

Non-Report Sexual Assault Evidence Program: Forging New Victim-Centered Practices in Texas

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TABLE OF CONTENTS

Acknowledgments	4
Executive Summary	6
Background	10
Methodology	16
Findings	20
Program Utilization	22
Impact on Victims and Professionals	26
Procedures and Protocols	32
Raising Awareness	38
Discussion and Recommendations	42
References	44

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Our thanks are also extended to the Texas Association Against Sexual Assault and the Office of the Governor, Criminal Justice Division, for their financial support of this project and their commitment to improving services to victims and survivors of sexual assault.

Notes about Language

Throughout this report, victims and survivors of sexual assault may be referred to simply as “victims” because this research is grounded in the criminal justice system and we wish to acknowledge that a crime has been committed. The word *victim* is not meant to be demeaning or judgmental. The research team recognizes that at the time of their contact with medical personnel, advocates, and/or the criminal justice system, individuals have survived a combination of sexual, physical, and emotional trauma. As advocates ourselves, our aim is to honor the journey of all persons and to respect the way in which they name their experiences.

In addition, this report describes the Non-report Medical Forensic Exam Program primarily from the perspective of Texas Sexual Assault Nurse Examiners (SANEs). However, the research team acknowledges that some hospitals are conducting medical forensic exams, and possibly non-report exams, without the assistance of SANEs.

It just makes me realize how lucky we are to have such a good program. I was talking to someone from [another state] last week, and they're not as on board with anonymous report sexual assault as we are. They don't even always call an advocate until a case is already done. That would be *unheard* of here. I guess we're just spoiled that we get along with most of the [SANE] coordinators. We have a really good rapport with all of them, and they call us and we call them. It's an open door.

EXECUTIVE SUMMARY

The Non-Report Sexual Assault Evidence Program was created by Texas House Bill 2626 and became law in July 2009. The program allows sexual assault victims throughout Texas to obtain sexual assault medical forensic examinations without making a report to law enforcement and at no cost. This program is a new strategy designed to raise the low reporting and prosecution rates of sexual assault. Non-report sexual assault examinations balance the needs of the victims and those of the criminal justice system by allowing victims to preserve important evidence to use against their perpetrators and still take the time they need to decide whether to report the assault. The non-report program represents a major shift in operations for law enforcement, Sexual Assault Nurse Examiners (SANEs), rape crisis center advocates, and the sexual assault victims themselves. This assessment aims to identify strengths and challenges within the program, and to make recommendations to improve its implementation and usefulness to victims.

In order to assess the non-report option, researchers conducted in-depth interviews (N=79) and Web-based surveys (N=131) of SANEs, medical personnel, rape crisis center advocates, law enforcement officers, prosecutors, and state agency personnel across Texas.

Findings

The implementation of the new non-report program has been highly successful and efficient during its first two years, especially given the low level of public awareness and limited organized efforts to date to increase that awareness.

- As of May 2011, the Texas Department of Public Safety (DPS) had received 228 non-report evidence kits for storage in the DPS facility in Garland, Texas. During this same period, 11 kits were returned to local law enforcement due to a decision by the victim to report the assault. This represents 4.8% of all non-report evidence

kits received by DPS to date. For those cases that were converted from non-report to reported cases, the length of evidence storage time at DPS ranged from one week to eight months (with an average of 9.6 weeks spent in storage).

- The study participants, a wide variety of individuals in direct practice with sexual assault victims across the state, confirm that the non-report option, while still in its infancy, is working relatively well. Those who have direct contact with the non-report program, primarily SANEs, are building procedures for, and becoming comfortable with, non-report cases.
- Rape crisis center advocates are incorporating the non-report option into community education activities.
- Most importantly, victims of sexual assault now have time to consider their reporting decisions, since evidence from their assault has been collected and securely stored.

Nonetheless, challenges remain if the program is to be fully utilized in the future. Findings from the study lead us to several recommendations for improvement of the non-report option in Texas.

1. Increase awareness of the non-report option among:
 - SANEs and medical personnel – including emergency room staff
 - Rape crisis center staff and volunteers
 - Law enforcement
 - General public
2. Explore the use of medical forensic exams by male victims of sexual assault and promote the non-report option among men and vulnerable populations.
3. Explore the dilemma facing hospitals and SANEs who treat 17-year-old victims. Provide clarification to guide practice in conducting sexual assault exams for 17-year-olds.
4. Consider the benefits and pitfalls of standardizing the storage protocols for evidence in non-report cases, in particular regarding the length of time evidence is kept in hospitals before being sent to the DPS storage facility.

5. Explore chain of custody issues. The Office of the Attorney General, Texas Department of Public Safety, and Texas Association Against Sexual Assault may provide guidance, if not policies, on these concerns.
6. Explore the impact of lost evidence in non-report cases on the criminal justice system. In-depth analyses of cases that began as non-report cases and converted to reported cases that were ultimately prosecuted would be useful to determine the *true* impact of differences in evidence collection for a sexual assault case that is initially a non-report case versus a traditionally reported sexual assault case.
7. Increase education in the criminal justice system – among law enforcement, prosecutors, and juries – using trauma-informed clinical expertise, about trauma and why victims may not initially report a sexual assault.

BACKGROUND

The Non-Report Sexual Assault Evidence Program was created by Texas House Bill 2626 and became law in July 2009. The program allows sexual assault victims throughout Texas to obtain sexual assault medical forensic examinations without making a report to law enforcement and at no cost. This program is a new strategy designed to raise the low reporting and prosecution rates of sexual assault. Non-report sexual assault examinations balance the needs of the victims and those of the criminal justice system by allowing victims to preserve important evidence to use against their perpetrators and still take the time they need to decide whether to report the assault. The non-report program represents a major shift in operations for law enforcement, Sexual Assault Nurse Examiners (SANEs), rape crisis center advocates, and the sexual assault victims themselves. This assessment aims to identify strengths and challenges within the program, and to make recommendations to improve service delivery to victims.

Sexual assault is best defined as any unwanted, non-consensual sexual contact with any individual made by another using manipulation, pressure, tricks, coercion, or physical force (Texas Association Against Sexual Assault [TAASA], 2011). The legal definition of sexual assault is outlined in the Texas Penal Code Section 22.011 and includes rape, sodomy, and penetrating, touching, or oral sex where the victim is unwilling or unable to give consent, for reasons that include being under 17 years old, drugged, or unconscious (TAASA, 2011). This definition includes assaults on both males and females.

Sexual assault is a traumatic event that may include other serious consequences including long-term physical injuries, sexually transmitted diseases, unwanted pregnancies, mental health problems, and reduced productivity (Centers for Disease Control and Prevention [CDC], 2009; Office for Victims of Crime [OVC], 2010; Tjaden & Thoennes, 2006). In addition to the major health risks that sexual assault poses (CDC, 2009), it can instill intense fear of retaliation and extreme feelings of shame that deter many from reporting (Tjaden & Thoennes, 2006). Research efforts, federal legislation, and wider prosecution

of cases have made sexual assault a politically potent issue as the American public has discovered that its pervasiveness is a serious issue (Government Accountability Office [GAO], 2007). While great progress has been made to protect the confidentiality and privacy of victims of sexual assault, there is still much to be done to protect victims and enforce their rights. Although the extent of the problem may always be difficult to measure due to the underreporting of assaults, scholars, policymakers, and the professional community continue to make progress at identifying ways to work together to best serve victims.

Prevalence of Sexual Assault

According to the National Crime Victimization Survey of 2009, more than 125,000 people nationwide reported having been sexually assaulted that year. However, only 88,000 sexual assault cases were reported in 2009 to law enforcement (U.S. Department of Justice, 2010). According to the Texas Uniform Crime Reporting Program (Texas Department of Public Safety [TXDPS], 2010), the official statewide crime reporting system, an estimated 8,286 attempted or completed rapes were reported to Texas police in 2009. Of the total, 89% to 93% were completed rapes, while 7% to 11% were attempted rapes. Although the Texas Uniform Crime Report accounts for all of the reported rapes of females over 18 years of age, it does not report statutory rape, sexual assaults of males, sodomy, or oral sex. Furthermore, these numbers only capture the total number of sexual assaults known to, and recorded by, the police.

Given the limitations of the Texas Uniform Crime Report, researchers from The University of Texas at Austin's Institute on Domestic Violence and Sexual Assault (IDVSA) in 2003 sought a more accurate estimate of the prevalence of sexual assault in the State of Texas (Busch, Bell, DiNitto, & Neff, 2003). Busch, et al., estimate that as many as 1.9 million adults (1,479,912 females and 372,394 males) living in Texas have experienced sexual assault at some point in their lifetime, affecting about 20% of Texas women and 5% of Texas men (2003).

Female victims of sexual assault are typically assaulted by a man they know. Often this man is an acquaintance or a relative other than the victim's spouse or partner. In only 19% of the cases, the perpetrator is a stranger (Busch, et al., 2003).

Sexual Assault Medical Forensic Exams

Regardless of whether or not a victim is willing to report the crime to law enforcement, victims have the right to seek medical attention in the form of a sexual assault medical forensic exam. The sexual assault examination that is provided to the victim by a SANE or other medical professional aims both to assess and treat injuries and to collect the forensic evidence for possible prosecution efforts (Texas Office of Attorney General [TXOAG], 2010). Although the sexual assault examination has undergone some changes regarding when or if a victim has to report the assault to law enforcement, many victims are still foregoing both the examination and the reporting for reasons that deserve further examination.

Sexual assault exams by SANEs began as a response by the medical and professional community to an identified need for specialized services for victims of sexual assault, needs not otherwise being met by regular emergency services. SANE programs were first implemented in 1976 in Memphis, Tennessee, and officially came to Texas in 1979. Specialized nurses known as Sexual Assault Nurse Examiners or Sexual Assault Forensic Examiners have the extensive knowledge and training necessary to provide a medical forensic examination of sexual assault victims (Ledray, 1999). In addition to providing benefits to the victim through their invaluable specialized knowledge, SANEs collect evidence of the assault that can later assist in successful prosecution of the crime (Gray-Eurom, Seaberg, & Wears, 2002; McGregor, DuMont, & Myhr, 2002).

Across Texas, SANE coordinators organize and manage the efforts of SANEs and SANE programs. The following map (Fig. 1) shows the locations of SANE coordinators in Texas as provided by the Office of the Attorney General (OAG).

Figure 1. SANE coordinators in Texas



Note: Listing provided by the Texas OAG

Non-Report Sexual Assault Forensic Examination

The 2005 reauthorization of the Violence Against Women Act (VAWA) expanded existing grant programs for sexual assault victims and added new requirements including that victims of sexual assault be provided with a medical forensic exam regardless of their participation or cooperation with law enforcement. The deadline for compliance was

January 2009, and Texas came into compliance when it passed House Bill (HB) 2626 in July 2009, implementing the Non-Report Sexual Assault Evidence Program.

Underreporting of sexual assault may largely be due to the traumatic experience of sexual assault and the difficulty with reporting the crime to law enforcement. The psychological effects of rape often include feelings of fear, hopelessness, anger, and humiliation, which can lead to inaction in reporting or seeking attention (Kirk & Okazawa-Rey, 2003; Wallace, 2005). Prior to the passing of Texas HB 2626, victims of sexual assault who sought to receive a sexual assault exam were required to report to law enforcement in order to receive that exam. When victims are recovering from an attack, however, many are unable to undergo the further traumatic experience of repeating details of the incident to law enforcement.

As a strategy to increase the prosecution of sexual assault cases, the Non-Report Sexual Assault Evidence Program was developed to provide adult victims two benefits: 1) a sexual assault examination within 96 hours of the incident, and 2) the time to decide whether or not they will report the assault. Through the program the victim can complete the sexual assault examination and request that the evidence be kept confidential and stored (for a period of two years), available if or when she or he is ready to report. This time period allows the victim to access formal or informal resources that may facilitate the healing process and to gain the strength that may be required for retelling the story to law enforcement. The program aims to alleviate the anxiety created by reporting an assault to law enforcement and to safeguard the forensic evidence for later use by the criminal justice system.

This major shift in scope of service delivery to victims requires appropriate training and assessment in order to ensure that all providers operating under this system and the victims themselves are working under the best delivery of services possible.

METHODOLOGY

This project's goal was to determine the impact, effectiveness, and efficacy of the Non-Report Sexual Assault Evidence Program in Texas. The study methodology was designed to assess the process of collecting and storing sexual assault forensic evidence in cases where the victim has not reported the crime to law enforcement, and to identify the strengths and gaps of this program.

Research questions included:

1. How is the non-report program currently being used?
2. What are the processes that SANEs and hospitals follow in non-report sexual assault cases?
3. What are the program strengths and what are areas for improvement?
4. What have we learned in the last year about sexual assault and non-reporting?
5. What are the recommendations for improvement?

Sample and Data Collection

Two phases were undertaken to achieve these research goals. First, in-depth interviews were conducted with professionals from the following five groups: 1) SANEs and other medical personnel; 2) rape crisis center advocates; 3) law enforcement officers; 4) prosecutors; and 5) state agency personnel. Second, Web-based surveys were conducted with professionals from similar groups. Table 1 provides data on the participants by group. Table 2 provides the number of participants from each Texas Association Against Sexual Assault (TAASA) region, shown on the map in Figure 2. A semi-structured questionnaire, with both closed and open-ended questions, was developed for both the in-depth interviews and the Web-based surveys. Almost always, the research conducted by IDVSA staff includes the voices and expertise of victims. However, given the need to maintain the confidentiality of the victim who has had a sexual assault exam but not reported the sexual assault to law enforcement, it was not ethical to include victims in the methodology. One recommendation for future studies might be to talk with victims who

had non-report exams, then converted their case status by reporting the assault to law enforcement.

Study participants were recruited using purposive and snowball methods. Researchers selected participants based on certain criteria, such as their experience and expertise in providing services to victims of sexual assault and/or their role in the investigation or prosecution of sexual assault crimes. For snowball sampling, current participants were asked if they knew anyone who might be willing to be interviewed and who met the criteria.

Table 1. Number of Participants by Group Representation

Category	Interview Participants	Web-Based Survey Participants
SANE/medical personnel	24	42
Rape crisis center	42	74
Law enforcement	9	8
Prosecutor	3	7
State agency personnel	1	0
TOTAL	79	131

Table 2. Interview Participants by Seven TAASA Regions

Region	Number of interview participants
A	17
B	22
C	7
D	12
E	17
F	4
Statewide	1

TOTAL	79
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Figure 2. Interview field sites



Protection of Research Participants

This study was reviewed and approved by the Institutional Review Board (IRB) at The University of Texas at Austin. Written informed consent was obtained for this study from

each interview participant. Web-based consent was also obtained from those participating in the survey. Participation in this study was voluntary.

Data Analysis Procedures

Data from participants were analyzed using thematic and content analyses, an iterative process in which interview transcripts were read and reread by members of the research team prior to coding. Each transcript was analyzed using line-by-line coding. Codes were grouped into themes. Themes specific to conditions of, and challenges to, the Non-Report Sexual Assault Evidence Program were identified within and across transcripts. The research team collectively confirmed the results by reviewing them against the associated quotes from the transcripts. Data from the Web-based surveys were also analyzed using thematic and content analyses, and descriptive statistics.

Challenges to, and Limitations of, This Study

This study utilized a non-probability convenience sample, and therefore the findings are not necessarily generalizable to other professionals working in the field of sexual assault services, investigation, and/or prosecution.

Due to the number of potential participants, and time and resource constraints, it was not possible to conduct in-person interviews with all direct service providers and other key informants across the state. For this reason, the Web-based survey was added in order to increase the feedback from areas that were not included in the site visit schedule.

FINDINGS

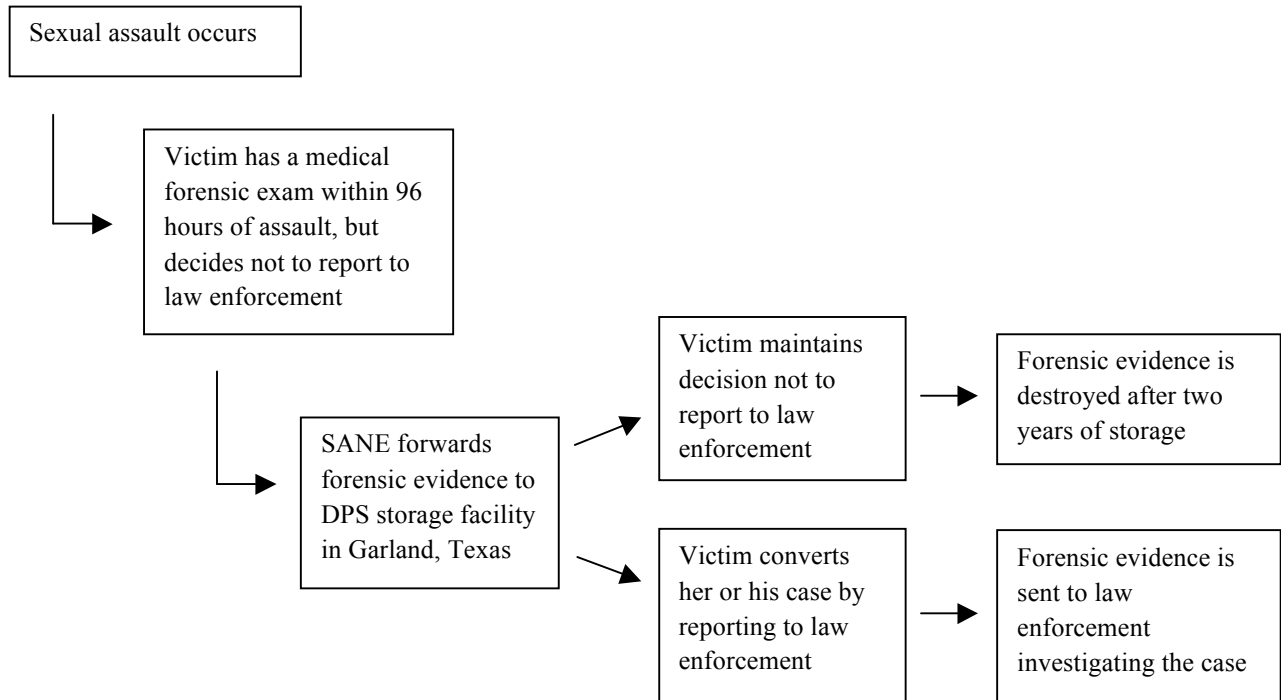
Findings from SANEs, hospital staff, rape crisis center advocates, law enforcement, and prosecutors during the interviews and Web-based surveys concerning the Non-Report Medical Forensic Exam Program are organized according to the following four themes:

- I. Program Utilization
- II. Impact on Victims and Professionals
- III. Procedures and Protocols
- IV. Raising Awareness

FINDING I: Program Utilization

Figure 3 below illustrates the general step-by-step process utilized by the non-report program, from the time of assault until either 1) the destruction of forensic evidence or 2) its ultimate use in an investigation. Victims may become aware of the non-report option via public awareness campaigns or after having disclosed the assault to an advocate, hotline, SANE, other medical professional, or law enforcement (prior to making a report).

Figure 3. Process in non-report cases



As of May 2011, the Texas Department of Public Safety (DPS) had received 228 non-report evidence kits for storage in the DPS facility in Garland, Texas. During this same period, 11 evidence kits were returned to local law enforcement due to a decision by the victim to report the assault. This represents 4.8% of all non-report evidence kits received by DPS to date. For those cases that were converted from non-report to reported cases, the length of evidence storage time at DPS ranged from one week to eight months (with an average of 9.6 weeks spent in storage).

SANE interview respondents reported having handled between one and 50 non-reports at the time of the interview or survey (approximately 15 to 21 months following implementation of the

We haven't had nearly as many as I thought we would have had, and I would like to see there be more. I think we're kind of afraid, because we have large numbers [of sexual assault cases] anyway, and if it was really, really out there, those who don't want to report would just be huge. I think we're kind of surprised it's not more.

state law). The two highest numbers reported during the interviews (22 and 50) were from programs that began non-reports with the passing of the federal law in January 2009, five months before implementation of the state law. Most SANEs reported having handled between one and five non-reports since implementation of the state law.

Of SANE survey respondents, 29 reported that their setting offers non-report exams, and seven reported not offering non-report exams. It is not known why some sites are not offering non-report exams, although lack of awareness of the option may play a role. Among those conducting them, non-report exams represented between 1% and 22% of the total number of sexual assault exams conducted by SANE respondents.

All hospital personnel survey respondents (n=6) reported being able to offer non-report exams. The number of non-report exams conducted by hospital survey respondents ranged from none to 17 (with an average of 5.6, although three had done none). The number of reported exams identified by hospital survey respondents ranged from two to 250. Among those hospital respondents who had conducted them, non-report exams represented between 0.5% and 11% of total cases.

Most participants were unaware of the number of non-report conversions. SANEs, in particular, often have little or no follow-up contact with a case unless they are called as a witness for the prosecution.

Underutilization by Special Populations

First, findings suggest that the non-report program has been underutilized by male sexual assault victims. Male victims are already thought to underreport assaults to law enforcement, and little is known about their experiences with sexual assault exams. One SANE shared her theory on why

males are not using the non-report option: “Once they have made this huge, huge step to go, they are going to go all the way [and report].”

Second, some programs along the border reported challenges in providing services to undocumented immigrant victims of sexual assault. While crossing the border, women in particular are frequently sexually assaulted. As the drug wars have intensified along the border, violence and security concerns have also risen. Fear and mistrust may play a role in victims’ ability to access services. Since law enforcement involvement is not required, the non-report program could potentially address barriers related to undocumented immigrants’ relationship with law enforcement, serving as a point of access to other victim services.

Challenges to Obtaining Accurate Data on Utilization of Non-Report Option

Given that some non-report cases convert to reported cases before exam results are sent to the DPS storage facility and that some hospitals are storing non-report exams in-house, the true numbers of non-reports are difficult to ascertain. Hospitals and SANEs (those who participate in the DPS non-report program as well as those who do not) are not necessarily tracking the numbers of reported cases versus non-report cases. Additionally, disclosure restrictions pose further challenges to collecting accurate data on program utilization.

It’s a federal law; it’s kind of like I’m not going to wait for the state. So we came together and came up with a plan and signed it into our protocol for our county, on December the 12th of 2008, and we were ready. We have been taking care of [victims] since the federal law was enacted, so we were ready when the state law came in.

FINDING II: Impact on Victims and Professionals

Findings from both interview and survey respondents suggest that the non-report program has a considerable impact on victims, SANEs, hospitals, and the criminal justice system. The impact is largely positive, although a few concerns remain.

Victim Impact

The non-report program supports victims and their decision-making about reporting to law enforcement in several ways. First, victims may not be emotionally or physically ready to report, given the trauma they have experienced. They may also be focused entirely on getting the medical attention they need, reserving the option of reporting for a later time. For example, one respondent reported that people “might want to go and do that first step and get the exam. You have given them some power back. You have given them some control, so they may think, ‘Now I can go further.’”

She was kind of on the fence and hadn't made her decision. I encouraged her to do that. I said that everything will be here. It took two weeks, and she called law enforcement, and they called here and asked if I had the kit here. I'd already forwarded it to DPS. I gave them all the information as to how to get to it. She needed some time to decide. There was some reason she felt she shouldn't do this – maybe she felt threatened or something by the assailant.

Another respondent explained:

If you can go in and get this stuff done and get your physical well-being taken care of and get the evidence collected, then you can think about what you want to do with the rest, instead of waiting so long that you end up being pregnant, that you end up having an STD that can't be treated, [or] that you end up having things that could've been taken care of if you had gone [to the hospital]. You get a resource in us. You get your medical well-being taken care of and someone to listen to you and someone who believes you.

Second, victims may be afraid of legal, familial, or social repercussions. Another respondent revealed how the non-report option fills a gap when victims have other fears of reporting, “One woman was on parole and was afraid the report would cause her problems. She must have had

some problems before.” Several respondents noted that the non-report option is helpful particularly when the perpetrator is a family member or acquaintance:

“Especially when there’s a known suspect and all the ramifications that she’s going through in her mind. ‘Should I report him? Should I get him in trouble? Am I going to have to go to court, and what am I going to do with my kids when I go to court? Is his life going to be ruined forever?’ They should not be making that decision the day that they were assaulted.”

We feel that if we provide the environment that’s safe and healing for them, and we give them understanding and support, there is a chance that before they leave, we do *not* have to mark that kit as a non-report. Rather, it can be sent through to the authorities where it needs to be, and gone ahead and processed, and the report finalized and worked. That’s our whole goal: not to coerce, but to support, inform, and let them make an informed decision on what’s happened to them.

Others fear that they will not be believed by law enforcement, based on past experiences or because they were using alcohol or drugs at the time of their assault. One respondent expressed concern about how law enforcement approaches cases involving drugs or alcohol: “I wouldn’t call the cops. If I were sexually assaulted when I was drunk or stoned, there is no way – given my experience – that I would deal with law enforcement.” Some also have little faith that the criminal justice system will seriously address the crime. One advocate relayed the concerns felt by

some disability groups: “A lot of deaf people refuse to report the situation, because they don’t think anyone is going to take them seriously because they are deaf.”

There were a few reported incidents of victims who tried to report to law enforcement, and law enforcement made a determination to not assign a case number (to allow for a reported SANE exam). In these situations, SANEs were able to conduct exams using the non-report protocol, ensuring that victims received appropriate medical care and that evidence was safely stored for future use.

Cost to Victims

The most frequently discussed challenge to the non-report option among SANEs and rape crisis center advocates was the cost to victims. When victims report to law enforcement, they can

apply for compensation to reimburse medical costs and/or to pay for counseling through the Office of the Attorney General's Crime Victims Compensation (CVC) Program. However, costs incurred for medical care and other recovery services are not reimbursable through CVC unless

Yes, they are going to get the SANE exam free, but the other tests at the hospital that are not part of the SANE exam, [the victim] is responsible for that.

the victim reports the crime to law enforcement. In non-report cases, the hospital is reimbursed for a portion of the costs of conducting the sexual assault exam; however, victims will generally be billed for other costs. These costs may include testing, medical care, and medications. If a victim later decides to make a report to law enforcement, those bills may be covered retroactively by CVC (after the victim's insurance is taken into consideration).

With their commitment to comprehensive medical care for their patients, SANEs in particular feel strongly about this barrier to non-reporting victims. As one respondent said, "I would like money to be available to those victims who don't report – for things other than the SANE exam, like medical expenses when they need to follow up and get tested for sexually transmitted illnesses and for counseling, if they are not able to go to a [healthcare provider at no cost]."

SANE Impact

The non-report program has helped nurses both understand and gain more legitimacy for their role in assisting victims of sexual assault – their *medical* forensic role, in particular. Typically, SANE programs are driven by law enforcement investigations, with a solitary spotlight on collection of evidence. With the non-report program comes a renewed focus on the SANE program's importance in responding to the medical needs and well-being of victims.

The non-report program has also given SANEs the support they desired, enabling them to treat sexual assault victims underneath the umbrella of a SANE program. Previously, victims who did not want to involve law enforcement were sometimes turned away or were seen by ER personnel who may not have had the specialized skills of SANEs. These victims were denied the holistic approach to trauma and enhanced competency offered by the SANE program.

Criminal Justice Impact

The non-report option has the potential to improve the criminal justice response to sexual assault by ensuring the collection and safe storage of evidence before it is lost, which improves chances of prosecution if a victim later decides to report.

Another benefit to the criminal justice system is the possibility that evidence collected during a SANE exam may assist in the investigation and prosecution of a broader or multi-incident crime, such as domestic violence or a serial rapist. One SANE participant whose hospital began conducting non-report exams before the state law went into effect described such a scenario:

Before the non-reporting [law], we had had 14 cases that flipped [converted to a report to law enforcement], and some of them were within a few days, and some of them were within months. So they had come here for one of the events that had happened to them. And then months later, they had had another event that really wasn't a sexual assault. It was more of a physical assault, a kind of domestic violence incident. They made a report to law enforcement, and law enforcement asked if that [had] ever happened before, and they were like, 'Yeah, and that one time he also did this to me, and I had to go to the hospital.' Then that becomes important for them because this isn't going to give them any DNA, the physical assault, but this [the sexual assault] will.

Even if a non-reporter does not change her or his mind and never eventually reports the crime, there may be other ways the non-report process can facilitate law enforcement investigations of multi-assault perpetrators. With good communication and collaboration between law enforcement and SANEs, potentially through a Sexual Assault Response Team (SART), anonymous tips or third party information-only reports made by SANEs may assist law enforcement. The non-report option has also led some communities to develop creative anonymous reporting strategies. For example, one community's method enables law enforcement to follow leads on a perpetrator who may be tied to multiple crimes, as a study participant described:

[Law enforcement officers] were feeling very left out of the whole [non-report] process, and they came up with a great idea. 'Here is what we want to do: If the victim does not want to report, offer to them [the option] to talk to a cop off the record; you can use your

We do staffing every month, and we wanted to go ahead and staff our non-reporters as well, because we feel it is really important to share the statistical data: the age, the sex, where it happened, and details that would not give away their identity, but would help law enforcement identify if there was a trend or a serial rapist.

personal cell phone and not theirs, so we don't even know who we're talking to. And they can ask us any questions without any commitment to report whatsoever.' I've had one victim take us up [on] the offer.

While respondents affirmed the criminal justice benefits to the non-report program, many still harbor concerns. In particular, respondents reported that delayed reports by victims can create an extra challenge in prosecution. Grand jurors often ask why the victim did not report the crime immediately after it happened. In describing why timely reporting is important, one respondent said:

I realize from working this stuff why it doesn't get reported quickly, but it's hard to overcome those things even at the prosecutor's office: "Well, she waited two weeks to report this, and we don't have any physical evidence." If I could talk to every rape victim after it happens, I would say, "You've got to report this right away. Later you can decide if you don't want to go through with this. But let's get it started now." That's probably the biggest barrier.

Another concern is that other types of evidence from the crime scene, such as bedding or clothing, and toxicology samples that may reveal a drug-facilitated sexual assault are not included in non-report evidence collection due to storage limitations. One respondent stated, "That's the only reason I don't like it – I just want the case to be complete. I think honestly it's hard enough for people to believe it happened." One respondent reported that for cases in which the victim and perpetrator are strangers, this is not necessarily a problem. However, in cases of acquaintance rape, or incest in particular, the extra evidence is sometimes important:

Hopefully there is evidence on the victim's body that the perpetrator was there. If not, there is diminishing return sometimes on whether those [additional] pieces of evidence would help. There *are* issues where those do help. Typically in cases of incest, or it's someone who lives in the house that's assaulted someone in the house, then [the added evidence] can place that person in a place where they shouldn't be. Like there is evidence of someone being in there (who shouldn't have) on the bedding.

[During a SART meeting], we were discussing this one particular [non-report] patient. We gave the first name of the individual who had done this to her and where he had done this to her. As we were telling the story, a law enforcement officer looked at me, and then he looked at another detective across the table, and said, "You know who that is, don't you?" I was panicking, thinking I gave away the victim. No, they were talking about the perpetrator. And they said, "Is there any way you can talk to her, and please get her to report this crime?" I tried, but she wouldn't return my calls. She wouldn't return the calls [from] the advocates. I had the [name of the] best friend who came in with the victim, and I had her permission to call her if I had any follow-up questions. I called the best friend and told her, "We would really like her to report it, if at all possible." And she said, "Well, my friend doesn't want to do that, but can I tell you that I know his name, and where he lives, and what his phone number is, as a witness with some concerns?" And I said, "I have no idea, but I'll take [the information]." So I took the guy's name and phone number to the detective, and he said, "It is exactly who we thought it was, and he has done this time and time again." I still couldn't give the victim's name, and I couldn't even give the best friend's name because she did not give her permission to do that. But the police looked him up, and he was a sex offender who had overstayed his welcome. He was on one of those things where every 90 days he has to report in. They have a 10-day grace period, and he was nine days overdue. They allowed the 10-day grace period to expire and put him back in prison on Day 11. To me it was like this system works! It doesn't work in any way we thought it would, but it works. The goal was to get the bad guy in jail and to get the very best level of care possible to her. *She* set our limits. We did the best job we could, but we at least got this guy off the streets. It was very important for our law enforcement.

FINDING III: Procedures and Protocols

In terms of procedures and protocols, study participants discussed practices and challenges with age eligibility, the 96-hour rule, toxicology screening, efficiency, evidence storage and shipment, and chain of custody.

Age Eligibility

The non-report program covers adults ages 18 and older. Some participants reported that 17-year-olds are sometimes caught in the middle. This age is one that creates a dilemma for service providers, medical personnel, and the criminal justice system, given differences between the non-report program's age guidelines and state laws regarding the age of consent and mandatory child abuse reporting. By law, 17-year-olds are not eligible for the non-report option.

One example of this dilemma is runaway teens. Hospitals may see children ages 14 to 17 who have been runaways and have now returned home. The parents bring them to the hospital to be assessed and have a SANE exam, even if the child does not report having been sexually assaulted. A SANE often may have reason to believe sexual exploitation took place during the teen's runaway period. While some may interpret such a finding to be grounds for filing a mandated child abuse report, Child Protective Services (CPS) sometimes refuses these reports since the alleged abusers are not parents or caretakers of the child, but pimps or strangers. Thus, the SANE may not be able to make a child abuse report. A further complication arises when the child does not admit to a sexual assault, or "make an outcry." When contacted, law enforcement may not authorize a SANE exam if the child does not make an outcry, even though the DNA evidence may strongly indicate that a sexual assault has occurred. Thus, the SANE is sometimes placed in a position of not being able to conduct an exam at all. One major metropolitan area reported seeing five to six of these patients per month. Some SANEs reported conducting the exam regardless of this dilemma, storing them in-house in the event that they are needed in the future.

This gray area leaves hospitals in a precarious position, unable to conduct either a reported exam or a non-report exam. One respondent called for legislative clarification to help guide SANEs

and hospitals. The state could 1) require law enforcement to heed the medical expertise of SANEs requesting authorization to conduct SANE exams for 17-year-olds even if there is not an outcry by the victim; or 2) make 17-year-olds eligible for the non-report option. Others called for increased training of law enforcement around the topics of commercial sexual exploitation and human trafficking, and increased collaboration between health care professionals and law enforcement.

Length of Time Evidence Is “Good”

Participants raised a concern about the 96-hour rule in the non-report program. This rule states that non-report exams can be conducted within 96 hours of the assault, while evidence is most likely to be present. However, some communities in Texas have adopted a new 120-hour standard of care, based on improved DNA techniques in evidence collection and testing. Many communities continue to operate under the 96-hour rule for all cases, both non-report and reported cases. If the 120-hour guideline were to become standard practice across the state in reported cases, non-report program eligibility should reflect that standard as well.

If there is a concern about drug-facilitated sexual assault, then there would be a urine drug screen done here at the hospital. And reporting or non-reporting has nothing to do with that. That's good medical care for our patients and what we need to do.

Toxicology Dilemmas

The DPS non-report storage facility in Garland, Texas, does not have the capacity to store liquids that need refrigeration – most importantly, urine, which is otherwise collected for toxicology screening. Thus, non-report evidence kits lack this piece of potential evidence. Study participants were concerned about this loss of evidence and the potential impact on patients who could benefit medically from having toxicology screening. One participant reported that those most likely to use the non-report option may be those for whom reporting would have a family or work impact, or those who may have been a victim of drug-facilitated sexual assault. Without toxicology evidence, drug-facilitated sexual assault cannot be proven, leaving prosecution improbable.

We were able to make arrangements with our laboratory at [the hospital]. We have a lockbox [and] a whole procedure set up, and we will store the toxicology samples in the non-reports that we think are drug-facilitated. We will store the samples here for the two years, whereas we will go ahead and ship the [other] evidence. But we'll take the samples and keep those because it's simple. It's just a couple of blood tubes and some urine cups, and we will have them frozen in the lab for two years.

Regardless of DPS storage capacity, many communities have found creative solutions in order to address victims' medical needs and possibly even future forensic needs. Some hospitals store urine and blood samples from non-report cases in-house while still sending other accepted evidence to the DPS storage facility. Nonetheless, a standard procedure should be developed.

One SANE described this capacity issue and her dedication to including toxicology screening in the medical care of her patients: "A majority of places don't do their own drug testing. That is all part of what they consider evidentiary [need]. For us, we consider it part of medical need. It does have an evidentiary value, but it is all part of their health care."

Program Efficiency

While the non-report forms are clear and user-friendly, additional time and care may be necessary on the part of the SANE or other medical professional completing them, since non-report exams are conducted infrequently and SANEs do not have the opportunity to develop familiarity with the process. Study participants also reported that additional time is spent on non-report cases (in contrast to reported cases), both in tracking and de-identifying bills associated with non-report cases and in packing and shipping the evidence. Participants reported that the time it takes to conduct non-report exams ranges from no added time to one hour and forty-five minutes more than a reported case. Other participants noted that the exam itself may take less time if the SANE is not collecting urine.

One SANE described the value of taking extra time to support the non-report option: "It is a lot of extra work for one person, but I feel in all fairness that's the way it has to be until we're 100% sure of the complete process and all the pieces of the puzzle."

Something I've learned through this process is that hospitals don't do their own billing. Even hospitals have a little bit of a difficulty with figuring out how the billing is done. Hospitals are set up to bill patients, and here we are telling them not to do that, and they are saying, "But that's all we do." Yes, that process could definitely be improved on, and it's slowly being worked through. There was one hospital I had five kits for and no invoices. I got tired of waiting, so I contacted the SANE, and she said she had been trying and couldn't get anybody to do anything. She gave me the name of a hospital administrator, who gave me the name of the billing guy, and I left him a message, saying, "You need to bill us so we can pay you." At this point it's up to [DPS] and the SANEs to make this work. I want to make this work, so the hospital doesn't quit doing it because we don't pay. I have several where I have a case without an invoice or an invoice without a case, and I have had to call and follow up on that.

Confidentiality in Tracking and Billing

Due to the confidential nature of the non-report program, very little data are collected and connected to each evidence kit. For each kit, the DPS storage facility has the hospital that sent the kit, the date it was received, and the victim's date of birth. Additionally, a unique identifier is associated with the non-report case, one that is typically created by the SANE. The unique identifier is used to track the kit in case the victim decides to report the assault and reclaim the evidence. Some SANEs create unique identifiers that are not related to other information. Others use medical record numbers that come with the UB04 (the billing document). This assists hospitals when DPS reimbursement arrives, so that they can apply it appropriately.

Although the evidence itself is "de-identified," study participants reported some problems with compromised confidentiality in the billing process. For example, the patient's name may be included on billing forms

submitted to DPS. Often bills are generated from a centralized billing facility, and SANEs may not have access to the process. This is problematic both because the program is designed to be confidential and because the DPS records may be subject to requests for public information. Currently, DPS officials manually redact invoices that arrive with patient names.

Some SANEs are getting involved in billing to ensure confidentiality, but it is time-consuming and takes them away from patient care. The SANE effort involved in correcting billing problems may not be an efficient use of their time.

Storage and Shipment of Evidence

Study participants reported a wide variety of practices in terms of storage of evidence prior to shipment to the DPS facility. Hospitals that participate in the DPS storage system may retain the evidence for a range of one day to three weeks. While some participants reported that they attempt to have the evidence shipped to DPS within 24 hours, others intentionally store the evidence for a period of time. In-house storage may be used with the assumption that the victim may change her or his decision about reporting within a week or two. Others store the evidence in the hospital for a period of time in order to batch kits until several can be sent at once. Hospitals report that storage internally before kits are sent to DPS is not a problem.

As mentioned above, some hospitals are sending most of the evidence to DPS, but retaining blood and urine samples in-house. Other hospitals are storing all non-report evidence internally and not utilizing the DPS storage facilities at all.

Chain of Custody Concerns

The chain of custody with non-report cases must be secure. Hospitals generally have protocols set up for secure storage until evidence is shipped to DPS. However, several participants expressed concern about their ability to protect and ensure the chain of custody with non-report cases in particular.

While it is legitimate to utilize FedEx and other mail carriers to send evidence to DPS, one SANE described her hospital's process and some of the persistent confusion around chain of custody:

When we have a non-report, if it's [during] business hours, Monday through Friday, we can walk it over to the mailroom. It's given to them. They FedEx it, and that's great. If it's on a weekend or a night when the mailroom's not open, we're locking these kits up in our SANE office until we can get to them in the morning and get them mailed, so they're waiting. I don't know what that does with chain of custody. I mean, I don't know if it's lost anyway once you give it to the mailman. That's been one of our questions: "What happens to the chain of custody once we give this to the FedEx driver?"

The kits go to [the DPS] lab in Garland, because that is the new facility with lots of space right now. So that's where they are being kept. They are usually shipped through FedEx or UPS or US Mail, whatever shipping method the hospital typically uses for sending their stuff. A secure carrier sends it to [the DPS] lab. There is a document that is a lab submission form, where they put just minimal information into our computer system. We have a computer program that is called a LIMS – a laboratory information management system. When we get a [non-report] case, ... it's being treated as a case, even though a police report hasn't been filed so it's not officially forensic evidence. So it's kind of in this *Neverland* until a report gets filed. So we have a separate database for it, [one] that is separate from all our actual crime cases. We have evidence techs who do that [enter data] when the evidence comes in through the mail. For this database, [the information] is much more limited. All they do is put in the hospital, so we know where it came from, [and] the date it was received, and we do take the victim's date of birth, because we need something to tie all the paperwork together. We have this unique identifier that's supposed to be created by the SANE or whoever is taking evidence. The tech puts it into our computer system and then sends me a receiving document, saying, "We got this case from this hospital, such and such a date was the exam," and we assign it a lab ID. So as soon as we put it in the computer, it gets assigned a number, and those get printed on the barcodes, and they put the barcodes on the receiving paper and on the evidence itself. Everything in our system is tracked through barcodes. So when people in the lab are processing evidence [or] when they pick up a package of evidence, they have to scan it, and if it goes to someone else, they have to scan it, because everything is a chain of custody.

FINDING IV: Raising Awareness

The non-report option has been available for two years in Texas. While communities have been focused on developing protocols and grappling with implementation, awareness-raising activities have been limited. Nonetheless, participants reported surprise that the non-report option had not been utilized more frequently in this infancy period.

Participants also identified the need to move toward awareness-raising activities among medical personnel, rape crisis center advocates, the criminal justice system, and the community at large, now that processes and protocols are becoming more familiar.

Awareness-Raising

Some participants reported adequate knowledge of the non-report option. SANE coordinator meetings have been useful in educating SANEs about the non-report program. Other professionals cited

We've kind of been waiting to see what the hospital is going to do, waiting to see what TAASA is going to do, just kind of hanging. If someone asked the question, most definitely we can give them correct information. My staff knows what to tell them because we like [the non-report option]. We really like it, and if they want to report, we like that, too. We like the new opportunity that you have because so many people don't know if they want to tell, and they think about it, and they throw it around in their mind forever.

communications from the Texas Association Against Sexual Assault (TAASA) and Texas Council on Family Violence (TCFV) as helpful in their learning about the new law. Participants reported very positive feedback on the usefulness of TAASA's brochure about the non-report option, citing its relevance for patients, rape crisis centers, law enforcement, and all other audiences.

SANEs and rape crisis centers are already providing education about the non-report program in the community, through hotlines (online and telephone), in hospital settings, and during SART (Sexual Assault Response Team) meetings. One SANE emphasized the importance of educating hospital staff:

We are only as good as our first contact [victims] make at the hospital, because [victims] are not calling 911. They are going directly to their doctors or the ER and saying, "I think I've been sexually assaulted; I think I've been raped, and I don't want to report to the

police.” Well, [what] if that triage nurse is there and says, “I think you have to tell the police,” or “What do you want us to do about it?” Wrong!

Another SANE described her creative efforts to educate hospital staff:

I put a PowerPoint presentation together, and I met every single nurse and physician over a period of seven days. I came in at midnight or seven in the morning or six or whatever time it was. But we had a list and we just checked them off. I printed off the PowerPoint and put it on a clipboard, and I found [the nurse or physician] by the bedside or in the break room, and I said, “We need to talk about this.” It was probably the single most successful training they had, because every single person got it. We didn’t have to rely on word of mouth to edit any of the information.

Interview and survey participants alike agree that more public awareness will be useful in terms of increasing access to, and utilization of, the non-report option. Advocates connect the need for

The non-report thing is not getting promoted because people are afraid to promote it. The hospital isn’t promoting it because they don’t need the influx of potential victims coming in – SANEs can’t handle it. Unless you are intelligent enough to go out there and read the laws, or read the paper, or whatever comes out at that time, you are not going to know.

greater awareness of the non-report option to the need for greater awareness of services for sexual assault in general. Education about the non-report option falls nicely into broader topics about sexual assault services.

A higher level of awareness among the general public is important even for those who know about the non-report option. If a victim reports to law enforcement, the law enforcement agency generally knows which hospitals

conduct medical forensic exams and can refer the victim appropriately. With non-reports, a community member who has been assaulted may not have that level of awareness and may not know where he or she can get a medical forensic exam.

In addition to the general public, many participants reported that law enforcement officials and some advocates are still largely unaware of the non-report option. Furthermore, first responders may have difficulty seeing beyond the forensic element of the SANE exam. In other words, law enforcement officers and advocates may focus heavily on the evidence collection that occurs

during a SANE exam, while missing the importance of the exam's attention to the victim's medical well-being. A comprehensive medical exam is precisely what some victims are seeking following a sexual assault, with forensics a secondary concern as they take advantage of the non-report option for a less pressured decision about whether or not to proceed with a report.

Finally, despite the materials available through TAASA, participants reported lack of resources as a barrier to fully marketing the non-report option. It should be noted that following the research team's completion of interviews and surveys, TAASA released a wide array of public awareness materials through www.hopelaws.org.

Collaborative Relationships

In sexual assault crimes, collaboration among medical personnel, rape crisis centers, and the criminal justice system is critical to develop awareness in, and ensure a smooth process for, victims. This is particularly true for non-report cases that might eventually convert to reported crimes. Respondents identified collaborative relationships and good communication as strengths that facilitate the development of non-report procedures and protocols, improve the efficiency of non-report exams themselves, and increase the potential for non-report evidence to inform open investigations.

The minute they make contact, [hospital personnel] don't even park [victims] in a chair. They take them back to the exam room. They notify the charge nurse in the ER, so they can make contact with [victims] and get more information – like what is the time line, and what are their true wishes. And then they get the rest of the team activated. It makes a huge difference. The feedback we have gotten from the patients is outstanding.

Good communication and relationships are also important within the medical community. Since the non-report option is relatively new and since there has been less opportunity to develop a well-oiled process (given the infrequent nature of non-reports to date), it is vital that SANEs communicate with one another to develop appropriate non-report processes. One SANE reported, “We muddled through the first one, then we called each other and we talked about it.” Another SANE stated, “Everybody [on the SART] stepped in, and after we established the protocol and signed it in, we took it to the emergency departments.” Learning from one another

is a skill that SANEs have honed, given their specialization and frequent isolation within the larger medical community.

DISCUSSION & RECOMMENDATIONS

The implementation of the new Non-Report Medical Forensic Exam Program has been highly successful and efficient during its first two years, especially given that the comprehensive Texas Association Against Sexual Assault (TAASA) public awareness effort was only recently released. Study participants from multiple disciplines in direct practice with sexual assault victims across the state confirm that the non-report option, while still in its infancy, is working relatively well. Those who have direct contact with the program, primarily SANEs, are building their procedures for, and becoming comfortable with, non-report cases, and rape crisis center advocates are incorporating the non-report option into community education activities. Most importantly, victims of sexual assault now have time to consider their reporting decisions while evidence of their assault is securely collected and stored.

Nonetheless, challenges remain if the program is to be fully utilized in the future. Findings from the study lead us to several recommendations for improvement of the non-report option in Texas.

1. Increase awareness of the non-report option among:
 - SANEs and medical personnel – including ER staff
 - Rape crisis center staff and volunteers
 - Law enforcement
 - General public
2. Explore the use of medical forensic exams by male victims of sexual assault and promote the non-report option among men and other special populations.
3. Explore the dilemma facing hospitals and SANEs who treat 17-year-old victims. Provide clarification to guide practice in conducting sexual assault exams for 17-year-olds.

4. Consider the benefits and pitfalls of standardizing the storage protocols for evidence in non-report cases, in particular regarding the length of time evidence is kept in hospitals before being sent to the DPS storage facility.
5. Explore chain of custody issues. The Office of the Attorney General, Texas Department of Public Safety, and TAASA may provide guidance, if not policies, on these concerns.
6. Explore the impact of lost evidence in non-report cases on the criminal justice system, in particular toxicology evidence, and the feasibility of including toxicology evidence in the DPS storage system. In-depth analyses of cases that began as non-report cases and converted to reported cases that were ultimately prosecuted would be useful in determining the true impact of differences in evidence collection among non-report and reported cases.
7. Increase education in the criminal justice system – among law enforcement, prosecutors, and juries – using trauma-informed clinical expertise, about trauma and why victims may not report a sexual assault immediately.

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IDVSA

INSTITUTE ON DOMESTIC VIOLENCE AND SEXUAL ASSAULT

The mission of the Institute on Domestic Violence and Sexual Assault (IDVSA) is to advance the knowledge of domestic violence and sexual assault in an effort to end interpersonal violence. IDVSA accomplishes this through research, education, training and technical assistance, and collaboration with university and practitioner communities, and the community at large.

It is the vision of IDVSA that its multidisciplinary, researcher-practitioner, collaborative approach will enhance the quality and relevance of research efforts and their application in service provision. That vision has been realized in our recent research focus in the areas of human trafficking, domestic violence, sexual assault, and resiliency in service providers.

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