Forensic Compliance
in Colorado:

An Examination of System Response to Sexual Assault

FCEP
FORENSIC COMPLIANCE
EVALUATION PROJECT

FORENSIC COMPLIANCE
EVALUATION PROJECT

Forensic Compliance
in Colorado:

An Examination of System Response to Sexual Assault

September 2013

COLORADO COALITION AGAINST SEXUAL ASSAULT
FREEDOM FROM SEXUAL VIOLENCE

STATE OF COLORADO
Division of Criminal Justice

FCEP

Acknowledgements

Authors:

Karen Moldovan
Program Manager
Colorado Coalition Against Sexual Assault

Terri Livermore
Sexual Assault Response Project Coordinator
Colorado Division of Criminal Justice

We are grateful for support from members of the Colorado Sexual Assault Response Protocol Committee in the creation and compilation of this study and report.

- Kim English, Research Director, Office of Research and Statistics, Colorado Division of Criminal Justice
- Nancy Feldman, Manager, Office for Victims Programs, Colorado Division of Criminal Justice
- Kate Horn-Murphy, Victim Witness Services Unit Director, Office of the District Attorney (17th Judicial District)
- Erin Jemison, Executive Director, Colorado Coalition Against Sexual Assault
- Linda Johnston, Project Director, Colorado District Attorney's Council, Ending Violence Against Women Project
- Anissa Jones, SANE Program Coordinator, St. Anthony's Hospitals
- Debbie Kasyon, VAWA Administrator, Colorado Division of Criminal Justice
- Amy Miller, Public Policy Director, Colorado Coalition Against Domestic Violence
- Alexa Priddy, Outreach Coordinator, Colorado Coalition Against Sexual Assault
- Carolyn Roberts, Detective, Boulder County Sheriff's Office (Retired)
- Mark Slavsky, Detective, Wheat Ridge Police Department
- Scott Snow, Victim Assistance Unit Director, Denver Police Department
- Michelle Spradling, Project Director, Denver Sexual Assault Interagency Council

We would like to also acknowledge Joanne Archambault and Kim Lonsway from End Violence Against Women (EVAW) International. EVAW International is the national technical assistance provider for state entities working to implement forensic compliance. Their resources and assistance contributed greatly to this report.

Additional thanks to Sara (Thome) Gonsalves and the staff of the Minnesota Coalition Against Sexual Assault (MNCASA) for training and technical assistance on forensic compliance. Their training session "Towards the Spirit of VAWA 2005: Multi-Disciplinary Strategies for Forensic Compliance" presented at the End Violence Against Women International 2011 conference assisted in the initial conceptualization of this report.

FCEP

Table of Contents

Executive Summary **1**
- Understanding Forensic Compliance 1
- Study Intent 1
- Methodology 2
- Major Findings 3
- Recommendations 3

Understanding Forensic Compliance **7**
- Forensic Compliance Background 8
- Reporting Decisions 9
  - National Models for Reporting Options 10
- Colorado Forensic Compliance Response 11

Methodology **12**
- Design and Data Collection 12
- Data Analysis 13
- Additional Data Collection and Analysis 14

Survey Response Demographics **15**

FCEP Study Findings **17**
- Medical Reporting Case Analysis: Findings 17
- Professional Responder Survey Analysis: Findings 20
  1) Victim Reporting Decisions 20
     - Reporting or Not Reporting to Law Enforcement 20
     - Seeking or Not Seeking Medical Services 20
     - Anonymous Reporting 21
       - Prosecutors – Challenges in Prosecuting Cases That Began as Anonymous 22
  2) Medical Mandated Reporting 22
     - Medical Mandated Reporting – Support for Colorado's Law 23
     - Medical Mandated Reporting – A Comprehensive Examination 24
       - Support for Medical Mandated Reporting 24
       - Reasons for Supporting and Opposing the Law 25
       - Barriers/Issues with the Law 26
       - Suggested Changes to the Law 27
       - Medical Facility Policies and Training 28
  3) Existence and Use of Response Protocols: Comparison between Law Enforcement Reporting Victims and Medical Reporting Victims 28
     - Response Protocols 29
       - Response Protocols – Law Enforcement Reporting Victims 30
       - Response Protocols – Medical Reporting Victims 31
       - Law Enforcement Interaction with Medical Reporting Victims 31

Advocate Response to Victims 32
Advocate Response – Law Enforcement Reporting Victims 34
Advocate Response – Medical Reporting Victims 35
4) Intimate Partner Sexual Violence (IPSV) 36

Recommendations **39**

Supplemental Information: Findings by Discipline **42**

Medical Professionals **43**
Respondent Demographics 43
Anonymous Reporting 43
Medical Mandated Reporting 44
Response Protocols 45
Policies – Law Enforcement Interaction with Victims 45
Advocate Response to Victims 46
Intimate Partner Sexual Violence 46

Advocates (System and Community-based) **48**
Respondent Demographics 48
Anonymous Reporting 48
Medical Mandated Reporting 49
Response Protocols 50
Advocate Response to Victims 51
Intimate Partner Sexual Violence 51
Advocates Screening for Sexual Assault in Domestic Violence Cases 52

Law Enforcement **53**
Respondent Demographics 53
Anonymous Reporting 53
Medical Mandated Reporting 54
Response Protocols 55
Advocate Response to Victims 55
Medical Reporting Cases 56
Policies – Law Enforcement Interaction with Victims 56
Documentation 56
Evidence Tracking 57
Intimate Partner Sexual Violence 57

Prosecutors **59**
Respondent Demographics 59
Prosecution Challenges – Case Conversion 59
Medical Mandated Reporting 60
Intimate Partner Sexual Violence 61

FCEP

Executive Summary

Understanding Forensic Compliance

The term forensic compliance commonly refers to victims' ability to access free medical forensic exams without the victims' participation with a law enforcement investigation. The sexual assault statistics regarding non-stranger perpetrators, combined with increased knowledge of sexual assault victim dynamics, constituted some of the reasons for the federal forensic compliance mandate. Through the passage of landmark legislation in 2005, victims can access critical medical services, including time-sensitive evidence collection, without having to make an immediate decision regarding participation in the criminal justice system. If implemented properly, this process gives victims opportunities to learn more about their options so that they can make empowered choices regarding participation in a formal law enforcement investigation, while simultaneously enabling time-sensitive evidence collection and access to medical care.

Study Intent

The Forensic Compliance Evaluation Project (FCEP) sought to identify effective approaches and challenges encountered with the implementation of forensic compliance[1] laws mandated through the federal Violence Against Women Act (VAWA) 2005[2] and related Colorado statutory changes in 2008.[3] The forensic compliance laws mandate that sexual assault victims receive medical forensic exams at no cost to the victim without required participation in a law enforcement investigation. In Colorado, victims fall into two reporting categories:

1 *Forensic compliance* means that states must be in compliance with federal medical forensic exam mandates to receive federal Violence Against Women Act funding.

2 42 USC § 3796gg-4(b)(3)(D)(d).

3 Colo. Rev. Stat. § 18-3-407.5.

1) Medical Reporting Victims – Victims who seek medical services following a sexual assault but elect not to participate in the criminal justice system at the time of receiving medical services.

2) Law Enforcement Reporting Victims – Victims who report the assault to law enforcement prior to, at the time of, or independent of a medical forensic exam.

The FCEP study examined the implementation and impact of forensic compliance laws through a quantitative analysis of adult forensic compliance cases, and quantitative and qualitative surveys of professional responders to adult sexual assault cases – medical professionals, victim advocates, law enforcement officers, and prosecutors. The FCEP study did not survey victims as the intent of the project was to determine the system response to forensic compliance laws. The purpose of the study was to gather data for three primary research objectives:

1) Examine the case outcomes that resulted from Colorado's forensic compliance 2008 statutory changes (Colorado House Bill 08-1217);

2) Detect challenges and identify gaps for medical reporting victims in the implementation of the forensic compliance laws among the four primary responding professions: medical, advocacy, law enforcement, and prosecutors; and,

3) Evaluate the effectiveness and clarity of current Colorado statutes related to the response to adult sexual assault victims.

Methodology

Two types of data collection were utilized:

Case Analysis: The project reviewed 151 adult medical reporting cases to determine the current reporting status of each case, and if applicable, the length of time between the exam and law enforcement report, as well as case outcomes.

Professional Responder Survey: The project conducted a snowball sampling method with SurveyMonkey® to collect responses regarding forensic compliance from 239 professionals comprised of: 89 law enforcement officers, 70 system and community-based victim advocates, 41 prosecutors, and 39 medical professionals.

Data was collected between June 15, 2011 and September 21, 2011.

4 Medical reporting case is defined as a case with a medical reporting victim who seeks medical services following a sexual assault but elects not to participate in the criminal justice system at the time of receiving medical services.

Major Findings

The **case analysis** found that, in a 33 month period beginning with the law's inception in July 2008 through March 2011, Colorado had a total of 151 medical reporting cases. Based on an analysis of 127 cases for which complete information was obtained, Colorado had an 18 percent case conversion rate[5] with 56 percent of those converting within 72 hours. The analysis also showed that most of the converted cases were investigated by law enforcement, but none were filed for prosecution.

The **professional responder surveys** collected information from 239 respondents with a geographic representation similar to Colorado's overall population distribution. Of the four professions surveyed, law enforcement officers contributed the highest number of responses with 89 respondents. Seventy advocates, 41 prosecutors and 39 medical professionals[6] also completed the surveys. The surveys examined: 1) victim reporting decisions; 2) utilization of the medical mandated reporting law; 3) existence and use of sexual assault response protocols; and 4) response to intimate partner sexual violence (IPSV). Anecdotal survey feedback indicated that reporting decisions articulated to the survey respondents by victims are complex and unique to each individual. However, distinct themes emerged regarding responders' perceptions of victims' reasons to report as well as the barriers they face in reporting. Additionally, the survey established that over half of all respondents have encountered at least one victim wishing to remain anonymous.

Responses indicated a more comprehensive advocate response to law enforcement reporting victims[7], where greater clarity exists around responders' roles and responsibilities, than for medical reporting victims. Formalized protocols are also more likely to exist for law enforcement reporting cases.

Intimate partner sexual violence cases involve potentially conflicting domestic violence and sexual assault statutes resulting in unique challenges that must be considered in the response to these victims. The study demonstrated a notable lack of consistency and understanding among responders regarding IPSV cases.

Recommendations

The data obtained in this study clearly demonstrates the issues and gaps in consistent, statewide implementation of forensic compliance. The report recommendations are delineated into six primary categories: 1) convene a statewide, multidisciplinary committee, 2) statutory changes, 3) policy/protocol development, 4) training needs, 5) outreach/education, and 6) further research.

---

5 Case conversion occurs when a victim later reports her/his assault to law enforcement after initially declining to participate in the criminal justice system.

6 Medical professional surveys were distributed primarily to a limited population of medical professionals who would likely have experience working with sexual assault victims such as SANEs and other Colorado hospitals and clinics with medical forensic exam programs.

7 Law enforcement reporting victims are those victims who report the assault to law enforcement prior to, at the time of, or independent of a medical forensic exam.

1) Statewide, Multidisciplinary Committee

The Colorado Coalition Against Sexual Assault (CCASA) and the Division of Criminal Justice (DCJ) should convene a statewide, multidisciplinary committee (including law enforcement, system and community-based advocates, medical professionals, prosecutors, and other key stakeholders) to develop a strategic plan to implement the following recommendations. Committee sustainability (including funding) and active participation is necessary to successfully achieve these goals.

CCASA and DCJ will also continue to work with other statewide entities addressing sexual assault and will partner and collaborate with local communities to address these issues and create system change.

2) Statutory Changes

- Clarify the medical mandated reporting statute, which requires licensed medical professionals to report injuries caused by suspected crimes to law enforcement:
    - **who** reports suspected crime,
    - **when** a report is required,
    - **whether** a medical professional should have discretion in determining if a crime occurred; and
    - **what** explicitly constitutes injury as related to sexual assault (physical and/or emotional injury).
- Address the conflicts between arrest on probable cause of domestic violence and sexual assault victims' right to obtain a medical forensic exam with limited or no interaction with law enforcement.

3) Policy/Protocol Development

Protocols provide a mutually-agreed upon framework to institutionalize interagency interactions and ensure a high quality, consistent response to sexual assault victims. The use of established protocols creates an environment for better victim care and potentially increases involvement in the criminal justice process. Protocols must also recognize the intensely personal nature of this crime and balance the need for uniformity and consistency with the flexibility needed to address individual victims' specific needs.

- **Colorado Model Multidisciplinary Protocol (CMMP)** – The statewide, multidisciplinary committee should develop, distribute, and ensure the provision of statewide training on a written Colorado model protocol for both law enforcement reporting cases and medical reporting cases. This protocol will be adaptable to Colorado's diverse communities. The Colorado model protocol will include the following components:
    - A victim-centered approach regarding contact between law enforcement and medical reporting victims

- Information to be provided to victims, such as case conversion options, follow-up medical care, financial assistance, and appropriate referrals for advocacy services
- Detailed information on the intersection of the *Health Insurance Portability and Accountability Act* (HIPAA) and Colorado's mandatory reporting law and how local communities can be in compliance with both laws
- Clarification for medical professionals on mandatory reporting obligations
- Guidelines to detail best practices in utilizing both types of advocates (community-based and law enforcement) in responding to law enforcement reporting and medical reporting victims
- Guidelines for defining, tracking, investigating, and prosecuting converted cases
- Guidelines for responding to cases involving IPSV victims

- **Individual Agency Protocols** – Each responding agency should develop and/or update an internal written protocol for their response to sexual assault.

4) Training

- The multidisciplinary committee should ensure the implementation of multidisciplinary training on the Colorado model protocol. This training will include, but not be limited to, the following:
  - Law enforcement interaction in medical reporting cases
  - How to provide a victim-centered response utilizing community and system-based advocates for law enforcement reporting and medical reporting victims
  - Mandatory reporting obligations for medical professionals and advocates
  - Intimate partner sexual violence response
  - Information on the structure and function of Victim Compensation, and the ability to waive requirements
  - Strategies for the successful prosecution of converted cases
  - Multi-disciplinary screening questions for improved case identification (sexual assault and IPSV)
  - Billing and costs of medical services specific to their communities, including available funds to cover medical costs

5) Educational/Outreach

- The multidisciplinary committee should create an education/outreach plan and strategies for implementation, including funding.
- The multidisciplinary committee should develop appropriate educational materials (such as a brochure, website, and/or public service announcements) to explain

reporting options for victims. Outreach materials should be applicable for use statewide and be created in a format that is accessible in foreign languages and for varying levels of literacy.

6) Further Research

- The multidisciplinary committee should survey and/or conduct focus groups of victims regarding, at a minimum, reasons for participating or not participating in the criminal justice system, accessing or not accessing medical assistance, and the impact of anonymous reporting options.
- The multidisciplinary committee should facilitate a discussion of anonymous reporting feasibility by researching national practices for the following issues:
    - The percentage of anonymous reports versus reported assaults in other states
    - Victims' perception about anonymous reporting
    - Overall reports/arrest rates in anonymous reporting jurisdictions
    - Prosecution filings and convictions in anonymous reporting jurisdictions
    - Other alternative reporting options where victims do not directly report the assault to law enforcement
- The multidisciplinary committee should pursue additional research on Colorado's medical reporting cases including the following: the jurisdiction and date on which the crimes occur, the cost of the medical forensic exam, case conversion status, investigation, filing, prosecution, and case outcome.

Understanding Forensic Compliance

Sexual assault victims can choose whether or not to participate in the criminal justice system at the time of receiving medical services and Colorado delineates those choices into two categories:

1) Medical Reporting Victims – Victims who seek medical services following a sexual assault but elect not to participate in the criminal justice system at the time of receiving medical services.

2) Law Enforcement Reporting Victims – Victims who report the assault to law enforcement prior to, at the time of, or independent of a medical forensic exam.

These two options arose out of state and federal laws which are explained in detail below.

The intent of this research is to:

1) Examine the case outcomes that resulted from Colorado's forensic compliance 2008 statutory changes (Colorado House Bill 08-1217);

2) Detect challenges and identify gaps for medical reporting victims in the implementation of the forensic compliance laws among the four primary responding professions: medical, advocacy, law enforcement, and prosecutors; and,

3) Evaluate the effectiveness and clarity of current Colorado statutes related to the response to adult sexual assault victims.

Forensic Compliance Background

Research over the past few decades consistently demonstrates that rape and sexual assault[8] are two of the most underreported crimes in our nation.[9] The U.S. Department of Justice report, *Rape and Sexual Assault: Reporting to Police and Medical Attention, 1992-2000*, found that most rapes and sexual assaults against females were not reported to the police.[10] The report also determined that most injured rape, attempted rape, and sexual assault victims did not receive treatment for their injuries. The Violence Against Women Act (VAWA), originally signed into law as part of the Violent Crime Control and Law Enforcement Act of 1994, was reauthorized in 2005 and included specific requirements related to sexual assault forensic examinations. These requirements constituted the start of a national effort to create more opportunities for victims to access the medical system and the criminal justice system.

Most rapes and sexual assaults against females were not reported to the police and most injured rape, attempted rape, and sexual assault victims did not receive treatment for their injuries.

Bureau of Justice Statistics Selected Findings, August 2002.

Prior to VAWA 2005, victims' ability to access medical forensic exams at no cost to them could be contingent upon the victims' willingness to participate with law enforcement. The 2005 reauthorization defined what constituted a sexual assault medical forensic examination and prohibited requiring participation in a law enforcement investigation as a prerequisite to receiving the exam. A medical forensic exam included, at a minimum: the examination of physical trauma, determination of penetration or force, patient interview, and collection and evaluation of evidence.[11] The reauthorization used that definition to ensure that "nothing…shall be construed to permit a State, Indian tribal government, or territorial government to 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, reimbursement for charges incurred on account of such an exam, or both."[12]

The term **forensic compliance** commonly refers to this federal requirement for all states, territories, and tribes receiving federal VAWA Services, Training, Officers, Prosecutors (STOP) grant funding. The federal law mandated a deadline of January 5, 2009 when all entities receiving those federal funds had to be able to certify, in good faith, that they were, and would remain, in compliance with the VAWA 2005 requirements to continue receiving STOP grant funding. VAWA included these requirements as greater knowledge and understanding about the trauma and reactions of sexual assault victims began to influence public policy.

There are many reasons why a victim of sexual assault may want a medical forensic exam but not want to go forward with an investigation of the case at the time s/he receives

8 Rape is commonly defined as forced sexual intercourse, including vaginal, anal, or oral penetration. Penetration may be by a body part or an object. However, the definitions of *rape* and *sexual assault* differ by state. The term *rape* does not exist in Colorado statutes. In Colorado, "sexual assault" functions as the equivalent of *rape* and is defined in C.R.S. § 18-3-402. Unlawful sexual contact is defined in C.R.S. § 18-3-404.

9 Kilpatrick, Dean. (2000). *Rape and Sexual Assault*. Retrieved at http://www.soc.iastate.edu/sapp/Rape1.pdf.

10 Bureau of Justice Statistics. (2002). *Rape and Sexual Assault: Reporting to Police and Medical Attention, 1992-2000*. NCJ 194530.

11 28 C.F.R. § 90.2(b)(1).

12 42 USC § 3796gg-4(b)(3)(D)(d).

medical services. A 2012 Special Report from the U.S. Department of Justice's *National Crime Victimization Survey* determined that from 2006 to 2010, a greater percentage of victimizations perpetrated by someone the victim knew well (62%) went unreported to police, compared to victimizations committed by a stranger (51%).[13] It is far more typical for victims of non-stranger rapes to initially seek out a close friend or relative, a health care provider, or a victim advocate than law enforcement. According to the U.S. Department of Justice's *National Crime Victimization Study (2005)*, 73 percent of total sexual assaults were perpetrated by a non-stranger,[14] which assists in explaining why so few sexual assaults are reported to law enforcement. Additional reasons why a victim may want a medical forensic exam but may not want to immediately, if ever, report the assault to law enforcement may include, but are not limited to the following:

- Fear of not being believed or being blamed for the crime;
- Knowing or being related to the perpetrator;
- Intimidation by the perpetrator's position, power, or social status;
- Having engaged in drug or alcohol use;
- Willingly entered the perpetrator's car or home;
- Uncertainty of how to identify what happened;
- Fear of retaliation from the perpetrator;
- Fear of engaging with law enforcement (e.g., immigration status, past arrest history, etc); and
- Concern of name becoming public (which may be compounded by rural, military, campus or tribal considerations).

The sexual assault statistics regarding non-stranger perpetrators, combined with increased knowledge of sexual assault victim dynamics, constituted some of the reasons that VAWA 2005 included the forensic compliance mandate. Through the passage of this landmark legislation, victims can access critical medical services, including time-sensitive evidence collection, without having to make an immediate decision regarding participation in the criminal justice system. If implemented properly, this process gives victims an opportunity to learn more about their options so that they can make an empowered choice regarding participation in a formal law enforcement investigation, while simultaneously enabling time-sensitive evidence collection and access to medical care.

Reporting Decisions

The deeply personal nature of this crime, as well as the fears associated with seeking help, contributes to a climate in which victims are commonly reluctant or unable to seek and

13 Bureau of Justice Statistics. (2012). *Victimizations not reported to the police, 2006-2010*. Retrieved at http://www.bjs.gov/content/pub/pdf/vnrp0610.pdf.

14 Bureau of Justice Statistics. (2005). *National Crime Victimization Study, 2004*. Washington, D.C.: U.S. Department of Justice.

access formal services. The forensic compliance requirements within VAWA 2005 and the 2008 Colorado statute were designed to promote a more victim-centered approach to reporting sexual assault with the following intent:

- Increase reporting by providing victims choice and control over the reporting process in a manner more consistent with trauma response;
- Increase victim access to the criminal justice system and improve case outcomes by creating a process for evidence collection, storage and payment without forcing the victim into an immediate decision while still engaged in trauma response;
- Create a process to better enable the possibility for investigating and prosecuting all cases;
- Increase victim access to medical professionals; and
- Improve physical and psychological outcomes for victims.

What are the Principles of a Victim-Centered Approach?

- Consider the needs and wants of the victim first
- Listen and promote victim self-determination
- Coordinate and collaborate in the victim's interest
- Promote victim safety
- Hold self and others accountable
- Seek just solutions for all

National Models for Reporting Options

While VAWA 2005 provided a federal mandate regarding victim access to medical forensic services, it also allowed for flexibility in how states and communities implemented forensic compliance. Consequently, nationally and within Colorado, a wide spectrum of reporting options developed around the concept that victims in trauma response may need additional time to make the decision to engage with law enforcement and the criminal justice system, as opposed to never reporting the crime and not seeking medical attention.

Victims that decide not to immediately report the assault to law enforcement encounter various processes, depending on their state and local jurisdiction. Some victims, choosing not to immediately report the crime while obtaining a medical forensic exam, may not have any contact with law enforcement, while others may have to directly inform law enforcement that they are not reporting the crime to law enforcement at that time. In some states (including Colorado) medical professionals are required to report suspected criminal activity inflicted upon their patients, although sometimes that information is only used for data gathering while victim-identifying information remains anonymous (not in Colorado). Nationally, in some locations, the hospital stores the evidence while in others it is turned over to law enforcement for storage. Storage time frames also vary widely across the country. However, despite all the varieties of forensic compliance reporting processes, several general reporting trends have emerged.

Q: How does the VAWA 2005 forensic compliance requirement affect sexual assault victims serving in the military?

A: The Department of Defense has separate and distinct reporting policies and procedures from the VAWA 2005 forensic compliance requirement.

For more information about these policies and procedures, please visit: http://www.sapr.mil/HomePage.aspx?Topic=Sexual%20Assault&PageName=Reporting.htm.

As detailed above, the multidisciplinary response to sexual assault victims varies considerably depending on the type of reporting process established in the community. However, all victims, regardless of the reporting process used in their community, retain the ability to later make the decision to report the assault to law enforcement. The change in status, from a medical, anonymous or third party report to a law enforcement report is typically referred to as a "case conversion" or "converted case." A converted case simply means that after a period of time following the medical forensic exam, the victim made the decision to report to and engage with law enforcement. A case conversion does not equate to an automatic investigation, or attempted or successful prosecution.

Colorado's Forensic Compliance Response

Reacting to the federal mandates, Colorado's General Assembly, in 2008, passed House Bill 08-1217. This law enabled sexual assault victims to receive a medical forensic exam, in which the evidence collection portion is provided at no cost to the victim, without having to participate in the criminal justice system. In law enforcement reporting cases, the law enforcement agency with jurisdiction over the case pays the cost of the forensic evidence collection. The statute also requires law enforcement to retrieve and store the medical forensic exam evidence for medical reporting cases for a minimum of two years. The Division of Criminal Justice pays the cost of the evidence collection portion of the medical forensic exam for medical reporting cases using federal VAWA and federal Victim Compensation funds. Medical facilities invoice DCJ directly in an effort to prevent victims from receiving a bill for the evidence collection portion of the exam.

Victims can incur costs outside of the evidence collection portion of the medical forensic examination. Those costs may include, but are not limited to, laboratory testing, x-rays, medical costs related to injuries sustained during the assault, physician fees, emergency room fees, and prescriptions. In Colorado, two of the most common additional costs consist of the emergency department fees, which can range from $125 to over $1,000, and prescription drug costs, which vary from $200 to $500 if dispensed at the hospital. Hospital policies regarding these types of fees vary widely across the state with some hospitals waiving some of the fees for sexual assault victims, but currently no consistent statewide approach exists.

In 2013, the Colorado Legislature unanimously passed House Bill 13-1163.[15] This law assists medical reporting victims with medical costs associated with obtaining the exam as well as some medical costs resulting from the sexual assault.

Because Colorado is a highly decentralized state with 22 separate judicial districts, there is no central repository of information about sexual assault cases and medical forensic exams. Other than the requirements described in the forensic compliance statute, there are no additional statewide requirements regarding the immediate response to sexual assault victims.

15 HB13-1163 created C.R.S. § 18-3-407.7; a program that assists medical reporting victims with some medical costs associated with the sexual assault.

Methodology

Design and Data Collection

The Colorado Sexual Assault Response Protocol Committee[16] determined a dual approach was the most viable method for collecting data to address identified issues related to forensic compliance: 1) an analysis of payment records of medical reporting victims, and 2) surveys of the four primary professions that respond to sexual assault cases. Staff reviewed 151 case files to meet the first objective, and analyzed surveys received from 239 professionals to address additional compliance questions.

Case Analysis

Staff from the Division of Criminal Justice (DCJ), the state agency responsible for paying for evidence collection from medical reporting victims, examined existing medical reporting case payment data to determine the number of medical reporting cases and the law enforcement agency responsible for storing the evidence in each case.[17] Following a request for information from DCJ, the law enforcement agencies provided data regarding which of those cases converted to law enforcement reporting cases, the elapsed time between evidence collection and the law enforcement report, as well as case outcomes if known. There were 151 cases included in the case file review process.

16 The statewide, multidisciplinary committee includes sexual assault nurse examiners (SANEs), law enforcement officers, community-based advocates, system-based advocates, prosecutors, lab personnel, and statewide advocacy representatives, among others.

17 Colorado law (C.R.S. § 18-3-407.5) mandates that the law enforcement agency with jurisdiction over the medical reporting case collect the evidence collection kit from the medical facility and store it for two years. If the assault jurisdiction is unknown, then the law enforcement agency in the medical facility's jurisdiction stores the kit for two years.

Professional Responder Surveys

The four professions surveyed were: 1) medical professionals, particularly those who conduct medical forensic exams, 2) community-based and system-based advocates,[18] 3) law enforcement officers, and 4) prosecutors. The Committee developed the surveys after identifying the most prominent issues regarding the implementation and impact of forensic compliance law. Separate surveys, with similar questions, were tailored for each profession around common, identified themes. Each survey consisted of a combination of 10 to 15 closed and open-ended questions.

SurveyMonkey®, an online survey software and questionnaire tool, was used to distribute the surveys and collect the responses. Due to the sensitive nature of determining compliance with federal and state laws, the Committee decided to conduct the surveys anonymously and not track respondents' agency affiliations. While this approach helped ensure the integrity of the answers, it also prevented the data analysis from determining if any one agency was over-represented, which may affect the outcomes and findings in unknown ways.

The surveys were initially disseminated on June 15, 2011 and were circulated through online communication tools, including email and Facebook® postings. Committee members distributed the surveys to partners and constituents, and requested that all recipients further distribute the surveys to appropriate colleagues. Survey data collection closed on September 21, 2011. A total of 239 professionals completed the survey during the 13 weeks of data collection. The distribution of respondents across professions is as follows:

- 89 law enforcement officers
- 70 victim advocates (justice system and community-based advocates combined)
- 41 prosecutors
- 39 medical professionals

Data Analysis

Data analysis included compiling basic information such as the total number of respondents, the number of respondents within each profession, the geographic distribution of the respondents and their professional titles. Quantitative analysis was conducted on the closed-ended questions. Qualitative, text analysis of the open-ended questions identified response patterns and broad categories into which answers could be assigned for the purposes of quantifying the information so it could be compared within and across professions.

18 Two types of advocates work with victims of sexual assault: community-based advocates and system-based advocates. Community-based advocate refers to paid or volunteer advocates who generally work for a private, non-profit agency. In Colorado, community-based victim advocates who meet specific training requirements are entitled to privileged communication with victims [C.R.S. § 13-90-107(k)(II)]. System-based advocates are paid and volunteer advocates employed by public agencies such as law enforcement agencies and prosecutors' offices, and are not entitled to privileged communication with victims. Because communities' abilities to access both types of advocates vary considerably across the state, this survey did not distinguish between the two types of advocates and compiled their responses as one group.

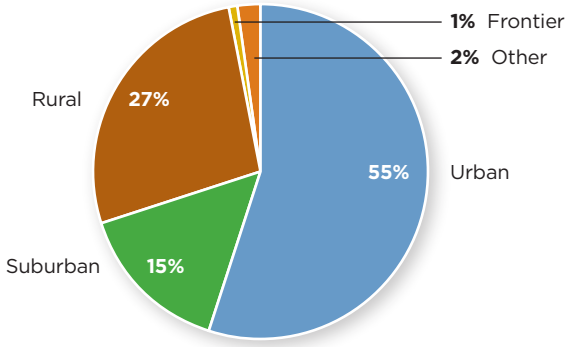
Additional Data Collection and Analysis

A preliminary analysis of the original survey data demonstrated that the survey question regarding medical mandated reporting, the Colorado law that requires medical professionals to report suspected crimes to law enforcement, needed clarification to ascertain all respondents' level of support for this law. A single question survey, specifically addressing medical mandated reporting of adult victims, was distributed on September 22, 2011 through the same mechanism as the original surveys. The survey closed on September 29, 2011. The 111 addendum responses were compiled and analyzed.

Survey Response Demographics

The surveys collected information from 239 respondents with a geographic representation similar to Colorado's overall population distribution. Of the four professions, law enforcement officers contributed the highest number of responses with 89 respondents. Seventy advocates, 41 prosecutors and 39 medical professionals[19] completed the surveys.

Figure 1. **Geographic Distribution of Respondents** (N=239)



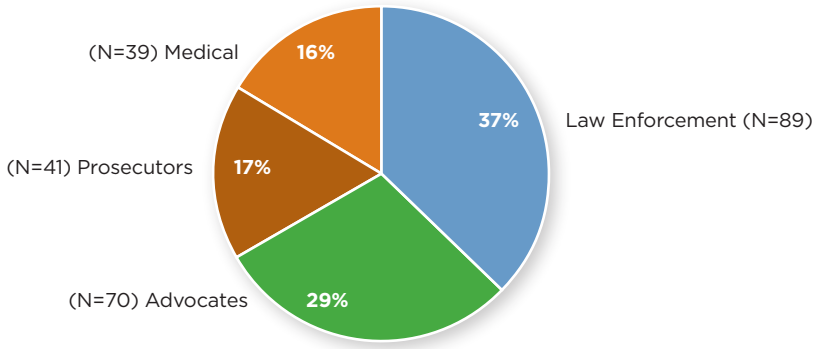
According to the U.S. Census Bureau, Colorado's total estimated population for 2011 is 5.1 million, with the rural population comprising 1.2 million, or 24%, of the overall estimated 2011 population.[20] Survey respondents were geographically consistent with Colorado's population

19 Medical professional surveys were distributed primarily to a limited population of medical professionals who would likely have experience working with sexual assault victims such as SANEs and other Colorado hospitals and clinics with medical forensic exam programs.

20 U.S. Census Bureau: State and County Quickfacts. Retrieved at http://quickfacts.census.gov/qfd/states/08000.html.

distribution as 70% of the FCEP survey responses were from urban areas and 28% were from rural areas (see Figure 1).

Figure 2. **Participation by Profession** (N=239)



FCEP

FCEP Study Findings

Medical Reporting Case Analysis: Findings

The Colorado Division of Criminal Justice analyzed payment records and case outcomes of 151 adult medical reporting victims. For the purposes of this analysis, converted cases were defined as cases in which the victim left the hospital as a medical reporting victim and, regardless of the time interval, later reported the assault to law enforcement. Additionally, the analysis counted any bill paid by DCJ as a medical reporting case, including six instances where law enforcement had no corresponding record of those cases. Further research is needed to determine why such discrepancies exist and, since an exam was completed, where the evidence from those cases is stored.

The study encompassed medical reporting cases from the inception of the law, July 2008, through March 2011, a period of two years and nine months. During that time, DCJ received bills from medical facilities statewide totaling 151 medical report cases that were associated with 33 law enforcement jurisdictions. DCJ staff then contacted the relevant law enforcement agency for each case to obtain the following information:

- Confirmation of the existence of the case in law enforcement agency records;
- Reporting status;
- Length of time between the exam and law enforcement report (if any); and
- Case outcome.

Twenty-two of the 33 law enforcement agencies provided confirmation of and follow-up information on a total of

It is important to note that case conversions can occur prior to the victim leaving the medical facility. For example, a victim may enter a medical facility seeking only medical care. However, by receiving a positive response while obtaining care, s/he may decide to engage in the criminal justice system. Medical professionals have anecdotally reported that case conversions of this type have occurred. Without the ability to access medical care prior to making a reporting decision, some of these victims may never have engaged with the criminal justice system.

127 cases. The analysis below does not include the 24 cases for which DCJ received no follow-up information from local law enforcement agencies.

Figure 3. **Total Number of Medical Reporting Cases Statewide, Confirmed Case Conversion Rate = 18%** (N=151)

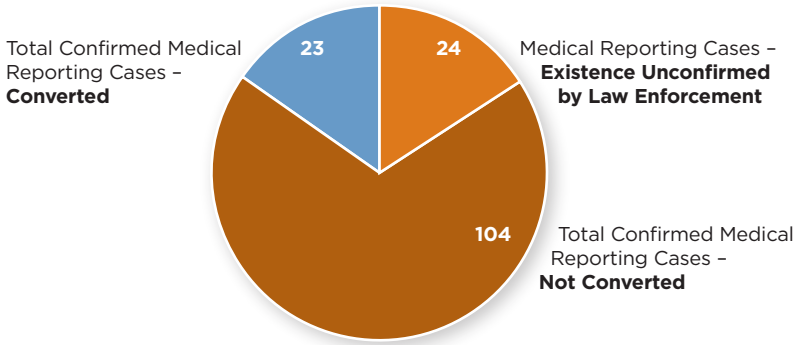
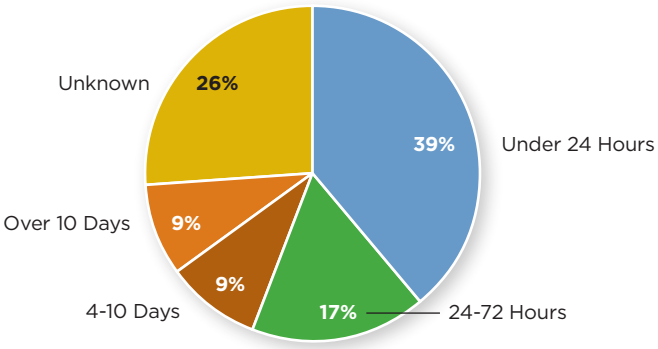


Figure 3 shows that of the 127 confirmed medical reporting cases, 104 remained as medical reporting while 23 converted to law enforcement reporting cases, a conversation rate of 18%.

Figure 4. **Converted Cases: Time to Conversion** (N=23)



Of the 23 converted cases, 39% converted to law enforcement reports in less than 24 hours and a total of 56% converted within 72 hours. The time elapsed between obtaining a medical forensic exam and reporting to law enforcement varied between two hours and 33 days (see Figure 4).

Of the cases that converted, several were deemed inactive due to unwillingness of the victim to pursue the case; one was unfounded according to the local law enforcement agency, several were closed for unknown reasons, two cases were still under investigation, and at least two were declined for prosecution by the prosecutor. As far as the study could determine, no medical reporting case has yet been prosecuted in Colorado (data not presented).

Figure 5. **Geographic Distribution of Medical Reporting Cases** (N=127)

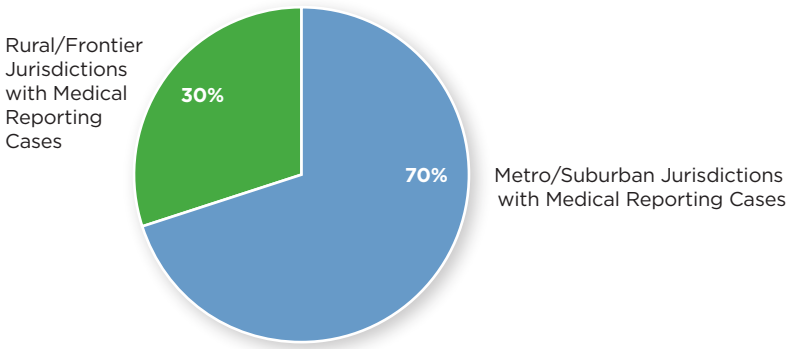
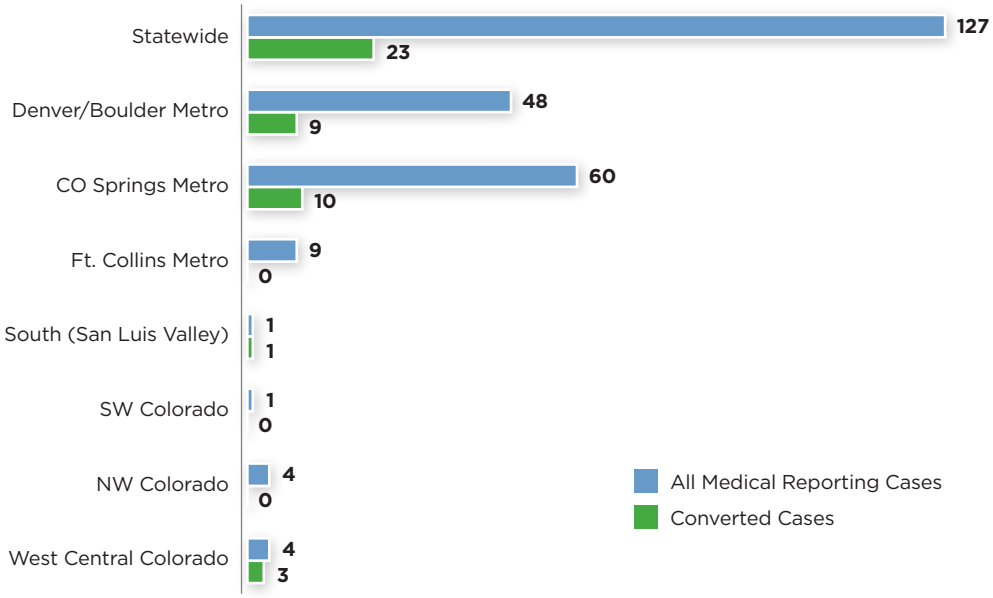


Figure 5 shows that most of Colorado's medical reporting cases have come from metro and suburban jurisdictions, with the cities of Colorado Springs and Denver accounting for 45% and 32% of the total medical reporting cases, respectively (data not presented). The rural/frontier cases tended to be scattered throughout the southern and western regions of the state, with no medical reporting cases from the eastern plains.

Figure 6. **Total Number of Medical Reporting and Converted Cases by Region** (N=127)



The metro areas had case conversion rates of 17% to 19%, which is consistent with the statewide rate of 18%. The rural regions of the state had a combined conversion rate of 40%, but represented only 8% of all medical reporting cases statewide (see Figure 6).

Professional Responder Survey Analysis: Findings

In addition to medical reporting case analysis, the project surveyed the four core disciplines that respond to sexual assault to determine variations across Colorado with regard to: 1) victim reporting decisions; 2) utilization of the medical mandated reporting law; 3) existence and use of sexual assault response protocols; and 4) response to IPSV.

1) Victim Reporting Decisions

Understanding victims' reasons for reporting or not reporting their assault to law enforcement is essential to developing appropriate response systems. The surveys asked medical professionals and victim advocates to anecdotally identify reasons articulated by victims regarding their reporting decisions. Advocates were also asked to identify reasons regarding decisions to seek or not seek medical services following a sexual assault.

Reporting or Not Reporting to Law Enforcement

Several common themes emerged regarding why victims **did not** want to report the assault to law enforcement:

- Fear of retaliation/safety concerns
- Distrust of the criminal justice system
- Victim blaming
- Shame
- Desire of privacy/confidentiality
- Wishing to protect the perpetrator

Common reasons were also noted with regard to victims choosing **to report** the assault:

- Desire to catch/punish the perpetrator
- Justice
- Victim compensation
- Get health care/sexually transmitted infection (STI) treatment
- Keep other victims safe
- Gain knowledge about what happened to them

Quote from Survey:

For victims, it is a difficult decision. There is a lot of concern regarding law enforcement and the perceived "requirement" to report. There is also concern about medical costs they may encounter.

- Advocate

Seeking or Not Seeking Medical Services

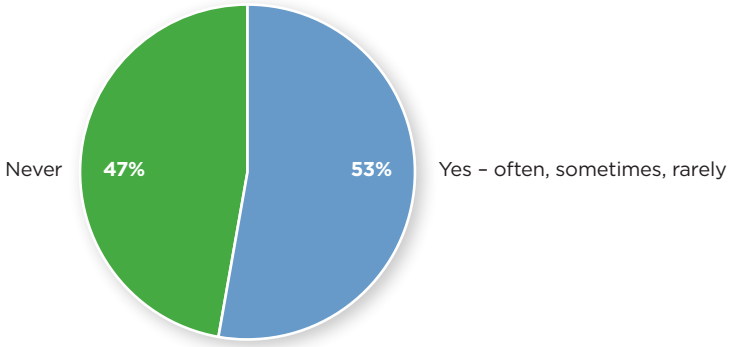
No discernible pattern emerged when analyzing advocates' experiences regarding why victims seek or do not seek medical attention following an assault. However, the most common words used in advocate responses indicated that **cost, shame, and fear** factored heavily into a victim's decision regarding obtaining medical attention. Additionally,

the analysis indicated that many victims lack knowledge of their options and available services, demonstrating that victims may be making initial decisions based on erroneous or incomplete information.

Anonymous Reporting

Nationally, some jurisdictions have developed anonymous reporting options for sexual assault victims.[21] In Colorado, one community created an anonymous reporting process while most others have a reporting system in which the victim is known to law enforcement and/or identifiable by name. The FCEP study sought to determine the extent to which Colorado's advocates, medical professionals, and law enforcement officers have received requests for anonymity from victims, even though this reporting option does not widely exist in Colorado.

Figure 7. **Estimated Requests for Anonymity Received by Surveyed Professionals** (N=183)



As demonstrated in Figure 7, survey responses indicated that slightly more than half of all respondents have encountered at least one victim requesting anonymity.

21 Archambault, Joanne and Lonsway, Kimberly. (2011). Direct anonymous reporting: Multidisciplinary protocols offer alternative option for victims. *Sexual Assault Report, 14*, 65-77.

Figure 8. **Estimated Requests for Anonymity by Profession** (N=183)

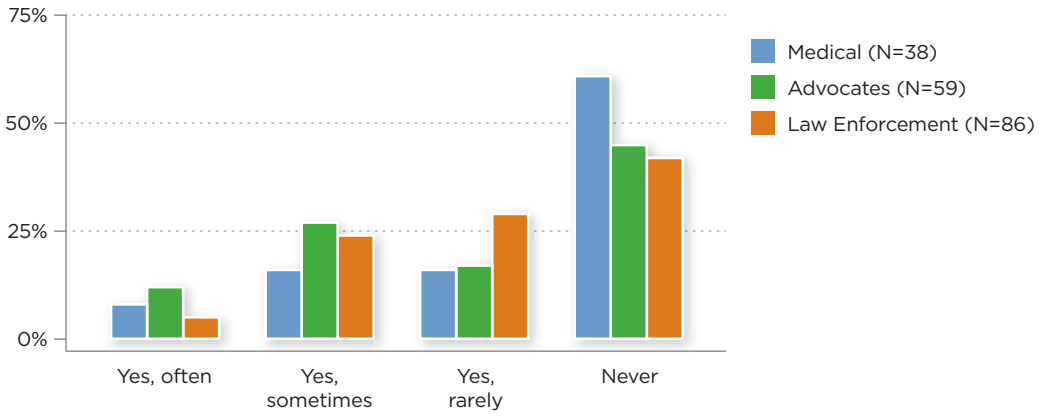


Figure 8 provides a closer look at the occurrence of anonymity requests by profession and category.[22] While the data did not provide a definitive conclusion regarding a need for the development of an anonymous reporting process, the number of responders encountering anonymity requests did indicate a need for further research to determine the feasibility and efficacy of anonymous reporting in locations utilizing this reporting option.

Prosecutors – Challenges in Prosecuting Cases That Began as Anonymous

Because prosecutors rarely have initial contact with sexual assault victims, they were not surveyed about encountering victims wishing to remain anonymous. However, because early reporting decisions made by victims can impact the filing and success of prosecutions, prosecutors were asked about the types of challenges which may be associated with prosecuting anonymous cases that later convert.

The majority of prosecutor respondents indicated a primary concern regarding the negative impact anonymous reporting would have on victim credibility. Many prosecutors also noted that it could complicate an already challenging investigation with regard to witnesses and evidence. Only one of the 38 prosecutors who responded to this survey question saw no challenges or barriers to prosecuting cases based on an initial anonymous report.

2) Medical Mandated Reporting

In addressing the intersection between the forensic compliance requirement and state medical mandated reporting laws, the United States Department of Justice, Office on Violence Against Women, specified that states with mandatory reporting requirements for sexual assault can be in compliance with the VAWA 2005 as long as the victim retains the

22 The 61% "never" response rate among medical professionals, significantly higher than all other surveyed professions, may be because victims already assume their medical care is protected under existing confidentiality laws.

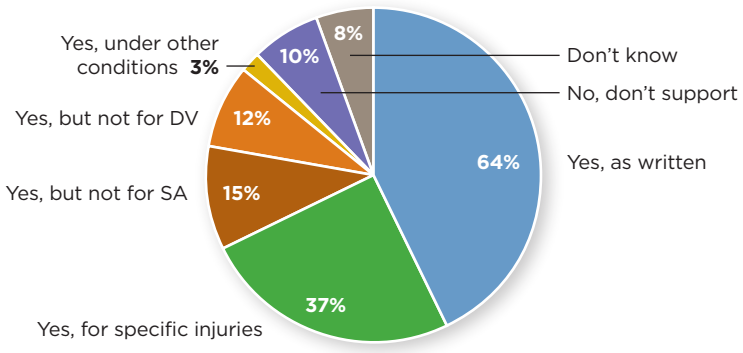
ability to choose not to participate with law enforcement or the criminal justice system and receives a medical forensic examination free of charge or with full reimbursement.[23]

Colorado has two primary laws regarding mandatory reporting for sexual assault: one addressing child abuse, which details a list of professions required to report;[24] and one specific to medical professionals addressing all victims of potential crimes regardless of age.[25] The surveys focused on the medical mandated reporting law as it applies to adult cases of sexual assault.[26] Colorado's medical mandated reporting statute does not explicitly require a medical mandated report to law enforcement for adult sexual assault, but it does require medical professionals to report, "any other injury that the licensee has reason to believe involves a criminal act, including domestic violence."[27] This phrase has been widely interpreted to include sexual assault, whether or not the victim has associated physical injury.

Medical Mandated Reporting – Support for Colorado's Law

The original survey asked respondents to indicate whether they supported or opposed Colorado's medical mandated reporting statute as it applies to adults, as well as several additional questions detailed below. However, based on several comments contained in the responses, many respondents clearly answered the question regarding support for the law assuming it pertained to either children or children and adults. Because confusion existed in the original survey responses, a follow-up one question survey was later distributed to the same respondents, asking them to specifically address the state's medical mandated reporting obligation for adults. The addendum question was significantly more specific in determining the level and nature of the respondents' support for this law.

Figure 9. **Support for Adult Medical Mandated Reporting** (N=111)



(Note: Respondents had the option to select more than one answer.)

23 U. S. Department of Justice. *Frequently Asked Questions: Anonymous Reporting and Forensic Examinations*, updated February 2012. Retrieved at http://www.ovw.usdoj.gov/faq-forensic-examinations.html#9.

24 Colo. Rev. Stat. § 19-3-304

25 Colo. Rev. Stat. § 12-36-135

26 While forensic compliance intersects with a number of laws addressing minors' ability to independently seek and receive medical forensic exams, this study focused on the mandatory reporting laws and their relationship to adult sexual assault victims.

27 Colo. Rev. Stat. § 12-36-135

Figure 9 illustrates the responses to the addendum adult medical mandated reporting question. The addendum question was asked without regard for professional affiliation, so the responses represent an aggregation of all 111 professional responders who answered this question. Nearly two-thirds (64%) supported the medical mandated reporting statute as written. However, the accompanying written comments revealed confusion over the interpretation and application of the statute, specifically regarding the definition of injury.

The respondents who chose "yes, under other conditions" noted two categories under which they believed medical reporting should be required:

1) When the injuries are inconsistent with the medical assessment; and

2) A system in which medical professionals only report statistical crime data which does not include victim identifying information.

Medical Mandated Reporting – A Comprehensive Examination

The original survey question regarding medical mandated reporting used a combination of multiple choice and open-ended questions to determine:

1) If respondents supported or opposed medical mandated reporting;

2) Why respondents supported or opposed medical mandated reporting;

3) What barriers or issues the respondents have encountered with implementing medical mandated reporting; and

4) Potential changes to the law.

Support for Medical Mandated Reporting

Figure 10. **Support for Medical Mandated Reporting, Comparison Across Professions** (N=222)

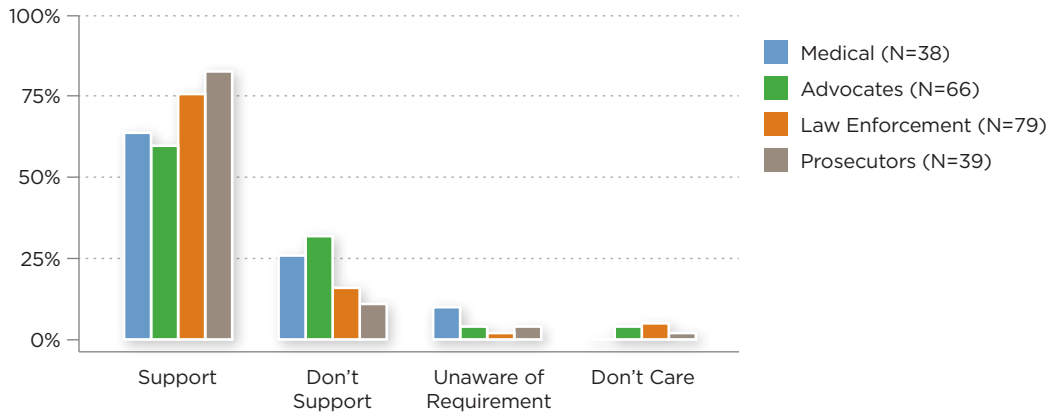


Figure 10 shows the level of support for medical mandated reporting within each respondent profession (original survey question). When the data from Figure 10 is examined in conjunction with the data from Figure 9 (p. 23), it is apparent that Colorado's existing medical mandated reporting law enjoys strong support across all respondent professions. Even among advocates, the least supportive group, 60% supported the law. Law enforcement, medical professionals and prosecutors all demonstrated at least 64% support for the law as written, with prosecutors indicating the greatest support at 83%.

In another finding from Figure 10, the largest group of professionals that indicated unfamiliarity with the law was medical professionals at 10%. All other professions' respondents registered less than 5% who indicated they were unfamiliar with mandatory medical reporting. While the 10% unfamiliarity rate among medical professionals is not a high percentage, it is noteworthy because the law is specific to medical professionals.

Reasons for Supporting and Opposing the Law

Reasons for Supporting the Law

Prevalent themes across all disciplines included:

- Provides help for victims without them being responsible for reporting the perpetrator
- Helps keep victims safe by engaging the criminal justice system on their behalf
- Helps overcome victim embarrassment/intimidation
- Improves reporting rates and evidence-gathering
- Protects public safety by identifying and potentially prosecuting sex offenders

Reasons for Opposing the Law

Prevalent themes across all disciplines included:

- Puts victims in more danger of retaliation
- Less likely for victims to seek medical care
- Removes individual privacy rights
- Interferes with victims' ability to make their own decisions

As can be seen in the above chart, respondents' opinions about the law vary significantly. There seems to be strong support for medical mandated reporting, but it is not clear that individuals all have the same understanding of the law.

Barriers/Issues with Law

The chart below details respondents' concerns, both those who supported and opposed the law, regarding the implementation of the medical mandated reporting law. Common themes across all disciplines included:

Respondents' Concerns – Both Those Who Supported and Opposed the Law – Regarding the Implementation of the Medical Mandated Reporting Law

Prevalent themes across all disciplines included:

» Statutory:

- Law is unclear – the definition of injury and what to report is vague. Confusion may arise as to whether injury is specific to physical injury or may include emotional injury.

» Criminal Justice:

- Victims fear law enforcement
- Puts victims in more danger – fear of retaliation
- Law enforcement imposes their authority but are frequently unfamiliar with mental health dynamics of victims
- Victims get arrested for outstanding warrants which complicates the role of law enforcement
- Mandatory arrest on probable cause issue – forces unnecessary report or arrest in domestic violence cases
- Perpetrators accompany victims to emergency department
- Survivors who are undocumented fear that interaction with law enforcement will result in deportation

» Health Care:

- Discourages patients from getting medical care
- The law is not implemented consistently – some medical staff do not report and will not take action that is against the patient wishes
- Forces patients to lie about their injuries
- Negative impact on practitioner-patient relationship – undermines trust and overall healthcare
- Perceived conflict with the privacy assurances in the Health Insurance Portability and Accountability Act (HIPAA)

» Individual Autonomy:

- Traumatizes victims not ready to report the crime
- Control is taken away from victim
- Victims are uncooperative or angry about law enforcement involvement

Suggested Changes to the Law

The survey also asked respondents to provide feedback regarding what, if any, changes they would make to the law. This question was asked irrespective of support or lack of support for the law. The below responses represent the respondents' ideas and will not necessarily be implemented but will be examined as possible solutions to the identified issues. Common themes across all disciplines are identified in the following table.

Table 1. **Suggested Changes to the Medical Mandated Reporting Law by Survey Respondents**

Category	Specifics	Author Comments
CLARIFICATIONS to the law	Clarify the medical mandated reporting law with regard to sexual assault and the definition of injury (physical and/or emotional)	*Because this law is inherently not victim-centered, any clarification or change must consider a victim-centered approach. Also, existing law relies on the existence of an injury as well as the medical professional's opinion as to whether or not that injury was caused due to a suspected crime.*
	Clarify that when medical professionals report, victims do not have to participate in a criminal justice investigation	*While this approach is consistent with Colorado law, more education and training is needed to first responders.*
REVISIONS to the law	Make reporting mandatory only in cases of gunshot or stab wounds	*Respondents had many ideas for potential statutory revisions, some of which were conflicting. All of these options need to be examined as possible solutions.*
	Ensure victim confidentiality through mandated anonymous reporting	*Many states developed anonymous reporting systems in response to VAWA 2005.*
	Make arrest of perpetrator discretionary when victim is uncooperative	*Arrest is already discretionary in sexual assault cases. Arrest is mandatory upon probable cause of domestic violence, which creates issues in IPSV cases. This conflict needs to be addressed.*
	Make domestic violence reporting **discretionary**, and clarify that sexual assault reporting is **mandatory**	*Under the medical mandated reporting law, domestic violence reporting is mandatory. Sexual assault is not as clearly defined as a mandatory report. This inconsistency creates challenges in IPSV cases. The conflict needs to be addressed.*

Category	Specifics	Author Comments
ELIMINATIONS from the law	Eliminate mandatory reporting for adults and allow for victim choice	*Not requiring medical mandated reporting for adults is more common throughout the United States.*
	Remove mandatory reporting unless the alleged perpetrator is in a position of authority	
ADDITIONS to the law	Mandate referral to advocates	*Most national protocols recommend utilizing advocates at the outset of every case.*
	Enforce strong penalties to encourage medical professionals to report	*Colorado has a misdemeanor penalty for failure to report, however it is rarely utilized.*
	Educate medical professionals about the law, safety and services	

Medical Facility Policies and Training

Medical professionals were also asked if their medical facility had any policy for reporting crimes beyond the medical mandated reporting statute and, if so, what subsequent training on this topic was available to them. Thirty-two percent of the respondents indicated they did not know or were unaware of any additional policies, although several respondents indicated that their facility has some form of a "reporting abuse" policy. Training on this issue occurred for most respondents at orientation, although a few stated they had computer-based training or the initial training was reinforced at meetings or through a yearly review. Several respondents also indicated they felt their hospital could use more training and one indicated they were working on developing an annual training program (data not presented).

In summary, while medical mandated reporting was widely supported, identifiable challenges exist with the implementation of the current statute.

Quote from Survey:

I think hospitals need to have more concrete policies on this matter. A lot of times it is such a grey area that nobody really knows what to do which creates huge problems for everyone involved.

- Medical Provider

3) Existence and Use of Response Protocols: Comparison Between Law Enforcement Reporting Victims and Medical Reporting Victims

Research demonstrates that the immediate response to sexual assault victims can make a considerable difference in the healing process for victims, as well as the decision-making process regarding interaction with the criminal justice system. Jan Hindman researched

sexual abuse for thirty-four years and found that "disastrous response" (e.g., disbelief, failure of support, lack of protection for the victim, protection of the offender) was the number one factor most commonly correlated with Primary Severe Trauma in victims. According to Hindman (1989), receiving a disastrous response upon disclosure created more long-term mental health issues for victims than any other indicator, including telling no one at all.[28] Studies have also indicated that early, positive interactions with law enforcement, advocates, and sexual assault nurse examiners impact victims' decisions about reporting the assault and participating in the criminal justice system. Debra Patterson (2011) interviewed victims about their initial interactions with law enforcement. Upon evaluating the case outcomes of interviewees, Patterson determined that law enforcement officers who took the time to build rapport, communicated their belief in the victim, and used a gentle, evenly-paced manner of questioning obtained stronger victim statements and built better cases for prosecution.[29] Another study, led by Rebecca Campbell (2008), found that positive experiences with SANE programs were healing and humanizing and indirectly gave victims hope which, at the least, prevented them from withdrawing from the criminal justice system.[30] The Patterson et al. study further indicated that the presence of victim advocates influenced law enforcement officers to behave in a more positive manner toward victims. Specifically, Campbell showed that advocates, when used in conjunction with SANEs, helped victims regain control of their lives and indirectly influenced their participation in the criminal justice system.

Because initial response is proving to be so critical, respondents were surveyed about their sexual assault response protocols.

Response Protocols

Respondents were asked about the presence and utilization of sexual assault response protocols for law enforcement reporting cases and medical reporting cases. This survey only addressed the existence of individual agency protocols, not multidisciplinary protocols, and did not pursue the efficacy of the protocols, including frequency of revision or staff training on protocols.

In addition to asking about the existence of protocols, the survey sought information regarding which types of advocates and what other service professionals, if any, respond to sexual assault victims receiving medical forensic exams. The survey also asked if the responders differ for law enforcement reporting victims and medical reporting victims.

---

28 Hindman, J. (1989). *Just Before Dawn: From the Shadows of Tradition to New Reflections in Trauma Assessment and Treatment of Sexual Victimization*. Boise, ID: AlexAndria Associates.

29 Patterson, D. (2011). T*he Impact of Detectives' Manner of Questioning on Rape Victims' Disclosure*. Sage Journals: Violence Against Women, 17: 1349.

30 Campbell, R., Bybee, D., Ford, J.K., Patterson, D. (2008). *Systems Change Analysis of SANE Programs: Identifying the Mediating Mechanisms of Criminal Justice System Impact*. Retrieved on May 9, 2013 at https://www.ncjrs.gov/pdffiles1/nij/grants/226498.pdf.

Figure 11. **Comparison of the Existence of Response Protocols for Law Enforcement Reporting Victims vs. Medical Reporting Victims**

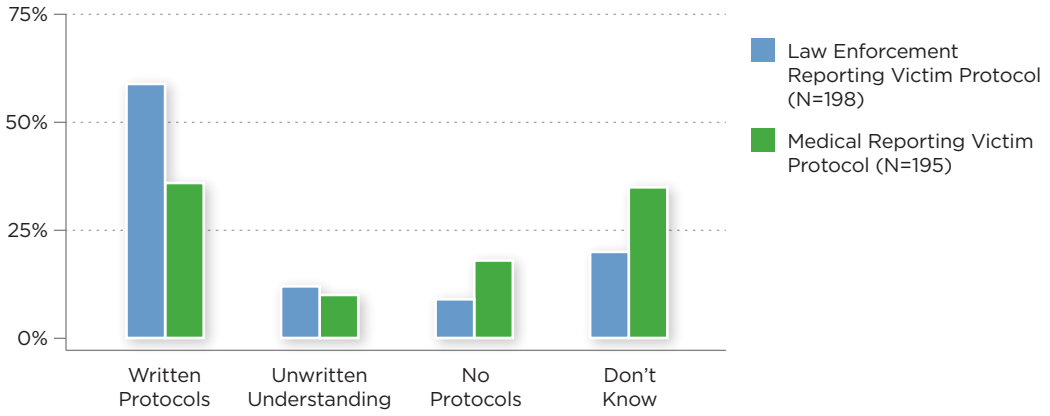


Figure 11 represents the aggregation of information from medical professionals, advocates and law enforcement regarding the existence of sexual assault victim response protocols for law enforcement reporting versus medical reporting victims.

The findings revealed that while 71% of those surveyed have written or "understood" response protocols for law enforcement reporting victims, only 46% have written or "understood" protocols for medical reporting victims. It is notable that many respondents did not know if response protocols existed, with over one-third of respondents marking "Don't Know" for medical reporting victims.

Response Protocols – Law Enforcement Reporting Victims

Figure 12. **Existence of Response Protocols for Law Enforcement Reporting Victims, Comparison Across Professions**

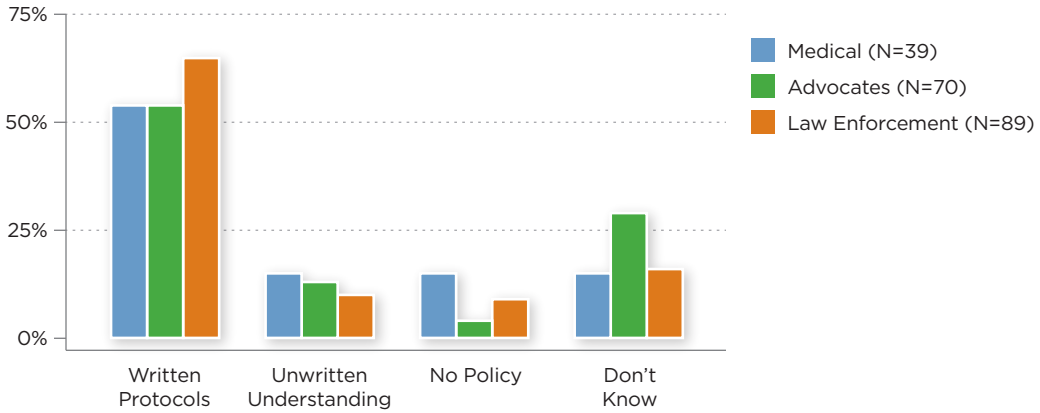


Figure 12 disaggregates the information in Figure 11 regarding the existence of response protocols for **law enforcement reporting** victims across the three surveyed professions.

Among the three professions who provide immediate services to law enforcement reporting victims, a majority of those responding indicated that they had written response protocols, although only 54% of medical professionals and advocates affirmed the presence of written protocols. An additional 10% to 15% within each profession indicated they had an unwritten understanding. Twenty-nine percent of advocates indicated they did not know if they had a protocol.

Response Protocols – Medical Reporting Sexual Assault Victims

Figure 13. **Existence of Response Protocols for Medical Reporting Victims, Comparison Across Professions**

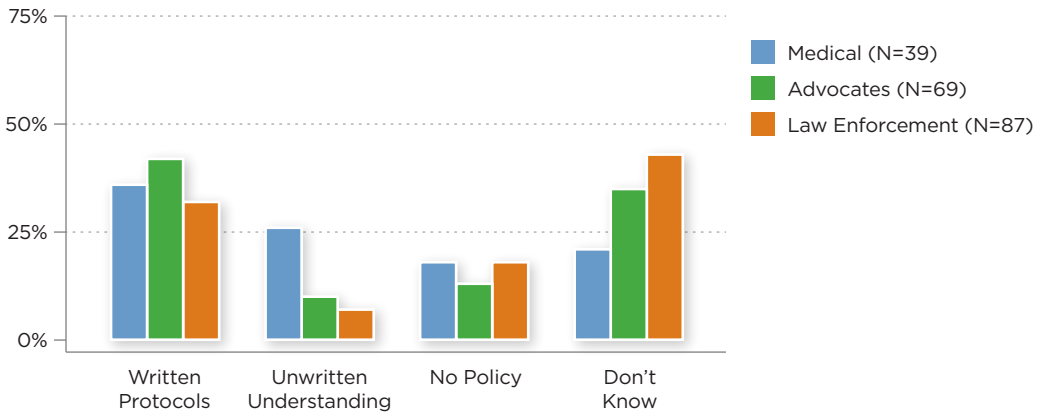


Figure 13 disaggregates the information in Figure 11 regarding the existence of response protocols for **medical reporting** victims across the three surveyed professions.

Less than half of the responding agencies have written response protocols for medical reporting victims. The "no policy" and "don't know" responses were significantly higher for medical reporting victims than law enforcement reporting victims.

Law Enforcement Interaction with Medical Reporting Victims

The survey specifically asked law enforcement professionals who had response protocols if they were required to respond to the medical facility and personally meet with victims. A large majority of 78 percent indicated they were required to meet with the victim, while nine percent indicated they picked up the evidence but did not meet with the victim (data not presented).

Medical professionals were also asked about the existence and content of policies specifically addressing law enforcement interaction with medical reporting victims. Possible responses

were divided into four categories: 1) no policy, 2) policy specifying no interaction, 3) policy allowing the victim to choose, and 4) "don't know." Thirty-six percent did not know if such a policy existed; 32 percent said they have a specific policy of no interaction; and 13 percent indicated their policy promoted victim option. Nineteen percent indicated they had no policy (data not presented).

Advocate Response to Victims

Rebecca Campbell's publication, *Rape Survivors' Experiences with the Legal and Medical Systems: Do Rape Victim Advocates Make a Difference?* (2006), detailed a comparison study of sexual assault victims at two hospitals: one that utilized community-based rape crisis advocates and one that used no advocacy services. This study found that rape survivors who worked with advocates reported receiving more services from the legal and medical systems compared to those who did not work with an advocate. Victims without advocates were more likely to report being told by responding officers their cases were not serious enough to pursue, and were less likely to receive sexually transmitted infection (STI) prophylaxis and corresponding information on STIs, as well as pregnancy-related services.[31]

Campbell and colleagues (2006) also studied the occurrence of secondary victimization through victims' involvement in professional response systems. Campbell et al. defines secondary victimization as insensitive and victim-blaming treatment by social system personnel that leaves victims feeling distressed. Campbell found that victims working with advocates were less likely to report incidences of secondary victimization by medical staff and law enforcement and they were also less reluctant to seek further help than those who did not have an advocate present.[32]

Because initial response to sexual assault victims is a strong determinant factor in case outcome, the survey sought to determine if advocates are routinely responding to the medical facility for both categories of victims receiving medical forensic exams, and if so, which types of advocates[33] respond to which victims. Additionally, respondents were asked what other professions might be included in response to sexual assault victims.

---

31 Campbell, R. (2006). Rape Survivors' Experiences with the Legal and Medical Systems: Do Rape Victim Advocates Make a Difference? *Violence Against Women*, 12, pp. 30-45.

32 Ibid. For additional information on this topic, see also Campbell, R., Sefl, T., & Ahrens, C.E. (2004). The Impact of Rape on Women's Sexual Health Risk Behaviors. *Health Psychology*, 23, pp. 67-74.; Campbell, R., Wasco, S.M., Ahrens, C.E., Sefl, T., & Barnes, H.E. (2001). Preventing the Second Rape: Rape Survivors Experiences with Community Service Providers. *Journal of Interpersonal Violence*, 16, pp. 1239-1259.; and Campbell, R., Raja S. (1999). Secondary Victimization of Rape Victims: Insights of Mental Health Professionals Who Treat Survivors of Violence. *Violence and Victims, Volume 14, Issue 3*, pp. 261-275.

33 In several Colorado jurisdictions, law enforcement agencies contract with community-based advocacy programs to provide services for law enforcement. Consequently, those jurisdictions have community-based advocates operating in a "law enforcement" advocate capacity.

Figure 14. **Comparison of the Type of Advocate Response to Law Enforcement Reporting Victims vs. Medical Reporting Victims**

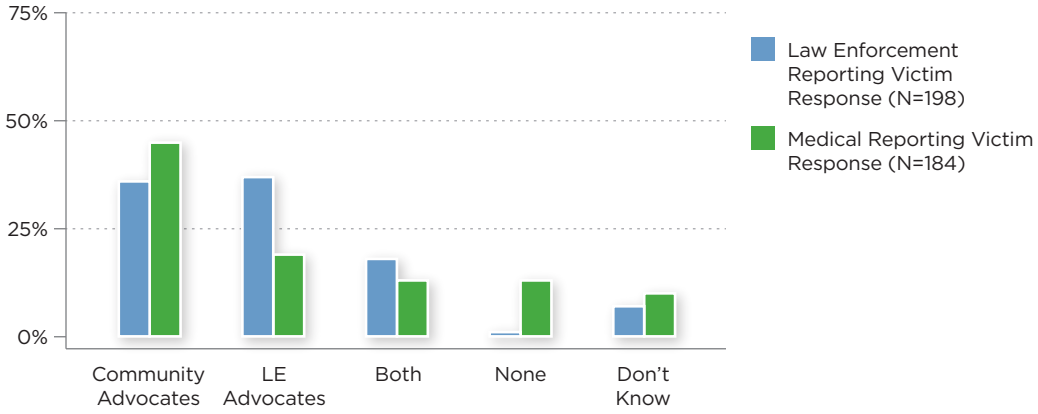


Figure 14 represents the aggregation of information from medical professionals, advocates and law enforcement regarding the advocate response to law enforcement reporting versus medical reporting victims.

Law enforcement officers, advocates, and medical professionals were asked if advocates routinely respond at the medical facility to law enforcement reporting and medical reporting victims. Findings, shown in Figure 14, demonstrate:

1) Law enforcement reporting victims almost equally see system-based and/or community-based advocates, while medical reporting victims are more likely to see community-based advocates;

2) Medical reporting victims are less likely to see any type of advocate; and

3) Greater uncertainty exists among responding professionals regarding whether or not advocates respond to medical reporting victims.

Advocate Response – Law Enforcement Reporting Victims

Figure 15. **Comparison Across Professions of the Type of Advocate Response to Law Enforcement Reporting Victims**

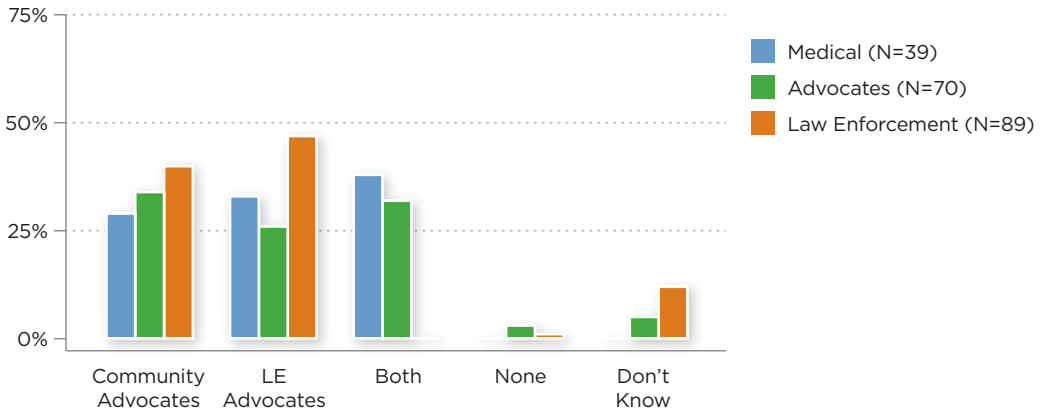


Figure 15 disaggregates the information in Figure 14 regarding the type of advocate response for **law enforcement reporting** victims across the three surveyed professions.

When specifically asked which type of advocate responds to the medical facility for law enforcement reporting sexual assault victims, the findings in Figure 15 show that nearly all respondents reported that law enforcement reporting victims have an advocate present at the medical facility.

When asked what other professionals might respond to law enforcement reporting victims, respondents noted that several entities or agencies might be called, depending on the circumstances of the assault: Department of Human Services (specifically for child victims), emergency medical services, prosecutors, mental health advocates, interpreters, social workers, nursing home personnel, campus officials, and crime lab personnel (data not presented).

Advocate Response – Medical Reporting Victims

Figure 16. **Comparison Across Professions of the Type of Advocate Response to Medical Reporting Victims**

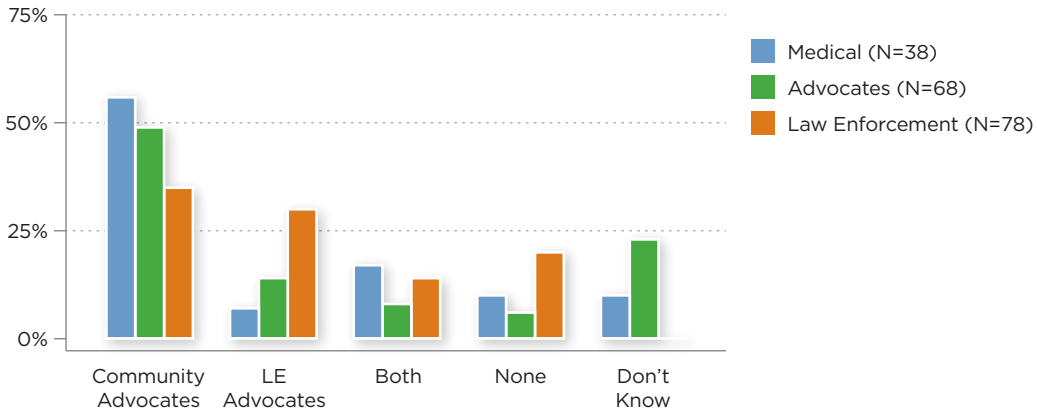


Figure 16 disaggregates the information in Figure 14 regarding the type of advocate response for **medical reporting** victims across the three surveyed professions.

When specifically asked which types of advocates respond to the medical facility for medical reporting sexual assault victims, the findings in Figure 16 show:

1) Medical reporting victims are less likely than law enforcement reporting victims to have any advocate present;

2) Medical reporting victims are significantly more likely than law enforcement reporting victims to see community-based advocates.

While many respondents (across professions) said no other agencies would be called to respond to medical reporting victims, several respondents listed other potential responding professions as: clergy, social services, social workers, medical facility counselors or other medical facility personnel.

In summary, law enforcement reporting victims are far more likely to have a victim advocate respond to the medical facility when compared to a medical reporting victim. Overall, advocate response to all sexual assault victims is not consistent. To meet the myriad needs of victims, developing protocols that promote advocate presence in all sexual assault cases is recommended.

4) Intimate Partner Sexual Violence (IPSV)

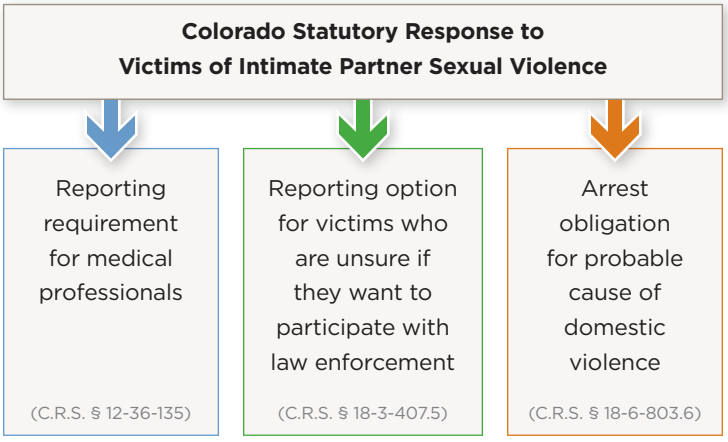
Intimate Partner Sexual Violence includes not only marital rape, but all other forms of sexual violence that take place within a current or former intimate relationship such as: forcing the victim to watch pornography, degrading the victim sexually, forbidding birth control, using dangerous and inappropriate objects (guns, bottles, etc.) as "sex toys," or demanding sex acts that the victim finds painful or humiliating. Sexual assault may occur in the context of any relationship – whether partners are legally married, living together, or dating, and regardless of whether they are in gay, lesbian, or heterosexual relationships. In IPSV relationships, the violence often occurs repeatedly and involves both sexual assault and domestic violence.

The surveys collected information regarding the three Colorado statutes relevant to IPSV:

- Medical Mandated Reporting: requires injuries stemming from a criminal act, including domestic violence, to be reported to law enforcement (C.R.S. § 12-36-135);
- Forensic Compliance: participation or cooperation with law enforcement is not required in order to receive a medical forensic exam at no cost to the sexual assault victim (C.R.S. § 18-3-407.5); and
- Mandatory Arrest upon Probable Cause of Domestic Violence: law enforcement arrest obligations for probable cause of domestic violence (C.R.S. § 18-6-803.6).

Policies specifying mandatory arrest for domestic violence instruct law enforcement to detain a perpetrator when there is probable cause of the crime. Under Colorado statute, the mandatory arrest upon probable cause of domestic violence occurs regardless of the victim's wishes. According to the National Institute of Justice, Colorado is one of twenty-three states with this type of statutory obligation.

http://www.nij.gov/publications/dv-dual-arrest-222679/exhibits/table1.htm



A physically-abused woman also experiencing forced sex [is] over seven times more likely than other abused women to be killed by the perpetrator.

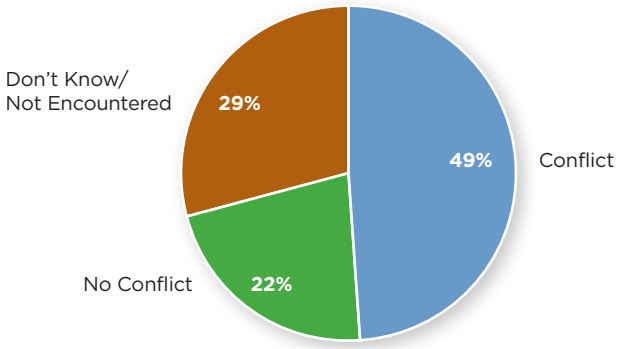
Professor Jacquelyn Campbell, Assessing Risk Factors for Intimate Partner Homicides, Vol. 250 NIJ JOURNAL 15 (2003)

These three statutes overlap and can cause confusion when determining, among other issues, the following:

- Whether law enforcement has a statutory obligation to investigate an IPSV case;
- Whether law enforcement has an obligation to honor the victim's desire to not participate in a sexual assault case within the context of a domestic violence situation; and
- Whether evidence obtained in a medical forensic exam following a sexual assault could be subpoenaed as evidence in a domestic violence case.

Respondents were asked to provide their perceptions of any conflict between the three laws and to provide information regarding how IPSV cases are handled at the local level.

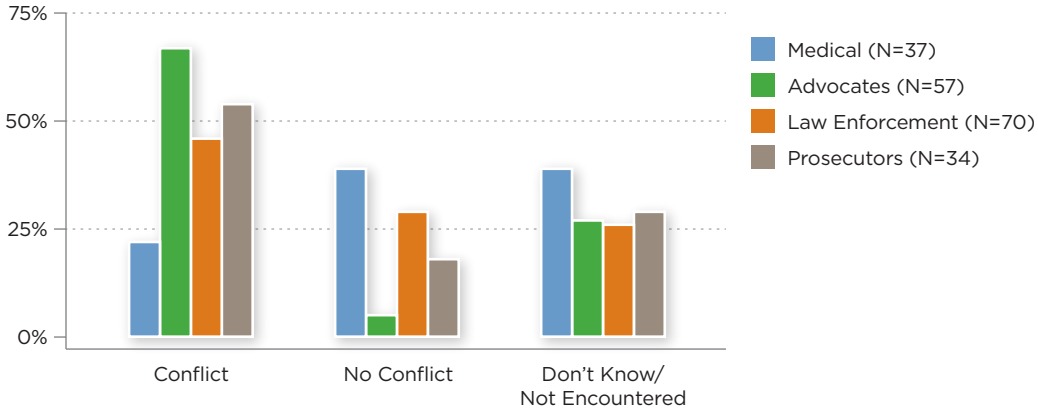
Figure 17. **Intimate Partner Sexual Violence, Perception of Conflict of Laws – All Respondents** (N=198)



"Intimate partner sexual violence, sometimes known as sexual assault in the context of domestic violence, is a pervasive and often hidden problem that warrants the focused attention of victim advocates, mental health and law enforcement personnel, and other professionals. IPSV creates a highly dangerous situation and is associated with increased risk of death, severe long-term trauma for victims, physical and psychological harm for children, and repeated victimization. From teens in abusive dating relationships to adults with long-time partners who use sex as a weapon of power and control, survivors of IPSV often feel isolated and misunderstood by the very professionals to whom they turn for help. Because IPSV involves both domestic violence and sexual assault, victims' needs may not be fully addressed by services focusing on one or the other of these issues."

Jennifer Y. Levy-Peck, Ph.D.
Intimate Partner Sexual Violence: Train the Trainer Curriculum, Washington Coalition of Sexual Assault Programs
http://www.wcsap.org/ipsv-train-trainer-kit

Figure 18. **IPSV – Perception of Conflict of Laws, Comparison Across Professions**



The study found widely disparate perceptions of Colorado's IPSV laws. Almost half of the respondents indicated they perceived conflict between the laws, as shown in Figure 17 on page 37. Figure 18 disaggregates this information by profession. Nearly two-thirds of advocates believe there are conflicts within Colorado's IPSV laws compared with approximately 20% of medical professionals.

Several law enforcement respondents did not perceive a conflict between the laws because of the belief that the mandatory arrest on probable cause statute took precedence, while others indicated no conflict because the forensic compliance statute had primacy. Some law enforcement officers indicated they believe an IPSV victim "loses the right to not report" while the domestic violence investigation is ongoing. Other officers indicated the forensic compliance law takes precedence because victim cooperation is viewed as paramount in proceeding with the domestic violence case. Additionally, many survey respondents indicated that IPSV cases are handled on a case-by-case basis and many times individual responders are unilaterally making decisions about how to proceed in these situations.

Quote from Survey:

This has been a topic of discussion in our office for some time as we typically will force a recanting Domestic Violence (DV) victim to trial, but not a recanting or reluctant Sex Assault victim. The research regarding the crossover of Domestic Violence and sex offending is astounding, which would indicate that we should lean more towards prosecuting a true DV sex assault the same as any other DV case. However, the impact of such an approach on a reluctant victim could be too high a price to pay...we remain torn.

- Prosecutor

Respondents described very few jurisdictions with formalized IPSV response protocols, although one responder noted their sexual assault response team (SART) team was working on developing a specific IPSV policy.

In summary, the response to IPSV, across and within all professions, is extremely inconsistent due to varying interpretation and application of the three relevant laws.

Recommendations

The data obtained in this study clearly demonstrates the issues and gaps in consistent, statewide implementation of forensic compliance. The report recommendations are delineated into six primary categories: 1) convene a statewide, multidisciplinary committee, 2) statutory changes, 3) policy/protocol development, 4) training needs, 5) outreach/education, and 6) further research.

1) Statewide, Multidisciplinary Committee

CCASA and DCJ should convene a statewide, multidisciplinary committee (including law enforcement, system and community-based advocates, medical professionals, prosecutors, and other key stakeholders) to develop a strategic plan to implement the following recommendations. Committee sustainability (including funding) and active participation is necessary to successfully achieve these goals.

CCASA and DCJ will also continue to work with other statewide entities addressing sexual assault and will partner and collaborate with local communities to address these issues and create system change.

2) Statutory Changes

- Clarify the medical mandated reporting statute, which requires licensed medical professionals to report injuries caused by suspected crimes to law enforcement:
    - **who** reports suspected crime,
    - **when** a report is required,
    - **whether** a medical professional should have discretion in determining if a crime occurred; and
    - **what** explicitly constitutes injury as related to sexual assault (physical and/or emotional injury).

- Address the conflicts between arrest on probable cause of domestic violence and sexual assault victims' right to obtain a medical forensic exam with limited or no interaction with law enforcement.

3) Policy/Protocol Development

Protocols provide a mutually-agreed upon framework to institutionalize interagency interactions and ensure a high quality, consistent response to sexual assault victims. The use of established protocols creates an environment for better victim care and potentially increases involvement in the criminal justice process. Protocols must also recognize the intensely personal nature of this crime and balance the need for uniformity and consistency with the flexibility needed to address individual victims' specific needs.

- **Colorado Model Multidisciplinary Protocol (CMMP)** – The statewide, multidisciplinary committee should develop, distribute, and ensure the provision of statewide training on a written Colorado model protocol for both law enforcement reporting cases and medical reporting cases. This protocol will be adaptable to Colorado's diverse communities. The Colorado model protocol will include the following components:
    - A victim-centered approach regarding contact between law enforcement and medical reporting victims
    - Information to be provided to victims, such as case conversion options, follow-up medical care, financial assistance, and appropriate referrals for advocacy services
    - Detailed information on the intersection of the *Health Insurance Portability and Accountability Act* (HIPAA) and Colorado's mandatory reporting law and how local communities can be in compliance with both laws
    - Clarification for medical professionals on mandatory reporting obligations
    - Guidelines to detail best practices in utilizing both types of advocates (community-based and law enforcement) in responding to law enforcement reporting and medical reporting victims
    - Guidelines for defining, tracking, investigating, and prosecuting converted cases
    - Guidelines for responding to cases involving IPSV victims
- **Individual Agency Protocols** – Each responding agency should develop and/or update an internal written protocol for their response to sexual assault.

4) Training

- The multidisciplinary committee should ensure the implementation of multidisciplinary training on the Colorado model protocol. This training will include, but not be limited to, the following:
    - Law enforcement interaction in medical reporting cases

- How to provide a victim-centered response utilizing community and system-based advocates for law enforcement reporting and medical reporting victims
- Mandatory reporting obligations for medical professionals and advocates
- Intimate partner sexual violence response
- Information on the structure and function of Victim Compensation, and the ability to waive requirements
- Strategies for the successful prosecution of converted cases
- Multi-disciplinary screening questions for improved case identification (sexual assault and IPSV)
- Billing and costs of medical services specific to their communities, including available funds to cover medical costs

5) Educational/Outreach

- The multidisciplinary committee should create an education/outreach plan and strategies for implementation, including funding.
- The multidisciplinary committee should develop appropriate educational materials (such as a brochure, website, and/or public service announcements) to explain reporting options for victims. Outreach materials should be applicable for use statewide and be created in a format that is accessible in foreign languages and for varying levels of literacy.

6) Further Research

- The multidisciplinary committee should survey and/or conduct focus groups of victims regarding, at a minimum, reasons for participating or not participating in the criminal justice system, accessing or not accessing medical assistance, and the impact of anonymous reporting options.
- The multidisciplinary committee should facilitate a discussion of anonymous reporting feasibility by researching national practices for the following issues:
    - The percentage of anonymous reports versus reported assaults in other states
    - Victims' perception about anonymous reporting
    - Overall reports/arrest rates in anonymous reporting jurisdictions
    - Prosecution filings and convictions in anonymous reporting jurisdictions
    - Other alternative reporting options where victims do not directly report the assault to law enforcement
- The multidisciplinary committee should pursue additional research on Colorado's medical reporting cases including the following: the jurisdiction and date on which the crimes occur, the cost of the medical forensic exam, case conversion status, investigation, filing, prosecution, and case outcome.

Supplemental Information:

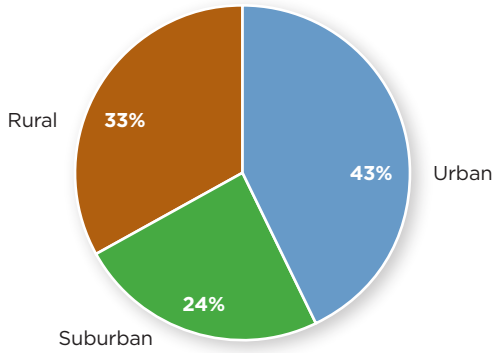
Findings by Discipline

The following sections provide additional information regarding specific responses from each of the four surveyed professions.

Medical Professionals

Respondent Demographics

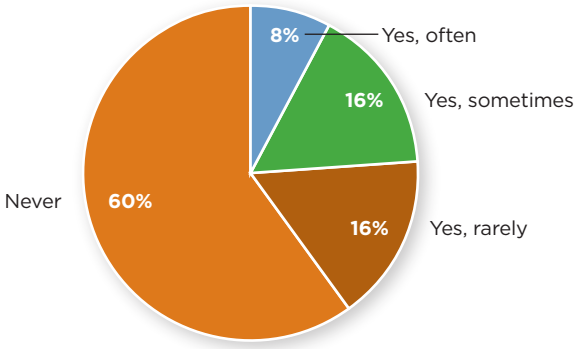
Figure 19. **Geographic Distribution of Respondents** (N=39)



Medical respondents, as shown in Figure 19, had a broad geographic response with 87% self-identifying as a Sexual Assault Nurse Examiner (SANE) or SANE trained nurse. Respondents also included a SANE-trained physician assistant, administrators, a professor and a therapist.

Anonymous Reporting

Figure 20. **Estimated Frequency of Victims Requesting Anonymity from Medical Professionals** (N=38)

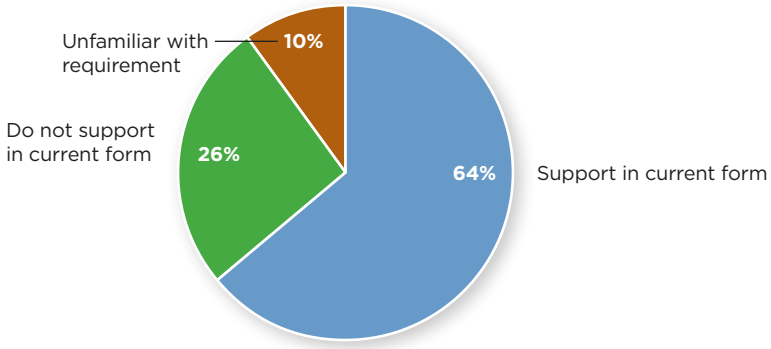


Medical professionals saw the lowest number of victims requesting anonymity amongst all surveyed professions, possibly because people commonly understand that medical

professionals are required to protect their confidentiality under HIPAA and other federal and state laws specifically addressing patient confidentiality.

Medical Mandated Reporting

Figure 21. **Support for the Medical Mandated Reporting Law by Medical Professionals** (N=38)



The pie chart in Figure 21 shows the responses by medical professionals to the original medical mandated reporting survey question (see pp. 24-28). Additional information provided in response to questions about the law included:

- Seven respondents indicated they both supported and did not support the law;
- Reasons cited by medical professionals for supporting the law were patient safety, and help and support for the patient;
- Reasons for not supporting this law included potential danger to the patient, as well as hindering the relationship between the medical professional and patient because the provider acts in opposition to the patient's wishes; and
- Patient fears of retaliation by the offender as well as fear of law enforcement and the subsequent erosion of trust in the provider/patient relationship were cited as barriers for compliance with the law.

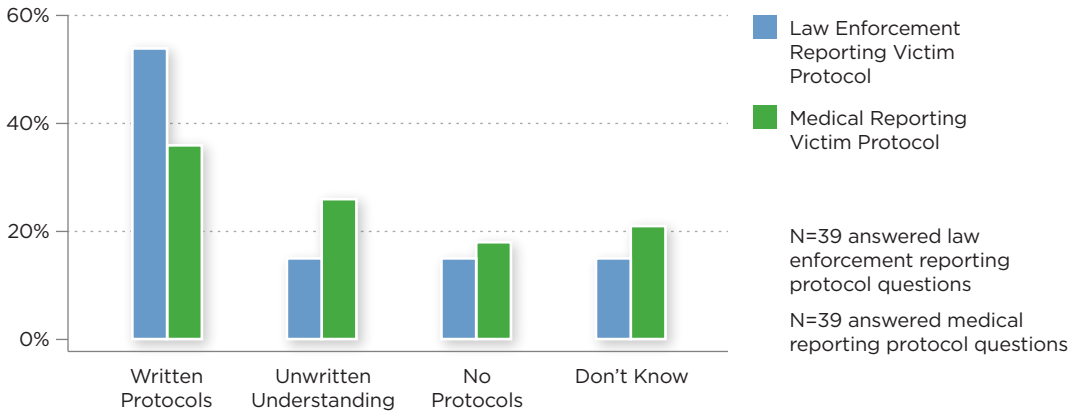
Quote from Survey:

I hear relatively frequently about patients who the Health Care Provider believes have been injured due to a crime and they "just don't go there" with their patient so (in part) they don't have to report.

- Medical Provider

Response Protocols

Figure 22. **Existence of Medical Facility Protocols for Law Enforcement Reporting vs. Medical Reporting Victims**



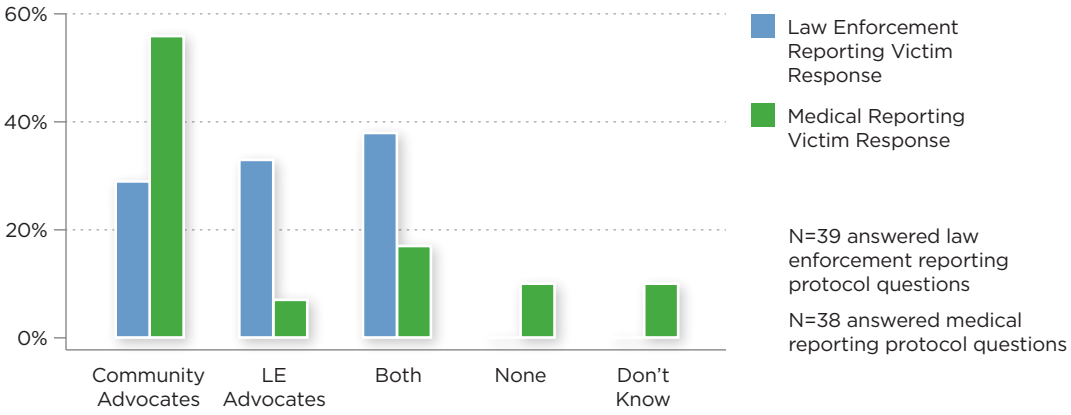
As depicted in Figure 22, medical facilities are more likely to have a response protocol for law enforcement reporting victims than for medical reporting victims. For medical reporting victims, protocols are less defined and more likely to operate on an unwritten understanding, which has greater potential for inconsistent response to medical reporting victims.

Policies – Law Enforcement Interaction with Victims

When medical professionals were asked whether their facility had a policy regarding law enforcement interaction with medical reporting cases, almost one third indicated they either did not know if such a policy existed or they did not have one. The remaining respondents indicated two distinct policy categories: a specific policy of no patient interaction with law enforcement if the patient chooses not to participate in the criminal justice system, and a more general policy of following the mandatory reporting law with no specific direction regarding victim/law enforcement interaction.

Advocate Response to Victims

Figure 23. **Comparison of the Type of Advocate Response to Law Enforcement Reporting Victims vs. Medical Reporting Victims**



As referenced in Figure 23, law enforcement reporting victims were more likely to meet with a law enforcement advocate, while medical reporting victims were more likely to meet with a community-based advocate. Medical reporting victims were more likely not to see any advocate.

Intimate Partner Sexual Violence (IPSV)

Figure 24. **Intimate Partner Sexual Violence, Perception of Conflict Laws – All Respondents** (N=37)

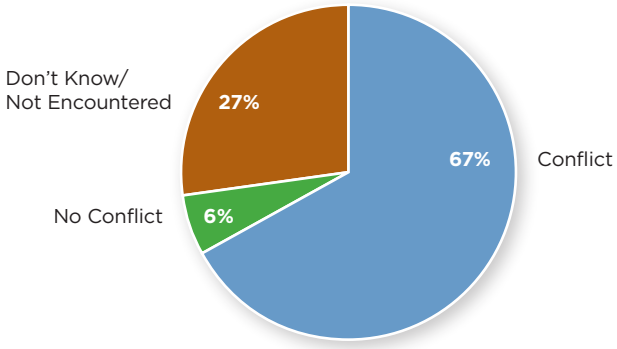


Figure 24 demonstrates that more than two-thirds of medical professionals saw a conflict between the three laws relevant to the response to IPSV (see pp. 36-38).

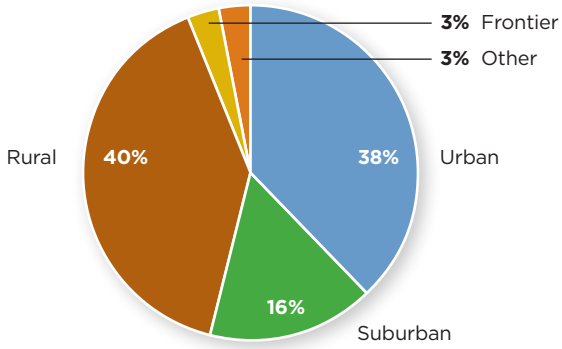
When asked to describe their approach to working with IPSV victims, their responses varied:

- The most common response was informing the victim of the medical professional's reporting obligation while advising the victim s/he did not have to cooperate;
- Others indicated if the victim did not wish to report, then the medical professional simply did not follow the medical mandated reporting law; and
- Several respondents noted the confusion regarding these laws, the lack of associated policies, and that the response each victim received depended on the law enforcement officer who responded.

Advocates (System and Community-based)

Respondent Demographics

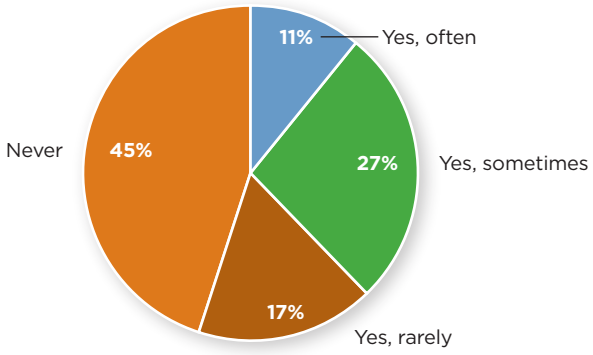
Figure 25. **Geographic Representation of Respondents** (N=70)



The geographic representation of advocates, as shown in Figure 25, was fairly evenly split with 54% from metro areas and 46% from non-metro areas. It was also one of the largest study groups, with 70 respondents. Of those respondents, 16% self-identified as system-based advocates with the rest identifying as advocates, program managers, SART coordinators and executive directors (data not presented).

Anonymous Reporting

Figure 26. **Estimated Frequency of Victims Requesting Anonymity from Advocates** (N=59)



More than half of all advocates have encountered at least one victim, at the time of receiving medical services, requesting anonymity from law enforcement (see Figure 26). This finding is noteworthy because anonymous reporting is not presented as an option in the vast majority of Colorado's jurisdictions.

Medical Mandated Reporting

Figure 27. **Support for the Medical Mandated Reporting Law by Advocates** (N=66)

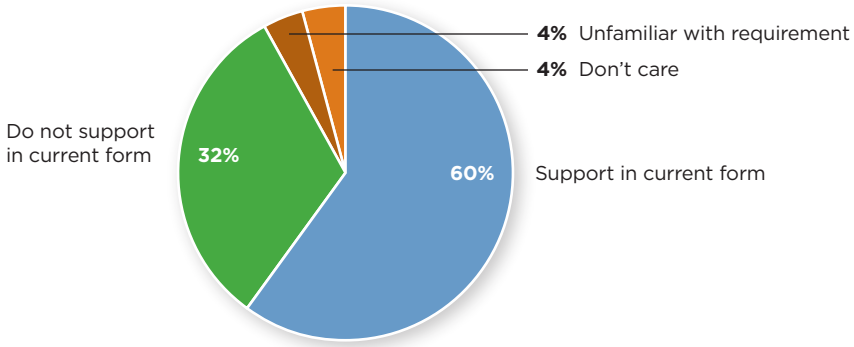


Figure 27 shows the responses by advocates to the original medical mandated reporting survey question (see pp. 24-28). The majority of advocates support the medical mandated reporting law in its current form. Additional information provided in response to questions about the law included:

Advocates support the medical mandated reporting law for the following reasons:

- Public safety related to the repeat nature of sex offenders;
- Victim safety; and
- Victims' access to services following a report.

Advocates do not support the medical mandated reporting law for the following reasons:

- Concern for victim safety;
- Loss of autonomy for the victim; and
- Concern it prevents victims from seeking medical help and supportive services.

The primary issue cited as a barrier to implementation was that the law prevents people from seeking medical assistance, particularly undocumented victims. Additionally, respondents highlighted the lack of clarity in the statute around "injuries" and what medical professionals are required to report.

Quote from Survey:

It is not always clear to victims that even though the police are called to keep or store the kit, that they do not have to talk to police...also advocates/ rape crisis counselors are not always called to the scene to help explain that. It is also not consistent if police will be calling to check-in with victim or how long they will keep kits.

- Advocate

When asked about potential statutory revisions, the responses included a range of ideas depending on support for or opposition to the law.

Those who support the law suggested:

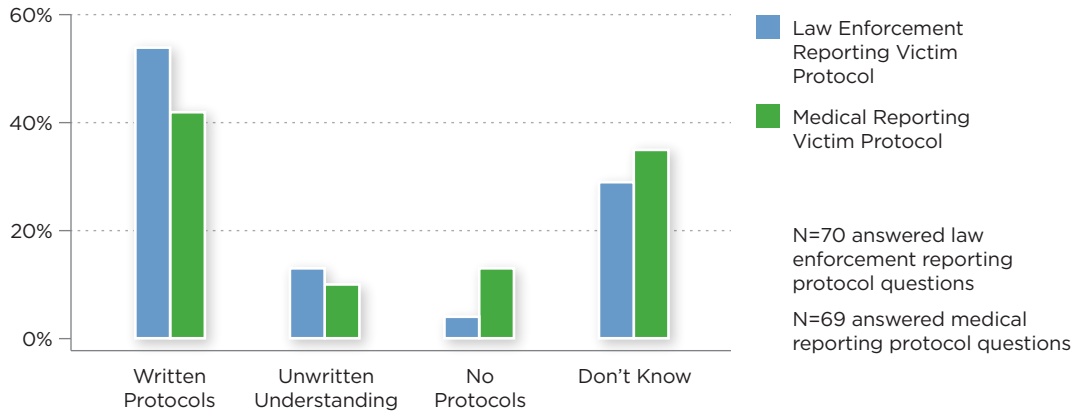
- No changes to the medical mandated reporting;
- Expanding it to include other professionals; and
- Educating medical professionals regarding their reporting requirements.

Those who oppose the law suggested:

- Eliminating the law;
- Clarifying that victims do not have to cooperate with law enforcement;
- Limiting law enforcement contact with victims;
- Defining the term "injury," particularly with respect to physical versus emotional injury; and
- Specifying what medical professionals are required to report.

Response Protocols

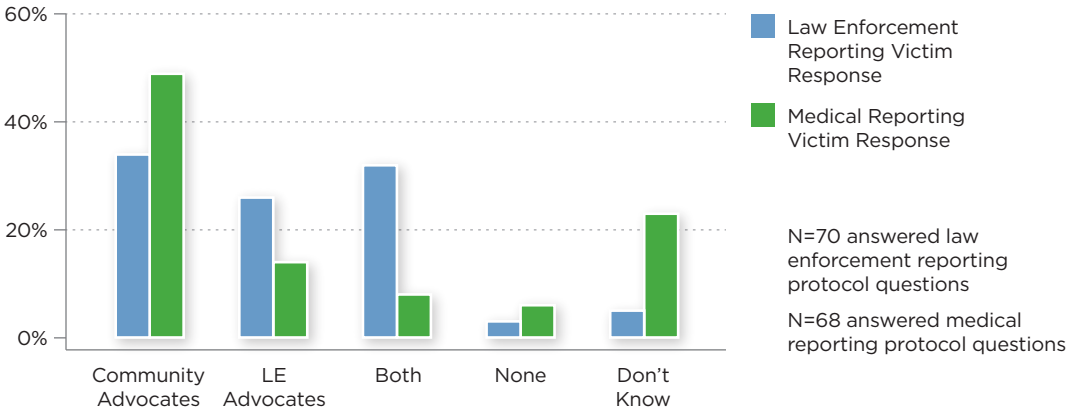
Figure 28. **Existence of Advocacy Protocols for Law Enforcement Reporting vs. Medical Reporting Victims**



Nearly one third of the advocate respondents did not know if any protocols, written or otherwise, existed for law enforcement and medical reporting victims (see Figure 28).

Advocate Response to Victims

Figure 29. **Comparison of the Type of Advocate Response to Law Enforcement Reporting Victims vs. Medical Reporting Victims**



According to Figure 29, law enforcement reporting victims were more likely to have a law enforcement advocate present at a medical facility, while medical reporting victims were more likely to have a community-based advocate present. Notably, over 20% of advocates responded "Don't Know" when asked which type of advocate responded to victims at the medical facility.

When asked if the responding advocates provide any information or follow-up services, the vast majority of advocates indicated that when they do respond, they provide information and/or follow-up services to victims in both law enforcement reporting cases and medical reporting cases.

Intimate Partner Sexual Violence (IPSV)

Figure 30. **Intimate Partner Sexual Violence, Perception of Conflict Laws** (N=57)

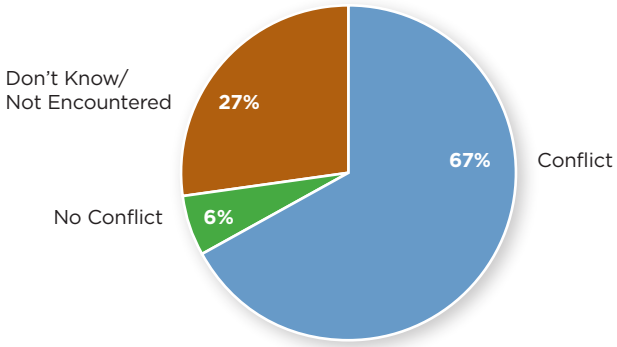


Figure 30 demonstrates that more than two-thirds of advocates recognized a conflict between the three laws relevant to the response to IPSV (see pp. 36-38).

Advocates' responses detailing how IPSV cases were handled varied widely. Many respondents indicated they were handled on a case-by-case basis while others indicated the domestic violence charge was pursued by law enforcement regardless of the victim's wishes on the pending sexual assault case. Still others said they were handled as a sexual assault case and pursued depending on the wishes of the victim.

Advocates' Screening for Sexual Assault in Domestic Violence Cases

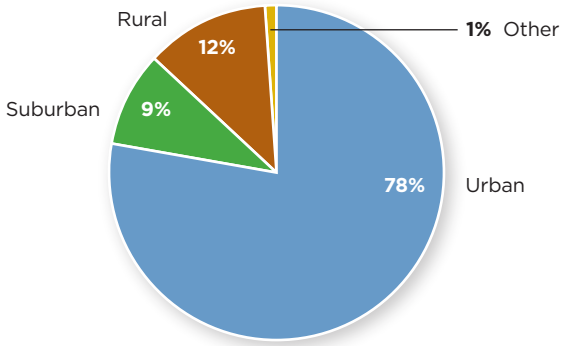
When asked if advocates used screening questions regarding IPSV, 56 percent said they used screening questions while 10 percent did not. Additionally, 13 percent either did not know or their agency did not respond to these types of cases. The answers depended significantly on agency type, with some system-based respondents saying they did not screen due to their lack of legal ability to protect a victim's privileged communications.[34] The responses also showed that community-based respondents were more likely to use screening questions.

34 Colo. Rev. Stat. § 13-90-107(k)(II)

Law Enforcement

Respondent Demographics

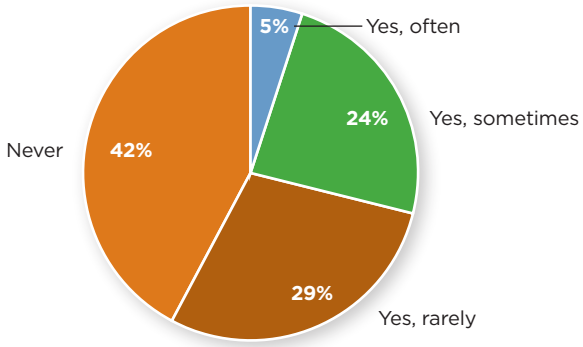
Figure 31. **Geographic Representation of Respondents** (N=89)



The law enforcement category had 89 survey respondents, the largest number of all responding professions, with a significant majority indicating they were from urban agencies (see Figure 31). While the law enforcement respondents did not have as broad a geographic representation as the other surveyed professions, they did have a wide range of positions represented with job titles including police officer, detective, detective-sergeant, undersheriff, assistant chief, administrative division commander, dispatcher, commander, captain, and investigator.

Anonymous Reporting

Figure 32. **Estimated Frequency of Victims Requesting Anonymity from Law Enforcement** (N=86)



According to Figure 32, more than half of law enforcement respondents have encountered at least one victim requesting anonymity. This finding is noteworthy because anonymous reporting is not presented as an option in the vast majority of Colorado's jurisdictions.

Medical Mandated Reporting

Figure 33. **Support for the Medical Mandated Reporting Law by Law Enforcement** (N=79)

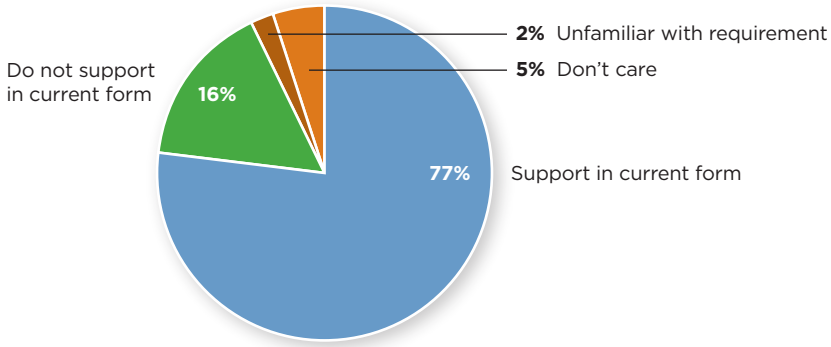


Figure 33 shows the responses by law enforcement to the original medical mandated reporting survey question (see pp. 24-28). A significant majority of law enforcement support the medical mandated reporting law in its current form. Additional information provided in response to questions about the law included:

Law enforcement professionals support medical mandated reporting because it:

- Ensures law enforcement can investigate the crimes; and
- Helps victims by entering them into the criminal justice system, which hold offenders accountable without the victim having responsibility of reporting.

Law enforcement professionals do not support the law because it:

- Infringes on individual choice; and
- Prevents victims from seeking medical attention.

The barriers to implementation cited by law enforcement included the lack of compliance by medical professionals either due to HIPAA[35] or the medical professional making a decision

Quote from Survey:

When someone has experienced a trauma, he/she does not always think to call for help or call to report injuries or want to be the one to have called police; it takes the burden off of the victim. An unbiased 3rd party mandated to report relieves the pressure off of the victim much like in child abuse cases. This law gets law enforcement involved and able to intervene when needed and when a victim is stuck between wanting/needing help and trying to stay safe at the same time.

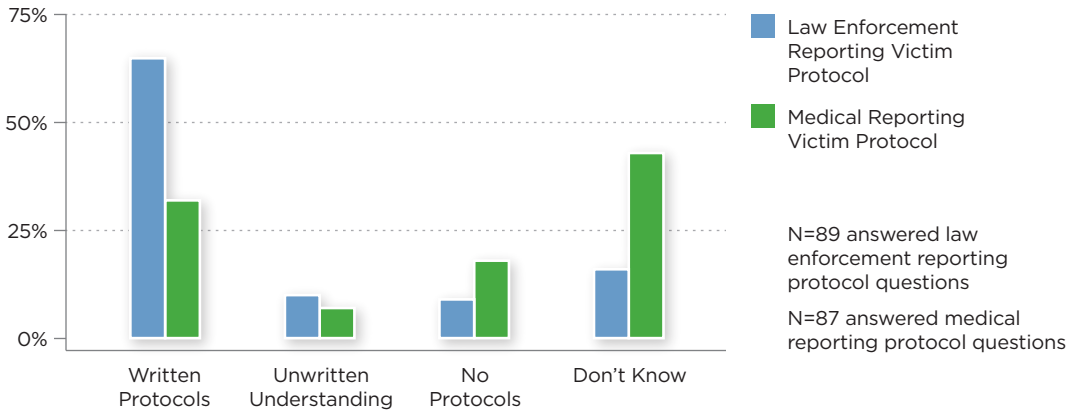
- Law Enforcement Officer

35 The FCEP survey did not ask a question specific to HIPAA. However, several law enforcement professionals, when asked to provide additional details regarding barriers to the implementation of medical mandated reporting, indicated that medical professionals cite HIPAA as a reason to not comply with medical mandated reporting. No medical professional who responded to the survey listed HIPAA as a barrier or issue.

to not report as required, and the absence of cooperation from victims. The minority who responded when asked how they would change the law overwhelmingly stated mandatory reporting should be made discretionary.

Response Protocols

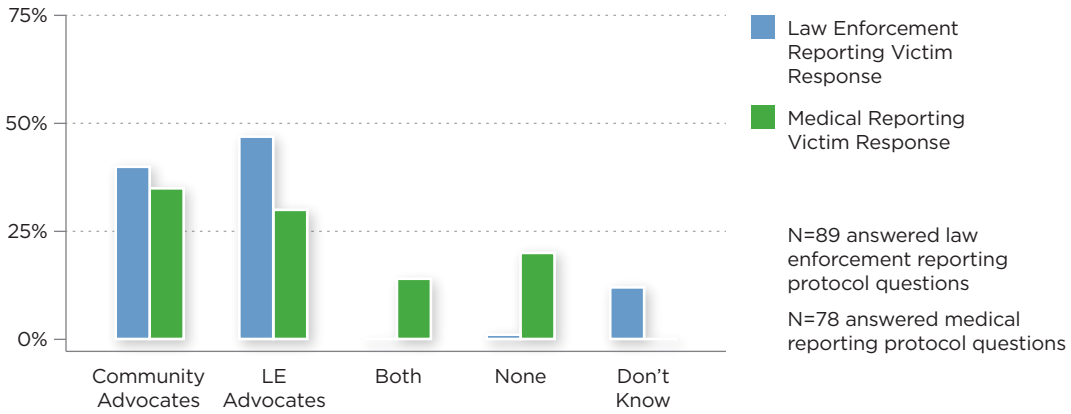
Figure 34. **Existence of Law Enforcement Protocols for Law Enforcement Reporting vs. Medical Reporting Victims**



Law enforcement agencies are more likely to have written protocols for law enforcement reporting victims and are also more likely to not have or know about protocols for medical reporting victims (see Figure 34).

Advocate Response to Victims

Figure 35. **Comparison of the Type of Advocate Response to Law Enforcement Reporting Victims vs. Medical Reporting Victims**

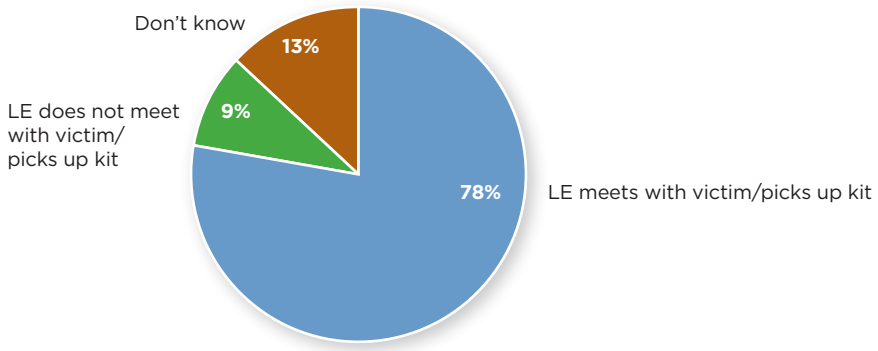


As shown in Figure 35,[36] medical reporting victims are considerably more likely to not have an advocate present at the medical facility following a sexual assault.

Medical Reporting Cases

Law enforcement responded to additional questions regarding interaction with victims, documentation of evidence, and evidence tracking for medical reporting cases.

Figure 36. **Law Enforcement Interaction with Medical Reporting Victims at the Medical Facility** (N=83)



Policies – Law Enforcement Interaction with Victims

Law enforcement respondents were asked whether their medical reporting victim response protocols required them to meet with the victim. A large majority said they met with the victim to ascertain whether they did not want to participate in the investigation and to ensure the chain of custody of the sexual assault examination kit.[37] Only a small percentage indicated they did not meet with the victim and only picked up the kit (see Figure 36).

Documentation

With respect to documentation for medical reporting cases, most respondents indicated they filled out an incident report with varying levels of detail, while others noted they wrote a letter to the detectives with the information they were able to obtain. A few respondents said their incident reports did not include victim information if the victim wished to remain anonymous. Some agencies also use an offense report specifically for medical reporting of sexual assault offenses (data not presented).

36 Law enforcement respondents did not have an option of answering "both" when responding about law enforcement reporting victims and did not have an option of answering "don't know" when responding about medical reporting victims. The lack of those response options did not alter the overall conclusion that medical reporting victims are more likely to not have an advocate present.

37 Colorado law does not require law enforcement to meet with the victim to ensure chain of custody. Any such requirement for a law enforcement agency results from an internal agency policy.

Evidence Tracking

Figure 37. **Law Enforcement Tracking and Storage for Medical Forensic Exam Evidence of Medical Reporting Victims** (N=85)

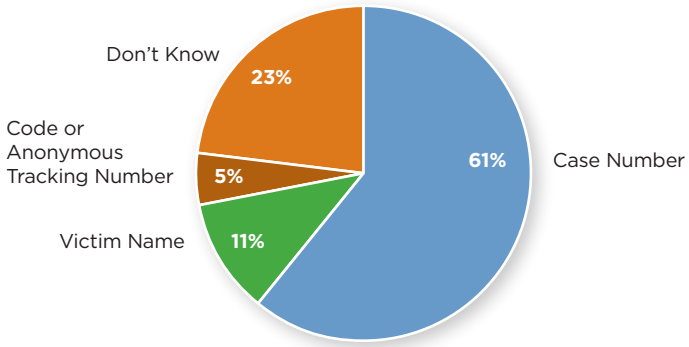


Figure 37 indicates how evidence was tracked in responding law enforcement agencies. When asked if cases could be tracked using a case number or an anonymous number, all respondents who knew how cases were tracked said they had this capacity.[38]

Intimate Partner Sexual Violence (IPSV)

Figure 38. **Intimate Partner Sexual Violence, Perception of Conflict of Laws** (N=70)

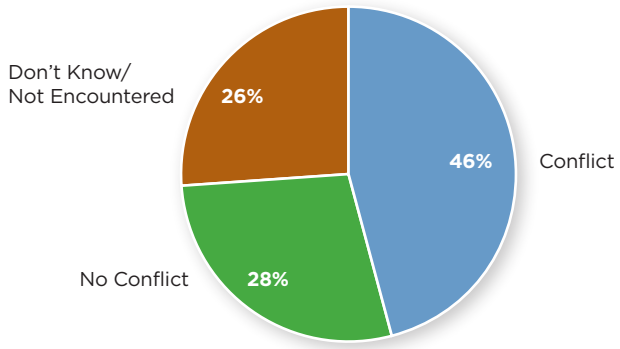


Figure 38 demonstrates that almost half of law enforcement respondents saw a conflict between the three laws relevant to the response to IPSV (see pp. 36-38). How IPSV cases

38 When the Colorado Legislature passed the forensic compliance law in 2008, one reason anonymous reporting was not created was because several law enforcement agencies stated they would not be able to track the evidence kits with the victim's name. At the time of this report, technology and systems had advanced and all responding agencies indicated they could now track evidence kits with a number rather than a name.

were handled varied considerably. A number of respondents indicated the domestic violence investigation took precedence with the victim "losing the right to not report" while the investigation into probable cause on the domestic violence crime was conducted. Other law enforcement respondents stated the sexual assault case had precedence with the victim having the option to not participate, regardless of the domestic violence investigation.

Prosecutors

Respondent Demographics

Figure 39. **Geographic Representation of Respondents** (N=41)

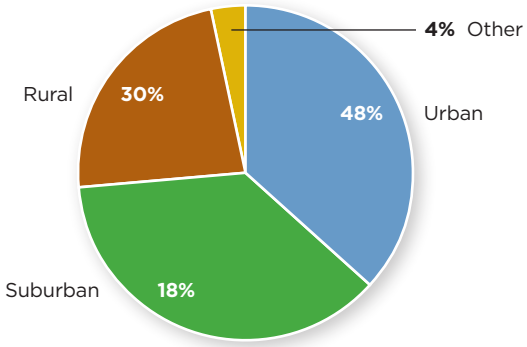


Figure 39 details broad geographic representation of the 41 Prosecutor respondents. Job titles included: district attorney, deputy district attorney, senior and chief deputy district attorney, and assistant district attorney.

Prosecution Challenges – Case Conversion

Prosecutors were asked about challenges that arose when prosecuting cases that began as medical reporting cases but later converted to law enforcement reporting cases. Respondents identified the following challenges:

- The need for jury education regarding rape myths and sexual assault dynamics;
- Victim credibility issues linked to delayed reporting;
- More complicated investigation when evidence is lost due to time delay;
- Diminished witness memory due to the extended time period between the event and prosecution; and
- Providing the defense a “change of motive” argument.

Quote from Survey:

The credibility of the victim would be perhaps lessened in the eyes of the jury if she/he had an intermediary call the police. But that could be balanced against the facts of the assault, relationships involved, etc. A call to police from an intermediary is certainly better than no call at all.

- Prosecutor

Medical Mandated Reporting

Figure 40. **Support for the Medical Mandated Reporting Law by Prosecutors** (N=39)

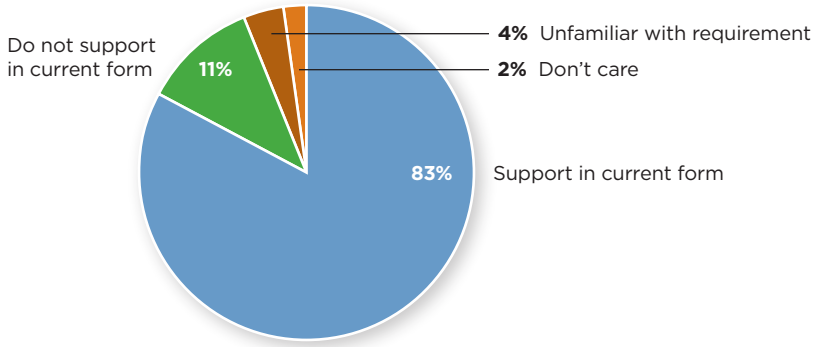


Figure 40 shows the responses by prosecutors to the original medical mandated reporting survey question (see pp. 24-28). Over three-quarters of surveyed prosecutors supported the medical mandated reporting law in its current form. Additional information provided in response to questions about the law included:

Prosecutors supported this law for the following reasons:

- Victim safety: Prosecutors said the law shifts the "blame" for reporting from the victim to the medical professional; and
- Public safety was enhanced because the medical obligation to report notified law enforcement of potential criminal activity, in which the perpetrator may be identified.

Prosecutors who did not support this law were concerned that victims would not get medical care and evidence would not be collected from a medical forensic exam.

Prosecutors identified the following barriers in implementation of the law:

- Offenders sometimes accompanied victims to the hospital;
- Medical personnel wanted to avoid involvement and do not report;
- Lack of education about the law among medical professionals; and
- Uncooperative victims.

With regard to potential statutory revisions, those responding had two suggestions: stronger penalty enforcement for medical professionals to encourage them to report, and enabling victims' names to remain anonymous.

Intimate Partner Sexual Violence (IPSV)

Figure 41. **Intimate Partner Sexual Violence, Perception of Conflict of Laws** (N=34)

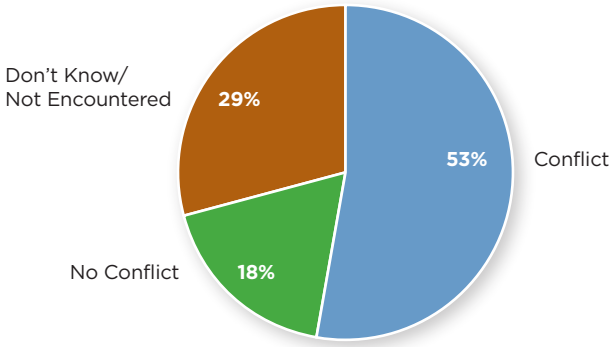


Figure 41 demonstrates that slightly more than half of the prosecutor respondents saw a conflict between the three laws relevant to the response to IPSV (see pp. 36-38). Prosecutors indicated that these cases were handled in a variety of ways with many respondents indicating they would be dealt with on a case-by-case basis. Several noted that the domestic violence charge should have primacy, although a subset of those respondents also indicated they would prosecute the domestic violence charge but not the coinciding sexual assault case. A smaller number of respondents said they would handle IPSV cases as sexual assault cases and not pursue the accompanying domestic violence case.