- Changes were due to new VAWA 2005 regulations
- Changes were due to something else that was happening in the state around sexual assault forensic exam payment practices. Please describe:

62. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that for victims who receive forensic medical exams, the ability of your locality to provide these exams free-of-charge has:

- Greatly improved
- Somewhat improved
- Remained the same (Go to #26)
- Gotten somewhat worse
- Gotten much worse
- I'm not sure (Go to #26)

25a. Were the changes described in Question #25 due to the new VAWA 2005 regulations or due to something else that was happening in your state around sexual assault forensic exam payment practices?

- Changes were due to new VAWA 2005 regulations
- Changes were due to something else that was happening in the state around sexual assault forensic exam payment practices. Please describe:

63. Is there anything else you would like to tell us about policies or practices around sexual assault forensic exams?

THANK YOU FOR YOUR INPUT! IT IS SO IMPORTANT TO THIS STUDY!

**APPENDIX B: STAKEHOLDER INTERVIEW PROTOCOLS AND
FOCUS GROUP PROTOCOL**

State STOP Administrator Interview

Introduction

Hello, my name is **(INSERT NAME AND INTRODUCE COLLEAGUE/S.)**. We are from the Justice Policy Center at the Urban Institute, a nonprofit, nonpartisan research organization that studies social and criminal justice policy issues. Urban Institute, along with George Mason University and the Pennsylvania Coalition Against Rape/National Sexual Violence Resource Center, is conducting a study funded by the **National Institute of Justice**, the research, development, and evaluation agency of the U.S. Department of Justice.

The purpose of this study is to:

- Understand how sexual assault forensic exams are paid for throughout the country;
- Identify best practices to ensure that victims are never required to pay for the forensic exam or to report the sexual assault to the police before receiving a free forensic exam;
- Examine obstacles related to providing free forensic exams for all sexual assault victims, and identify ways to overcome them; and
- Provide information and analysis to states and localities across the nation to help develop policies and practices that best serve victims.

So you know who we are, we'd like to take a minute and introduce ourselves. **(INSERT BACKGROUND INFORMATION ABOUT SITE VISIT TEAM MEMBERS.)**

We would like to thank you for taking the time to participate in this meeting. The interviews are intended to get your perspective on sexual assault forensic exam processes in **(INSERT LOCALITY)**. This study is not a compliance audit, and will not produce a "report card" rating of states or other jurisdictions. Your responses during this meeting will be combined with responses from others we visit here, in other jurisdictions in this state, and in other states, and presented as aggregate findings. No individuals, jurisdictions, or states will be identified in our research report. Your participation is voluntary and you can decline to answer any question throughout our discussion. We will be taking notes and after the final reports are written, we will destroy all notes from this meeting. This form provides more information about our study. You can just keep that copy. **(HAND OUT INFORMED CONSENT FORM)**

1. What's your job title? How long have you been in this position? How long have you worked in the victim service field?
2. *Confirm our information on payment practices in the state.* Do you have any revisions to our understanding of how forensic exams are paid in this state?
3. Has there been any discussion of using STOP funding to cover forensic exams in this state (don't ask in jurisdiction that uses STOP funding)? Why or why not?

4. Regarding the VAWA 2005 reauthorization and the STOP administrators new responsibility of reporting compliance around the new mandates....What are your thoughts about these policy changes?
5. What have been the challenges in implementing the new policy mandates?
6. What has gone particularly well in implementing the new policy mandates?
7. Does your office provide training, or funding for training, for jurisdictions to assure compliance on this issue?
8. What types of policies and practices are in place throughout your state to address how exams conducted for non-reporting victims get handled?
9. What types of jurisdictional issues occur in your state regarding access to and payment of forensic exams?
10. We understand that most of the exams in your state are conducted by*based on survey responses....*? How do these providers get trained? Who pays for the training?
11. How well do the exam providers work with victims? How could their treatment of victims, and their relationship with other agencies involved, be improved?
12. Are there requirements for healthcare providers to report sexual assaults to the police for certain types of victims (children, elders, disabled, or other) or for certain types of injuries sustained by victims?
13. How well do advocates work with victims? How could their treatment of victims, and their relationship with other agencies involved, be improved?
14. How well do the police work with victims? How could their treatment of victims, and their relationship with other agencies involved, be improved?
15. How well do prosecutors work with victims? How could their treatment of victims, and their relationship with other agencies involved, be improved?
16. Are there any obstacles for non-English speaking victims, immigrants, Native Americans, or other minority groups in accessing free forensic medical exams?
17. *Only ask in compensation states....*How do you feel about the use of crime victim compensation funds to pay for sexual assault forensic exams? Is this an appropriate use of these funds?

18. Do you think that allowing victims to get a free forensic medical exam without having to report to the police encourages more victims to get the exam, or doesn't make any difference? Do you think it encourages victims to make a report to the police later on, or doesn't make any difference? Have you seen any changes in the last several years in victims' willingness to get exams? In their willingness to report to the police (either at the time of the exam or later on)?
- 19.
20. What policies and practices around SAFEs do you think need to be improved (for example, who performs them, where they're done, when they're done, how they're paid for, how PERKs/Kits are processed, how the evidence is used, the victim's role in making decisions, and so on)?
21. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that the percentage of victims of sexual assault who receive forensic medical exams in your state has increased? Tell me more about that.
22. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that the percentage of victims of sexual assault who report their assaults to law enforcement in your state has increased? Tell me more about that.
23. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that the percentage of victims of sexual assault who receive medical care after their assault in your state has increased? Tell me more about that.
24. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that for victims who receive forensic medical exams, the ability of your state to provide these exams free-of-charge has increased? Tell me more about that?
25. What additional resources would be useful to you?
26. Is there anything else that you feel it's important for us to know, to understand survivors' experiences with the forensic medical exam and the criminal justice system?

Thank you very much for your time and for sharing your experiences with us. Your perspectives are really important to our research on how to make the system more responsive to survivors of sexual assault.

Victim Compensation Fund Administrator Interview

Introduction

Hello, my name is **(INSERT NAME AND INTRODUCE COLLEAGUE/S.)**. We are from the Justice Policy Center at the Urban Institute, a nonprofit, nonpartisan research organization that studies social and criminal justice policy issues. Urban Institute, along with George Mason University and the Pennsylvania Coalition Against Rape/National Sexual Violence Resource Center, is conducting a study funded by the **National Institute of Justice**, the research, development, and evaluation agency of the U.S. Department of Justice.

The purpose of this study is to:

- Understand how sexual assault forensic exams are paid for throughout the country;
- Identify best practices to ensure that victims are never required to pay for the forensic exam or to report the sexual assault to the police before receiving a free forensic exam;
- Examine obstacles related to providing free forensic exams for all sexual assault victims, and identify ways to overcome them; and
- Provide information and analysis to states and localities across the nation to help develop policies and practices that best serve victims.

So you know who we are, we'd like to take a minute and introduce ourselves. **(INSERT BACKGROUND INFORMATION ABOUT SITE VISIT TEAM MEMBERS.)**

We would like to thank you for taking the time to participate in this meeting. The interviews are intended to get your perspective on sexual assault forensic exam processes in **(INSERT LOCALITY)**. This study is not a compliance audit, and will not produce a "report card" rating of states or other jurisdictions. Your responses during this meeting will be combined with responses from others we visit here, in other jurisdictions in this state, and in other states, and presented as aggregate findings. No individuals, jurisdictions, or states will be identified in our research report. Your participation is voluntary and you can decline to answer any question throughout our discussion. We will be taking notes and after the final reports are written, we will destroy all notes from this meeting. This form provides more information about our study. You can just keep that copy. **(HAND OUT INFORMED CONSENT FORM)**

27. What's your job title? How long have you been in this position? How long have you worked in the victim service field?

28. *Confirm our information on payment practices in the state.* Do you have any revisions to our understanding of how forensic exams are paid in this state?
a. *Be sure that you understand:*

- i. *Whether there is a specific funding source from the state for sexual assault forensic exams (a line item or some specific funding stream) or whether general compensation funds are used.*
- ii. *Whether compensation pays in all cases or is a payer of last resort for non-reporting victims.*
- iii. *If victims pay out-of-pocket and get reimbursed by compensation funds or if victims are never billed and providers are paid directly.*
- iv. *If compensation pays for both forensic evidence collection and medical services and interventions during the exam.*
- v. *Issues related to deadlines for filing claims or deadlines for paying claims.*
- vi. *Issues related to claim denials or reductions.*
- vii. *Payment issues/procedures for particular groups (e.g., minors, etc.).*

29. Regarding the VAWA 2005 reauthorization and the STOP administrators new responsibility of reporting compliance around the new mandates....What are your thoughts about these policy changes?
30. What have been the challenges in implementing the new policy mandates?
31. What has gone particularly well in implementing the new policy mandates?
32. What types of policies and practices are in place throughout your state to address how exams conducted for non-reporting victims get handled?
33. What types of jurisdictional issues occur in your state regarding access to and payment of forensic exams?
34. Are there any obstacles for non-English speaking victims, immigrants, Native Americans, or other minority groups in accessing free forensic medical exams?
35. How do you feel about the use of crime victim compensation funds to pay for sexual assault forensic exams? Is this an appropriate use of these funds?
36. Has there been any discussion of using STOP funding to cover forensic exams in this state (don't ask in jurisdiction that uses STOP funding)? Why or why not?
37. Do you think that allowing victims to get a free forensic medical exam without having to report to the police encourages more victims to get the exam, or doesn't make any difference? Do you think it encourages victims to make a report to the police later on, or doesn't make any difference? Have you seen any changes in the last several years in victims' willingness to get exams, or the number of exams

- performed for victims who don't report to the police at the time of the exam? In their willingness to report to the police (either at the time of the exam or later on)?
38. What policies and practices around SAFEs do you think need to be improved (for example, who performs them, where they're done, when they're done, how they're paid for, how PERKS/Kits are processed, how the evidence is used, the victim's role in making decisions, and so on)?
 39. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that the percentage of victims of sexual assault who receive forensic medical exams in your state has increased? Tell me more about that.
 40. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that the percentage of victims of sexual assault who report their assaults to law enforcement in your state has increased? Tell me about that.
 41. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that the percentage of victims of sexual assault who receive medical care after their assault in your state has increased? Tell me about that.
 42. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that for victims who receive forensic medical exams, the ability of your state to provide these exams free-of-charge has increased? Tell me more about that?
 43. What additional resources would be useful to you?
 44. Is there anything else that you feel it's important for us to know, to understand survivors' experiences with the forensic medical exam and the criminal justice system?

Thank you very much for your time and for sharing your experiences with us. Your perspectives are really important to our research on how to make the system more responsive to survivors of sexual assault.

Crime Lab Tour Interview

Introduction and Informed Consent

Hello, my name is **(INSERT NAME AND INTRODUCE COLLEAGUE/S.)**. We are from the Justice Policy Center at the Urban Institute, a nonprofit, nonpartisan research organization that studies social and criminal justice policy issues. Urban Institute, along with George Mason University and the Pennsylvania Coalition Against Rape/National Sexual Violence Resource Center, is conducting a study funded by the **National Institute of Justice**, the research, development, and evaluation agency of the U.S. Department of Justice.

The purpose of this study is to:

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- Identify best practices to ensure that victims are never required to pay for the forensic exam or to report the sexual assault to the police before receiving a free forensic exam;
- Examine obstacles related to providing free forensic exams for all sexual assault victims, and identify ways to overcome them; and
- Provide information and analysis to states and localities across the nation to help develop policies and practices that best serve victims.

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Background Information

1. What's your job title? How long have you been in this position? How long have you worked in the field?
2. What unit within your agency do you work in (if any)? Does this unit specialize in sexual assault cases? Is there another unit in your agency that specializes in

sexual assault? What is the unit's (*say agency's if there is no specialized unit*) average annual sexual assault caseload?

The Lab

1. How are the lab and the lab personnel accredited or certified to analyze evidence for use in the justice system? What's the lab personnel's educational background? How many people work at the lab?
2. How is the lab funded? Do current funding levels provide adequate support for the lab to handle its caseload? If not, what additional support is needed? How much does it cost to analyze a sexual assault PERK?

Incoming Sexual Assault PERKs

1. What percentage of your total caseload is sexual assault PERKs? How many SA PERKs do you receive per year, on average? Has the number of SA PERKs increased in the last several years?
2. Where do your SA PERKs come from, in terms of agencies that send them to you (police, prosecutor, hospitals, etc.)? In terms of geographic service area (what counties/cities)?
3. Do you receive all SA PERKs that are conducted in your jurisdiction? If not, where are they stored before they're sent to the lab, and what triggers a PERK to be sent to the lab (for example, prosecutor's request)? What's the time period between when a PERK is done and when it's sent to the lab?
4. How are the PERKs identified – by the victim's name? A coded identifier? Are they identified in any way that denotes which involve active police investigations and which don't? Whether the victim is participating with law enforcement or not?
5. If they are identified in a way that indicates investigation or victim participation status, are they analyzed, stored, or handled differently depending on whether there's an active police investigation or not? Whether the victim is participating with law enforcement or not?
6. What are the chain of custody procedures for receiving and analyzing PERKs?

Analysis and Storage of SA PERKs

1. Do you analyze all PERKs you receive, or do you just store some until an event triggers the PERK to be analyzed (such as a request from the prosecutor's office)?

2. If you analyze them all, is it on a first-come-first-served basis or is it prioritized? If prioritized, what are the priority factors?
3. If you store some until a triggering event, what is that event that triggers the analysis (e.g., request from prosecutor)? How do you preserve the integrity of the evidence during the storage period? Is storage space tight?
4. How long is the storage period for unanalyzed PERKs? What do you do with them when the storage period expires?
5. What tests does the lab do on sexual assault PERKs? Do you perform all tests on every PERK, or do you perform only some tests? How is it determined which tests will be performed? What other evidence on sexual assault cases, besides PERKs, does the lab receive?
6. How long is it from the time you receive a PERK until its analyzed? Do you have a backlog, and how many sexual assault PERKs are in it? Are there different backlog issues in different parts of the state? What's needed to resolve the backlog (if any)?
7. How long does it take to analyze a PERK, once the lab has started working on it? Does this vary by full vs. partial testing of the components of the PERK?
8. Do you often see PERKs that are contaminated, possibly tampered with, or otherwise unfit for lab testing? How does this happen? What do you do about it?

Reporting Lab Results

1. What agencies do you report the lab results to? How long does it take from the time of analysis until the report is issued? What happens to the PERK after it's been analyzed?
2. What role does the lab analysis report play in investigations and prosecutions?
3. How does your staff interact with law enforcement and prosecution for investigations?
4. Do lab staff testify in court? How does that affect resources available for lab work?
5. Is the lab involved in uploading results to CODIS? If so, how does the process work?
6. Do the lab personnel ever have any contact with the sexual assault victim? How does that work?

Thank you very much for your time and for sharing your experiences with us. Your perspectives are really important to our research on how to make the system more responsive to survivors of sexual assault.

State Sexual Assault Coalition Interview

Introduction

Hello, my name is **(INSERT NAME AND INTRODUCE COLLEAGUE/S.)**. We are from the Justice Policy Center at the Urban Institute, a nonprofit, nonpartisan research organization that studies social and criminal justice policy issues. Urban Institute, along with George Mason University and the Pennsylvania Coalition Against Rape/National Sexual Violence Resource Center, is conducting a study funded by the **National Institute of Justice**, the research, development, and evaluation agency of the U.S. Department of Justice.

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- Examine obstacles related to providing free forensic exams for all sexual assault victims, and identify ways to overcome them; and
- Provide information and analysis to states and localities across the nation to help develop policies and practices that best serve victims.

So you know who we are, we'd like to take a minute and introduce ourselves. **(INSERT BACKGROUND INFORMATION ABOUT SITE VISIT TEAM MEMBERS.)**

We would like to thank you for taking the time to participate in this meeting. The interviews are intended to get your perspective on sexual assault forensic exam processes in **(INSERT LOCALITY)**. This study is not a compliance audit, and will not produce a "report card" rating of states or other jurisdictions. Your responses during this meeting will be combined with responses from others we visit here, in other jurisdictions in this state, and in other states, and presented as aggregate findings. No individuals, jurisdictions, or states will be identified in our research report. Your participation is voluntary and you can decline to answer any question throughout our discussion. We will be taking notes and after the final reports are written, we will destroy all notes from this meeting. This form provides more information about our study. You can just keep that copy. **(HAND OUT INFORMED CONSENT FORM)**.

45. What's your job title? How long have you been in this position? How long have you worked in the victim service field?
46. *Confirm our information on payment practices in the state.* Do you have any revisions to our understanding of how forensic exams are paid in this state?
47. What have been the challenges in implementing the new VAWA 2005 policy mandates?

48. What has gone particularly well in implementing the new policy mandates?
49. Does your office provide training, or funding for training, for jurisdictions to facilitate compliance on this issue?
50. What types of policies and practices are in place throughout your state to address how exams conducted for non-reporting victims get handled?
51. What types of jurisdictional issues occur in your state regarding access to and payment of forensic exams?
52. We understand that most of the exams in your state are conducted by*based on survey responses....*? How do these providers get trained? Who pays for the training?
53. How well do the exam providers work with victims? How could their treatment of victims, and their relationship with other agencies involved, be improved?
54. Are there requirements for healthcare providers to report sexual assaults to the police for certain types of victims (children, elders, disabled, or other) or for certain types of injuries sustained by victims?
55. How well do advocates work with victims? How could their treatment of victims, and their relationship with other agencies involved, be improved?
56. How well do the police work with victims? How could their treatment of victims, and their relationship with other agencies involved, be improved?
57. How well do prosecutors work with victims? How could their treatment of victims, and their relationship with other agencies involved, be improved?
58. Are there any obstacles for non-English speaking victims, immigrants, or other minority groups in accessing free forensic medical exams?
59. *Only ask in compensation states....*How do you feel about the use of crime victim compensation funds to pay for sexual assault forensic exams? Is this an appropriate use of these funds?
60. Do you think that allowing victims to get a free forensic medical exam without having to report to the police encourages more victims to get the exam, or doesn't make any difference? Do you think it encourages victims to make a report to the police later on, or doesn't make any difference? Have you seen any changes in the last several years in victims' willingness to get exams? In their willingness to report to the police (either at the time of the exam or later on)?

61. Do you see many cases of police investigating the assault even for victims who haven't filed a report? Is this more or less likely to happen when the victim has had a forensic medical exam, or does that not matter? How do victims react when the police investigate without the victim's report? What do you think of it when the police investigate without the victim's report?
62. Overall, do you think it's valuable to the criminal case if the victim has an exam performed (in terms of the investigation and prosecution)? Do you think it's valuable to the victim if he/she has an exam performed (in terms of her/his physical and psychological recovery)? How could the value of the exam to the criminal case, and to the victim, be improved?
63. Overall, do you think it's valuable to the victim if he/she reports the crime to the police (in terms of her/his physical and psychological recovery)? How could the value of the police experience be improved? What police practices or policies around sexual assault cases do you think need to be improved?
64. Do you see many cases in which the prosecutor prosecutes the case without the victim's participation (evidence-based prosecution)? Do you see many cases in which victims who don't want to be involved in the court case are subpoenaed? What's your opinion of evidence-based prosecution, from the standpoint of the criminal justice system? From the standpoint of the victim's best interests?
65. Overall, do you think it's valuable to the victim if the case is prosecuted (in terms of her/his physical and psychological recovery)? How could the value of the prosecution experience be improved? What prosecution practices or policies around sexual assault cases do you think need to be improved?
66. What policies and practices around SAFEs do you think need to be improved (for example, who performs them, where they're done, when they're done, how they're paid for, how PERKs/Kits are processed, how the evidence is used, the victim's role in making decisions, and so on)?
67. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that the percentage of victims of sexual assault who receive forensic medical exams in your state has increased? Tell me more about that.
68. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that the percentage of victims of sexual assault who report their assaults to law enforcement in your state has increased? Tell me more about that.
69. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that the percentage of victims of sexual

assault who receive medical care after their assault in your state has increased?
Tell me more about that.

70. Since January 2009, when VAWA 2005 regulations were required to be in place, would you say (in your best estimation) that for victims who receive forensic medical exams, the ability of your state to provide these exams free-of-charge has increased? Tell me more about that?

71. What additional resources would be useful to you?

72. Is there anything else that you feel it's important for us to know, to understand survivors' experiences with the forensic medical exam and the criminal justice system?

Thank you very much for your time and for sharing your experiences with us. Your perspectives are really important to our research on how to make the system more responsive to survivors of sexual assault.

Healthcare Provider Interview

Introduction and Informed Consent

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- Provide information and analysis to states and localities across the nation to help develop policies and practices that best serve victims.

So you know who we are, we'd like to take a minute and introduce ourselves. **(INSERT BACKGROUND INFORMATION ABOUT SITE VISIT TEAM MEMBERS.)** We would like to thank you for taking the time to participate in this meeting. The interviews are intended to get your perspective on sexual assault forensic exam processes in **(INSERT LOCALITY)**. This study is **not** a compliance audit, and will **not** produce a "report card" rating of states or other jurisdictions. Your responses during this meeting will be combined with responses from others we visit here, in other jurisdictions in this state, and in other states, and presented as aggregate findings. No individuals, jurisdictions, or states will be identified in our research report. Your participation is voluntary and you can decline to answer any question throughout our discussion. We will be taking notes and after the final reports are written, we will destroy all notes from this meeting. This form provides more information about our study. You can just keep that copy. **(HAND OUT INFORMED CONSENT FORM)**

Background Information

3. What's your job title? How long have you been in this position? How long have you worked in the healthcare field?
4. What unit within your agency do you work in (if any)? Does this unit specialize in sexual assault cases? Is there another unit in your agency that specializes in

sexual assault? What is the unit's (*say agency's if there is no specialized unit*) average annual sexual assault caseload?

5. Have you been specially trained to conduct forensic medical exams? *If so*, What type of training did you receive? Who provided the training? Did the training employ a victim-centered approach? Are you certified in any way? Do you periodically need to be re-trained or re-certified? Who paid for the training?
6. Can you describe the patients the (unit/agency) works with, in terms of sex, age, race/ethnicity? What are the most common types of assaults that your patients have experienced (for example, stranger vs. acquaintance vs. partner/family member; forcible vs. drug-facilitated vs. other means of coercion; felony rape vs. misdemeanor fondling/groping; and so on)?
7. How do you initially connect with patients (*what are the most common sources of referrals*)? How long after the sexual assault do you typically make first contact with your patients?
8. What forensic and medical services are provided as part of the sexual assault forensic medical exam? Do the exam procedures depend on the patient's description of the assault, or on other factors? What other services does the (unit/agency) provide to patients, besides forensic medical exams? Do you often have any follow-up contact with the sexual assault patient, after the exam?
9. Is there a Sexual Assault Response Team (SART) in your community? Who's involved in it, and how does it work? How well do advocacy, healthcare, law enforcement, and prosecution work together in your community? Where is there room for improvement? Would you describe your community's approach to sexual assault as victim-centered (placing the victim's best interests in the forefront)? How or how not?

Patients' Needs

1. What are patients' most common concerns, when you first make contact with them? What differences do you see among patients, based on age, sex, culture, circumstances of the assault, whether they know the assailant, and other factors that may be relevant?
2. What agencies do you refer patients to for needs that your services don't address?

The Sexual Assault Forensic Exam (SAFE)

1. What facilities and providers (such as sexual assault nurse examiners) perform exams in your jurisdiction? What specialized training in sexual assault forensic

- exams have the exam providers had? *If so*, What type of training did you receive? Are they certified in any way? Do they periodically need to be re-trained or re-certified? Who paid for the training?
2. What proportion of your patients have a SAFE done? What are your patients' concerns about the SAFE? What information do you provide them about the SAFE? What information do you provide to patients about what will happen to the PERK/Rape Kit after the exam, and what they should do (if anything)?
 3. What are the reasons that patients get the exam? What are the reasons they don't get the exam? Do you encourage victims to get the exam or not get the exam? Does anyone ever pressure the victim to get the exam, or not get the exam?
 4. How long after the assault can exams be performed? How long do patients typically wait between the time they get to the healthcare center and the time they're seen for the exam? How long do exams take? How is informed consent handled? Can patients refuse some exam procedures but consent to others? What are best practices for how exams should be performed? What problems are there, if any, with the way forensic medical exams are done? How could exam procedures be improved?
 5. What's the relationship between having an exam and reporting to the police in your jurisdiction? Does anyone ever pressure victims to report to the police, or not to report? In practice, do patients have to report to the police to get a free exam in your jurisdiction? Are the exams conducted differently depending on whether the victim has reported to the police?
 6. How are exams conducted for victims if they don't want to report at the moment, but may want to in the future?
 7. Does law enforcement or prosecution have to authorize the exam for it to be free of charge to patients? What happens if law enforcement or prosecution decides not to authorize the exam but the victim still wants one?
 8. Are there requirements for healthcare providers to report sexual assaults to the police for certain types of patients (children, elders, disabled, or other) or for certain types of injuries sustained by victims?
 9. How are exams paid for in your jurisdiction? Is patients' insurance ever billed? Do patients ever have to pay out-of-pocket for any exam-related services (medical or forensic)? When they pay out-of-pocket, do they get reimbursed, and how does that work?
 10. *Only ask in compensation states....*How do you feel about the use of crime victim compensation funds to pay for sexual assault forensic exams? Is this an appropriate use of these funds? How well does the claims process work? Do

- patients file claims for compensation or does the exam provider file the claim? How much does compensation pay? Does compensation cover all the necessary expenses (different types of forensic and medical services provided during the exam)? Does compensation pay the right amounts for these services?
11. What happens to the physical evidence recovery kit (PERK/Rape Kit) after a patient has an exam? Is it identified by the patient's name or by a code number? Is there a tracking system, and how does it work? Who takes custody of it, and where is it stored? Do identification and storage vary depending on whether the victim reported the crime to the police? How long is it stored, and does length of storage vary depending on whether the victim reported the crime to the police?
 12. Are all PERKs/Rape Kits sent to crime labs, or only some (which ones)? What triggers a PERK/Rape Kit to be sent to the lab? What crime labs are PERKs/Rape Kits sent to, and how long does it take to send them there? Do the labs process all PERKs/Rape Kits they receive? How quickly do the labs process the PERKs/Rape Kits, and who do they send the results to? What problems, if any, do you see in the way labs process PERKs/Rape Kits, and how could lab processing be improved?
 13. Are there any obstacles for non-English speaking victims, immigrants, or other minority groups in accessing free forensic medical exams?
 14. Do jurisdictional issues ever present any problems (for example, when a victim is assaulted in another jurisdiction but gets the exam in your jurisdiction, or vice versa)?
 15. How is the forensic exam used in the investigation and prosecution of cases in your jurisdiction? Are cases handled differently, depending on whether the victim had the exam? Does the forensic exam make a difference in the outcome of the investigation or prosecution?
 16. Overall, do you think it's valuable to the criminal case if the victim has an exam performed (in terms of the investigation and prosecution)? Do you think it's valuable to the victim if he/she has an exam performed (in terms of her/his physical and psychological recovery)? How could the value of the exam to the criminal case, and to the victim, be improved?
 17. What policies and practices around SAFEs do you think need to be improved (for example, who performs them, where they're done, when they're done, how they're paid for, how PERKs/Rape Kits are processed, how the evidence is used, the patient's role in making decisions, and so on)?

Victim Advocacy

1. What victim advocacy agencies do you work with? How many of your patients are referred from an advocacy agency, and how many of your patients do you refer to an advocacy agency?
2. What's the advocate's role in the exam process? Do advocates encourage victims to have or not have exams? Do you think advocates are a useful resource for healthcare providers? For victims? How could the advocates' services be improved or expanded to be more effective?

Law Enforcement

1. What law enforcement agency (agencies) has jurisdiction for the assaults your patients have experienced? How well do these agencies work with victims, and with your agency? Is there a special unit focused on sexual assault cases and investigations? How could their treatment of victims, and their relationship with your agency, be improved?
2. What are victims' concerns about talking with the police? What information do you provide them about the police? What's your role during the police contacts?
3. What are the reasons that victims talk to the police? What are the reasons they don't talk to the police? Do you encourage victims to talk to the police or not talk to the police? How many of your patients talk with law enforcement about the assault?
4. Do victims have the option of speaking with the police anonymously or off the record, without necessarily filing an official report of the crime?
5. How many of your patients file an official report of the crime with law enforcement? What are the reasons that they file a report, and what are the reasons that they don't file a report? Do victims freely choose whether to report to the police?
6. For those who do report to the police, how many report soon after the crime (say, within a few days), and how many file a delayed report? What are the reasons that victims may file a delayed report?
7. Do you see a difference between victims who have the forensic medical exam and those who don't, in terms of whether they're more likely to file a report with the police immediately, after a delayed period, or not at all? Do you have many patients who have the exam without filing a police report at that time? Do many of those patients later file a delayed report with the police?
8. Do you think that allowing victims to get a free forensic medical exam without having to report to the police encourages more victims to get the exam, or doesn't

- make any difference? Do you think it encourages victims to make a report to the police later on, or doesn't make any difference? Have you seen any changes in the last several years in victims' willingness to get exams? In their willingness to report to the police (either at the time of the exam or later on)?
9. Do you see many cases of police investigating the assault even for victims who haven't filed a report? Is this more or less likely to happen when the victim has had a forensic medical exam, or does that not matter? How do victims react when the police investigate without the victim's report? What do you think of it when the police investigate without the victim's report?
 10. Overall, do you think it's valuable to the victim if he/she reports the crime to the police (in terms of her/his physical and psychological recovery)? How could the value of the police experience be improved? What police practices or policies around sexual assault cases do you think need to be improved?

Prosecution

1. What prosecution agency has jurisdiction for the assaults your patients have experienced? How many of your patients have a case in the prosecutor's office? How well does the prosecutor's office work with victims, and with your agency? How could their treatment of victims, and their relationship with your agency, be improved?
2. What are victims' concerns about working with the prosecution? What information do you provide them about prosecution?
3. What are the reasons that victims work with the prosecutor? What are the reasons they don't work with the prosecutor? Do you encourage victims to work with the prosecutor or not work with the prosecutor?
4. Do you see many cases in which the prosecutor prosecutes the case without the victim's participation (evidence-based prosecution)? Do you see many cases in which victims who don't want to be involved in the court case are subpoenaed? What's your opinion of evidence-based prosecution, from the standpoint of the criminal justice system, and considering the victim's best interests?
5. Overall, do you think it's valuable to the victim if the case is prosecuted (in terms of her/his physical and psychological recovery)? How could the value of the prosecution experience be improved? What prosecution practices or policies around sexual assault cases do you think need to be improved?

State and Federal Laws

1. Are you familiar with the 2005 reauthorization of the federal Violence Against Women Act, and its provisions for forensic medical exams for sexual assault victims? Have you ever received any training, policies, or other information on the federal requirements? Who provided that information?
2. What additional resources would be useful to you?
3. Is there anything else that you feel is important for us to know, to understand victims' experiences with the forensic medical exam and the criminal justice system?

Thank you very much for your time and for sharing your experiences with us. Your perspectives are really important to our research on how to make the system more responsive to survivors of sexual assault.

Victim Advocate Interview

Introduction

Hello, my name is **(INSERT NAME AND INTRODUCE COLLEAGUE/S.)**. We are from the Justice Policy Center at the Urban Institute, a nonprofit, nonpartisan research organization that studies social and criminal justice policy issues. Urban Institute, along with George Mason University and the Pennsylvania Coalition Against Rape/National Sexual Violence Resource Center, is conducting a study funded by the **National Institute of Justice**, the research, development, and evaluation agency of the U.S. Department of Justice.

The purpose of this study is to:

- Understand how sexual assault forensic exams are paid for throughout the country;
- Identify best practices to ensure that victims are never required to pay for the forensic exam or to report the sexual assault to the police before receiving a free forensic exam;
- Examine obstacles related to providing free forensic exams for all sexual assault victims, and identify ways to overcome them; and
- Provide information and analysis to states and localities across the nation to help develop policies and practices that best serve victims.

So you know who we are, we'd like to take a minute and introduce ourselves. **(INSERT BACKGROUND INFORMATION ABOUT SITE VISIT TEAM MEMBERS.)**

We would like to thank you for taking the time to participate in this meeting. The interviews are intended to get your perspective on sexual assault forensic exam processes in **(INSERT LOCALITY)**. This study is not a compliance audit, and will not produce a "report card" rating of states or other jurisdictions. Your responses during this meeting will be combined with responses from others we visit here, in other jurisdictions in this state, and in other states, and presented as aggregate findings. No individuals, jurisdictions, or states will be identified in our research report. Your participation is voluntary and you can decline to answer any question throughout our discussion. We will be taking notes and after the final reports are written, we will destroy all notes from this meeting. This form provides more information about our study. You can just keep that copy. **(HAND OUT INFORMED CONSENT FORM)**

Background Information

73. What's your job title? How long have you been in this position? How long have you worked in the victim service field?
74. What unit within your agency do you work in (if any)? Does this unit specialize in sexual assault cases? Is there another unit in your agency that specializes in

- sexual assault? What is the unit's (*say agency's if there is no specialized unit*) average annual sexual assault caseload?
75. Can you describe the sexual assault survivors the (unit/agency) works with, in terms of sex, age, race/ethnicity? What are the most common types of assaults that your clients have experienced (for example, stranger vs. acquaintance vs. partner/family member; forcible vs. drug-facilitated vs. other means of coercion; felony rape vs. misdemeanor fondling/groping; and so on)?
 76. How do you initially connect with survivors (*what are the most common sources of referrals*)? How long after the sexual assault do you typically make first contact with your clients?
 77. What services does the (unit/agency) provide to sexual assault survivors? How long, on average, does the (unit/agency) work with a sexual assault survivor? How many different types of services does a survivor receive, on average?
 78. Is there a Sexual Assault Response Team (SART) in your community? If so, who's involved in it, and how does it work? How well do advocacy, healthcare, law enforcement, and prosecution work together in your community? Where is there room for improvement?
 79. Would you describe your community's approach to sexual assault as victim-centered (placing the victim's best interests in the forefront)? How or how not?

Victims' Needs

1. What are sexual assault survivors' most common concerns, when you first make contact with them? How do these concerns develop over time? What differences do you see among survivors, based on age, sex, culture, the circumstances of the assault, whether they know the assailant, and other factors that may be relevant?
2. What agencies do you refer victims to for needs that your services don't address?

Victim Advocacy

1. How do your agency's advocacy services benefit victims? How do they benefit healthcare providers, law enforcement, and prosecution?
2. How could your agency's services be improved or expanded to be more effective?

The Sexual Assault Forensic Exam (SAFE)

1. What facilities and providers (such as sexual assault nurse examiners) perform exams in your jurisdiction? How well do they work with victims, and with your agency? How could their treatment of victims, and their relationship with your agency, be improved?
2. Are the exams done by providers who are specially trained to conduct the exam?
3. What proportion of your clients have a SAFE done? What are your clients' concerns about the SAFE? What information do you provide them about the SAFE? Do you go with them to get the SAFE? What's your role during the exam process? What information do you provide to patients about what will happen to the PERK/rape kit after the exam, and what they should do (if anything)?
4. What are the reasons that survivors get the exam? What are the reasons they don't get the exam? Do you encourage victims to get the exam or not get the exam? Does anyone ever pressure victims to get the exam, or not get the exam?
5. How long after the assault can exams be performed? What forensic and medical services are provided during the exam? How is informed consent handled? Can victims refuse some exam procedures but consent to others? Do exam providers make referrals for other medical, counseling, or advocacy services? What are best practices for how exams should be performed? What problems are there, if any, with the way forensic medical exams are done? How could exam procedures be improved?
6. What's the relationship between having an exam and reporting to the police in your jurisdiction? Does anyone ever pressure victims to report to the police, or not to report? In practice, do victims ever have to report to the police to get a free exam in your jurisdiction? Are the exams conducted differently depending on whether the victim has reported to the police?
7. Does law enforcement or prosecution have to authorize the exam for it to be free of charge to victims? What happens if law enforcement or prosecution decides not to authorize the exam but the victim still wants one?
8. Are there requirements for healthcare providers to report sexual assaults to the police for certain types of victims (children, elders, disabled, or other)?
9. How are exams paid for in your jurisdiction? Is victims' insurance ever billed? Do victims ever have to pay out-of-pocket for any exam services (medical or forensic)? When they pay out-of-pocket, do they get reimbursed, and how does that work?

10. *Only ask in compensation states.....*How do you feel about the use of crime victim compensation funds to pay for sexual assault forensic exams? Is this an appropriate use of these funds? How well does the claim process work? Do victims file claims for compensation or does the exam provider file the claim? How much does compensation pay? Does compensation cover all the necessary expenses (different types of forensic and medical services provided during the exam)? Does compensation pay the right amounts for these services?
11. What happens to the physical evidence recovery kit (PERK/rape kit) after a victim has an exam? Is it identified by the victim's name or by a code number? Is there a tracking system, and how does it work? Who takes custody of it, and where is it stored? Do identification and storage vary depending on whether the victim reported the crime to the police? How long is it stored, and does length of storage vary depending on whether the victim reported the crime to the police?
12. Are all PERKs/Rape kits sent to crime labs, or only some (which ones)? What triggers a PERK/Kit to be sent to the lab? What crime labs are PERKs/Kits sent to? Do the labs process all PERKs/Kits they receive? How quickly do the labs process the PERKs/Kits, and who do they send the results to? What problems, if any, do you see in the way labs process PERKs/Kits, and how could lab processing be improved?
13. Are there any obstacles for non-English speaking victims, immigrants, or other minority groups in accessing free forensic medical exams?
14. Do jurisdictional issues ever present any problems (for example, when a victim is assaulted in another jurisdiction or state but gets the exam in your jurisdiction, or vice versa)?
15. How is the forensic exam used in the investigation and prosecution of cases in your jurisdiction? Are cases handled differently, depending on whether the survivor had the exam? Does the forensic exam make a difference in the outcome of the investigation or prosecution?
16. Overall, do you think it's valuable to the criminal case if the victim has an exam performed (in terms of the investigation and prosecution)? Do you think it's valuable to the victim if he/she has an exam performed (in terms of her/his physical and psychological recovery)? How could the value of the exam to the criminal case, and to the victim, be improved?
17. What policies and practices around SAFEs do you think need to be improved (for example, who performs them, where they're done, when they're done, how they're paid for, how PERKs/Kits are processed, how the evidence is used, the victim's role in making decisions, and so on)?

Law Enforcement

1. What law enforcement agency (agencies) has jurisdiction for the assaults your clients have experienced? How well do these agencies work with victims, and with your agency? Is there a special unit focused on sexual assault cases and investigations? How could their treatment of victims, and their relationship with your agency, be improved?
2. What are survivors' concerns about talking with the police? What information do you provide them about the police? Do you go with them to talk to the police? What's your role during the police contacts? What services do you provide to victims in regard to the police?
3. What are the reasons that survivors talk to the police? What are the reasons they don't talk to the police? Do you encourage victims to talk to the police or not talk to the police?
4. How many of your clients talk with law enforcement about the assault? Do they have the option of speaking with the police anonymously or off the record, without necessarily filing an official report of the crime?
5. How many of your clients file an official report of the crime with law enforcement? What are the reasons that they file a report, and what are the reasons that they don't file a report? Do victims freely choose whether to report to the police?
6. For those who do report to the police, how many report soon after the crime (say, within a few days), and how many file a delayed report? What are the reasons that survivors may file a delayed report?
7. Do you see a difference between victims who have the forensic medical exam and those who don't, in terms of whether they're more likely to file a report with the police immediately, after a delayed period, or not at all? Do you have many clients who have the exam without filing a police report at that time? Do many of those clients later file a delayed report with the police?
8. Do you think that allowing victims to get a free forensic medical exam without having to report to the police encourages more victims to get the exam, or doesn't make any difference? Do you think it encourages victims to make a report to the police later on, or doesn't make any difference? Have you seen any changes in the last several years in victims' willingness to get exams? In their willingness to report to the police (either at the time of the exam or later on)?
9. Do you see many cases of police investigating the assault even for victims who haven't filed a report? Is this more or less likely to happen when the victim has had a forensic medical exam, or does that not matter? How do victims react when

the police investigate without the victim's report? What do you think of it when the police investigate without the victim's report?

10. Overall, do you think it's valuable to the victim if he/she reports the crime to the police (in terms of her/his physical and psychological recovery)? How could the value of the police experience be improved? What police practices or policies around sexual assault cases do you think need to be improved?

Prosecution

1. What prosecution agency has jurisdiction for the assaults your clients have experienced? How many of your clients have a case in the prosecutor's office? How well does the prosecutor's office work with victims, and with your agency? How could their treatment of victims, and their relationship with your agency, be improved?
2. What are survivors' concerns about working with the prosecution? What information do you provide them about prosecution? Do you go with them to talk to the prosecutor? What's your role during the court process? What services do you provide to victims in regard to the court process?
3. What are the reasons that survivors work with the prosecutor? What are the reasons they don't work with the prosecutor? Do you encourage victims to work with the prosecutor or not work with the prosecutor?
4. Do you see many cases in which the prosecutor prosecutes the case without the victim's participation (evidence-based prosecution)? Do you see many cases in which victims who don't want to be involved in the court case are subpoenaed? What's your opinion of evidence-based prosecution, from the standpoint of the criminal justice system? From the standpoint of the victim's best interests?
5. Overall, do you think it's valuable to the victim if the case is prosecuted (in terms of her/his physical and psychological recovery)? How could the value of the prosecution experience be improved? What prosecution practices or policies around sexual assault cases do you think need to be improved?

State and Federal Laws

1. Are you familiar with the 2005 reauthorization of the federal Violence Against Women Act, and its provisions for forensic medical exams for sexual assault victims? Have you ever received any training, policies, or other information on the federal requirements? Who provided that information?
2. What additional resources would be useful to you?

3. Is there anything else that you feel it's important for us to know, to understand survivors' experiences with the forensic medical exam and the criminal justice system?

Thank you very much for your time and for sharing your experiences with us. Your perspectives are really important to our research on how to make the system more responsive to survivors of sexual assault.

Law Enforcement Interview

Introduction and Informed Consent

Hello, my name is **(INSERT NAME AND INTRODUCE COLLEAGUE/S.)**. We are from the Justice Policy Center at the Urban Institute, a nonprofit, nonpartisan research organization that studies social and criminal justice policy issues. Urban Institute, along with George Mason University and the Pennsylvania Coalition Against Rape/National Sexual Violence Resource Center, is conducting a study funded by the **National Institute of Justice**, the research, development, and evaluation agency of the U.S. Department of Justice.

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- Identify best practices to ensure that victims are never required to pay for the forensic exam or to report the sexual assault to the police before receiving a free forensic exam;
- Examine obstacles related to providing free forensic exams for all sexual assault victims, and identify ways to overcome them; and
- Provide information and analysis to states and localities across the nation to help develop policies and practices that best serve victims.

So you know who we are, we'd like to take a minute and introduce ourselves. **(INSERT BACKGROUND INFORMATION ABOUT SITE VISIT TEAM MEMBERS.)**

We would like to thank you for taking the time to participate in this meeting. The interviews are intended to get your perspective on sexual assault forensic exam processes in **(INSERT LOCALITY)**. This study is **not** a compliance audit, and will **not** produce a "report card" rating of states or other jurisdictions. Your responses during this meeting will be combined with responses from others we visit here, in other jurisdictions in this state, and in other states, and presented as aggregate findings. No individuals, jurisdictions, or states will be identified in our research report. Your participation is voluntary and you can decline to answer any question throughout our discussion. We will be taking notes and after the final reports are written, we will destroy all notes from this meeting. This form provides more information about our study. You can just keep that copy. **(HAND OUT INFORMED CONSENT FORM)**

Background Information

1. What's your job title? How long have you been in this position? How long have you worked in the law enforcement field?
2. What unit within your agency do you work in (if any)? Does this unit specialize in sexual assault cases? Is there another unit in your agency that specializes in sexual assault? What is the unit's (*say agency's if there is no specialized unit*)

- average annual sexual assault caseload? What services does the (unit/agency) provide to sexual assault victims?
3. Can you describe the victims the (unit/agency) works with, in terms of sex, age, race/ethnicity? What are the most common types of assaults that victims have experienced (for example, stranger vs. acquaintance vs. partner/family member; forcible vs. drug-facilitated vs. other means of coercion; felony rape vs. misdemeanor fondling/groping; and so on)?
 4. How do you initially connect with victims (*what are the most common sources of referrals*)? How long after the sexual assault do you typically make first contact with the victim?
 5. Is there a Sexual Assault Response Team (SART) in your community? Who's involved in it, and how does it work? How well do advocacy, healthcare, law enforcement, and prosecution work together in your community? Where is there room for improvement? Would you describe your community's approach to sexual assault as victim-centered (placing the victim's best interests in the forefront)? How or how not?

Victims' Needs

1. What are victims' most common concerns, when you first make contact with them? What differences do you see among victims, based on age, sex, culture, the circumstances of the assault, whether they know the assailant, and other factors that may be relevant?
2. What agencies do you refer victims to for needs that your services don't address?

The Sexual Assault Forensic Exam (SAFE)

1. What facilities and providers (such as sexual assault nurse examiners) perform exams in your jurisdiction? How well do they work with victims, and with your agency? How could their treatment of victims, and their relationship with your agency, be improved?
2. What proportion of victims have a SAFE done? What are their concerns about the SAFE? What information do you provide them about the SAFE? What information do you provide to victims about what will happen to the PERK/Rape Kit after the exam, and what they should do (if anything)?
3. What are the reasons that victims get the exam? What are the reasons they don't get the exam? Do you encourage victims to get the exam or not get the exam? Does anyone ever pressure victims to get the exam, or not get the exam?

4. How long after the assault can exams be performed? What are best practices for how exams should be performed? What problems are there, if any, with the way forensic medical exams are done? How could exam procedures be improved?
5. What's the relationship between having an exam and reporting to the police in your jurisdiction? Does anyone ever pressure victims to report to the police, or not to report? In practice, do victims have to report to the police to get a free exam in your jurisdiction? Are the exams conducted differently depending on whether the victim has reported to the police?
6. Does law enforcement or prosecution have to authorize the exam for it to be free of charge to victims? What happens if law enforcement or prosecutions decides not to authorize the exam but the victim still wants one?
7. Are there requirements for healthcare providers to report sexual assaults to the police for certain types of victims (children, elders, disabled, or other)?
8. How are exams paid for in your jurisdiction? Is victims' insurance ever billed? Do victims ever have to pay out-of-pocket for any exam-related services (medical or forensic)? When they pay out-of-pocket, do they get reimbursed, and how does that work?
9. *Only ask in compensation states....*How do you feel about the use of crime victim compensation funds to pay for sexual assault forensic exams? Is this an appropriate use of these funds?
10. What happens to the physical evidence recovery kit (PERK/Rape Kit) after a victim has an exam? Is it identified by the victim's name or by a code number? Is there a tracking system, and how does it work? Who takes custody of it, and where is it stored? Do identification and storage vary depending on whether the victim reported the crime to the police? How long is it stored, and does length of storage vary depending on whether the victim reported the crime to the police?
11. Are all PERKs/Rape Kits sent to crime labs, or only some (which ones)? What triggers a PERK/Rape Kit to be sent to the crime lab? What crime labs are PERKs/Rape Kits sent to, and how long does it take to send them there? Do the labs process all PERKs/Rape Kits they receive? How quickly do the labs process the PERKs/Rape Kits, and who do they send the results to? What problems, if any, do you see in the way labs process PERKs/Rape Kits, and how could lab processing be improved?
12. Are there obstacles for non-English speaking victims, immigrants, or other minority groups in accessing free forensic medical exams?

13. Do jurisdictional issues ever present any problems (for example, when a victim is assaulted in another jurisdiction but gets the exam in your jurisdiction, or vice versa)?
14. How is the forensic exam used in the investigation and prosecution of cases in your jurisdiction? Are cases handled differently, depending on whether the victim had the exam? What challenges are presented when victims don't have the exam? Does the forensic exam make a difference in the outcome of the investigation or prosecution? Are exam results uploaded to CODIS? What happens if there's a hit? Is the suspect arrested? Is the victim notified?
15. Overall, do you think it's valuable to the criminal case if the victim has an exam performed (in terms of the investigation and prosecution)? Do you think it's valuable to the victim if he/she has an exam performed (in terms of her/his physical and psychological recovery)? How could the value of the exam to the criminal case and to the victim be improved?
16. What policies and practices around SAFEs do you think need to be improved (for example, who performs them, where they're done, when they're done, how they're paid for, how PERKs/Rape Kits are processed, how the evidence is used, the victim's role in making decisions, and so on)?

Law Enforcement

1. What are victims' concerns about talking with the police? What information do you provide them about police services, policies, and procedures?
2. What are the reasons that victims talk to the police? What are the reasons they don't talk to the police?
3. Do sexual assault victims have the option of speaking with the police anonymously or off the record, without necessarily filing an official report of the crime?
4. How many of the victims you contact file an official report of the crime with law enforcement? What are the reasons that they file a report, and what are the reasons that they don't file a report? Do victims freely choose whether to report to the police? What challenges are presented when victims don't report to the police?
5. For those who do report to the police, how many report soon after the crime (say, within a few days), and how many file a delayed report? What are the reasons that victims may file a delayed report? What challenges are presented when victims file a delayed report?

6. Do you see a difference between victims who have the forensic medical exam and those who don't, in terms of whether they're more likely to file a report with the police immediately, after a delayed period, or not at all? Do many victims have the exam without filing a police report at that time? Do many of those victims who had the exam later file a delayed report with the police?
7. Do you think that allowing victims to get a free forensic medical exam without having to report to the police encourages more victims to get the exam, or doesn't make any difference? Do you think it encourages victims to make a report to the police later on, or doesn't make any difference? Have you seen any changes in the last several years in victims' willingness to get exams? In their willingness to report to the police (either at the time of the exam or later on)?
8. Do the police often investigate the assault even for victims who haven't filed a report? Is this more or less likely to happen when the victim has had a forensic medical exam, or does that not matter? How do victims react when the police investigate without the victim's report? What do you think of it when the police investigate without the victim's report?
9. Overall, do you think it's valuable to the victim if he/she reports the crime to the police (in terms of her/his physical and psychological recovery)? How could the value of the police experience be improved? What police practices or policies around sexual assault cases do you think need to be improved?

Victim Advocacy

1. What victim advocacy agencies do you work with? How many of the victims are referred from an advocacy agency, and how many of the victims do you refer to an advocacy agency?
2. What's the advocate's role in the exam process? Do advocates encourage victims to have or not have exams? Do you think advocates are a useful resource for exam providers? For victims?
3. What's the advocate's role in the police process? Do advocates encourage victims to report or not report the crime to the police? Do you think advocates are a useful resource for the police?

Prosecution

1. What's your agency's arrest rate for sexual assault cases? Of those cases with an arrest, in about what percent does the prosecutor's office file charges? How well does the prosecutor's office work with victims, and with your agency? How could their treatment of victims, and their relationship with your agency, be improved?

2. What are victims' concerns about working with the prosecution? What information do you provide them about prosecution?
3. What are the reasons that victims work with the prosecutor? What are the reasons they don't work with the prosecutor? Do you encourage victims to work with the prosecutor or not work with the prosecutor?
4. Do you see many cases in which the prosecutor prosecutes the case without the victim's participation (evidence-based prosecution)? Do you see many cases in which victims who don't want to be involved in the court case are subpoenaed? What's your opinion of evidence-based prosecution, from the standpoint of the criminal justice system? From the standpoint of the victim's best interests?
5. Overall, do you think it's valuable to the victim if the case is prosecuted (in terms of her/his physical and psychological recovery)? How could the value of the prosecution experience be improved? What prosecution practices or policies around sexual assault cases do you think need to be improved?

State and Federal Laws

1. Are you familiar with the 2005 reauthorization of the federal Violence Against Women Act, and its provisions for forensic medical exams for sexual assault victims? Have you ever received any training, policies, or other information on the federal requirements? Who provided that information?
2. What additional resources would be useful to you?
3. Is there anything else that you feel it's important for us to know, to understand victims' experiences with the forensic medical exam and the criminal justice system?

Thank you very much for your time and for sharing your experiences with us. Your perspectives are really important to our research on how to make the system more responsive to victims of sexual assault.

Prosecution Interview

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Background Information

1. What's your job title? How long have you been in this position? How long have you worked in prosecution? How long have you been prosecuting sexual assault cases?
2. What unit within your office do you work in (if any)? Does this unit specialize in sexual assault cases? Is there another unit in your office that specializes in sexual

- assault? What is the unit's (*say office's if there is no specialized unit*) average annual sexual assault caseload? What services does the (unit/office) provide to victims?
3. Can you describe the victims the (unit/office) works with, in terms of sex, age, race/ethnicity? What are the most common types of assaults that victims in your cases have experienced (for example, stranger vs. acquaintance vs. partner/family member; forcible vs. drug-facilitated vs. other means of coercion; felony rape vs. misdemeanor fondling/groping; and so on)?
 4. When the police make an arrest in a sexual assault case, what decision factors does your office use to decide whether and what charges to file? In what percentage of arrests are charges filed?
 5. Is there a Sexual Assault Response Team (SART) in your community? Who's involved in it, and how does it work? How well do advocacy, healthcare, law enforcement, and prosecution work together in your community? Where is there room for improvement? Would you describe your community's approach to sexual assault as victim-centered (placing the victim's best interests in the forefront)? How or how not?

Victims' Needs

1. What are victims' most common concerns, when you first make contact with them? What differences do you see among victims, based on age, sex, culture, circumstances of the assault, whether they know the assailant, and other factors that may be relevant?
2. What agencies do you refer victims to for needs that your services don't address?

The Sexual Assault Forensic Exam (SAFE)

1. What facilities and providers (such as sexual assault nurse examiners) perform exams in your jurisdiction? How well do they work with victims, and with your office? How could their treatment of victims, and their relationship with your office, be improved? Do exam providers often testify at trial? How useful is their testimony to the case?
2. What proportion of sexual assault victims in your cases have a SAFE done? What are victims' concerns about the SAFE? What are the reasons they get the exam? What are the reasons they don't get the exam? Does anyone ever pressure victims to get the exam, or not to get the exam?

3. How long after the assault can exams be performed? What are best practices for how exams should be performed? What problems are there, if any, with the way forensic medical exams are done? How could exam procedures be improved?
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12. Do jurisdictional issues ever present any problems (for example, when a victim is assaulted in another jurisdiction but gets the exam in your jurisdiction, or vice versa)?
13. How is the forensic exam used in the investigation and prosecution of cases in your jurisdiction? Are cases handled differently, depending on whether the victim had the exam? What challenges are presented when victims don't have the exam? Does the forensic exam make a difference in the outcome of the investigation or prosecution? Are exam results uploaded to CODIS? What happens if there's a hit? Is the suspect arrested? Is the victim notified?
14. Overall, do you think it's valuable to the criminal case if the victim has an exam performed (in terms of the investigation and prosecution)? Do you think it's valuable to the victim if he/she has an exam performed (in terms of her/his physical and psychological recovery)? How could the value of the exam to the criminal case, and to the victim, be improved?
15. What policies and practices around SAFEs do you think need to be improved (for example, who performs them, where they're done, when they're done, how they're paid for, how PERKs/Rape Kits are processed, how the evidence is used, the victim's role in making decisions, and so on)?

Law Enforcement

1. How well do the law enforcement agencies in your jurisdiction work with your office on sexual assault cases? How could their relationship with your office be improved?
2. What are victims' concerns about talking with the police? What are the reasons that victims talk to the police? What are the reasons they don't talk to the police? Do sexual assault victims have the option of speaking with the police anonymously or off the record, without necessarily filing an official report of the crime?
3. What are the reasons that victims file an official report with the police, and what are the reasons that they don't file a report? Do victims freely choose whether to report to the police?
4. For those who do report to the police, how many report soon after the crime (say, within a few days), and how many file a delayed report? What are the reasons that survivors may file a delayed report?
5. Do you see a difference between victims who have the forensic medical exam and those who don't, in terms of whether they're more likely to file a report with the police immediately, after a delayed period, or not at all? Do many victims have

- the exam without filing a police report at that time? Do many of those victims later file a delayed report with the police?
6. Do you think that allowing victims to get a free forensic medical exam without having to report to the police encourages more victims to get the exam, or doesn't make any difference? Do you think it encourages victims to make a report to the police later on, or doesn't make any difference? Have you seen any changes in the last several years in victims' willingness to get exams? In their willingness to report to the police (either at the time of the exam or later on)?
 7. Do you see many cases of police investigating the assault even for victims who haven't filed a report? Is this more or less likely to happen when the victim has had a forensic medical exam, or does that not matter? How do victims react when the police investigate without the victim's report? What do you think of it when the police investigate without the victim's report?
 8. Overall, do you think it's valuable to the victim if he/she reports the crime to the police (in terms of her/his physical and psychological recovery)? How could the value of the police experience be improved? What police practices or policies around sexual assault cases do you think need to be improved?

Prosecution

1. What are victims' concerns about working with the prosecution? What information do you provide them about prosecution?
2. What are the reasons that victims work with the prosecutor? What are the reasons they don't work with the prosecutor? How do you encourage victims to work with the prosecutor's office? Does your office ever subpoena a victim who doesn't want to appear in court?
3. Do you see many cases that are prosecuted without the victim having reported to the police? How is it different prosecuting a case in which the victim reported the assault right away, vs. a case with a delayed report, vs. with no police report by the victim? Are case outcomes likely to be different?
4. Do you see many cases that are prosecuted without the victim's participation in the court case (evidence-based prosecution)? Are case outcomes likely to be different from cases in which the victim cooperated with prosecution? What's your opinion of evidence-based prosecution, from the standpoint of the criminal justice system, and considering the victim's best interests?
5. Overall, do you think it's valuable to the victim if the case is prosecuted (in terms of her/his physical and psychological recovery)? How could the value of the

prosecution experience be improved? What prosecution practices or policies around sexual assault cases do you think need to be improved?

Victim Advocacy

1. What victim advocacy agencies do you work with? How many of the victims in your cases do you refer to an advocacy agency? Do you think advocates are a useful resource for victims?
2. What's the advocate's role in the prosecution process? Do advocates encourage victims to cooperate, or not to cooperate, with prosecution? Do you think advocates are a useful resource for prosecutors?

State and Federal Laws

1. Are you familiar with the 2005 reauthorization of the federal Violence Against Women Act, and its provisions for forensic medical exams for sexual assault victims? Have you ever received any training, policies, or other information on the federal requirements? Who provided that information?
2. What additional resources would be useful to you?
3. Is there anything else that you feel it's important for us to know, to understand victims' experiences with the forensic medical exam and the criminal justice system?

Thank you very much for your time and for sharing your experiences with us. Your perspectives are really important to our research on how to make the system more responsive to victims of sexual assault.

Sexual Assault Forensic Exam Payment Practices Study Victim Focus Group Protocol

INTRODUCTION

Hello, my name is **(NAME OF FACILITATOR)**. I am part of the Urban Institute and George Mason University team that is doing an evaluation of sexual assault forensic exam payment practices. **(INTRODUCE COLLEAGUE.)** We are doing this study to understand the experiences individuals have receiving sexual assault services, including a forensic medical exam and interactions with the police. We really appreciate your contributions to our study.

Thank you for taking the time to participate in this group session. Just to make sure, is everyone here at least 18 years old? The group discussions are intended to find out about your experiences after the sexual assault and your opinions about those experiences. Your involvement is voluntary and you can refuse to answer any question throughout our discussion. Also, at any point you can decide to stop participating in this group session. You will receive \$40 at the end of the session in appreciation for your time today.

(NAME OF PERSON) will be taking notes. To make sure that we get complete and accurate notes, we'd also like to audiotape the discussion. However, we will destroy the tapes as soon as we have made complete notes of this meeting, and will not use your names in preparing the notes. Also, we will not use your names in preparing any reports and will disguise your comments so that no one can identify who made specific remarks. In fact, you do not have to even share your name with us. If you would like, you can choose a false name for yourself today that we will use during the course of this discussion. After the report is written, we will destroy all notes and tapes from this meeting. Does anyone object to us audio-taping this meeting? **(NOTE: IF SO, THEN REFRAIN FROM TAPING.)**

As the facilitator, my role here is to ask questions and listen. I won't be participating in the conversation, but I want you to feel free to talk with one another. Everyone's participation today is important to us and we want everyone to have an opportunity to speak. If one of you is sharing a lot, I may ask you to let others talk. So, if you aren't saying much, I may ask for your opinion.

This paper explains more about our study. You can just keep this information. **(HAND OUT INFORMED CONSENT FORMS)**

OPENING QUESTION

1. To begin, let's find out some more about each other by going around the table and telling us whether you had a forensic medical exam after the assault, and whether you reported the crime to the police.

TRANSITION QUESTIONS

1. After the assault, how did you feel about getting medical care? What questions or concerns did you have about getting medical care?
2. After the assault, how did you feel about talking to the police? What questions or concerns did you have about talking to the police?

KEY QUESTIONS

1. Are you familiar with the forensic medical exam? (*If this term doesn't seem familiar...* This is the exam that provides medical treatment and collects evidence of the assault to use in a criminal case. Sometimes it's called a PERK or a SAK or a rape kit. It's done by a nurse or a doctor, usually in a hospital or a clinic.) How did you first learn about this exam?
2. Who received this exam? (*Note who did and did not receive exams, and appropriately direct questions below*)
 - a. *For those who received the exam:*
 - i. How long after the assault did you get the exam?
 - ii. Where did you get the exam?
 - iii. What were your reasons for having the exam done? (**Probe: did you feel like it was your own free choice, or did you feel pressured to get it? If pressured....what or who made you feel that way? Was it important to make your own choice about having the exam?**)
 - iv. Did you think that you had to make a report to the police in order to get the exam done?
 - v. Did anyone ever discuss whether you could report the crime without using your name?
 - vi. Did you think that having the exam would mean you were agreeing to participate in the criminal justice system (*talk to the police, press charges*)?
 - vii. Did the police or prosecutor's office have to give approval for you to have the exam done?
 - viii. Tell us about the process of the exam...who was there, how you felt treated, what you would have changed about the process....

- ix. Did anyone talk to you about how the exam would be paid for ...How was it paid for? (**Probes: Did you receive a bill for the exam? Was your insurance billed for the exam? Did you have to pay for anything either as a co-pay or deductible? Were you later reimbursed for the payments you made?**)
 - x. What other services did you get from the forensic medical exam? (**Probes: treatment for injuries, pregnancy, or STDs; referrals for additional medical care, counseling, and/or victim advocacy services**)
 - xi. What kinds of information did the exam provider give you during the exam? Did s/he give you information about what would happen next?
 - xii. Looking back on it now, are you glad you got the exam? (**Probe: what are the reasons for your answer...**)
- b. *For those who did not receive the exam:*
- i. What were the reasons you did not get the exam?
 - ii. Did you feel it was your own free choice or did something prevent you from getting the exam?
 - iii. Did anyone talk to you about how the exam would be paid for? (**If yes, probe: who was it, what was discussed?**)
 - iv. Did anyone make you feel like you had to make a report to the police in order to get the exam done?
 - v. Did anyone ever discuss whether you could report the crime without using your name?
 - vi. Did you think that having the exam would mean you were agreeing to participate in the criminal justice system (*talk to the police, press charges*)?
 - vii. Did the police or prosecutor's office have to give approval for you to have the exam done?
 - viii. Looking back, were you glad you did not get the exam? (**Probe: what are the reasons for your answer...**)
3. For those of you who talked with the police, tell us about that experience. Who did you contact; how long after the assault did you contact them; how did the interaction go? (**Probes: what were the reasons you spoke to the police; did you discuss the forensic exam with the police; what was discussed regarding the exam?**)
4. Did the agency open a case and start a criminal investigation? (**Probes: How did it open—did you give the go ahead or did the police open the case themselves?; Why was a case not opened if it was not?**)
5. Are you satisfied with the decision that was made about opening an investigation? What are the reasons you feel this way?

6. What was the outcome of the investigation? (**Probes: Was an arrest made? Did the prosecutor file charges against the suspect? What was the outcome of the charges?**)
7. Do you think the forensic medical exam you had made a difference in the case? (*In the case of no exam...*) Do you think it would have made a difference if you had done the forensic medical exam?
8. How do you feel about your interactions with the police and prosecutors? (**Probes: How were you treated? Did they show respect/concern? Are you glad you talked with the police/prosecutors?**)
9. For those of you who did not talk to the police, what were the reasons you did not? (**Probes: Do you know if the police were notified about that assault? Did an investigation and case occur without your participation? If so....probe on what happened.....Are you satisfied with the decision not to talk to the police?**)
10. How did you first learn about services for victims of sexual assault? These services include advocacy, counseling, etc. Did you speak to anyone from victim services after the assault? What agency was it? How did you make contact with them?
11. Tell us more about your experiences with victim services. (**Probes: What were the reasons that you spoke with the advocates or counselors? Did you want to speak with them? Did you discuss the forensic medical exam with the advocates or counselors? Did you discuss talking to the police with the advocates or counselors? How do you feel about these interactions?**)

ENDING QUESTIONS

1. Tell us a bit about how the different agencies worked together to assist you....Did it seem like the people from the different agencies worked together and communicated with each other? (**Probes: Did you have to answer the same questions again and again? Did you ever get conflicting information from different people? Were there times you didn't get information you wanted from anyone?**)
2. Is there anything else that you feel it's important for us to know, to understand why survivors get involved with the forensic medical exam or the criminal justice system, or don't get involved?

Thank you very much for your time and for sharing your experiences with us. Your perspectives are really important to our research on how to make services work better for survivors of crime.

We have \$40 to thank you for your time and insights. We also have some information on community resources available, in case that would be of interest to you. **Provide both to the survivor, if she/he wants them. Also provide parking payment, if necessary.**

APPENDIX C: DISSEMINATION EFFORTS TO DATE

Presentations:

Newmark, L.C., Raja, D. Denver, M., & Zweig, J.M. (2012). *Sexual Assault Forensic Exam Payment Practices Study: Preliminary Findings*. Paper Presented at The National Institute of Justice Conference: June 18-20; Arlington, Virginia.

Zweig, J.M. & Newmark, L. C. (2012). *Sexual Assault Forensic Exam Payment Practices Study: What We Know About Retention and Storage*. Sexual Assault Medical Forensic Examination Protocol Research Forum, The National Institute of Justice/Office for Victims of Crime: March 28-29; Washington, DC.

Zweig, J.M., Denver, M., Newmark, L., & Raja, D. (2012). *Sexual Assault Medical Forensic Exam Payment Study*. Paper Presented at the American Society of Criminology, 64th Annual Meeting: November 14-17; Chicago, IL.

Zweig, J.M., Raja, D., Newmark, L.C. & Denver, M. (2012). *Sexual Assault Forensic Exam Payment Study: Report of Practices from the Field*. Paper Presented at the 2012 International Conference on Sexual Assault, Domestic Violence, and Stalking: April 2-4; San Diego, CA.

Newmark, L.C., Denver, M., Raja, D. & Zweig, J.M. (2011). *Sexual Assault Forensic Exam Payment Study*. Paper Presented at the American Society of Criminology, 63rd Annual Meeting: November 16-19; Washington, DC.