Accessing Sexual Assault Medical Forensic Exams

Victims Face Barriers

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SEXUAL ASSAULT MEDICAL FORENSIC EXAMS AND VAWA 2005 BRIEF 2

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The Violence Against Women Act required that as a condition of eligibility for federal STOP (Services*Training*Officers*Prosecutors) grant program—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 federal requirement. In 2010 the National Institute of Justice funded the Urban Institute, George Mason University, and the National Sexual Violence Resource Center to study how this new provision was being met by states. From this study, we learned which entities pay for medical forensic exams in state and local jurisdictions throughout the United States, what policies and practices determine payment, which services are provided in the exam process, how exams are linked to counseling, advocacy, and other services, and whether exams are provided to victims regardless of their reporting or intention to report the assault to the criminal justice system.

We also learned that these issues are irrelevant for some victims for whom gaining access to the exam is the issue. Barriers to accessing the exam prevent some victims from seeking help. Specifically, individuals identifying as non-English speakers, immigrants, or American Indians face barriers in getting the exams, such as lack of culturally relevant practices among first responders, lack of trained sexual assault nurse examiners (SANEs) to conduct the exam, and language barriers. When victims are unable to get the exams, or do not get the exams in a culturally relevant and appropriate manner, people who are victimized are not helped, perpetrators of sexually violent crimes are not prosectued, and public safety is not improved.

Accessing the Exam

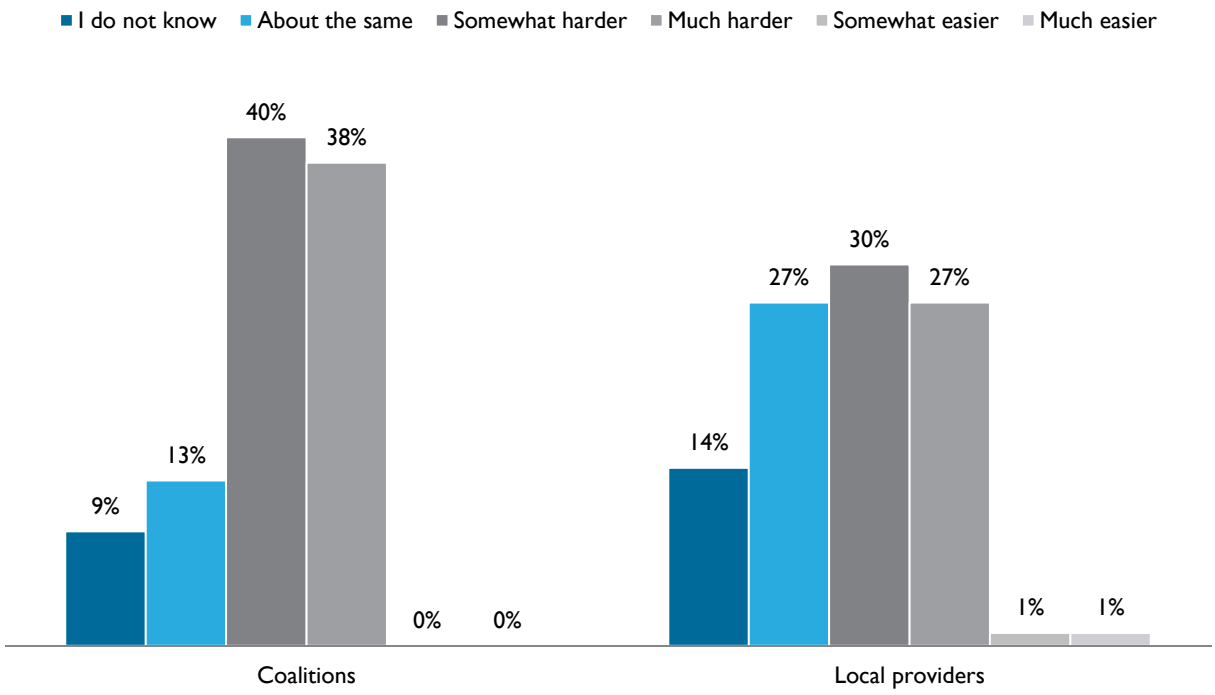
The sexual assault medical forensic exam (often referred to as a rape kit), if a victim chooses to undergo one, is often the first step in addressing his or her medical needs. The forensic exam has two major components: medical services and forensic evidence collection. The medical services are intended to treat minor injuries and concerns around possible pregnancy or sexually transmitted infections. Serious injuries are treated as separate medical care from the forensic exam. The forensic evidence collection 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 be a valuable link to additional medical, counseling, and advocacy services.

We conducted online surveys with representatives from 47 state-level sexual assault coalitions and 407 local community-based service providers about medical forensic exams. We also conducted case studies that involved in-person interviews with state and local stakeholders (e.g., victim advocates, SANEs, law enforcement, and prosecution). These representatives have considerable experience and expertise in the issues, and the data provided represent their professional opinions and perceptions. In addition, we conducted focus groups with victims where we took a closer look at what is happening around these issues in 19 jurisdictions across six states.

According to survey respondents, non-English-speaking victims have a more difficult time accessing the exam than English-speaking victims (figure 1). Through the surveys, 78 percent of coalitions and 57 percent of local providers reported that non-English-speaking victims had a somewhat or much harder time obtaining exams than did English-speaking victims. Thirteen percent of coalitions and 27 percent of providers reported the ability to access exams for English-speaking and non-English-speaking victims at about the same rate.

We also asked survey respondents how it is harder for non-English-speaking victims to obtain exams. Both respondent groups indicated that these barriers are both language and cultural. During case studies, these themes and other themes were reiterated in several interviews, such as geographic issues and issues for American Indian victims and tribal jurisdictions.

Figure 1. Respondents on the Ease with Which Non-English-Speaking Victims Can Obtain an Exam Compared with English-Speaking Victims



Note: *N* = 47 valid responses from state-level sexual assault coalitions; *N* = 409 valid responses from local providers.

Language Barriers

State and local survey and case-study respondents reported that non-English-speaking victims face many challenges to accessing the exam, understanding the exam process, and/or understanding the criminal justice process and their rights as victims. Several case-study respondents 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; it is also difficult for SANEs to understand the chronology of events to make decisions on what types of evidence to collect. In some cases, family members or members of law enforcement may be relied upon to communicate between the SANE and victim. When family members are used, the victim's privacy may be compromised. When law enforcement is used, it complicates the victim's 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.

Cultural Barriers

Non-English speakers and immigrant populations face many cultural barriers to accessing exams and other services. Primary among these barriers is a lack of sensitivity and cultural competency on the part of local service providers. In interviews, some respondents 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.

Immigrant and non-English-speaking victims do not know about the exams and other services. Coalitions reported minimal outreach to such communities to educate them on how to contact local sexual assault service providers, and that information was not available to victims in multiple languages.

Coalitions 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.

In both survey responses and case-study interviews, we heard that immigrant and 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 is a major barrier to such victims accessing exams. This fear may come from a 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 his or her state, undocumented victims are afraid to seek services.

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 acknowledgment 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 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 face unsafe environments as a result.

Geographic Barriers

Geography can make it hard to find medical care and forensic exams. Certain rural areas may be many miles from a hospital or facility with a SANE program. In some cases, communities do not have trained examiners, so victims receive exams from someone who is not specially trained to conduct them. In other cases, victims may travel long distances to get examined by a trained provider. To reduce victims' travel burden, one state with large rural areas is developing a satellite system of mobile SANE units that are based in hospitals but can respond in clinics in rural areas.

American Indian Victims and Tribal Jurisdictions

In three case-study states, we learned about American Indian victims' experience with services after sexual assaults. We conducted focus groups with American Indian victims and met with stakeholders—including victim service, SANEs, law enforcement, and prosecution, on two tribal reservations, a state-level American Indian coalition, and three local jurisdictions—that served American Indian victims within both urban and tribal localities. Several of these respondents indicated what research has already reported—that rates of sexual assault victimization among the American Indian population are higher than among other groups of women. The Bureau of Justice Statistics' national study found that American Indian/Alaska Native women are victimized at higher rates than white, black, Hispanic/Latina, and Asian/Pacific-Islander women.[1]

Although large numbers of American Indian women have experienced sexual assaults, few get the help and response they need to restore their well-being and hold their perpetrators accountable. Across all respondents focused on the American Indian population, we heard that these victims face many challenges accessing and receiving the exam and other medical services, and have difficulty receiving a criminal justice response.

Accessing Services

Across the three states with sizable Native American populations, American Indian victims on tribal reservations face significant challenges to accessing exams 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 an exam and treatment.

In the two other states where we visited tribal reservations, we learned more about the significant issues faced when accessing exams. In one of these states, sexual assault cases are forwarded to Indian Health Services facilities, which lack 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 might 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.

In another state, issues around accessing the exam were even more complex. Their local health service also 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. These SANEs pursued gaining access to two area hospitals off the reservation and met several challenges. Both hospitals expressed reluctance in allowing these nurses 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 because the hospital was being territorial about performing the exams or if it was because of racism.

Culturally Relevant Services

Across several stakeholders during case studies, we learned there was a lack of culturally relevant approaches in working with individuals who are American Indian, which made it more difficult for these victims to go through the exam process. Some areas had few resources for Native service providers. Other non-Native service providers and medical personnel were not trained to understand how to interact with individuals who are American Indian, sometimes leading to misunderstandings. Victims might be interpreted as reluctant to cooperate or passive about their experience; though this might not be the case. One advocate recounted witnessing SANEs becoming impatient with the pace American Indian women participate in the process, with their lack of crying, and quietness; she felt SANEs might also misunderstand the value of silence in the American Indian communities. The exam process can be another assault on the senses for those not comfortable with the intrusive nature of the questioning and procedures.

Various stakeholders posited that they frequently observed racism when working with American Indian victims, living both on the reservation and within the urban community. 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 American Indian victims differently from women from other groups. Perceived racism was a constant theme in our investigation; it was raised during interviews with each agency that works with American Indian women, including victim service providers, law enforcement, nurses, and prosecutors. These respondents reported seeing racism happening with other providers with less experience and with less interest in working with individuals who are American Indian.

Cultural Barriers

Finally, several stakeholders 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 those committing the sexually violent crime. A non–American Indian respondent who works with victims who are American Indian reported that there appeared to be some tribal protection of those who commit such crimes.

Voices of Victims

"Almost all of the [police] officers are white, very rarely are they Native. They are not sensitive to us and our community. When my daughter got assaulted, and they took her to [the hospital], there were two white nurses at the hospital. No one offered us any condolences."

Another barrier to victims' seeking help, as several respondents cited, is American Indian communities' distrust of systems, such as law enforcement agencies, child protective services, hospitals, and other government agencies. This mistrust is based on historical trauma and mistreatment of tribal communities by such systems. Advocates noted mistreatment from the past (e.g., nonconsensual sterilization of American Indian 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. One state-level respondent reported that her perception is that few American Indian women get exams because of access issues and, perhaps more disturbingly, because of the criminal justice response these women receive. She 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. However, when this reluctance to refer a victim occurs, that victim is not given full information to make an educated decision about whether to get the exam; medical services, which a victim may want and need more than the evidence collection, are thus not emphasized.

What Should Be Done?

When victims face barriers to accessing exams, they lose much more than the evidence that might build a criminal case against their perpetrator and an immediate medical response. They lose opportunities to seek important services in both the short- and long-term periods following the assault. Our findings lend themselves to implications for policy and practice in several ways:

- Continue efforts to make trained examiners available throughout states. The 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 exam process. Continued funding, technical assistance, and training efforts at the federal and state level are essential to continue such progress.
- 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.

Note

1. Marcus Planty, Lynn Langton, Christopher Krebs, Marcus Berzofsky, and Hope Smiley-McDonald, *Female Victims of Sexual Violence, 1994–2010* (Washington, DC: Bureau of Justice Statistics, 2013).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